REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At Orange on 25 March 2004

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Kayee Griffin
The Hon. Greg Pearce
The Hon. Ian West

MARTYN ANDREW PATFIELD, Medical Practitioner, Medical Superintendent and Director of Acute Services, Bloomfield Hospital

JOHN OLIVER HOSKIN, Semi-retired Psychiatrist, former Medical Superintendent, Bloomfield Hospital, and

PAUL EDWARD FANNING, Director, Mental Health Services and Acting Director, Clinical Services, Mid Western Area Mental Health Services, sworn and examined:

CHAIR: I declare the hearing open. I thank all of you for your attendance. I doubt whether we will need to consider going into a confidential session. I know that you have seen the questions that have been prepared and that Merrin has discussed them with you. Are you happy if we commence with questions, or do any of you want to make an opening statement?

Associate Professor FANNING: No.

CHAIR: As I said earlier, you have the questions that have been sent to you and that you have gone through. Some of them might be more relevant to one of you than to the other two. Given the amount of evidence that we have taken so far, we are really anxious to discuss what kind of service system we should have. I guess the hard part of the question is: What do we do? We might try to go through some of the early questions and then we will see whether we can pick your brains to establish what you think the solutions might be. Bloomfield is really important because you are taking people under inebriate orders.

You have people at the moment. We have precise evidence about the numbers, who they are, what happens when you get them and what you find out about them. Would you give us some sort of case study or some examples of those people? How does the system work from your point of view, given that this is one of the few places in the State that has people of this nature? John might want to contribute something as well as it is not that long ago that he was at the hospital. We have heard about cases that occurred 10 years ago, so we are not just dealing with cases that occurred this year.

Dr PATFIELD: I have a list of inebriate admissions for the last 10 years. I can table that list as we have removed all the names. You will I see that in general the numbers have been declining over the last 10 years. Unfortunately, we do not have statistics before that, but you will know that there were many more in past years. We have a breakdown of the numbers. In 1994, for example, there were 20. This year there have been three. It shows two on the list, but we had another one just this week. In preparation for this I had a look again at the files relating to the last 20 admissions here, which goes back to the beginning of 2002. I thought it might be useful generally to categorise roughly what I thought those admissions were about.

I thought that, of the last 20 we had had, 12 of them were about community burnout—basically, people who had had many hospital presentations, who had called for an ambulance on many occasions, who had had police involvement and who were recurrently being brought before the court for public nuisance offences, sometimes for domestic violence, drunkenness, being disorderly and so forth. Communities, in particular, small communities, were heartily sick of it. That eventually led to inebriate orders being made. Of the last 20, about three of them were about someone drinking constantly. There was genuine and heartfelt concern from family members who were desperate to know what to do and who eventually secured an inebriates order.

I thought that five of the 20 were fairly clearly—and sometimes quite cynically—about avoiding the legal consequences of offensive behaviour. Sometimes a solicitor had suggested that the magistrate give an inebriates order fairly clearly instead of a custodial term. Sometimes patients had asked for it. But, because of the circumstances, I thought it was fairly clear what was going on. Ten of those 20 admissions were at least double-ups; in other words, one person had had two inebriate orders in that period—which was 2½ years—and one person had had three. Four of them had had two admissions and one had three.

CHAIR: So we are not talking about 20 individuals?

Dr PATFIELD: We are talking about 20 admissions and about 10 individuals. I know that you are pressed for time. There are a few examples that I have prepared and that I can talk about. One of them is an example of someone who was a particular danger to the hospital. He was a young fellow of about 25 who had had five recent admissions to the hospital under the Mental Health Act—under the 21 (d) provisions—as being mentally disordered. That was usually after violence and agitation, probably as a result of speed or overdoses. He was sent down from a major town in our catchment area always after he had been threatening and aggressive towards people—usually hospital staff.

He was sent down as a 21 (d) and he quickly became quite rational again. As per the requirements of the Act he was discharged very quickly. He had been repeatedly very threatening to hospital staff in the town from which he came. Eventually an inebriates order was secured. This man's drugs were heroin and cocaine. I thought this might be of interest to you because in one of your previous hearings it was said that no inebriates order had been issued other than for alcohol. This man was mainly on heroin and cocaine. He arrived here, absconded the next day from the ward and was returned by police. During his stay there were considerable fears for the safety of one patient, because this fellow was constantly threatening and intimidating him. He made numerous threats to kill staff.

During his stay there was an allegation of sexual assault by a woman who had been admitted six weeks after delivery with post-partum depression. We do not know whether or not he did sexually assault her; we think he probably did. He was dealing in drugs with his associates over the back fence of our special care unit. Eventually, because he was well connected in the town where he had come from, he secured a stay of his inebriates order. Luckily, he went after one week, because we were starting to have industrial problems as he was so dangerous to staff here. After he was discharged the hospital was very heavily criticised by health staff at the referring hospital because they felt that we had not kept him secure enough; therefore, their staff were at risk. But they did not seem to pay much attention to the safety of our staff and patients. It was a very frightening time for us.

Recently we had another fellow. He first turned up at the hospital under section 33 of the Mental Health (Criminal Procedure) Act after a charge of break and enter. He was refused by us and not admitted. The essential diagnosis was an antisocial personality. He turned up four days later under the Inebriates Act for one month. On admission he was extremely angry with the psychiatrist who had seen him a few days previously because he believed that he was mentally ill. In his mind his mental illness seemed to be that he was very angry. He was on methadone. During his stay with us he was drinking and using cannabis on the ward. Generally, he was not a management problem, but very frequently he became demanding.

He was a very entitled sort of person, often expressing his anger that he was not being given a diagnosis of mental illness. In his mind he thought that it would lead to financial assistance. The other thing is that he had two court cases pending. He was hoping that that might be useful. He was discharged on expiry of his order and he returned a couple of months later with another one-week order, apparently with a view to him being seen by the Salvation Army and possibly going into a rehabilitation centre. The rehabilitation centre was on holidays for Christmas and the Salvation Army said that his methadone dose was too high anyway. I mention that because there was a total lack of co-ordination between the court and what was available here. But he was an example of someone who was clearly all tied up with his legal charges and his hopes to get out of that.

The Hon. GREG PEARCE: I refer to the first example that you gave. Was he someone that you would have categorised as being tied up with legal charges in the summary that you gave us? Where would you put him in the summary that you gave us?

Dr PATFIELD: I think there were some legal charges in the background. But, really, he was sent because of community burnout. He was an incredible problem to the hospital, to the police and to the ambulance people. They really did not know what to do. But it was really about locking him up.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How old was the second one?

Dr PATFIELD: The second one was in his late twenties.

The Hon. GREG PEARCE: The second one, in your description, was really avoiding legal issues?

Dr PATFIELD: Yes, and I thought in very calculated way.

The Hon. GREG PEARCE: And he was a multiple order?

Dr PATFIELD: He had two orders. The first one was for a month and the second one was just for a week.

CHAIR: We have heard complaints from the hospital that people arrive basically with no documentation. You obviously know quite a bit about these people, but it sounds as though you pieced it together after their arrival.

Dr PATFIELD: I got a wheelbarrow the other day and took all the files down to my office. So I have been through the files. I am glad that you brought up that issue. I went through 20 cases. When inebriates orders are made there are a few affidavits that support the orders. Generally, we get only the order. Sometimes we do not get even that. Sometimes they just turn up and we have to ring up and say, "Can you send us the order to give us legal authority?" Of the 20 I have been through there was only one where the supporting affidavits had come with the order.

CHAIR: We gather that those supporting orders are pretty minimal from your point of view?

Dr PATFIELD: They are, but at least you get an idea of who has been involved and you are aware of the people that this person worried. But the fact that they are so rarely sent underlines the poor communication between courts and health. It really makes you wonder whether it is about the person's problems. They are just getting them out of sight and sound. They just want to get rid of them and lock them up.

CHAIR: Some of this material that you have put together is fairly unofficial. You have been piecing it together to get a history of the person?

Dr PATFIELD: I guess that is part of the point. In any health setting what you are doing is unofficial. If you are dealing with a health problem. That is what you do in Health. You piece together what the problems are, what the symptoms are and how long it has been going on. It is not evidence as such, but you piece it together. That is what you do in health. It is important to us. It is not the courts that try to piece together what the relationship is with person X and so forth. I would like to get onto that aspect later.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it is not a medical problem is also not a legal problem. There are two models, a health model and a legal model. If a person does not fit in, everybody scratches their head. That is what is happening. We cannot say that drug addiction is simply a legal problem, because it is not.

Dr PATFIELD: One of the problems—it may be part of our age—is that we have only a couple of models. There used to be all sorts of other models; people used to talk about education models, moral models, family models and so on. One of the problems is that we have been looking at this too narrowly as a medical problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that is surely better than looking at it as a legal problem.

Dr PATFIELD: Perhaps, but perhaps we should be looking at many models at the same time. One of the problems is that the magistrates have a very pure medical model and they say this person has a sickness and we will send them to hospital. The magistrates make the diagnosis and prescribe the treatment. We have nothing to do with diagnosis and management plans; we are simply custodial agents.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Most of the treatment they impose is to put people in gaol. The only question is the dose.

CHAIR: We are talking about non-offenders, even though some of these people have legal issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Committee needs a model and then we can talk about resourcing it.

CHAIR: We will deal with that later.

Dr PATFIELD: It is not fair, especially nowadays, to say that the courts deal only with custody. They have all sorts of flexible dispositions, but this is one of the least flexible.

I have an example of a referral because of complex relationship problems that lay behind the drinking and where a forced hospitalisation did not achieve anything. The patient was a 39-year-old man with a long history of alcohol abuse. He had been a policeman and his wife had left him eight years previously because of his drinking and he had limited contact with his ex-wife or his son. He also had a difficult childhood and was living in the same town as his parents, and the relationships were very fraught. He has had 12 admissions here since 1998 under section 21(d) of Mental Health Act. The Mental Health Act allows for two sorts of compulsory admission. One is called "mentally ill", which is essentially for people with psychotic illnesses, such as schizophrenia and bipolar disorder. People are admitted and reviewed by the magistrate within a week, and the magistrate has the power to make orders of two weeks, four weeks and so on.

The point of the admission is for assessment and treatment for a substantive mental illness. When the 1990 Act was enacted there were concerns that some people who were not mentally ill but who were at risk because of a temporary emotional perturbation were missing out. As a result, the “disordered” provisions were enacted. Those situations are frequently the result of a person busting up with a girlfriend, having a few drinks and feeling overwhelmed by despair and suicidal. They are brought to the hospital for a brief admission and the next morning, they are sober and think it through and everything is not so bad and they leave. Our admission rate over the past 15 years has tripled, primarily because of these provisions.

CHAIR: How many orders did this person have?

Dr PATFIELD: He had had 10 since 1998, and two admissions under the Inebriates Act. The Act had been instigated by his mother with whom he had had a very enmeshed, problematic and difficult relationship over many years. He had many other admissions to other psychiatric units around the State, but I do not know the numbers. He placed a huge burden on services, especially the police, ambulances, casualty departments and so on. He had scores of presentations for intoxication. The Guardianship Board made a 12-month order on the basis of his inability to manage himself—he was impulsive, exercised poor judgment and so on. Interestingly, the order was not extended because they had formal psychometric testing and he was extensively assessed. It was determined that he was capable of making decisions for himself. Although there was evidence of frontal lobe damage, it appeared that he was choosing to drink. I think it was a passive aggressive way of getting to his mother, whom he could not stand. That was borne out in the hospital because he was deliberately subverting anything designed to help him. An enormous amount of time was spent trying to set up something for him when he left, but it all fell apart.

Someone asked me before the hearing started about outcomes. We know this guy continued to drink and nothing much was achieved. It seemed that the key to doing something, if anything was possible, was to modify his situation outside hospital, where he was living in proximity to his mother and so on. Of course, we knew that and we had been suggesting things, but we had no power to compel. So things just kept going on.

The final case is a 68-year-old fellow with a long history of alcohol abuse with some frontal lobe damage and gait disturbance as a result of his abuse. He was socially isolated and his concerned son sought the order. Soon after the patient said he was glad. The son liaised well with hospital staff during his stay. Plans were made for appropriate discharge, and the file notes suggest that things have worked out pretty well. I thought I should include a happy story.

CHAIR: On the question of outcomes, to some extent the problem is that you have no real control, no way of knowing.

Dr PATFIELD: Yes. That is built into the thinking behind the Act. It appears that illness equals hospital for a certain time, and then goodbye and keep our fingers crossed. That is a very narrow and inflexible view. These people are not particularly interested in keeping in contact. We provide them with information about follow-up services and make connections. It is part of the nature of the problem that they are not interested in following up.

CHAIR: Does the area health service get involved in making the links with services in the towns that people came from?

Associate Professor FANNING: We do. It is difficult because the catchment is two-thirds of New South Wales. In the more remote communities it is a fairly set picture and the services are not available. These people are going back virtually to nothing. Sometimes there is not even a general practitioner and there are very few community nursing services. Other government agencies, such as the Department of Ageing, Disability and Home Care provide services in major centres that could be hundreds of kilometres away. Trying to develop a comprehensive, cross-departmental management plan is incredibly difficult. It can delay discharge, not only those subject to an inebriate order but also those subject to the Mental Health Act generally.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have a model from a number of inquiries that focuses on de-institutionalising people and having graded community support that is more tailored. That seems to be where the resources in health, disability and welfare ought to go. Is that a good starting point? If so, what alternatives would you see under health, or would you see them coming under some other department?

Associate Professor FANNING: It is a good question and we have given it some thought.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It tends to keep coming up.

CHAIR: Perhaps we can table the material you have prepared. Does that include the case studies?

Dr PATFIELD: I do not have names in my notes.

CHAIR: Does anyone want to add anything to that picture?

Dr HOSKIN: Our catchment stretches from a little west of Moree to Collarenebri, Burke, Wilcannia, Wentworth and Balranald, then on to Cowra and Lithgow. We have formal responsibility for that population of nearly 400,000 people. We have many people coming from Wilcannia. Because of the big numbers coming in I have maintained a relationship with the area over the years. It is one of the war zones of New South Wales. The river towns are all a bit fraught along those lines. At one stage we had six people arrive on one bus one evening.

Dr PATFIELD: Under the Act.

CHAIR: All from Wilcannia?

Dr HOSKIN: Yes.

CHAIR: Was that a police bus?

Dr HOSKIN: No, they just hopped on the bus. They turned up at court themselves. That is when I made contact with the magistrate Sue Schreiner and asked why. She said they turn up in her court and ask to be sent to Bloomfield.

The Hon. GREG PEARCE: What year was that?

Dr HOSKIN: That was 1992.

The Hon. GREG PEARCE: Was that prior to the 20 orders?

Dr HOSKIN: Yes. When I look at the figures I can see that in the past few years there has been a decrease in the number. There were 20 at the beginning over the 10-year period, which is when I was more receptive. Perhaps Martyn told me to go easy. There were six people in the one group from Wilcannia.

CHAIR: They each had an order, but they sought it themselves.

Dr HOSKIN: Magistrate Schreiner told me that was common. The "Catholic underground" was working in Wilcannia. It was also trying to get some help for a community that is submerged in alcohol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I assume that is not an official name.

Dr HOSKIN: No, that is my name for a very effective group of three. We seem to have had quite a few referrals from the Walgett, Lightening Ridge and Collarenebri areas. Sometimes they are under Inebriates Act orders and sometimes under mental health orders, but with the same problems with alcohol and more recently increasing amounts of heroin and amphetamines.

CHAIR: How many of the 20 were Aboriginal people?

Dr PATFIELD: That is marked on the list I have tabled. I think four or five of them were Aboriginal.

Associate Professor FANNING: For the period between 1994 and 2004, there were 124 inebriate admissions. Of them, 43 were Aboriginals.

