Corrected transcript

REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At Sydney on Thursday 29 April 2004

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)

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

WAYNE DENIS HALL, Research Psychologist, University of Queensland, affirmed and examined:

CHAIR: In what capacity do you appear before the Committee?

Professor HALL: I give evidence because I have worked in the area of addiction treatment.

CHAIR: Do you want to give us an opening statement before we go specifically into the questions we have sent you?

Professor HALL: Yes, I thought I would give you a bit of an overview of what my experience has been and what my broad view on the issues is, and then move onto questions. Between 1994 and 2001 I was the Director of the National Drug and Alcohol Research Unit here at the University of New South Wales. Our brief was to do research into the treatment of drug dependence, and one of the things I did while at the centre was to review the literature on the effectiveness of legally coerced treatment for addiction. I believe I have made a copy of that available to the Committee. Almost over 30 years ago I worked as a psychiatric nurse at Callan Park Hospital and had direct personal experience of the Inebriates Act as it then was in all its glory. In 1977/78 I worked in the New South Wales then Health Commission evaluating psychiatric services, and again had an opportunity to see the Inebriates Act on its way out. At that particular time it was falling into disuse, and I have some information on that. I guess at that time, too, the divorce between mental health services and services for the treatment of addiction was under way.

More recently, in 1989, I was asked, while at the National Drug and Alcohol Research Centre, to give an opinion on the proposal at that time to repeal the Inebriates Act, which, as I am sure you are well aware, failed. That has been my acquaintance with it, and I am happy to elaborate on any of that if you want me to do so. I guess in terms of the position on the broad ethics and acceptability of involuntary treatment of people who have severe problems with addiction, my attitude, I guess, could be summed up in the word "ambivalence". I would accept, in principle, there certainly are individuals who may well benefit from such treatment under unusual circumstances. I believe it is ethical to provide that treatment under certain circumstances, that I am happy to elaborate on later. But in actual fact the conditions that I think need to be met are rarely met in practice, and the quality of treatment that is provided, and has been provided under these sorts of Acts, has been sort of de facto imprisonment rather than effective treatment. That is just to give you an idea of an overview of where I am coming from. I am happy to elaborate on that position and spell out anything that you might like to know more about.

CHAIR: Knowing your views from your conversation with Ms Thompson and so on, our third question invites you to tell us what you see as the key ethical issues, if you distinguish, in relation to offenders and non-offenders.

Professor HALL: I guess I probably would. Most of the literature on this topic and most of the discussion has been around the very special situation of offenders, where people are legally coerced into treatment because they have committed an offence or been convicted of an offence to which their drug and alcohol dependence has contributed. That has been the situation on which most of the research has been done. Surprisingly, there is very little research on treatment for people who are not offenders, as was possible under the Inebriates Act. I guess if we look first at the situation of legally coerced treatment, and that is the scenario I looked at in the paper I wrote, the position I took there was the one set out in 1986 by the World Health Organisation that it was ethically justified to provide treatment for a person who was drug and alcohol dependent who had been convicted of an offence to which their drug dependence contributed, and that that treatment be undertaken under threat of imprisonment if they fail to comply with these conditions. That is the scenario I want to be fairly specific about.

I regard that as ethically acceptable if the following conditions were met: that there was judicial oversight of the system—so there was a member of the judiciary, whether a magistrate or a judge, who took the evidence and was involved in the decision; and that the offenders were given a constrained choice—as they were not sentenced to a particular form of treatment they had the choice on the first instance of whether they want to be treated or not, and if they chose not to then they would be processed in the usual way by the criminal justice system and that might involve imprisonment. If

they chose treatment then they ought to have a choice on the type of treatment rather than be sentenced to a particular variety of one. The other condition is that humane and effective treatment had to be provided. I think there has been a real concern about the way in which a lot of these systems have operated.