CHAIR: We may come back to that, because we have had mixed evidence from Aboriginal people about them being culturally more or less inclined to go down that path.

Dr HOSKIN: The Wilcannia Aborigines tend to be young and in much better shape than some of the non-Aboriginal people. They are in their 20s and 30s.

CHAIR: Over the time you are talking about did you have the same problems with people turning up with very little documentation, or has that got worse?

Dr HOSKIN: That is how it was; I did not expect anything. If I had a contact locally I would try to use them to get more information afterwards.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was it the case that people came into psychiatric hospitals for a bit of a drying out period and to build up their bodies a bit and then they went out to drink again? That was certainly the case in the general hospitals working with Dr Harding Burns. They would get in if they could. Indeed, at the base years ago, there was a very Christian doctor there whose name escapes me at the moment, and all the alcoholics used to come in for the days he was on because he would give them admission for a few days.

Dr HOSKIN: Well, I thought that that was our duty, too—to give the best hospitality and food that we could provide and build them up as well as we could.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it was a support function—really, a hostel function—and they came and went in accordance with that function. Nowadays it has been stopped because of the resource considerations and there are fewer beds per thousand population.

Dr HOSKIN: Yes.

CHAIR: Not necessarily. The GP who spoke to us yesterday spoke about admissions to small country hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But he is in a fairly exceptional situation, really.

CHAIR: That may be. You people might know better than we do, I guess.

Associate Professor FANNING: Historically—I can go back 30 years here and I note that on that issue you have asked for a brief historical overview—the ward next to this room, that was an inebriates ward. When I first came here there were up to 90 people who were mostly under inebriates orders, with a high Aboriginal population. They were brought here from all over New South Wales and sometimes from Canberra as well. They were a very difficult group of people to manage. They were primarily males, not so many females. In that group there was a spectrum of people who were relatively mentally intact: There were also people who were severely brain damaged with Korsakov psychosis who ended up going into our other wards here until they died because there was nowhere else for those people to go. These days we do not see that level of Korsakov psychosis in the community any more.

I know that John Hoskin has a view on this as well, but there are several reasons why that happened. One that you alluded to was the downsizing of psychiatric hospitals, so there simply were not the resources here any more as we devolved resources into the community to take large numbers of people who primarily suffered from alcoholism. The second issue was that policy changed. Mental health, which used to own alcohol and other drug [A and OD] services in New South Wales, suffered a split in the 1980s and A and OD moved out, as you are aware, into its own department today this is the New South Wales Drug Programs Bureau. So whose responsibility were they? Earlier you alluded to the issue of where these people fall and the various models that are used in terms of servicing their needs. The combination of downsizing, the change in policy and the point that Martyn made is really important, I think, in relation to the 1990 Act.

While I have not looked at it closely, it seems to me that the mentally disordered provisions of the Act became very important in getting people into treatment for short bursts. People who were temporarily unwell and who required care, treatment and control and whose behaviour was so irrational that they needed treatment came in under the mentally disordered provisions. As pointed out, our admissions here have tripled over the past 12 or 13 years. A lot of it has been around this mentally disordered group. They come in; they are on various substances. In some cases they needed detoxification and frequently there is a history of alcohol and drug problem, so de facto the mentally disordered provisions, I believe, are looking after this group, not the Korsakov group we were getting before. So the Inebriates Act is not used for that purpose any more.

CHAIR: Does that also mean that that provision is, in the sense, reinventing the wheel and going back to perhaps more like 30 years ago whereby people affected by alcohol and drugs are now in fact coming in under the Mental Health Act so that alcohol, for instance, is back under the Mental Health Act in an indirect sort of way?

Associate Professor FANNING: I think so. The Mental Health Act, though, specifies that simply because somebody uses alcohol and other drugs alone, they should not be compelled into treatment.

CHAIR: But I mean, that mentally disordered definition comes into it.

Associate Professor FANNING: It is a behavioural question, so when their behaviour is so irrational as to require care, treatment and control; they tend to come here. The difference is that before, when you would see people under inebriates orders for three months, six months and even 12 months—sometimes very long orders—the mentally disordered provisions actually restricted the amount of time that a person can be here. So the medical superintendent under the Act or a delegate can actually authorise three or four periods of treatment for 72 hours as a maximum and then that person must be discharged. What you do basically is you get them over the hump. You stabilise them and they are often incredibly difficult people to manage, and then they go out. Sometimes they bounce and sometimes they do not.

CHAIR: Most of that tripling of admissions and so on of the group you are talking about, are they mostly alcohol affected, drug affected or a mix? Can you put some sort of figure on it?

Dr PATFIELD: I think 80 or 90 per cent of our patients have some element of substance use involved which is relevant to their problems and their presentation. The percentage that are exclusively about drugs and alcohol are much, much smaller than that. I do not know—5 or 10 per cent. You know, I suppose the difficulty is that, even with the cases I was talking about, it is not just about alcohol. It is all a rich conglomeration of all sorts of issues which lead to the problem and the presentation which need to be sorted out.

CHAIR: But also I guess we are trying to establish, particularly, if the group is getting younger and whether it is more likely to be heroin and cocaine or whatever, and whether alcohol has diminished as the major contributor to their problems.

Dr PATFIELD: I think that most substance uses who have problems are using all sorts of substances. You get people who specialise in alcohol and specialise in other drugs [ODs], but most people do a bit of lots of things.

Associate Professor FANNING: I suspect that if we looked at it that what we would find is that there was a slow decline in the 1970s in the number of people on inebriates orders and in the early 1980s there was a more rapid decline in a response to a change in government policy around mental health, alcohol and other drugs services. Then with the advent of the 1990 Mental Health Act, that changed again and there was a further reduction. Consequently you now have a situation today where magistrates have learnt that there are not many places in New South Wales that will happily take people on inebriates orders, although the magistrates that I have met with over the years, like John discussed this issue with, do like to see this as a medical problem, so they are sending people here for treatment. They do not always recognise our incapacity to provide that treatment.

CHAIR: I guess our question about the difficulties that the Act creates for you as administrators also raises the fact that you have not really told us what you do for people we are talking about and the extent to which they do create problems for the other clients that you have here. All of these come under your difficulties as administrators, I guess, so perhaps we could move on to that.

Associate Professor FANNING: I would like Martyn and John to comment on this. The everyday problems for us are that when people come in under inebriates orders we no longer have a large separate unit, so they are integrated into the acute inpatient unit, one of the step-down units to one of the long-term units. They are not a good fit anywhere because once they have dried out, if they need to dry out, some of their personality characteristics lead to situations like Martyn has described, particularly if there are antisocial qualities where they actually take advantage of the patients in the unit. They also, from a clinical point of view, tend to be smarter but they flout the rules so it is often very difficult for nursing staff and medical staff to get compliance.

From time to they will simply run away because they are not in a locked unit. They will leave the hospital or—again alluding to Martyn—they will arrange for substances to be brought in and they will be dealing in substances over the back fence or they will provide substances to other patients. So they are some of the day-to-day issues. That is not just around the inebriates, can I say. Also people under the mentally disordered provisions of the Act—we have problems around that as well. If they are Aboriginal people it creates another set of problems because Aboriginal people do not like coming here anyway. They never have, and so they tend to isolate themselves as much as possible.

CHAIR: Do you say that about here, the Bloomfield Hospital?

Associate Professor FANNING: Yes.

CHAIR: It has got a stigma attached to it?

Associate Professor FANNING: Yes, for Aboriginal people. It is interesting that the further you go west, the higher are the walls around Bloomfield. So for Aboriginal people, coming to Bloomfield is as big a problem now as it was 30 or 40 years ago. The stigma is still greater. They see

it in a way that they are coming in to do time and they are being locked up. They do not see themselves necessarily as coming here for treatment. Generally, after you have detoxified them and they have gone into a routine in our unit, they will settle in, but they will settle in on the basis, not that they have come here to recover from their alcoholism, but that this is time out. They will build up a bit of a bank roll and then they will go out into the community again. In terms of charting the outcomes when they go out, well it is very difficult, as you have already established, for us to actually do it. They are some of the day-to-day problems in managing inebriate patients here for us.

CHAIR: If you have enough inebriates here, would you actually put them in one ward, one unit, one group? Will that not solve the problem? Is it partly a question of the small numbers in trying to mix unlike people with other unlike people?

Dr PATFIELD: I think that is part of the problem, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are creating a mini gaol, are you not?

CHAIR: Would it be easier if you had all of that group we have been talking about together?

Dr PATFIELD: It would be easier, but I am not convinced that we would achieve much.

CHAIR: I guess that is really what I am getting at, yes.

The Hon. GREG PEARCE: Well, you would have done it, I would have thought.

CHAIR: Not if you have only one or two at the time. It makes it difficult, but if you had about 10 or 15 or whatever, you still would not achieve much.

Dr HOSKIN: Well, look Jan, I tried.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did it. You must have had wards full, so what did you do then?

Dr HOSKIN: That ward was full once and because the numbers were so great—I think it got up to 90, and how many people live in there now?

Dr PATFIELD: Sixteen.

Dr HOSKIN: So they went up to the other ward, which is the same size as the current one, and that was when there were 90 to 100 in there. Again I suppose it was mainly keeping the situation under control because you can imagine what, say, 100 fellows who do not particularly want to be there would be like. It could get a bit stiry at times. You would feed them well for a period and then head them back, mainly to Sydney in those days. The time when I am talking about was when there had been big philosophical and program changes around, say, 1980 because the big changes around 1980 were the civil liberties movement that was behind the changes to the Mental Health Act and, I think the Inebriates Act was probably all ready to be rolled in 1983, and there were program shifts.

There was uncertainty about whether mental hospitals would provide that kind of service. I was here with moderate numbers—and that is like 20 people a year and sometimes more—and I was trying to get some kind of program going. Bloomfield had had a long relationship with Alcoholics Anonymous [AA] and I was trying to foster that kind of relationship still. There were a couple of people from Orange and one man from Blayney who used to come in here regularly and try to give some kind of AA background to people who were here.

At the time that I came back in 1991 I was trying to find some members of staff who were interested in taking it on as being a program—not necessarily one like area health was suggesting or, as Arthur was suggesting, maybe it was mini gaol stuff. I had in mind some kind of program that was operating during the day that could also be supported by AA-type thinking, and I thought maybe that was worth something. But I could not find any staff who were especially keen at that stage to take it on. I think the changes suggested that maybe this was not our business here and we have got other

priorities, and that meant that there were fewer of the male staff particularly who grew up under the other era who wanted to dedicate themselves to it. The man who became our Director of Nursing, Tim Sullivan, carried it as a heavier burden than most.

Associate Professor FANNING: He was amazing.

Dr HOSKIN: In fact he then helped us to negotiate a special arrangement with Lyndon, which was at the end of my time. So I really do not know how the Lyndon program fitted in with our own burdens. In relation to that program, I wonder whether Lyndon's co-operation with mental health services has been helpful.

CHAIR: We will be talking to them this afternoon so we will be able to raise those questions then.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you had those 90 people you must have had a history of the program. Did you just feed them and hope for the best?

Dr HOSKIN: It involved a bit more. A former medical superintendent used to come out four days a week. She would know all the people and she would perform physical examinations to ensure that they were in reasonable physical shape. They became a fairly keen source of information. There is a beautiful golf course here, which helped in part. Some of the building was done by staff members who had a team of patients as assistants behind them. That also included people who were under the Inebriates Act. But that is going back along way—to the 1970s.

Associate Professor FANNING: I should raise a couple of other administrative issues that are important. While the inebriates are relatively small in number, their length of stay tends to be inordinately long. So that blocks beds. You might have people who are mentally ill under the Mental Health Act who are either acute patients or in long-term care. If you look at the length of stay for inebriates you see that it is going to be much longer. The normal length of stay in acute units is about eight days, whereas inebriates can be with us for up to six months.

Dr HOSKIN: I have never seen someone come down with a three-year order, which is what a judge can give.

Associate Professor FANNING: That is a frustration. The next step for us is to try to get a recision. I have had this out with magistrates in the past, going back to the 1980s. As the legislation stands at the moment, the recision must come from the magistrate who gave the order, or that is their view. The magistrates do not want to rescind the order. If they have sent someone here for six months they do not want that person necessarily to be out of here before six months because of this community burnout issue. They believe this is the best place for treatment. We therefore end up chasing magistrates across the State trying to find the one who gave the order. We try to convince him into giving a recision.

When push comes to shove sometimes they co-operate but sometimes they say, "No way. That patient is in the right place." On one occasion John's predecessor and I met with the magistrates and said, "Bloomfield is changing, the world is changing and we no longer have the resources or the facilities to take large numbers of inebriates." They said, "Well that is not a problem for the Attorney General; that is a problem for health. We consider that Bloomfield is the best place for these people to go." Holy smoke, they started sending us more. That taught us a very valuable lesson.

CHAIR: It sounds as though nothing is very rational in the decision to send someone for three months, six months or whatever. It is not based on medical criteria, or on the needs of the person. It appears to be a bit random.

Dr PATFIELD: I have thought about that. Generally, in the cases that I was looking at, the longer orders were given commensurate with the degree of problems that people were causing.

CHAIR: For the family or the community?

Dr PATFIELD: For the community. If they were causing big problems they would get a big order.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the cost every year of keeping people in this hospital?

Dr PATFIELD: It would be the same as the cost for housing a patient.

Associate Professor FANNING: For an acute patient it works out at around $400 a day. When you are in an acute unit it costs $400 a day. In non-acute areas it costs about $270 a day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Patfield referred to 20 case studies. It appears as though those people caused as much trouble as offenders would cause.

Dr HOSKIN: They are not necessarily non-offenders. Magistrates believe that they appropriately have carriage of this matter. Under the Act those people might be carrying out misdemeanours that are related to drugs and alcohol.

CHAIR: Martyn, you probably dealt largely with question No. 4 when you referred earlier to your case studies. We need to get on the record your views about compulsory treatment. We will then deal with the service system that you recommend. Could we get your views on those issues? Do we, as a community, have the right to order compulsory treatment? If so, apart from the need for safeguards, why do we have the right to do it? Is it to save a life or to protect the community from intolerable behaviour? What sorts of comments would you make about those issues?

Dr PATFIELD: I could take a radical, libertarian view and say, "Each to his own. Let us not worry about it; it is their business." In a way that is a sort of Thatcherite view. I do not think that is reasonable because I think societies exist and we have to look after people who seem not to be making the right choices. There has been a lot of discussion in past hearings about whether we are dealing with an illness. Lots of analogies are drawn with mental illness. Mental illness, in itself, is an analogy of physical illness. I suppose compulsory treatment and mental illness are justified because there is a view that people are behaving and making choices temporarily because of a failure of function—a disability that can be treated—and that they can be returned to a position where they can make choices for themselves.

The Mental Health Act quite properly is predicated on the view that something beneficial can be done during that period of treatment. That is one reason why at the moment the Inebriates Act is unethical. People are put in for long periods when everybody is saying, "There ain't anything useful being done here." It really becomes a little like Soviet psychiatry. We are using psychiatric hospitals to keep people locked up. I do not believe that is ethical. In some ways it is a little distracting to get into an argument about whether or not this is an illness. I know that it is an important question, but there are strong views on either side. Maybe it would be more useful to think about the person. I know you were talking to Stephen Jurd who was talking about the severity of damage and the length of time.

If you have people who are causing significant damage to themselves or to others for an extended period of time and it seems as though they are sort of stuck, you hope that you can take them out of that and restore them to a position. You want to know that they are making these choices and that they were the choices they wanted to make. They did not make those choices because they were so clouded because of alcohol or they had been a bit knocked off in their frontal lobe and so forth. If you provide them with that opportunity and they were able to make that choice I believe that is ethically justifiable because we are a society; we are not individuals. But you have to be careful.