I guess it was implicit in that paper of mine, but I would make it more explicit now, the major concern I would have would be ensuring that this system is adequately resourced so that it was not at the expense of the voluntary treatment system. We have to think clearly in considering the involuntary treatment and its potential impact on the quality of treatment provided for people who request assistance with their addiction. If that is not properly resourced, that can be a real issue and I think there are issues I will come to later on, the circumstances in which the treatment is provided. If we end up having locked wards where people are compulsorily treated and they are the same sorts of locations as people seeking voluntary treatment, I think that can have adverse effects on the attractiveness of treatment both for patients and also for staff who work in those sorts of treatment centres. I guess we are looking more at the scenario where people have not committed an offence, and I think of this as involuntary treatment for paternalistic reasons, and by that I mean we are overriding the autonomy of adults in their own interests to protect them from themselves and from their behaviour.

I do accept that paternalism can be justified under certain circumstances. When we are doing something for a person's own good, I think the bar has to be higher than it is in the case when we are doing something because people have committed an offence against third parties, as in the case of offenders. Clearly, there has to be evidence that a person's autonomy and capacity to make informed decisions is impaired by reason of their addiction. They have to be at some immediate risk of serious harm. The interference with their autonomy ought to be temporary, for the minimum required to intervene to prevent that harm from occurring and to provide them with an opportunity for treatment. Again, I would be in favour of there being judicial oversight, preferably with the same kind of representation as occurs under the Mental Health Act. Humane and effective treatment should be provided to people who are treated in that particular way.

CHAIR: It is particularly interesting talking to you about some of these things this morning because of the discussions we had in Melbourne yesterday about their 1968 Act and the shorter period compared to the New South Wales Act, the seven-day period where, really, you are much more focused on detoxification. We will probably ask more about that as we go on. Because of your views on these things and because your views are slightly different, we have a lot more questions than we have been asking lately on the compulsory treatment area. One of the things we also found yesterday from the literature review that the Victorians have been doing is just how little real research and evidence there seems to be around the whole area of what they were referring to as civil commitment. But a very important of that, obviously, is related to our question 4 about whether there is a sound enough evidence base to indicate that compulsory treatment can actually be of benefit.

Professor HALL: I think the short answer would have to be “no”. I think there is somewhat better evidence for coerced treatment than there is for civil commitment, if we use that in the sense of drug dependent people being committed for their own good rather than because they have committed an offence.

I do not know of any controlled studies of civil commitment, certainly with alcohol. There was some work done in California in the 1960s, the civil commitment addict program there, although a lot of those people in fact were committed because they had committed offences rather than because they were simply using opiates and were dependent on them.

There was a recent update of the review which I did in 1997, which is now seven years old. There was a recent paper in the European *Addiction Research Journal* reviewing the literature since then, which comes to broadly the same conclusion: that there is not a lot of strong evidence for efficacy and it is almost all in the area of coerced treatment.

The evidence consists of comparisons of outcomes for people who have been coerced into treatment with the outcomes of people who have not. The two groups have not been matched or randomised so that there are real issues about how comparable the two groups are. Very broadly, it suggests that coercion of offenders results in better retention in treatment and probably no worse outcome, so it

does not appear to impair outcomes. Therefore there is probably some benefit, in some circumstances, in coercing some offenders into treatment.

With regard to the civil commitment addict program, I do not know of any evidence that would support that. There has been a recent evaluation, which you may or may not know of, in the *British Medical Journal* of involuntary treatment and community-based orders of psychiatric patients, which has not found startling evidence of benefit there either, although there is some evidence of benefit. I think we have to be realistic about what we can produce with these sorts of interventions.

The Hon. IAN WEST: How do you measure benefit, and to what extent does the adequacy or inadequacy of resources and follow-up muddy the outcomes?

Professor HALL: I think they are tied up together, as I said earlier. One could imagine a well-designed treatment system that was well resourced producing pretty reasonable results, but what you have to look at is what is likely to happen in practice. These sorts of treatment programs are typically not well resourced, and they are not attractive programs for staff to work in. So the two are linked up; I would agree with you on that.

The Hon. ROBYN PARKER: In relation to that well-resourced and well-defined treatment program, if as a result of this inquiry we made recommendations that put some of that in place, and if such a program were to be well resourced, do you think we would then see an increase in the numbers of clients treated?

Professor HALL: Under a civil commitment program?

The Hon. ROBYN PARKER: Yes.

Professor HALL: I do not think there would be any doubt about that. The thing you would have to worry about, given the shortage of voluntary treatment programs, is the extent to which they might be used as an express lane into treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you speak about effectiveness of treatments, I suppose I am increasingly thinking about the cost effectiveness. A psychiatrist's view of effectiveness is often functional: do they function in society; do they hold a job; can they have relationships, and so on? Often that is not a clearly defined outcome. It seems that you can have either a residential or a community-based program, whatever that means; you can put them in gaol, or you can have them die in intensive care. I come from a background of watching them die in intensive care. We have also seen a lot of people going to gaol. When you say something is not effective, if you are to avoid either of those two outcomes in terms of expense and trouble for society, you could call that an outcome, could you not?

Professor HALL: Yes. The outcomes I am talking about involve the unrealistic expectation that this is going to produce people who are abstinent and will end up back in society holding down jobs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you look at the ones who are criminalised, you are comparing treatment systems with incarceration in terms of cost.

Professor HALL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you look at civil ones, you may be comparing them with dying from liver failure in care units.

Professor HALL: You may.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a question of probabilities that has to be taken into account: What percentage of alcoholics will end up dying in intensive care units, at what cost, and what percentage of alcoholics will get better at what cost? It might sound callous, but they do it in relation to road accidents. They say: Will we fix this road given the number of people who have been killed?

Professor HALL: There are doubts even on those sorts of criteria, if it is purely based on harm reduction. I do not think the evidence is there that this sort of intervention does that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has anyone looked at it, though?

Professor HALL: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you not do it on an envelope calculation?

Professor HALL: I do not know whether the data would be good enough. It is an exercise that is well worth doing. The conclusion we ought not jump to is that civil commitment is the only one to achieve this goal. I think there are a lot of other ways, eg proclaimed places and other forms of intervention that give time out for people who are heavy drinkers that attempt to reduce the harm are a good idea. I would be very supportive of them. It is a question of whether they have to be accompanied by coercion or whether they ought to be services that are more readily available in areas where heavy drinkers congregate and where they are to be found. I think we need to look at a range of options rather than simply either coercing treatment or leaving people to the mercies of the street.

The Hon. IAN WEST: However, you could have a mixture of the two?

Professor HALL: Yes, you could. The other trade-off with coerced treatment is the extent to which people who are heavy drinkers or drug users are fearful of treatment seeking because they may end up being coerced into treatment. You may well have counterproductive effects. Word gets around that if you turn up to that service when you are in trouble, they are likely to commit you.

The Hon. IAN WEST: Would you be able to use the coercive trigger, if you like, as an invisible wall to enable them to be more receptive to voluntary treatment?

Professor HALL: It depends on what sort of penalties are going to be used in the event of non-compliance and the extent to which hospital staff would be prepared to act as de facto warders, locking people up. There are lots of practicalities which we need to get onto. There is the front-end issue of how you go about making decisions and protecting individual liberties.

The Hon. IAN WEST: However, assuming that you do not have to deal with the resources and follow-up issues, in terms of a concept what is your view?

Professor HALL: As I said earlier, I could imagine there being a case made for coerced treatment. In the scenario that the Hon. Dr Arthur Chesterfield-Evans spoke about, where people are seriously ill and there is the risk of liver failure or serious complications. Those are cases in which one would argue for the right to intervene and coerce people into some emergency medical treatment, possibly for a period of 7 to 10 days, to help sort them out and provide respite and an opportunity and an encouragement to enter treatment. Whether there would be any case to be made for doing things longer than that is where the argument might arise.

CHAIR: Given your view, you may have very limited answers to parts of question 5, but it is certainly helpful to us if we can run through them.

Professor HALL: Yes. Unfortunately I do not have the list of questions with me.

CHAIR: I will provide you with a copy of the questions. Question 5 relates to the major focus of the inquiry being on non-offenders, and the majority of inquiry participants arguing for some degree of compulsory treatment.

Professor HALL: I am happy to restrict attention to that from here on.

CHAIR: Do you think compulsory treatment is ever necessary and ethically justified? I think you have dealt with that, and we have just discussed some of the questions listed in question 5.