One of the things about the Mental Health Act is that it is a carefully worded document. The reason you have to be careful is that I do not think, for example, the people who formed the 1990 Act really believed we would have so many 21(d) cases. One of the risks of the new Inebriates Act is that the numbers will just burgeon. There would have to be burgeoning numbers, so I think there have to be clear safeguards and definitions. With respect to the question of illness, it is interesting that the Mental Health Act never mentions diagnoses. It does not mention schizophrenia or bipolar disorder. It mentions mental illness, which it defines in operational terms. It states, "This person has either

hallucinations, delusions, severe disorder of thought, or severe abnormality of mood, which leads to significant risk of harm."

If you were going to have an Inebriates Act you could do the same thing. You could get away from this question of illness, which I know is strongly in the mind of magistrates and in the minds of the community. But I do not think it is particularly helpful. You could have a behavioural approach. You could say to the person, "We have these affidavits here. These people are saying, "You are destroying your family, you are destroying your health and it seems to us that you are not actually thinking about this clearly. We therefore believe that we, as a society, need compulsorily to take you aside and make you think about it at least." I am now sort of stretching into question No. 6, if you will allow me to do so.

One of the problems is that as well as being locked into an illness model people are locked into a hospital model. If it were reasonable for a magistrate to say, "There is this evidence, behaviourally, of damage over a long period of time", and the magistrate then went on to make an order, the order should not be, "Go there and stay for six months", because that really does not achieve anything. The magistrate is not the person who has the skill or the ability to do a full assessment. If the magistrate were to say, "I am making this order and it requires you to be assessed by this group of people", they could see the inebriate either as an inpatient or as an outpatient and write back to the magistrate and say, "These things might be helpful."

With respect to the case histories that I gave earlier, it would be great if one fellow could be told, "You cannot live in the same town as your mother." You could say to another person, for example, "You are spending all your money. We are going to insist that you have a Protected Estates Order." Those orders are readily available; we use them all the time under the Mental Health Act. We would then say, "The principal executive officer will require a certain amount of money to come out for rent. We have sorted it out with a cafe that you get one meal a day." We have done that under a protected estates order. We once had a deal with the Wattle Cafe in Forbes to give one guy lunch every day. You can do it.

These technological things are coming in.

Dr HOSKIN: I have discussed this issue. I think it is really good stuff.

Dr PATFIELD: Another technological development that is coming in is something called a CDT—carbohydrate deficient transferrin—a blood test that allegedly can tell you whether a person has had any alcohol in the last three or four weeks. I understand that the science is a bit wobbly and that there are a few too many false positives and false negatives. But I think they are getting close. What I am saying is that if that test works—and I think it is close—the magistrate could say, "You are not allowed to drink. We are going to do these tests every two weeks. If you are positive I will have you back here. I have got some more cards up my sleeve that I can pull out."

The magistrate could make an order about accommodation, or about partaking in a residential alcohol program. There are voluntary alcohol programs around the place run by GROW, the Salvation Army and all sorts of other non-government organisations. I think the assessment team should say, "We have talked to this guy. We have looked at the family background. Your Worship, we think that these things are a good idea. If you think it is legally okay, we think you should require these." Or, more simply, the magistrate could say to the inebriate, "You have to do what the treatment team says."

Very often the treatment team would get to the point at which it might have to write back to the magistrate and say, "Listen, this guy is hopeless. We have tried everything and nothing works." That also happens under the Mental Health Act. If treatment was not working, they could be discharged. It is frustrating that the magistrate makes the diagnosis and prescribes the treatment and we have to have them for six months in a facility. There is no need to think in hospital models.

At the end of the day, if we have a hard case and we have tried everything in the community—we are talking about a long-term problem—and it has not worked, if we had one 30-bed unit in the State, like John's old lockable 30-bed unit with specific programs for the hard cases, we might reach that stage. This is an elective admission. At the moment these people arrive in a fashion of urgency. The magistrate sees them and sends them down. They are usually intoxicated when they

arrive. There is no need to respond like that; there should be a graduated response. If it is not working, the magistrate, in liaison with the treatment team, might say that the person needs six months out. However, he or she walked out of a voluntary unit so the next step is a locked unit. That would be an ultra filtrate. Importantly for the development of services, we are not talking about a lot of money—we are talking about one unit, not many around the State.

The Hon. GREG PEARCE: It sounds like the drug court model.

Dr PATFIELD: Yes.

The Hon. GREG PEARCE: If so, would it be better to have an alcohol and drug court rather than leave this with the magistrates? The problem with that, given the number of cases, the assessments and so on, is the resources involved in each individual magistrate being able to use this tool.

Dr PATFIELD: I do not want the magistrate to do a lot of work. I want the magistrate to say that a person has transgressed the limits of his or her community and the next step is compulsory assessment. An assessment team in Dubbo does not need specific inebriates' beds. It might need the authority of the magistrate to require that a person go to Dubbo Hospital for detoxification to get some sense out of him and talk to him properly. Then the team can recommend this, that or the other. All the magistrate has to know is that what is being suggested is within legal bounds—what the law finds acceptable. That is what our magistrate does under the Mental Health Act.

CHAIR: You would not need a specialised magistracy.

Dr PATFIELD: I do not believe so.

The Hon. IAN WEST: When you go from the initial behavioural and factual issue, which is a judicial issue of fact, you then refer it to the assessment team and the team comes up with a medical management plan. How do you then localise it to ensure the individual's mobility so you can follow the outcome?

Dr PATFIELD: One of the points is that drug and alcohol services are area based. The drug and alcohol team in Dubbo will know the services that are available and what is feasible for that person in that area. They are in Dubbo and will be able to follow up. That is what they are there for.

The Hon. IAN WEST: The assessment team would be able to say whether a person was not playing ball and refer the case back to the magistrate.

Dr PATFIELD: It is important. I know that the Committee has been very concerned not to turn non-offenders into offenders. We are talking about people repeatedly, over a long time, seriously transgressing what the community sees as acceptable behaviour. No-one wants to put people in gaol, but increasing sanctions can be applied to contain people's behaviour. That is part of treatment for a condition that has a huge behavioural component.

The Hon. IAN WEST: Could general practitioners play a role in the assessment team?

Dr PATFIELD: Sure. There would be the director of the local agency for the statutory region. Someone would have to be given the power to undertake the assessment. However, that person, because he is a local, would be indemnified to exchange information with a GP, the family and the probation and parole agency and come up with sensible, individualised and flexible plan for this person. The Inebriates Act does not do that.

The Hon. GREG PEARCE: How do you think this could be initiated? One of the things troubling me is that it seems to be self initiated, family initiated or solicitor initiated in some cases. There is no consistency. A few people see that it is available and for various reasons, some of which are not necessarily pure, take advantage of it. You have expressed concern that if there were a new system the numbers would increase. That is fairly self evident if people have this initiation process.

Dr PATFIELD: I guess it might be initiated in the same way as it is now. Families are concerned. We have a lot of inquiries about the Inebriates Act. To be honest, I try to hose them down because I do not think it is very valuable. There are many families, police officers and hospitals who are concerned about continuing damaging behaviour on the part of individuals.

The Hon. GREG PEARCE: I am focusing on process. How do you get the issue before a magistrate? It has to come to the attention of the police. There must be a process.

Dr PATFIELD: Any of those groups would approach the magistrate and say, "We would like you to consider this person as an inebriate." It is not the magistrate's job to make the diagnosis but to consider whether there is adequate evidence to support his taking the grave step of infringing this person's liberty by requiring an assessment. That is all the magistrate has to do. It is a legal decision about the limits of community tolerance and reasonable behaviour.

CHAIR: Unless you went down the drug court path, you would need a fair amount of training for the magistrates. Magistrates have a very different understanding of the Act and how it works. I assume you have experience with one magistrate who is easy to deal with and one who is not.

Dr PATFIELD: It might need to be regionalised. You might need five magistrates in the State specialising in the area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It appears that the drug court model would be better. Your model seems to involve the treatment team working it out and the magistrate giving it the force of law. The problem is that you then give the treatment team the idea that it has a fist that it can bring in when it is required. It is a problem with assertive case management and this is the ultimate. Community-based workers cannot find the people to give assertive treatment. They would spend their time chasing people.

Dr PATFIELD: We have community treatment orders under the Mental Health Act that sometimes do not work. Basically, if a person does not want to play and goes underground, it does not work and we cannot do it. The information is fed back to the magistrate that we have tried, this person is deliberately sabotaging, it will not work this way and perhaps we need to consider the next step, such as my proposed specialist a unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The civil libertarians will be concerned about assertive treatment.

Dr PATFIELD: They should be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The community treatment team might make suggestions about rent, food and so on being provided and impose conditions about residence, bills being taken care of and the individual having a small surplus of capital. However, the worry is that the person will use Metho rather than alcohol. The plan would be worked out and the power would come from the court rather than from the treatment team. If the power comes from the court, the treatment team is off the hook because it is not the compulsion unit.

Dr PATFIELD: I am not proposing that treatment teams be the policemen. The plan it has proposed has been put to the magistrate and he thinks it is reasonable that it have his authority behind it.

CHAIR: Would you build in an appeal mechanism, just like that in the Mental Health Act?

Dr PATFIELD: Sure, but it must be time limited. Orders under the Mental Health Act are time limited. When we ask for an order from a magistrate here there is an implicit understanding between us and the magistrate that the duration of the order reflects the difficulty of the problem and the treatment must require that timeframe. Everything is done according to the needs in the situation. So, if a person were brought before the magistrate, there was a real problem, an order was issued, an assessment undertaken and a program put in place. If it worked, the order would lapse after three months. If it was not working, it might need to be continued.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The difference you are proposing is that the inebriates order be negotiated with the treatment providers rather than imposed, and it would not necessarily be hospital based.

Dr PATFIELD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are asking for two significant changes. First, that the mental health drug court model should be negotiated between the treatment team and presumably through an adversarial legal process to ensure civil liberties are protected and the power being with the court rather than the treatment team recommendation being rubber stamped.

Dr PATFIELD: It must be flexible. If we are proposing that this person has some sort of condition, any condition in any branch of medicine needs an assessment in respect of the effect it is having on the individual and appropriate treatment should be offered. At the moment it is ham-fisted. We are talking about a group of people for whom compulsion must have some role perhaps for a short time. The magistrate's role is to protect civil liberties and to ensure there are not maverick drug and alcohol treatments involving people being tied to a tree for six months.

The Hon. KAYEE GRIFFIN: The Committee heard a lot of evidence yesterday, and I think Paul mentioned the issue, about rural communities and the fact that some of the expertise you would need would not necessarily exist in these small towns. How do you see the proposal working with some of those difficulties in relation to travel and the fact that some towns have no doctor? If you had a team working with someone under a magistrate's order, how would you see it working?

Dr PATFIELD: It is difficult and we have problems maintaining mental health teams in isolated places. The simple answer that gets me off the hook is to say whichever is the drug and alcohol authority it would be its job to provide treatment. It would be hard in very small towns. It must be regionalised.

The Hon. KAYEE GRIFFIN: It was stated yesterday that in order for people from the drug and alcohol agencies to visit some of these remote towns they must do a lot of travel. Obviously the complaint from the people using the services is that the workers are not there for very long periods.

Dr PATFIELD: It is all about flexibility. In those situations the distance problems come into it. One might opt for enforced residential placement earlier rather than later. We have that now. If we get someone sent from Broken Hill for treatment, we sit on them a bit longer than someone from Orange. If we discharge someone from Orange and the wheels fall off it is not such a big deal because they will come back in a week and we can pick up the pieces. But when someone from Broken Hill is discharged and the wheels fall off in Broken Hill, it is a major problem. It involves another flight down and all that sort of stuff, and, you know, it is all about a flexible response for this person in his location, with his set of problems.

The Hon. IAN WEST: Part of the assessment team, I assume, would be that once you have made an assessment you then have to determine how you run through to the outcome. The assessment part of it would be at a regional level?

Dr PATFIELD: Yes.

The Hon. IAN WEST: But the ongoing program of implementing the program and determining the outcome of the program will have to be at a localised level in the regional and far remote areas.

Dr PATFIELD: Yes.

The Hon. IAN WEST: I assume that you would have to be pretty innovative about how you implement videoconferencing and having community service support groups out in the local community, the family and the GP.

Dr PATFIELD: We have got a great mental health worker who runs around the north of the State, and he has great links with a GP here and the local community nurse there, and he keeps tabs on

people by these contacts. I suppose one of the problems at the moment is that the drug and alcohol services do not have the degree of resources that we do, and Paul will be able to speak much more eloquently about this than I, but I guess it is possible that if drug and alcohol comes in again with mental health, they might have more resources.

Associate Professor FANNING: Yes, that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There seems to be a big reluctance on the part of both subcultures to be amalgamated. Some other groups are telling us that groups with a dual diagnosis for mental health and substance abuse problems are hugely growing. I am always trying to get my head around that if you go with separate models and have drug and alcohol and mental health separately, what would you do about that interface? Wherever there is interface, there is a mess in general in bureaucratic structural or societal terms, I would say. When you talk about mental retardation or mental illness, even between health and education in children, you have got these muddled areas.

Associate Professor FANNING: That is right. I think Kayee's point is a very good one. We struggle to do it in mental health because of a vast catchment area, and even sometimes when we have the resources we cannot recruit the staff who are prepared to work in those centres. Then we have consultants from way out west saying, "I am going under out here and the last GP has left the town, so start sending registrars out to support me or I am going to go." I think that Martyn's model is a very good model. How you implement it in rural and remote areas will require a fair amount of thinking and a fair amount of innovation.

CHAIR: You would virtually have to have a cross-agency approach.

Associate Professor FANNING: It would be essential.

CHAIR: You would have to mix mental health and drug and alcohol because there are not enough people for each to specialise.

Associate Professor FANNING: Yes, and there are housing issues and probation and parole sometimes. But the other point I would like to make about where the ultrafiltrate goes is that I think there would be an enormous reaction from rural people and families if, wherever this one centre was—if it was on the coast and you were sending people from the plains country to Rozelle hospital or something like that, it would not be an issue just for Kooris; it would be an issue for communities generally. It would be seen as an enormous step backwards. In 1989 the Barclay commission recommended that there be only two or three major psychiatric centres for this State and there was a tremendous outcry from rural people because there would not have been anywhere in the rural areas for these people to go. When you find a point that is geographically central for all rural and regional referrals to go, I do not know how easy that is going to be or how acceptable; but I do know that if there is one centre in the State and that centre is based in Sydney, there will be problems.

CHAIR: I think Martyn was suggesting perhaps only one centre for that section, that residential-based unit for when everything else has failed.

Dr PATFIELD: Well, maybe I should have said one or two for the State. For those ultrafiltrate, maybe we could have one in Sydney and one in Orange—or a rural base, anyway.

CHAIR: That assessment is happening all over the place.

Dr PATFIELD: That would be localised, yes.

The Hon. GREG PEARCE: The model or approach that Martyn is suggesting certainly has some appeal. The resources issue is I think is a follow-on from agreeing on the approach to these issues. I was going to ask Paul and John to comment on the model or the approach that you are taking. I wondered whether John wanted to add anything.

Dr HOSKIN: I was trying to slow Martyn down. I suppose I thought you were concerned about the ethical basis of it and I have been through some of this with Martyn. I am very much behind

his idea of where you move in terms of possible legislation. It sounded to me as if it was almost closely modelled on the Mental Health Act. In fact, you are giving the local magistrate a bigger part, but it is following very closely on the Mental Health Act. Coming back to the ethics, I thought you might have been interested in holding it there for a while. I think that the ethical kind of questions of how much society bears in on people—Martyn says it is a civil libertarian one—but that was hottest, in terms of my experience, in about the 1980s when the Mental Health Act was rewritten, probably fairly disastrously. But there was a big push and I think the Inebriates Act was going to be rescinded at that time. That was when that argument on liberties was really hot.

I personally have not got any problems about the ethical basis of what does society do about someone who is really destroying themselves and other people close to them. I really think there has to be some societal response to that. When you come down to substances including alcohol, it is such a big thing in our community now that I would have thought there is some point in having a specialised response to the damage that comes out of that area. I would be more than happy with the kinds of things that Martyn is just trying to outline related to the Mental Health Act.

I think the local magistrate would not want to let it go. I think they would want some kind of leverage on antisocial behaviour which was largely substance related. I think they would want to have a go at each, to protect their community and to protect that person. I think that is one of the reasons why the Inebriates Act has stayed in place—because there is some usefulness in it—but I think it does need to be redone, maybe according to the Mental Health Act or something else. But then I think that in coming down to how to be effective, really that is tough stuff. Resources is one issue and whether you can spread the resources out into the community, Kayee, I think that is tough. I think this area in the central west has done incredibly well in relation to mental health. For whatever reason, it has done well.

The Hon. GREG PEARCE: Coming back to the ethical question, that is why I was asking the question about how it gets investigated. It is a very subjective area about how much damage people are doing by substance abuse and it really needs to be thought through very carefully about what the initiating process is and if you are going to broaden it out essentially the way the model does. You may have quite a debate.

Dr PATFIELD: But the Mental Health Act at the moment has phrases like "serious risk of harm", which is subjective too. Somehow or other there is a culture that has developed around what that means, what the thresholds are.

CHAIR: That worries me a bit about your model because it sounds as if it could easily be considerably net widening, particularly if it is fairly decentralised and you have got magistrates and teams and perhaps the sort of pressure groups we have been referring to from families and the community. You could suddenly have a whole lot more people being brought into it. That would also mean, getting back to the ethical question, particularly if you are dealing with teams that have not for instance learned to work under something as tight as the Mental Health Act, you might end up with compulsion being applied to people who previously no-one would ever have thought of applying compulsion to.

Dr PATFIELD: I totally agree. It is a big risk, and any Act would have to be very carefully worded.

CHAIR: But the magistrates and the assessment teams and so on would need a fairly strict planning regime.

Dr PATFIELD: In the Mental Health Act there are all these pregnant phrases which are always hanging around us like "least restrictive environment", and things like this that are part of the culture. As I say, I think the pregnant phrases in the Inebriates Act would have to be things like "an extended period of time" and "very significant damage" and "with no apparent regard to personal best interests", and so forth. Phrases like that would have to be in the mind very centrally of those who were dealing with it. I guess there would have to be a review, like when the current Mental Health Act was introduced. There was a review process and it would have to be reviewed. I would be very concerned about us creating another section 21 (1) (d), yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you be willing to suggest some wordings?

Dr PATFIELD: Not really. Not right now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When we suggest that amendment, we write it in our words, what type of amendment we want and then we give that to the parliamentary draftsman and turn it into laws, which is obviously very complex and has models and so on. But you simply write down the key elements of what you want as the model. It is a big job.

CHAIR: Merrin can probably look into that and look at the transcript too.

Dr PATFIELD: I am sure that lots of people would have a go at that, but I think the question that the Chair has raised is a very important one. I have to deal with these people probably more than anyone else in the State on a day-to-day basis, and I do not want to see more of them in the non-productive way that I see them at the moment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that the section 21Ds are not being productive?

Dr PATFIELD: No, I am talking about the Inebriates Act. I can easily imagine that there are scores or hundreds of people out there who are very concerned about these people and who would want the threshold brought lower, thereby expanding the numbers, so I think any proposed Act needs to be aware of that.

CHAIR: The other thing that struck me when we were talking this morning about the net widening is that if you see, say, alcohol dependence as something of a continuum, and the group we are talking about is at the very severe end and there has been an earlier period when this was not quite so severe, some people say that if we had a better network of community and support service of all kinds, maybe people would not get to that very severe end. But I guess the other side of that is if you should intervene earlier, it raises again the question of how severely do you intervene, how much compulsion do you use, and how much in the way of teams and so on.

Dr PATFIELD: Yes.

CHAIR: I want to get on the record an answer to this. Broadly speaking you think that the main framework that the Mental Health Act contains is a suitable one for dealing with the inebriates but that you actually think that it should be a separate Act. Is that it?

Dr PATFIELD: I certainly think that because I suppose I am very frightened that there will be some sort of cobbled-together amendment which would just mean that all these people come straight into psychiatric services again. I think it really needs to be thought out afresh.

CHAIR: So the Mental Health Act for one group and some sort of legislation which focuses on drug and alcohol services?

Dr PATFIELD: I think the community wants an Inebriates Act or a drug and alcohol Act of some sort.

CHAIR: But in terms of the processes and the safeguards and so on, the Mental Health Act is a reasonable proposition?

Dr PATFIELD: I must admit I would rather have a separate one because it would force legislators to really think afresh.

CHAIR: You might have answered our last question: What would you like to see come out of this inquiry? Martin probably has, but I do not know whether Paul or John would want to add any comments to round things off?

Associate Professor FANNING: We have had a long discussion with Martyn about the model that he has proposed generally. We are all in agreement with it. On the issue relating to Aboriginal people, they currently make up a large proportion of referrals. I suspect that any new system would generate more referrals, both in mental health and in Alcohol and Other Drug Services. Despite everybody's best efforts I do not think that the treatment and rehabilitation models that we have been using are all that effective for Koori people. What we are thinking in mental health at the moment is that we have to create better relationships with the Aboriginal Medical Service, which is in a fledgling state at the moment, but it is growing in western New South Wales.

In any community treatment program, from the point of view of community assessment for Koori people, I strongly recommend that you look at the Aboriginal Medical Service. It has probably already given evidence to see whether it can be brought into this process in a much stronger way than it is at the moment. For example, in this area we have six dedicated Aboriginal mental health workers who have been mainstreamed and integrated with our adult mental health teams. That has been good in many respects. What the indigenous workers are now saying to us is that in relation to culturally acceptable community issues, it would be better if we were part of the Aboriginal Medical Service.

We believe that we would be more effective if we were part of that organisation, particularly when we are working in rural and remote areas, as opposed to the way we are working at the moment. When you are looking at community treatment, or at issues relating to community treatment, some sort of consultation with the Aboriginal Medical Service would be important. I think you will find increasingly that, as it is becoming more acceptable and better known, more Aboriginal people with alcohol and drug problems are being referred to it. It would have had contact with a lot of these people and it would know about them and their families. Bringing Aboriginal people from 1,000 kilometres away—an 11-hour trip in the back of an ambulance or a police car—to spend six months at Bloomfield does not do a lot of good. In some cases I believe that it does more harm.

CHAIR: Is there anything that you want to add, John?

Dr HOSKIN: The future belongs to these fellows more than it does to me. If you are going to look at something that is a redo of the Inebriates Act, particularly if it is along the lines that Martyn was suggesting, the drug and alcohol directorate needs to be resourced differently. I cannot imagine at this stage that it has any ability to relate to the Mental Health Act, or to something such as Martyn is proposing. I do not know whether it has any experience in running back-up units—an institutional facility or a hospital—to back up whatever is happening as a result of community treatment orders. I am in favour of this, so I am wondering how you could put some muscle behind it to ensure that it is relevant to all communities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would it be fair to say that there is a seismic or paradigm shift in disease frequencies and their significance? Drugs and alcohol is now becoming a much bigger speciality than it was.

Dr HOSKIN: I am sure it is bigger than it was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Generally, the resourcing system works on an historic basis. Whenever there is a big change in disease prevalence it takes quite a few years for the resourcing to catch up. The fact that we are having this inquiry and the fact that the specialities are being created by some of the colleges reflects that. That might be the direction in which we have to go. Perhaps the Committee has to take that into account when it is writing its report.

Dr HOSKIN: Epidemiology might be taking over. I am thinking about some of the simple parts of resourcing the service, which might relate to legislation. I think drugs and alcohol might be better back with mental health services, for the reasons you were raising earlier.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you remember how poorly resourced mental health was?

Dr HOSKIN: For the reasons that you were raising earlier.

CHAIR: About overlaps and dual diagnoses?

Dr HOSKIN: There are big overlaps. I checked on, say, 100 consecutive admissions. Forty-two of them were using drugs and alcohol at a level that would damage their health. One hundred people were being admitted here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that the overlap is big.

Dr HOSKIN: Seven years ago there would have been 42 of the 100 admissions where drugs and alcohol was a major contributor. I suspect that that figure is bigger now.

CHAIR: The figure you quoted—42 out of 100—relates to seven years ago?

Dr HOSKIN: It was 42 out of 100 consecutive admissions. I suspect that that figure is bigger now. It is increasingly important to deal with drugs and alcohol as part of mental health. If you are going to have separate legislation—I support that view of having separate legislation—it would be mainly so that you can get the message across to magistrates that people in these communities are messing up their lives. The magistrate can make a decision on behavioural grounds.

CHAIR: But you cannot totally separate drugs and alcohol from mental health.

Dr HOSKIN: I think they are in there together. I would tend to say that, at a departmental level, there is some sense in saying, "Get stuck into it."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There has been much discussion about whether drugs and alcohol should be separate from mental health. A lot of people are saying that it should be separate. However, the problems are very different.

Dr HOSKIN: Some might be different. If you are saying, "In this area we are looking at behavioural issues", it might not be defined but it clearly relates to the untidy behaviour of your neighbour. He is destroying himself and his family.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are both untidy behaviours.

Dr HOSKIN: At the behavioural level keep it behavioural. Put the services in together. I do not have problem with any ethical issues.

Associate Professor FANNING: The last question related to Alcohol and Other Drug Services generally. Psychiatry used to own alcohol and other drugs in Australia. I lived through that period. In a lot of respects it was easier because people fall through the cracks now more than they ever did before. So it is often an ideological argument as opposed to a service argument as to where is the conflict. There are a lot of models to consider. If that model were picked up and Alcohol and Other Drug Services and mental health were separate and continue to be separate, whose responsibility would it be to make sure that these assessment teams and the community treatment and rehabilitation teams worked together and organised the management plans?

Who would be responsible for running the specialist unit? Would it be Alcohol and Other Drug Services, or would it be mental health services? All these units are gazetted under the Mental Health Act and they are our responsibility. But I think that needs to be clearly established right up front. I doubt at the moment that Alcohol and Other Drug Services has the resources—financial or human—to implement that model.

CHAIR: Do you think that someone would solve this problem by carving off another section of Bloomfield, as happened with disability services many years ago? Existing complexes were carved up into two complexes.

Associate Professor FANNING: We are seeing it in other ways. With that example it is a weekly occurrence. We are dealing with people who are developmentally delayed and behaviourally disordered. Other departments do not want to have anything to do with them. They do not neatly fit our criteria from a clinical or legislative point of view. Alcohol and Other Drug Services, by default,

through the mental disorder provisions for this group, continue to hit us. So it is bit of a furphy that Alcohol and Other Drug Services is looking after the bulk of the problems. I think a lot of the problems are still being looked after by mental health, by default. This problem could be handed back to us.

CHAIR: You have had experience with Bloomfield and Riverside which have had similar problems of overlaps, definitions, resources and so on over the past 20 years. Thank you for ensuring that we pay much more attention to the future. It has come at a good point in our inquiry as we have talked to many people in many places. Thank you for attending before this Committee.

(**The witnesses withdrew**)

DEIDRE KILLEN, Co-ordinator, Alcohol and Other Drugs Program, Mid Western Area Health Service,

KIM LEWIS, Alcohol and Other Drugs Project Worker, Mid Western Area Health Service, and

CHRISTINE McINNES, Program Director, Lyndon Withdrawal Unit, affirmed and examined:

CHAIR: Thank you for coming, particularly from [Town X]. Do you wish to make an opening statement before we start?

Ms KILLEN: No.

CHAIR: The first question asks each of you to give the Committee information about what you do and your broader experience.

Ms KILLEN: I was a originally a pharmacist. I retrained as a social ecologist and then became involved in the drug and alcohol field about 13 years ago when I was living at Nyngan. I have lived all my adult life in rural and remote locations, including the Northern Territory. I became involved in the drug and alcohol field, working first as a counsellor in remote locations out from Nyngan. Then I was involved in other client work at Dubbo. I then moved into the prevention end of work at Orange. I am now working as the co-ordinator of the program.

Ms LEWIS: I would like to thank the Committee for taking the time to look at the Inebriates Act. I provide drug and alcohol assessments, counselling and referral. I also do case management work with people—inpatients, clients of the community health sector or community members, whether they be the clients, carers, family members or loved ones. I support generalist workers in the community as well as allied health workers and general practitioners. We help to identify people with drug and alcohol issues and try to implement early intervention. We follow primary health care principles and look at sustainable health promotion, early identification and community development. We participate in client case reviews and case management, whether they are in-service at places like this or with the Department of Community Services. When I say "like this" I mean a mental health facility.

We contribute to reducing harm associated with the use of drugs and alcohol in line with national, State and area policies. We try to implement capacity building to educate other workers in the health and welfare sector to help them deal with people with drug and alcohol issues. My experience is relatively new; I have been a drug and alcohol worker with the health service for three years. Prior to that I had seven years in the health and welfare sector, always in [Town X]—a small community of about 19,500 people.

Ms McINNES: I was a generalist nurse before becoming a psychiatric nurse some 20 years ago. After a few years I moved over to community mental health, which was still responsible for drug and alcohol at that stage. I was particularly interested in that field. Then I moved into child and adolescent and family psychiatry for 10 years. I was a counsellor and had a private practice. I then got sick of the whole thing and decided to become a methadone co-ordinator. I had a complete career change. I did that for three and a half years and then I was offered this position, which I started four and a half years ago. I have been there ever since. The Lyndon Withdrawal Unit is an illicit drug detoxification unit with eight detoxification beds. We also offer a four-week living skills program with 16 beds. The funding is from the drug illicit strategy through the Commonwealth Government. There is no alcohol detoxification.

CHAIR: Between you, you should be able to solve all our problems. How do you see the key issues and challenges facing us in relation to drugs and your communities?

Ms McINNES: The key issues are that we do not have any alcohol detoxification in this area. Some small hospitals with the agreement of isolated GPs will do some alcohol detoxification, but only on a minor scale. The big centres like Orange and Bathurst do not, and that creates a huge problem for our clientele in this area.

CHAIR: Do they go anywhere else?

Ms McINNES: Our nearest referral facility is at [Town W]. People are not always able to get themselves where they want to go at a certain time—buses and trains are wonderful and but they do not run often from the country. The acceptability was difficult. Before [Town W], which has been going only a couple of years, there was nowhere. I tried Fairfield, but it was not interested in taking people from the country.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They do alcohol detoxification in general hospitals?

Ms McINNES: Not in Orange.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They used to.

Ms McINNES: They used to, but not anymore. They have not done so for some time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The inebriates were stuck in the back wards and filled up with sedatives.

Ms McINNES: Not officially for the past four or five years.

CHAIR: Whose decision was that?

Ms McINNES: I assume the decision was made by the director of the hospital. The accident and emergency manager has a lot to do with that. They will, under some duress or pressure, admit people with associated medical problems, but not purely for detoxification.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Often they come in with a medical problem and then detoxify. Is there not still a lot of detoxifying going on in general hospitals?

Ms McINNES: It does take place, but not under the guise of detoxification. They certainly do not make referrals. You have to have the right person at the right time. A nurse who knows about us and cares about the fact that someone has a drug and alcohol problem might ring us and tell us that a patient is having his gallbladder looked at but he or she is detoxing as well. It does not happen as systematically as it should.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think there should be special units? Surely general hospitals should be able to cope.

Ms McINNES: They should be able to cope, and that is where it has always happened. However, I wonder if it is the right place. Attitudes in general hospitals are not geared towards anyone detoxing, even methadone clients who have to be hospitalised for operations. They are often treated differently from other patients and they feel uncomfortable. It should be a specialised unit.

CHAIR: Do you have any other comments?

Ms LEWIS: The [Town X] Hospital takes people for detoxification. We have a local detoxification policy that was written by the hospital services manager, drug and alcohol workers, a clinical nurse consultant at Mid Western Health Service and a clinical director. They are open to that. However, as Mr Chesterfield-Evans has pointed out, most of it happens as secondary not primary treatment. People are not necessarily going in for detoxification, but because of their other injuries—ulcers, liver problems and injuries from stumbles—they are detoxed appropriately. [Town X] Hospital does quite good alcohol medical detoxification, but most treatments are secondary. It sounds as though it is a separate issue for each hospital. Nothing is consistent by the sound of things.

Ms KILLEN: Access to detoxification in general hospitals has been less than ideal. It has certainly improved, but we need more improvement.

CHAIR: You agree it is a hospital-by-hospital decision.

Ms KILLEN: Yes. We do not have an area policy. We have developed a draft plan and model.

CHAIR: What about the other key issues and challenges?

The Hon. GREG PEARCE: Can you give the Committee an estimate of the demand?

Ms McINNES: We kept statistics in our first 12 months. There were about 300 requests for alcohol detoxification in that period. When we were funded Bathurst had a private hospital that did most of the detoxification and Orange had four gazetted beds for alcohol detoxification. When we opened they assumed we would do it all. Our facility was not set up to do that; it was funded only for illicit drugs. It would have been too dangerous; we have only 10 hours of visiting medical officer [VMO] time a week. It is not a hospital ward in the sense of dealing with an emergency. Our VMOs adamantly said they would not do severe alcohol detoxification and we were not funded to do it.

The funding body reviewed the situation after the first year of operations. We had been doing some alcohol detoxification, and they jumped up and down and said we could not do any more. For the next two years we did none. We have undergone another review and they have said that if we have beds we can do mild to medium alcohol detoxification if we can support it and if we feel comfortable doing it. Most of the time we do. Only when people have associated problems do we feel uncomfortable. We have an arrangement with the accident and emergency service that we can ring the ambulance and get them sent to hospital. However, we are still 10 or 15 minutes from town. We have stopped taking statistics because we could not. There is enormous demand for alcohol detoxification. The alcohol and other drug workers know not to ring us; they send them straight to [Town W]. If we get the call, we send them straight to [Town W]

The Hon. GREG PEARCE: How many beds are there at [Town W]?

Ms McINNES: About 12 or 14.

Ms LEWIS: The same can be said about [Town X]. Detoxification is not done through the alcohol and other drug service. It happens at the hospital and are GP directed. The GPs set up the detoxification and do it in the hospital. They then ask the alcohol and other drugs team to provide inpatient support. That is the way we support our GPs; we do not organise the detoxification through our services. We must refer to [Town W].

CHAIR: The GPs get patients into the small rural hospitals. There is probably very little back up.

Ms McINNES: In those towns and communities the population varies between 500 and 1,500. It depends on the GPs and their relationship with hospital staff whether it happens, regardless of whether the hospital is under the area health service, which all of them are. However, the little hospitals have always had this historical thing with their GPs that the GPs run the hospital rather than the area health service. So it works for them.

Ms KILLEN: We have specialist drug and alcohol medical back up in the mid western area. We are extremely lucky to have a fellow of the newly formed chapter of addiction medicine in the Royal Australian College of Physicians, Dr Rob McQueen. He is available to give back up to medical people for detoxification. We have tried to promote his service. I guess it is a growing thing—utilising that expertise. There is another medico in [Town W] who is likely to become a member of the chapter soon. We are very fortunate and that is a counter to some of the challenges. We share the challenges with health services in rural and remote locations generally. They include trying to deliver services over a vast geographic, sparsely populated area and achieving a critical mass of expertise that can go to those various areas.

We are trying to make sure that there is access for people in all the different types of towns, wherever they are, ranging in sizes. Then you have to equitably allocate the resources across the area for that access, and then there is the issue of attracting and retaining skilled and appropriate personnel and training them in a rural area. That has been a particularly difficult task, I think, in drug and

alcohol in the past few years. Even though it has been wonderful to have additional funding in the field, with the rapid expansion, that has made it difficult to find enough skilled people.

CHAIR: Do people tend to come here for brief periods and move back to the coast, for instance?

Ms KILLEN: That happens sometimes, and it is more difficult the farther west you go. But, some people come and they stay and we are pretty pleased that they do.

CHAIR: And some people were here in the first place, and have always been.

Ms KILLEN: Yes. Trying to spread those services over a wide geographic area brings in access, and with access there is also the transport issue. Maybe you cannot provide the service there, but how do you actually move people to the service. That is fairly lacking. There is a stigma about drug and alcohol issues, and I think that is even more so in rural areas than possibly the city, and also there is the confidentiality issues of treatment in rural areas. People might not access services in small rural areas because they might be concerned about the confidentiality or that their treater might be somebody they work closely with in the community. This is, I guess, drug and alcohol treatment generally. Then there is also the challenge of trying to build the capacity of the general health work force to intervene or to manage their clients' drug and alcohol problems.

CHAIR: That is quite a list.

Ms KILLEN: There are also the environmental systemic issues of the way that alcohol is part of the culture. Some of the other factors in the community that impact on whether someone will have a substance abuse problem, which can be common with criminality or mental health problems down the track, are a problem. There is the challenge of how do you reduce the risk factors and increase the protective factors in the community so that perhaps people do not develop drug and alcohol problems down the track, which then might progress to perhaps frequent intoxication or maybe an inebriated state down the track.

CHAIR: That is enough; you have said them all. Are there any particular comments about the more severe end, the inebriate's end that our inquiry is focused on? Would you say that all of those things that you have mentioned are as relevant to the severe end as they are to be more moderate end?

Ms KILLEN: They would probably work in all and at all of the levels. I guess then there are particular problems with the Inebriates Act which you have certainly gone into.

CHAIR: We will get on to the detail later. Kim, did you want to add anything to the issues and challenges as you have seen them?

Ms LEWIS: No. I think that Didi has covered it quite adequately. I guess that we do not have any dual diagnosis residential or even specialist facilities, which I see as a problem for our severe drug and alcohol dependent people. That higher level of speciality is not really on the ground and certainly not in each little community that we have. I guess I see that as a problem.

CHAIR: What about Bloomfield Hospital, as such? Does it offer assistance?

Ms LEWIS: With dual diagnosis?

CHAIR: Yes.

Ms LEWIS: Specifically, no, not as a residential. It is really hard to find any in New South Wales at all because a lot of our people with severe alcohol and comorbid problems might actually be post-traumatic stress disorder or personality disorder, and they are not as openly welcomed as someone with a mental health disorder that might be schizophrenic or bipolar.

CHAIR: Is that because they are not defined as mental health, strictly speaking?

Ms LEWIS: They are in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition [DSM4], so I just have real difficulties trying to place those people. Chris McInnes has more of a background of mental health than I do.

Ms McINNES: I guess it is more of an issue of the suitability of placing people with personality disorders. They can be extremely destructive in residential units. You have got to be careful. I mean, they are everybody's problem but they are very difficult to cure. There is no cure, and treatment is very difficult. I do not blame the mental health system for saying, hang on, they are going to cause trouble here and they are really a drug and alcohol problem and we do not really want them because they cause the same problems in the rehabilitation units in terms of being difficult and undermining. They are a different group of people and there will always be problems getting help for them—not all of them but some of them, the majority of them—and some of them just need constant attention over time. It might take years of interventions, so they are just a group that we have to accept will be around for a long time.

CHAIR: Quite a few of the people who have been considered or placed under an inebriates order would probably fall into this category, would they not?

Ms McINNES: I think it is hard to assess. If they are coming in under an inebriates order, one assumes that they are consuming large amounts constantly, so it would be hard to ascertain whether that was an underlying thing until you have them in a drying out period. Certainly it might be something that comes up after treatment, whatever their treatment is.

CHAIR: I am thinking more of the evidence we have heard that many people who are placed under an inebriates order are people with the history of pretty awful behaviour in the community. I think the phrase used this morning was "community burnout", so they are reasonably well known.

Ms McINNES: I think that a lot of the time that comes down to individuals not being able to express why they feel like that and why they feel the need to attract attention to themselves. They are not even sure why they need to have support and help and make a noise and all the rest of it. It is something that they have not even worked out, so the communities only see the end result rather than the reasons why, and I think sometimes periods of stabilisation can help people move past that. We have certainly seen that. I know that Kim has a case study that addresses that. After three or four orders under the Inebriates Act a so-called personality disorder person did stop the behaviour that was impacting on the community.

CHAIR: We will have our case study a little bit further on. That deals with the issues and challenges. You said in your opening descriptions of yourselves a fair bit about the services that are available or not available. Is there any more detail that you want to give us about these services that are available in the mid-western area, particularly for people with severe drug and alcohol problems, and whether you think that is similar or different from other rural parts of New South Wales?

Ms KILLEN: With "severe", are you meaning they are people who might come under the Inebriates Act?

CHAIR: Potentially, yes. You are more expert on definitions and so on than we are, I guess. But, clearly, we are dealing with the Inebriates Act which obviously is at the severe end, but there is probably another group described as severe, given the small numbers in relation to the Inebriates Act. Most people with severe problems will not end up under it.

The Hon. GREG PEARCE: Didi, perhaps you might just outline what is the alcohol and other drugs [AOD] program, as you co-ordinate it.

Ms KILLEN: Okay. If someone was wanting to access drug and alcohol services, they would first ring the 1 300 number, which is the centralised intake that we set up a couple of years ago. A brief assessment would be conducted and then there would be triage to what would be considered to be the most appropriate treatment model or regime. That is for all services apart from Lyndon detoxification which actually has its own intake system. They might be referred to detoxification or they might be referred to residential rehabilitation, or they might be referred to community health drug and alcohol specialist counselling, or they might be referred to a pharmacotherapy program such as

methadone or buprenorphine, or to their own GP, just depending on what the situation was and what services might be available. They might also be referred to mental health.

The Hon. GREG PEARCE: Who does those assessments?

Ms KILLEN: We would provide that—a senior drug and alcohol clinician.

CHAIR: In person?

Ms KILLEN: Over the phone. That is a brief assessment and then a full assessment would be conducted by the person to whom they were referred, the case manager.

The Hon. GREG PEARCE: How many people do you have doing those phone assessments?

Ms KILLEN: We have only one at the moment. We did have a job-share situation with one person but we need a back-up for when she is on leave.

The Hon. GREG PEARCE: So that is just a nine to five sort of job, is it, or service?

Ms KILLEN: Yes.

The Hon. GREG PEARCE: And the people who call are the whole gamut—people who are addicted, relatives and so on?

Ms KILLEN: Yes. There is one of those centralised intake services in every area health service.

CHAIR: If you get a call from someone furthest away, in one of your smallest centres, you do a brief telephone assessment and then who they next see is determined a bit by where they live and who is close to them, whether it is a GP or a counsellor.

Ms KILLEN: Yes, and their availability. For some people, that might involve travel—travel by them or travel by the counsellor, depending.

CHAIR: Is the picture here broadly similar to the picture in other rural health service regions?

Ms KILLEN: I think so, and I think the sparseness of the specialist personnel—they become sparser as you move farther west.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that the drug and alcohol should be stand-alone or that it should be under mental health? It came out from under mental health, did it not?

Ms McINNES: Yes.

Ms KILLEN: I think that there is a lot to be gained from working much more closely than we currently are. We are certainly working more closely together than we were previously. Particularly with the findings that have come out of the mental health and wellbeing surveys and research into comorbidity, that would indicate that there could be some positives to come out of that, particularly in rural areas where I guess mental health is larger and probably better resourced than is drug and alcohol. That might give us a better critical mass even though we still need the drug and alcohol specialist critical mass.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Within that overarching umbrella of resources?

Ms KILLEN: Yes. We know that that is certainly being put forward at a Federal level, that approach.

CHAIR: This is a co-operative arrangement rather than reunification or remarriage?

Ms KILLEN: Yes. I would not see that a total assimilation at this stage would be appropriate. Maybe that would be something way down the track, but at this point I do think, certainly from our point of view, we could benefit from working more closely together.

The Hon. GREG PEARCE: Why would you not see it as a total assimilation?

Ms KILLEN: I just think that it would probably be too quick to do that. Maybe that is something that you take an action research approach to—move closer and see how that works, and things might develop over time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But historically, have you not been forced to separate fairly recently?

Ms KILLEN: I think it would be more than 15 years ago.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Twelve or 15 years ago?

Ms KILLEN: We were certainly separated when I came into the field. It is more than 12 or 15 years ago because they were separate when I came into the field. But in different area health services, there are different models. In some area health services they work more closely together than in others as well, and I guess it is something for which each individual case probably needs to be looked out on its merits.

CHAIR: Do you have a view, Chris or Kim, on that question?

Ms LEWIS: I guess initially I would think that in [Town X] we try to work really closely with mental health, just as on-the-ground workers. I am sorry that I do not really have much of an understanding of the whole structure and the overarching aspect, but as ground workers we work really closely with the mental health team in [Town X] and we get together monthly to case conference because a lot of our drug and alcohol clients are shared with mental health teams, so we work together very closely although we work very differently. So if we were merged or assimilated or to join forces, in marriage or de facto, I do not really know what we would have to shift. It seems to work well the way it is now where mental health appears to be a little bit more medically minded whereas drug and alcohol appears to be a little bit more psychosocial. To me together they cover the whole sort of biosocial psychosocial aspect. I have only been around three years, so I am probably not the right person to ask.

CHAIR: You have a manageable community in [Town X] to use as a case study?

Ms LEWIS: We do. We try to do that for our clients.

Ms KILLEN: Yesterday I came across a paper on the web site from the World Health Organisation about looking at the neuro-scientific basis for substance dependence. I would have looked at it as a bio-psychosocio-ecological approach, but the report was looking at it as a neuro-bio-psychosocial approach to drug problems. My brief reading of that document would indicate perhaps even more of a basis for moving closer to mental health.

CHAIR: We will come back to that issue later. Chris, would you like to make any comments?

Ms McINNES: This is in an old bugbear of mine that I did not think would come up. I have worked in both systems. There are differences and there are advantages to both systems—differences and advantages that are not in the other. I tend to agree that drugs and alcohol is close to mental health. Under the DSM4s and all the rest of it alcoholism, drug abuse and addiction are mentioned. It has been cast aside a little by mental health. After working under both systems what I think would work is much more of a collaborative approach. We do not want a "them and us" approach—it is not a mental health problem it is a drug and alcohol problem. So they get kicked out of Canobolas Clinic,

the kids psychological unit, when they are having a psychosis as a result of their speed use or whatever.

There has to be a unit dedicated to people who suffer mental health symptoms and particularly drug-induced psychoses where they can be safe and still get the care they need for both. The drug-induced psychosis can go on for months if it is not treated properly. Sometimes people stop using speed but they continue to use cannabis, so it can still continue in one form or another, yet they have been put on zyprexia or rispiridol to deal with their psychosis. We are seeing an enormous number of people who are on antipsychotic medication but who are still coming through the poly-drug use. They are still smoking their pot but they do not want to give up speed or whatever. There should be much more collaborative approach from mental health.

It should not be just a "them and us" approach. We do not want to hear, "Sorry, they are not psychotic at the moment. We will not help you out", or "They are not suicidal enough yet because they have not made a deep enough cut", or whatever it is. There should be something a little safer for those clients because they are difficult to deal with in a drug and alcohol environment where you do not have mental health trained people. I am the only mentally health trained person in my unit. Unless I see them and I keep getting called in and I say, "Okay, I will talk to this person", or whatever, I am not able to manage them. My welfare officers, who are at one level, are not equipped to deal with these people, their delusions and their psychoses. That makes it difficult.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not a transient situation? If there are not enough people trained in the drug and alcohol field should it therefore go back to mental health?

Ms McINNES: I do not think it should go back to mental health. There should be more attention given to units that can deal with both. We should be provided with sufficient funding so that we can resource those units and so that clients can be safe in their psychotic state and still have people understanding them and educating them about that. At the same time they should be dealing with their drug and alcohol problems and not dismissing them by saying, "It will pass. Here, take some zyprexia." We know that it does pass, but it does take more time for some people than it does for others. In our harm minimization environment if they are still smoking cannabis on top of taking their antipsychotic medication we try to take them off it or we review what they will be like after a few months. They can still be psychotic underneath.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that the clinical people do not want them because they are not real mental health patients. Earlier you said that general hospital staff cannot detoxify them because they do not want them either. Effectively, you are saying that the drug and alcohol people have been rejected by the physical health and mental health people. That has been the cry from the drug and alcohol people for as long as I can remember. They believe that their condition is not taken seriously. It was brought on by substance abuse.

Ms McINNES: It is their fault. It is so stigmatised. The thing that the drug and alcohol clients are told is, "You did it to yourself, therefore, you are responsible." We know that is not right. It is not completely true. They cannot be responsible once the addiction has taken hold. They have not got that ability until they have had some form of treatment.

Ms KILLEN: I do not think I was saying that drug and alcohol should go back to mental health. I was saying that I think there is a lot to be gained from a much a closer collaborative approach. That might be achieved if drug and alcohol is not subsumed.

CHAIR: We understood that. Kim, perhaps we should move on to your case study?

Ms LEWIS: I have done four case studies.

CHAIR: Part of our problem has been our inability to establish those who are coming under the Inebriates Act and those who are not.

Ms LEWIS: I am aware that you have already spoken with people from Bloomfield. They would have painted a very different picture of the way in which these people present here. So I will

only refer to what they look like from our end—when they leave our communities. I am talking about four different residents of the [Town X] community over a decade. Although I have been around only for three years, as I said earlier, prior to that I was in the health and welfare field in [Town X] for seven years. So I knew of these people, even though I was not involved at the time. I was not involved in the orders of one person, but I have been around for the other three. You asked for individual circumstances, social characteristics and outcomes. I have presented them in that way but I am not sure whether that might be a bit too lengthy.

CHAIR: You can table that document and just speak to it briefly now. We will look at it in more detail later.

Ms LEWIS: I think that the relevant things are social characteristics. They are all Caucasians. We do not have a large Aboriginal or other culturally diverse community in [Town X]. Three of them are male and one is female There have been other people—both male and female—and all Caucasian from [Town X] who could have been put up for the orders, but their family, their GPs, their drug and alcohol workers, or other health workers did not go to a magistrate. The interesting thing that we found is that if these people have good family support—a wife, a husband, a mother, a father, a brother or a sister they seem to be absent; we do not know of them. They are still as harmful within their homes, their families and their bodies, but we do not see them until they spill out to the community.

It is at that time that they become known to us. Their health is a major risk. You would know all the factors relating to alcohol-related brain damage in particular. These people are often emaciated. Most of the time they are getting their calorie intake through alcohol, so there is no thiamine on board and they have more chance of contracting Korsakov and those types of things. Their social worlds are out of control, their relationships have broken down and employment, if it is existing, is about to end. Other safety issues include walking in front of cars, having tingling fingers and feet, falling down, burning their hands and feet and those types of things.

Those are the things that we have seen and that their parents have told us about. More often that than not if the parents are still alive they are caring for these people up to the age of 57 and 58. They are pretty much exhausted by them. They are the people we are normally seeing—some as young as 37. Methylated spirits drinkers are mainly the people that we see that young. They are involved in public mischief. They are not particularly bad people; they are just involved in public mischief or causing trouble as you have said. Someone mentioned community burnout earlier. I would not agree with that but I understand what they are saying.

CHAIR: When you say you would not agree with that, are you not comfortable with the description?

Ms LEWIS: No, I am not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you not think that the community has burned out?

Ms LEWIS: I get stuck with this thing about the stigma of these people. It is like, "I cannot be bothered with them." It is that whole attitude of the stigma of these people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is personal experience; it is not a stigma. If you have tried to get your loved one or client off for a long time, eventually you say, "I cannot do anything for them." That is how we are defining the word "burnout".

Ms LEWIS: I see that as personal burnout, so I accept that.

CHAIR: The phrase was probably used in relation to much smaller communities. Most people in the community would be conscious of these people because of their behaviour.

Ms LEWIS: The four people to whom I have referred in this document that will be tabled have all ended up at Bloomfield. One person was here on three different occasions. I do not have the details of how long that person was here for, but I think they were short orders—perhaps two months

at a time. Another person was here on one occasion for two months. The other person was here three times in two years for about two months at a time. I am sure that term "community burnout" has been used in relation to that person on more than one occasion, but not by me and definitely within the [Town X] community. That person was charged with public mischief because he was always calling triple 000, getting to accident and emergency in an ambulance and the police were always taking him to accident and emergency.

He presented at [Town X] hospital 21 times in three months at accident and emergency presentations and I think that term was used. The last person was here one occasion for 5½ months. There are different outcomes for all of them, but what we feel was missing in all of those was treatment. Chris has a really good way of explaining this. They get contained and they get drug and alcohol treatment—the types of things that Chris was talking about earlier. That really intense knowledge of drugs and alcohol and mental health combined is not factored in here perhaps because it is not the right place for them, or perhaps there needs to be more money put in to look after these people if they are going to continue to be contained. Maybe some neuro psyche testing or an alcohol-related brain damage speciality is missing once they are here.

But all of them ended up having reasonable outcomes. The young woman who was here three times ended up eventually grateful that someone had made the choice for her when she was unable to do so herself. So she started making some different choices for her life. She was here three times; it was not just once. Another person was on the methadone maintenance program. He came here only one time, but he was at risk of overdosing because he already had opiates on board and he was still drinking alcohol. So his central nervous system was at risk of becoming depressed. Once he was here for while he realised how at risk he was of losing his life. He went back to the community and maintained his methadone maintenance in a more harm minimisation way.

The other person was here three times. He has been said to be trouble to the community overall. We tried to put him in front of a magistrate a fourth time and the magistrate would not hear about it. He was in hospital with internal bleeding at that time. I do not have the medical records but he was bleeding on the inside. If we had a choice we put that person under an inebriates order and he would go to Bloomfield. The other choice that he has is to continue to drink methylated spirits but the chances are that he will have another bleed and he will die. Another choice for him is long-term rehabilitation. After three goes at coming through this system, of being contained against his choice, he chose to go to a long-term rehabilitation service, which was a Salvation Army provided service.

CHAIR: Whereabouts?

Ms LEWIS: In Canberra. I am not sure whether that would have happened if we had not had the other three goes at containing him against his will.

CHAIR: Do you know what has happened to him since?

Ms LEWIS: He made it through there for five and a half months and he is out again. I would say he is drinking. The last case involved an older person who had one long stay here for five and a half months. His family were burnt out and his GP approached us because his mother had early-onset Alzheimer's. He was 58 when the GP came to us. His family were furious with him because he continued to drink and his elderly mother was caring for him. The family was busted up because of it. When she became unwell the GP said we had to do something. We encouraged the family to go through with the order. After he was here for five and a half months they were reunited and got to know him again. When he came out he did not make it back to [Town X] on the train or bus. He drank all the way home and they refused to deal with him. They moved him to an aged care facility and they visit him twice a week. The family is not fragmented now. They were very angry with him and they stopped visiting their mum because he was there.

CHAIR: At the age of 58 he went into a nursing home.

Ms LEWIS: Yes. He is at [Town Y]. I have phoned them and he is doing well and does not want to leave. He is involved in activities.

CHAIR: Is he in a secure part of the nursing home? Is he drinking?

Ms LEWIS: No.

CHAIR: Does he have the choice to drink?

Ms LEWIS: They have an outing once a fortnight to a hotel where they have dancing, pool and light beer. I do not know whether he goes, but he knew the option was there when he went in. They told me he never misses a cigarette break. They are the only four cases I have had experience with.

CHAIR: Those cases were predominantly families saying action must be taken, or a doctor on behalf of a family, getting affidavits and going to the magistrate.

Ms LEWIS: In three out of the four cases it was family and the magistrate who determined it should happen and in the other case it was determined that the person would have to be put away for public mischief if he did not stop calling 000. The fourth time he went to court the magistrate did not want to hear it again.

The Hon. IAN WEST: When he left here he made his own way to the train station and caught the train to [Town X] via the pub.

Ms LEWIS: There is a pub across the road from the railway station.

CHAIR: And he drank all the way on the train.

Ms LEWIS: Yes.

The Hon. IAN WEST: He had been here for five and a half months.

Ms LEWIS: It is tricky. It is hard to imagine that this is part of the treatment, this cyclic behaviour of relapsing to the old ways. He is the gentleman at the nursing home. He does not have to stay there; he is not locked in. There is a train station at [Town Y]; he could leave. They are the only ones I have had experience with.

CHAIR: It is a bit of a mixture in terms of whether the use of the Act did any good. As you said, it is more containment here rather than any particular program or treatment. However, compared to other case studies we have heard it sounds as though they are all still alive, which is different.

Ms LEWIS: The young lady died a number of years later. I do not have the medical records, but it appears it may have been related to an eating disorder.

CHAIR: Presumably their physical health improved while they were here.

Ms LEWIS: Definitely. I hardly recognised them. We usually pop in to touch base when we have an area meeting. You can be shocked at how well they are in such a short time. There is an incredible shift. People put on 12 kilograms in a month and are able to say a whole sentence instead of being stuck on words.

The Hon. IAN WEST: When you visited them here and spoke to them what was their view? What did they say?

Ms LEWIS: I have noted that they all commented that they did not really want to die. The language is different, but they have all given me the message that they did not want to die. They knew they were drinking themselves to death, but it was not their ultimate goal. They were grateful to be alive. As I said, I have been involved with only three face-to-face cases, and a worker told me about the other one.

CHAIR: Thank you for those case studies. Does anyone want to make any further comment?

Ms McINNES: They are good accounts. We run a living skills program, both residential and outpatient. Ms Lewis, or whoever the alcohol and other drugs worker is, contacts us and tells us that they need to stabilise someone in detoxification and when they are clearer they can do the 28-day living skills program. We have always said yes and tried to accommodate that. We have had a few referrals. However, the difficulty is that they have to walk from where they are held down to us. On the way there is a detour called the Ex-services Country Club. Often they arrive intoxicated and we have had to send them away. The difficulty is sending these inebriates to a place where the doors are not locked and that where there is a country club on the grounds. It is difficult to get people to stop drinking. Some people do not know it is there so they stay in the unit and they are fine. However, it is not uncommon to find two or three clients behind the tennis shed with multiple bottles of long necks and cans of rum and Coca Cola having a wonderful time. They are all on anti-psychotics. I alert the staff every time I find them because we use those facilities for our clients to play tennis. I am trying to get my people away from alcohol and there are all the bottles and cans.

CHAIR: Is the implication that you favour a compulsory and reasonably strict regime for people who need it?

Ms McINNES: It is one thing to have people under the Act in a psychiatric unit, but the reality is that if the institution does not have bars they can leave. Restrictions are lessened as time goes on, which is fine, but at the same time there is not enough staff to supervise them. We do not have fences around our building; ours is a voluntary unit. However, the rule is that if you leave then you are automatically discharged. That is it. Invariably they have to think about that, so they step back knowing the consequences.

CHAIR: I refer to question six. Most people seem to be comfortable with compulsion as a philosophy, provided there are safeguards, and most people say that we need more than there are in the Act. People point to the regime in the Mental Health Act with its legal framework, tribunals, appeals and so on. We have tried to get the comments of experienced people like yourselves on the record about the ethical issue of using compulsion, why we use it and whether we should use it only in life-threatening situations or when family members are at their wit's end. If we are going to consider replacement legislation then a fundamental question is what the community thinks about the compulsory aspect. You certainly just raised that. They are officially locked up but they are down the road at the country club.

Ms McINNES: Not all of them.

CHAIR: Do you have a general view?

Ms KILLEN: We have had discussions generally and in the service. Although we try to work in a collaborative way with clients, sometimes in the end, as a last resort, we might need compulsion. The criteria could be similar to that in the Mental Health Act, where there is a duty of care to the person who might be a danger to themselves or others. Also there should be some treatment on offer that is humane and likely to be effective.

CHAIR: Apparently people are often sent without documentation to a centre like Bloomfield or Macquarie Hospital where there is no program for them and they are mixed with other clients with different issues. It is not really fair that that should be compulsory.

Ms KILLEN: No. It is not fair to the clients or the other people in the institutions.

Ms McINNES: Including the staff. It is not fair to them.

CHAIR: Kim, do you agree?

Ms LEWIS: Yes.

CHAIR: We would like to move on to question seven because we spent a lot of time on this issue morning with the Bloomfield people. We have now had a number of hearings and we are very aware of the level of criticism of the existing system. What do you suggest as a replacement? How would it work in your area?

Ms KILLEN: We do not have a coherent, documented model to offer. I would like to see something involving comprehensive assessment and well thought out criteria about how people get into treatment. That goes back to what might be in the Act. The duration of treatment should also be considered. My assessment and the consensus view is that that time might need to be assessed in regard to an individual case, but with inebriates it would need to be three or six months. However, there might be a provision for review on an individual basis. The experience is that people who are heavy alcohol users and who are dependent take a long time to come out of the haze before they can start working on themselves and try to change behaviour. We strongly support comprehensive assessment and it is very important to have neuro psychological testing, particularly if there is brain damage, and it is very common. It is important to be able to pinpoint the level of damage and the degree of deficit. We must be able to appropriately tailor the assistance for a person. There should be a range of co-ordinated, integrated, evidence-based care. I cannot say exactly what it should be, but it would probably involve some cognitive behaviour therapy and motivational enhancement. There should be something along the lines of the co-ordinated, integrated care that is seen as best evidence-based care for the treatment of schizophrenia. We have referred to mental health as a model, but that field is much better resourced. We may be able to develop some of those things.

CHAIR: How would it work in terms of where assessments would be carried out, where people would be sent and the mix? They may move from one place to another during a six-month period. How do you envisage the services and what would they be?

Ms KILLEN: To start with, the clients might be in a more secure environment. Since this is coercive treatment, one would imagine that people might already have been recommended for treatment in a non-coercive environment and refused it. They might need to be in a secure environment for the first few days or weeks. Then, after the full assessment, a management plan will be developed and that could bring in a whole range of different services between the various sectors, hopefully within Mid Western Area Health Service or a rural area, but maybe some people might have to go somewhere else.

CHAIR: Because of the sheer smallness of numbers?

Ms KILLEN: Yes, and I guess that would have to be worked out. There is an issue that I understand there have been quite a high proportion of indigenous people referred in the past under that Act, so if that were still the case, then it would be very important that that was culturally appropriate, and that would be part of the management plan for individuals. Part of that cultural appropriateness might involve the actual geographic location or at least whether it was metropolitan or not. Travel is another issue that has to be taken into consideration. For instance, if people in rural areas need to access specialist treatment for some mainstream type of health issues, they can use the Isolated Patients' Travel and Accommodation Assistance Scheme [IPTAAS] which gives them free travel and support for someone who might accompany them, et cetera. I would hope that that would also be involved.

CHAIR: Does that apply? Are people eligible for that?

Ms KILLEN: I am not sure. I do not understand that it does apply at this point in time, no. In particular now that the drug and alcohol is seen as a medical specialty, then I think it should be the case.

Ms McINNES: The sheer nature of the paperwork to fill it out in terms of people trying to apply for it, a lot of people just do not bother because there are not the resources to help them to fill it out or the family or whoever is taking them, but I think it should be delegated to workers who say, yes, this person has to travel here. The person who is inebriated is not going to do it. Someone has to do it for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: IPTAAS had a big inquiry from the New South Wales Council of Social Services [NCOSS], did it not, to try to integrate the various problems because it has veterans' affairs, transport, disability services and health and a whole lot of different agencies involved in it. There was a report on that a couple of years ago.

CHAIR: We could check that out.

Ms McINNES: I am sorry, I am not familiar with that. I have not seen the report.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has been a problem for all people who want to access it.

Ms McINNES: It would be good if they had had an inquiry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it has had a problem with too many volunteers because they are burning out and getting too old as well.

Ms KILLEN: And the other thing that is important is that all of that is linked. I guess if you are looking at it from a system's point of view and you are looking at that as a subsystem—you have a subsystem for dealing with people who come under the Inebriates Act or whatever other legal mechanism you have to assist those people; then you might have a subsystem for people who come under the Intoxicated Persons Act or the repealed Act or the protocols for dealing with intoxicated people; and a subsystem for how we assist people with other levels of drug and alcohol problems; a subsystem for dealing with people who have comorbidity issues; and a subsystem for various levels of mental health problems, all within the big system of dealing with people with drug and alcohol and mental health problems, which also sits within another big system. But linking of all of those systems is what is really important at all levels.

CHAIR: But compulsion would be applicable only to the group that we are currently calling inebriates?

Ms KILLEN: Yes.

CHAIR: In terms of assessment and sending people away to perhaps a secure environment for a period, that applies to the compulsory part and therefore the most severe end?

Ms KILLEN: For a period, but maybe down the track they might link in. As part of their treatment down the track they might link in with other more mainstream drug and alcohol or mental health services that are already there. Also relapse prevention is another component that is important, and that would fit in with the co-ordinated discharge planning and after care.

CHAIR: Which does not exist at the moment, or exists a bit?

Ms KILLEN: We all try to do it to the best of our ability.

Ms McINNES: I mean, after care means nothing if you cannot get somebody somewhere to live. It has got to be a collaborative approach between housing, employment agencies, and other services as well as just drug and alcohol workers just trying to care for their client because basically they have been isolated from all of these things. They have usually exhausted all the hospitality of the local charities' service, but that is the only place that that they can go to, if you know what I mean.

CHAIR: Quite a few people have said to us that the after care or relapse prevention is the crucial ingredient that is missing at the moment.

Ms KILLEN: Yes.

CHAIR: If you cannot put those structures in place, then the chances of success in the long term are diminished.

Ms LEWIS: It is almost like there needs to be clinical guidelines for what happens within the treatment phase and those clinical guidelines could include discharge planning and what that discharge planning might include. Some of the time that I have had experience with the people I have mentioned earlier, I know they are back in [Town X] when accident and emergency [A and E] phone me. I did not even know—I have not even seen the discharge plan—that they were coming back to the community.

CHAIR: Which is crazy.

Ms LEWIS: Yes. I know what we are talking about here is expensive, and I think that is something that we keep sort of holding back on and some of it is to do with the stigma of the people we work with: Are they worthy of the health dollar? In some way that is a bit stuck there for us as well. What we are talking about is expensive treatment and we do not really know what the outcome is going to be.

The Hon. GREG PEARCE: The Chair has made the same point—that the issue of the housing problem afterwards is not something that is within our terms of reference—but it actually goes to the core of whether these sorts of programs can work.

Ms McINNES: It is a huge problem. I mean, a lot of the time people are turfed out of where they live and that is why they come to services' attentions in terms of the law and whatever. They have hit rock bottom, particularly with narcotic use and drug use and polydrug use. It is no different for alcoholics, too. Eventually they cannot pay the rent because they are drunk or whatever. Until we have got something set up in the community where we have got somewhere for these people to go back to, that is not in a tiny little 4 x 4 bed sit among six other alcoholics or in a drug squat, which is basically what they become, it is not going to change. We have to start to normalise people's lives a little bit more and living in a 4 x 6 bed squat is not doing it—not for me, anyway.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have dealt with the infirm. When I worked in hospitals, they did not have any discharge plans. I understood that as the bed stays dropped, nobody got discharged from the hospital without a discharge plan, at least in theory, and contact made with some discharge person who was going to be in charge—a transfer of responsibility, shall we say. That is not actually happening in mental health, is that what you are saying, or in general health?

Ms McINNES: I think it is happening in terms of burdening the responsibility but it is not happening in terms of continuity of care. I think it is all too easy to get hospitals to say—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is a name in the slot.

Ms McINNES: Yes. Just for instance to get a discharge summary from Bloomfield, even for me who is just three buildings down the road here—for me to get a discharge summary from Canobolas Clinic can take up to six weeks. The person is already usually gone from my facility by the time I get it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Right. And there is no hope of getting it two hours before they leave?

Ms McINNES: I mean, I can ring up and harass somebody and try to get an interim one, but that will not be the complete discharge summary, typed up, entered into medical records, signed off by the psychiatrist and everybody else, for up to six weeks.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But Kim will not even know that they are gone. Let us assume that all you knew was the diagnosis and then they were gone, and you presumably would have known the case, you could do without the discharge summary if you knew they were there. It is more important to know that they are there than is for you to know the fine detail, presumably.

Ms McINNES: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it does not happen at all is what you are saying.

Ms McINNES: Yes. It does not affect me as much because I have either sent people from my facility to there because they need that and I know why they need it, or usually they are long gone from even their facility and they have been sent to me as an afterthought because we were the referring agency, and that is fine. But in Kim's case, there is nothing worse than being an outreach

worker. I worked for four years in mental health out at [Town Z] and one particular thing that happened out there was that this fellow was returned from Bloomfield to the community. I was never informed. I worked for the same organisation and I was never informed. He killed his parents and himself and torched the house.

I had to spend the next three weeks up their debriefing the whole town. These are the sort things that happened quite regularly. Workers on the ground are not told when their client comes back from wherever they are. My facility has a policy in place because I have got such a bugbear about this that the discharge summary is done on the day they leave and I do not care whether that worker has to stay back and work extra time to do it. It is faxed through to where they are referred back to, or to whoever referred them.

CHAIR: It is faxed through to that place but then I guess sometimes the people we are talking about have gone through many hands and through many services.

Ms McINNES: And they often do not go back to that place.

CHAIR: That is what I am wondering. It sounds easy in theory but in practice it is quite difficult. With some of the people in Kim's case study, her predecessors did not handle them directly. Lots of people had indirect contact with people, and it is not easy to notify everyone.

Ms McINNES: No.

CHAIR: Or to say "Hey, this person is coming back today."

Ms LEWIS: I guess that is why I raised that dirty word, "money". I think people are all trying to do the best jobs that they can now. I do not think that the discharge plans are not done here because people cannot be bothered. I know that it is a big process and it needs to be done and they need to be signed off with certain people signing off those discharge plans, at the same time I am thinking about whether we would be involved from day 21. We would be in here, we would be involved, we would be thinking forward for this person because in some way we need to be that person's external brain.

CHAIR: So someone like you should have an input into the discharge plan?

Ms LEWIS: Definitely, and family, as family, as well, and a whole lot of services such as housing.

CHAIR: I am looking at the different bits in question 7 particularly because Chris and the rest of you are here. We have got a question about the role of non-government [NGO] agencies and the range of services delivered by non-government agencies in rural New South Wales. Some people have suggested that maybe compulsory treatment should not be a matter for non-government agencies; that it is a big step, and perhaps it should stay in government-controlled services. That is one issue. But I guess the broader issue, since we are talking about collaborative ways of working, is whether there are particular issues or problems associated with, say, government mental health services working with non-government services and drug and alcohol services and so on? Does that raise problems?

Ms McINNES: Huge—I have to say it. We as an NGO already take people on court, probation parole and the Magistrates Early Referral into Treatment [MERIT] Program, and they are basically given an alternative in front of the magistrate: you either go to gaol or you go to rehabilitation. Even though we are saying that they are voluntarily choosing to come, they are still coerced into some form of treatment, are they not?

CHAIR: Yes.

Ms McINNES: Certainly there is no difference if a person is directed by the magistrate to attend due to multiple break and enters [B and Es] or being a public nuisance with three strikes and you have to go somewhere under the Inebriates Act or whatever. But I think what we would have to be very very careful of is that the existing services, particularly at the Lyndon Withdrawal Unit

[LWU] are inadequately funded. We do not have recurrent funding. We have funding for only another 12 months.

CHAIR: And your funding is Federal funding, I think you said?

Ms McINNES: Yes.

CHAIR: You do not have State funding?

Ms McINNES: No. The only State funding we get is through MERIT and that is very local and through MWAHS through the State MERIT program for rehabilitation. That is only minute compared to the Federal funding.

CHAIR: In terms of bricks and mortar, you are in a building that was part of Bloomfield?

Ms McINNES: It is still Bloomfield's. We are unwanted leaseholders.

CHAIR: But you have got Federal money?

Ms McINNES: Basically the Lyndon community, which was an old established 21-year-old rehabilitation unit out at Canowindra, got together with Mid Western Area Health Service and said, yes, we need a detoxification unit, so let us do something about it. They were many many meetings across the table about this being a collaborative approach and about doing this and doing that, and what it came down to in the application and submission was that Lyndon would run it as an NGO but that the Mid Western Area Health Service would support it and also put in X dollars—initially $300,000—to refurbish and find a building and so forth. That got down to, okay, you can have a building left over out at Bloomfield, and it was the last one left and it had been closed for five years and it was overrun by possums. They put in $40,000 to paint it.

Incidentally I only found out recently that that did not come through the Mid Western Area Health Service but actually came through the State's New South Wales Drug Programs Bureau. They actually had to find the money in the end because locally would not give it. Ever since then we have been getting: do not touch the trees, do not walk off the path, pay to use the tennis court and the pool when it comes to my clients but everybody else in town can use them for free, and that is fine, and we will just put up with you, and you do your job and we will do ours. That kind of co-operation is not helpful for clients.

CHAIR: I think I have opened the floodgates.

Ms McINNES: It has been difficult, but it goes in cycles. For ages I could not get anybody assessed by a psychiatrist because, no, you are not part of the Mid Western Area Health Service so go away. It is like, well hang on, this client is living here now, this is her address, and I am willing to vouch for them. I have got them for six weeks or whatever, so can I have an assessment?

That has changed. I have jumped and down now to ensure that that has changed. If I ring up I can usually get an assessment within a couple of days. It does not happen very often, probably once a month, which is not a lot. That has improved. There is still a long way to go in collaboratively approaching this issue. The latest thing—and I am sure you do not want to hear about this—is the antiquated water system. Everybody else's water system was changed but not ours. Now it will cost thousands of dollars to be fixed and it will have to be closed down to do it because there is asbestos and whatever else involved. Basically they are saying it is our responsibility but they are still the owners of the building. These are the problems that you have to put up with while you are trying to help clients.

Ms KILLEN: I was not aware of all those issues.

CHAIR: From your point of view are their challenges involved in government and non-government organisations, working together? Is there an extra layer of complexity?

Ms KILLEN: There are always challenges in building partnerships and in maintaining them between organisations, government departments and sectors. I believe that that is the only way in which we will achieve the outcomes that we are after. We have to collaborate and co-operate as much as we can. I think that things will definitely not be assisted by short-term funding arrangements that really do not allow us to plan for the future and to attract and retain staff. We should be able to share resources in a more collaborative and ongoing way.

CHAIR: An overlap of Federal and State money and programs is another layer that makes it difficult, particularly when they are short-term programs.

Ms KILLEN: We are grateful for the funding that we receive. It would be helpful if we had more of a long-term tenure on funds. Although I understand the need to evaluate new services as well. The role of NGOs would need to be looked at. We have good evidence-based treatment. We would need to assess in individual situations what organisations were best able to do that at the time or in the future. I think we agree that the detoxification and assessment would need to be done in a fairly secure establishment. We would have to establish whether that is possible. It is usually possible in mental health hospitals so I suppose it should be physically possible in other sorts of organisations as well. I am not intimating that that is necessarily where people should be, certainly not in a major mental health unit or facility.

CHAIR: What about the role of GPs in the sort of system that you are thinking of? We have had some discussion about community treatment orders that are a bit analogous to probation and parole. At some stage through the six-month period you might move into a community treatment order where you may have to do different things twice a week.

Ms KILLEN: I have not given it a lot of consideration, but I have read and thought a little bit about it. I understand the arguments. Rather than putting people in a more secure institution you should put them into a community order for a non-criminal offence. By not acceding to the requirements of that order they would then be committing a criminal offence. Are we setting up someone to fail by doing something like that? If that were to be an option it would need careful looking at. It all needs careful looking at and careful phrasing, with a lot of consultation as the legislation is formed.

The Hon. GREG PEARCE: When there is a community order is it the alcoholic person who is punished or is it the community?

Ms McINNES: For some people with an addiction problem those checking mechanisms really help, for example, drug court program and things like that. For some people they work because they do not use them. Those people who go onto a community treatment order after a forced treatment period, for example, a probation or parole period, for another six months are out of gaol but they would still have to report for treatment, or see a counsellor, or take certain medication. I think that would be a useful tool and a guide for a lot of people. Obviously it will not help people who do not want to do that anyway as they will just jump the system. But some people actually like having something to measure up to. They need that reassurance. I think it is a part of the personality disorder that some people have. They like to do things and to meet certain criteria for a while.

The Hon. IAN WEST: Do we not all do that? I am obliged to drive on the left-hand side of the road. There are certain requirements that people have to face as part of society. I do not have any difficulty comprehending that, but is it necessarily as bad as setting up someone to fail by ensuring that they meet certain criteria?

Ms McINNES: The reason that you stay on the left-hand side of the road is that you will get a fine or you will lose points off your licence. If the consequences are set and there are goals to meet people are more likely to respond to them and to keep to them, in the main. There will always be a percentage that will not, but that is why we have gaols.

The Hon. IAN WEST: That is why cars crash.

Ms KILLEN: We suggest that as a first step along that line, or a step before the incarceration into a secure place if someone was on a community treatment order. We would closely

monitor that person to ensure that the goals and conditions were met. If we determined that it was not going to work the next step would have to be taken quickly.

CHAIR: When we talked to Martyn Patfield this morning he constructed a possible model for us. On this point of following up a community treatment order his suggestion was that you do not go to gaol if you fail; you basically then go into some sort of a secure unit. You are proving that you cannot cope, or you cannot handle that freer period, so you are reverting to a more secure position, which is the gaol you are having when you are not having a gaol. At least it is a medical facility and it is within a treatment framework; it is not just a locking-up framework. That is the difference.

Ms McINNES: That is assuming that, during the community treatment order phase, everything is looked at, for example, housing, companionship for people and trying to get them linked up with the community. We must do anything to keep them from being on their own and getting miserable again. That might include mental health counselling. It is not only drug and alcohol workers that should be providing that sort of counselling; mental health councillors should also be involved because a lot of their deep-seated problems originally started with depression and anxiety, post-traumatic stress and whatever. Those issues still need to be addressed.

Ms LEWIS: For me it sounds as though we are talking about the chicken and the egg. We are going to implement this treatment and all these other things. If it does not work they will be on community treatment orders and then go back to something else. They will be on community treatment orders and, if they fail on those orders, they will go somewhere else, but where is that? I am concerned about people with severe, chronic long-term histories of alcohol abuse because of their cognitive functioning. They do not seem to be without a lot of support. I am no expert in this and I am not pretending that I am, but they do seem able to grasp new concepts or to be able to learn from past errors.

If they were on community treatment orders it is tough, is it not? If they are not learning from past errors, the community treatment order does not work and they go back to this place, that seems to me to be more about treatment than it is about intervention and about putting systems in place without appropriate case management. A lot of work needs to be done for people with alcohol-related brain damage. We have to teach them how to take on new skills. I do not know anything about that. I do not know how that works. They used to have systems like that at Rozelle, but I do not understand the functioning of the brain well enough. By the sounds of these community service orders I am scared that they will keep falling back into their old behaviours.

CHAIR: That is undoubtedly true. At the moment we are looking at a system where people are falling back into their old behaviours. We are looking at a system that is not working very well but no-one wants no system. Everyone says, "We need something." Everyone says, "What we have is not working." I guess that we are unlikely to come up with a perfect system and it is unlikely to be perfectly resourced. So everything that you are saying is true, but is it better than what we have now? Does it introduce more variety and more flexibility? Have any of you spoken to Martyn Patfield about the model that he put before us this morning?

Ms McINNES: He started to talk to us earlier while we were waiting for you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: His submission did not include that model. When he received the Committee's questions he realised what we wanted and he developed the model fairly recently, only after he made his submission. I have the feeling that he put it together only fairly recently. There is nothing wrong with the model.

CHAIR: We agreed that we could get more from him. Summarising quickly, he stressed the need for proper assessment teams within the framework of a replacement Inebriates Act. He stressed that you cannot start off with the magistrate, with one family member or with one policeman, or whatever who initiates this order and a person turns up at Bloomfield or some other institution. No matter how the case initially comes to your notice you have to have a properly qualified and diverse assessment team. That person should be placed for a period in a secure place, for however long it is necessary to conduct the assessment. You have to have a medical team doing that.

Martyn then suggested that the team would then make a recommendation to a magistrate. So you have the safeguards of protecting people's rights and so on. Basically, the team would recommend a program to the magistrate and the magistrate would tick off the program with provision for reporting back to him if the program is not working. So there would be that mix of detoxification, rehabilitation, community treatment and GPs, all bearing in mind that in areas of sparse population—and this was taking into account the whole Bloomfield catchment, so we are talking about two-thirds of the State—you will never be able to have a building for this and a building for that. So you will have to be fairly flexible in the sorts of services you set up.

Ms KILLEN: And you would possibly use the tele-psychiatry tele-health technology.

CHAIR: He did not mention that, but I am sure that that would easily fit within what he was suggesting, particularly from the assessment team. All of that would fit within the framework of new legislation, something like the Mental Health Act, the safeguards, the view put forward by different people, the appeal possibilities and so on. We had a few questions about whether or not these medical people were getting a degree of power that might create problems. It also struck me that a possible net widening issue was involved. If you open up the routes by which people come under such legislation you may end up with many more problems and that would create difficulties. Other people might like to add things that I have forgotten. Broadly, that was the system that Martyn was thinking of. He certainly wanted to stop having people come to Bloomfield, unless a mix of problems meant that there was still a place for them. I do not know whether anyone else wants to add anything that I may have forgotten. \

The Hon. KAYEE GRIFFIN: If someone had to come to a place such as Bloomfield instead of a place that was dedicated to drugs and alcohol, the people should be mixed in, as is happening at the moment. In rural and remote areas people could access those services. If someone had to go somewhere like Bloomfield the problem for people in regional New South Wales relates to taking someone so far away, as is happening now, from their family and from their comfort zone. They would not have that family support. It would be difficult for a person to be taken such a distance away. That is an issue now and it would be if there were a dedicated place or a couple of places across the State. That would be another argument and the issue would need to be considered.

Ms KILLEN: They might be smaller or larger locations.

The Hon. KAYEE GRIFFIN: The discussion this morning related to the need for a place or a couple of places like that.

CHAIR: For the whole State.

The Hon. KAYEE GRIFFIN: But the problem would be where these places could be sited and the tyranny of distance as there is now with people coming to Bloomfield from long distances. If they have a support network at home, the issue is being so far away. It is a particular issue in the Aboriginal community.

CHAIR: As I said, talking from a Bloomfield perspective, they were talking about two-thirds of the State. That is something rather bigger than the western area. That was one attempt to put together a service system that might meet the objectives people seem to be agreed. I know it is out of the blue, but it fits in roughly with what you are saying.

Ms McINNES: It is not really who is doing it rather than how it is to be done. We need to be really careful. We know it is not useful to send people to places like Poplars under an inebriates order. The alternative is to send them to places where there is treatment. We have to be careful that there is realistic recurrent funding to maintain the services. We lose face with magistrates or GPs because they set up one system and start using it and folds because funding is stopped. Magistrates in particular have trouble trusting health people. It has become clear through the MERIT program that they prefer to trust people from the legal side. They do not trust health workers to do the right thing. We must do a lot of work there, but it will cost dollars and there must be recurrent funding. It must be very well thought out—who will do it and where it will happen. It should not be dumped on one organisation. There should be a lot more thought about where it goes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are worried about a carefully drafted legislative model but with no resources to back it up.

Ms McINNES: Absolutely. It means nothing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Effectively, the magistrate applies the law and they all fall off the sheet.

Ms McINNES: The first thing the magistrate will do here is ring us and tell us we have to take a person because this is the new system. I will say that I still do not have money for alcohol detoxification; I still cannot do alcohol detoxification. It must be backed up. That is what has happened time and again in this area. Beaut ideas and research come out of Sydney, but the infrastructure and the money is never allocated where it is needed to run with it. The classic case was 15 years ago when child sexual assault became a huge thing. People were encouraged not to be ashamed and to come out and tell everyone that they had been assaulted. It was said that one in four had been assaulted. What did they do? They did not increase the number of workers. There was one worker here and it stayed that way. That worker burnt out in three months because people were flooding into the system.

Ms KILLEN: I am not sure what percentage of people might otherwise have been subject to an inebriates order if it had worked better. It might have been used more. I am not sure how many would have ended up in the criminal justice system.

CHAIR: There is a great shortage of data, including about how many people are under inebriate orders.

Ms KILLEN: When the Act is redeveloped in a more workable form it is likely that more people will be referred. That could be good if they were costing more though other services. On the other hand, we probably need to project the figures to a realistic level given the number of people who might come in under the revamped Act. There would probably be many more.

CHAIR: That is our suspicion. Many people say they are not using the Act because it is bad, out of date and totally wrong headed in many ways. Presumably if we had a better Act more people would use it. Martyn Patford has suggested more separation between alcohol and/or drugs and mental health. One of the other people said the trouble with that is that if we keep the link with mental health there might be more resources because both are historically under resourced. There was a warning this morning very much along the lines of what you are saying.

Ms McINNES: It is sad, but true.

CHAIR: I think we have probably dealt with most of the other questions. We have talked about whose role it is. You might want to say more about the suggestion that drug and alcohol workers might feel uncomfortable seeking orders. Do you feel there is a bit of a conflict of interest or is it a reasonable part of your ongoing role?

Ms LEWIS: The word "dilemma" shocked me. It is not a dilemma for on-the-ground workers. The question is whether it is our role. Should we be the seekers of orders? It was suggested earlier that one GP might be involved in the Act as it is, or one family member. The four cases that [Town X] has been involved in have involved affidavits from numerous services, family members or neighbours. It has not been a case of simply telling a GP to tell a magistrate to send a person away, although it must happen that way.

CHAIR: The suggestion is that the affidavits are perfunctory. There is a feeling that if someone should be under an order people fill in the relevant forms.

Ms LEWIS: We have not seen that, but I am sure it happens. As a rule, drug and alcohol services and clients work on motivation. It might have been seen as a dilemma for drug and alcohol workers to approach clients with this. That is not something I know. We work well with clients and develop a rapport and engage them well. It is along the same lines as saying to someone, "Because you have told me A, B, C and D about your children, I need to notify," or "Because you have told me

your feelings about harming yourself, I have to refer you to mental health services." If someone is drinking a huge amount we do not have a problem telling them that their right to drink should be removed to make them safe.

CHAIR: Have we covered what you might want to tell us about question 10? The Act covers other drugs, not only alcohol.

Ms McINNES: I can remember it once being used for someone other than a drinker in this area, but that was a long time ago.

CHAIR: The issues are broadly the same.

Ms McINNES: They are the same. Illicit drug users fall foul of the law and usually go that way rather than having a caring GP using the Inebriates Act. It is just another course they take. It is much the same; they still get incarcerated.

Ms KILLEN: Perhaps with different treatment afterwards.

CHAIR: Is the MERIT alcohol pilot being conducted, or is about to start in this area?

Ms KILLEN: We have advertised for a project officer, who will be developing the parameters around that project in collaboration with the department.

CHAIR: When is it likely to start?

Ms KILLEN: It will be started some time in the next financial year.

CHAIR: In Orange?

Ms KILLEN: The exact parameters have not been established. That will all have to be worked out in the next few months.

CHAIR: There is not much you can tell us at this stage.

Ms KILLEN: No, except that it is a very worthwhile pilot.

The Hon. GREG PEARCE: So you have run out of money for this year and you have to do it next year.

Ms KILLEN: No.

CHAIR: It has not been done anywhere before. This is the pilot for the State.

The Hon. GREG PEARCE: It has been used in other places.

CHAIR: Not for alcohol. Are there any pilots anywhere else or just in this area?

Ms KILLEN: I am not aware of any other pilots.

CHAIR: Do you have any views on it, Ms McInnes? You are involved in a MERIT program dealing with drugs. Do you see any major differences?

Ms McINNES: It is great that it is being expanded to cover alcohol. We have often wanted to make referrals to MERIT, but they could not take them because they were not illicit drug users. They fit the criteria beautifully. It will open up far more referrals because we know that alcohol is a bigger problem in this area. Drink driving offences are increasing. We will see many people put through this system to us, and that is fine. I do not know that all of them need to come through the system we have. We will have to look closely at whether they do residential rehabilitation or outpatient treatment. Many people with alcohol problems work. We must consider those things. We could have after-work lessons, lectures, groups, treatment, therapy or whatever.

CHAIR: Is all this in the melting pot?

Ms KILLEN: It has to be established and agreed between the various departments. However, the illicit MERIT program we have had running has been very well received by the magistrates in the area. The evaluation has been conducted on the Northern Rivers project, and that is positive.

CHAIR: We have heard some evidence that there is a bit of resentment and some difficulties for the service. The MERIT people who have chosen that path as an alternative to gaol sometimes interfere and create dissension among the people in the centre for another reason.

Ms McINNES: That is true. We still have magistrates bailing people to rehabilitation. There is always that. Regardless of that, a percentage of people will always come along because they think it is the best thing to do at the time because they are coerced. They are not finished using. They are 18, 19 or 20—especially young people—who really cannot understand why one possession charge of marijuana has caused them to be shipped to this horrible place with all these old junkies—"I am not like them", and all the rest of it kind of stuff. They do play up and they do hate it and tend to leave very quickly, despite our best efforts to keep them there, but we cannot please everybody. To keep it safe for everybody you have got to get rid of, or sometimes encourage people to go when they are becoming difficult.

CHAIR: So you do not think, for instance, that MERIT, either for drugs or alcohol, should operate in a different centre?

Ms McINNES: I think it is actually good and that there is a benefit to having a balance of clientele. We find that people who come with no orders and who are doing it for themselves or for their family—it might have come to a push because of a relationship or something or a child order, or something not necessarily legal—they actually add a calming influence to the units in terms of they are usually older and usually a little bit wiser and they have had other life experiences. Some of the other people who come on orders might come with what I always call a chip on their shoulder. They come through the door with the attitude.

They actually settle down if they are given time and learn to talk to other people and find out that this is not such a bad place and they can be treated humanely and with respect if they treat other people with respect, and so forth. We do occasionally see change. It is not very often that people just get up and walk out, but certainly it is more of the case when they are forced to come here than when they voluntarily come. But I think the mix is good. You may as well put people in gaol if you are going to separate them. Why not have the people undergoing rehabilitation in gaols and spend money there in the first place if you are going to have a special place for people who have been put on orders like MERIT or court and bail. You may as well have them in gaol and do it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not sure that that is right in the sense that there is a different paradigm. It seems to me that any gaol would be more than happy to have as many programs as you like as long as you fund them.

Ms McINNES: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that does not mean that the people who go into those programs will quickly go back into society. Being outside the gaol, presumably the reintegration would be better.

Ms McINNES: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But I am interested in your comments. You made two comments, one about the difference involved in integrating with mental health and the other one is that you said that the health system has difficulty integrating with the legal system. I think that has been very true. For this Committee's conclusions, we have to decide the degree of integration or have some concept of the integration of mental health and drug and alcohol and also between the legal system and the system that MERIT is going to deliver, if that is going to

expand, and I guess also the prisons system, if it comes to that. The inebriates this morning were talking about really wanting some work. Presumably that would have to be done with parole because it would be unpaid work that was giving someone something to do besides drink. Could you make a comment about the integration of systems and what sort of things have to happen on the ground so that when a new system goes forward, the steps that there are needed to integrate the systems?

Ms McINNES: I could, but whether I will make any sense or not, I do not know. My observations about any of these systems—any government system—is that if it is not coming from above downwards from leadership, it is not changing, it is not happening. That can go straight back to the State level in terms of if it is not being pushed through and people are not being made to do this, to work collaboratively with people and communicate, then it does not happen because they get so snowed under with bureaucracy and red tape and paperwork and are so underresourced sometimes that it just does not happen. I have seen that so often in the past 25 years. People sit in positions, do this job—a project or whatever it is—for 12 months and then move on and nothing has changed. There might be a little bit of benefit, but not a big benefit, and things move very, very slowly in that respect. As far as the magistrate is concerned, your comment about that was that the local magistrate herself has said to us that she does not trust Health. She has had bad relationships with Health in the past and does not trust Health. She only trusts the people who were coming from the probation and parole [P and P] side or the legal side. Fortunately she did not include me in that. She saw me as outside Health because I had gone and left Mid West and had gone to an NGO.

The Hon. IAN WEST: This was while she was talking to you.

Ms McINNES: Yes. That was her opening statement when we met her when she came to town, so yes. But anyway, it is true. I have seen her in court say that she will not take any notice of that worker's statement, whereas she will listen to a probation and parole officer. That is a mind set. We have to change that through training and more closely working together, but also have to understand where we are coming from. We have done huge things with the magistrates, both this one and the past one, in terms of inviting them out to the unit and being involved in open days and forums and stuff. That does make them feel involved so that they know what goes on, and they have both done that, which is great. But I do not think that happens everywhere.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is bottom upward, is it not?

Ms McINNES: Yes. It has got to happen.

CHAIR: What do you want to see come out of the inquiry?

Ms KILLEN: Let us see better legislation and a better system in place to assist people who are at this difficult end of the spectrum of drug and alcohol dependence. I guess I would like to see maybe as an offshoot of that a lessening of the stigma surrounding drug and alcohol generally and maybe a continuance of improvement in the sector.

Ms McINNES: I think an important point is that the stigma is not just the uneducated community. It is also health professionals and it is also legal professionals—is police. It is everybody. It is out there. A lot of it is because it is just misunderstood or it is their own fears about their own consumption of alcohol, and whether they might be having a problem.

Ms KILLEN: I just want to say also that I do think the Drug Summit and the Alcohol Summit—and the Drug Summit certainly—have improved the way things happen substantially. Hopefully this is part of one of the outcomes of the Alcohol Summit. I guess I am just hoping that this can continue.

Ms LEWIS: I guess I would still like to see the availability of compulsory treatment for people who are incredibly unwell, at risk of harm to themselves or of harm to others. I am not sure what Martyn's idea is, but I do not agree with the three-day schedule because I think these people need a much longer time within the initial treatment to get out of that haze, and I do believe that it needs to be expensive. The treatment will cost money and it will need to be resourced really well, but I hope that there are good outcomes. I once heard Stephen Jurd speak at [Town W] saying that he believed that the effective intervention was a wonderful cost saving: If you are putting $50,000 into a drug and

alcohol wage, you might actually take $200,000 away from the health system or the legal system elsewhere. That is the type of stuff I am thinking.

Ms McINNES: I would just like to say again that I agree with all of that and we need realistic money placed on a recurrent basis. You just cannot do these things for 12 months or two years and then walk away from it. They have to be recurrent.

CHAIR: Thank you very much for attending, and thank you, Didi, for organising it for us. We will go away now and carefully consider everything we have heard.

(The witnesses withdrew)

The Committee adjourned at 3.07 p.m.