Professor HALL: To elaborate on the answer to the Hon. Dr Arthur Chesterfield-Evans, I think the shorter period of compulsory treatment is easier to justify. The scenario we have been talking about where people's health is at serious risk is arguably defensible. We are probably looking at detoxification and some basic medical care and some prophylaxis against Korsakoff's syndrome.

A lot of that used to be done under the Inebriates Act. If one were to look at the more positive side of the Inebriates Act, there is certainly an important harm reduction function that was served in the wards that I worked in. We did clean people up and got them into much better shape, and by the end of the week they were looking a lot better, before they were shipped off to Bloomfield Hospital in Orange, often for six months at a time.

For that shorter-term intervention, I think I would agree that some form of coercion or compulsory treatment would be justified. Longer-term treatment options are much more problematic. Certainly long-term residential rehabilitation becomes an issue. You have to have security to prevent people from absconding. I think a lot of residential programs might be reluctant to return to locked wards and doors. In this case, you do not have, as you do with coerced treatment of offenders, any legal penalties for non-compliance. I suppose you have civil penalties, but enforcing them might be difficult.

I suppose there would be the analogue of supervised maintenance medication for some forms of dependence, as occurs with long-term treatment of psychosis with medication and so on.

That is a possibility, but there might be some reluctance on the part of the community to compel people to take long-term opiate maintenance medication in the case of methadone or buprenorphine, or naltrexone in the case of opiates. Certainly one could encourage, and it would be reasonable to persuade people while they are in for a shorter period, to contemplate those treatment options and to do whatever could be done to hook them into existing services.

CHAIR: From what you have said, compulsory treatment would be appropriate only to avoid serious self-harm?

Professor HALL: Yes, I think so. Otherwise you will end up with what happened under the Inebriates Act; a chronic alcohol abuser would end up "doing time". It would end up sweeping large numbers of people into the system for that purpose. It might be more humane than imprisoning them and maybe marginally less costly but we should not kid ourselves that it would be therapeutic.

CHAIR: Would you accept the argument that in the interests of a family or the community, someone whose behaviour has become very difficult is a reason for locking up that person?

Professor HALL: I can certainly understand the difficult predicament that alcohol and drug dependence causes families. There are enormous problems, as there are with psychosis. Whether locking up people is a solution to that, I have my doubts, other than as a short-term solution for people who are acutely ill and a serious risk to themselves. They could be hospitalised for brief periods to try to stabilise them.

CHAIR: Would you rule out for arguments about respite for a family, or a broader rehabilitative approach?

Professor HALL: I would not rule them out but I think one has to be realistic about how likely it is that those systems will work.

CHAIR: You would have gone through the criteria fairly well. Referring to treatment, you mentioned basic detoxification and attention to physical health.

Professor HALL: That is the most that you could reasonably expect to do in seven to 10 days, and introduce people to treatment services and make them aware of it. When talking about alcohol you would certainly try to get people involved in Alcoholics Anonymous [AA] and programs of that sort and encourage them to contemplate admission to a residential program of some sort and look for social support. If their social circumstances were better, you might offer some of the pharmacotherapies to assist people in remaining abstinent. That would need to be given in a socially

supportive setting, with a family doctor or other person involved. There is a limit to what you can do with coercion. You have to try to engage people in that treatment, you cannot compel them to attend a group, such as an AA group. That would be a contradiction in terms.

CHAIR: The Committee has heard a lot of evidence from practitioners and others who have said that there is a great gap in follow-up. Even knowledge of longer-term outcomes is lacking, partly because of the absence of follow-up. Obviously some of it is incredibly difficult to do. Clients come out of various forms of treatment and vanish. Should we look more at the kind of follow-up that compels the service providers to follow-up so that there is much more attention to getting them into longer-term support programs?

Professor HALL: Yes, I would agree with that aim. That was one of the recurrent complaints I made in my previous position. So many services put so much resources into the front end of treatment and detoxification, and short-term residential programs, but once the people are out of the programs there is no organised follow-up. Mental health services have begun to recognise the importance of aggressive outreach. We really need to put those sorts of programs into effect in the treatment of alcohol dependence as well.

CHAIR: Why does the gaps exist? Why do the services put so much attention into the front end and little into the follow-up?

Professor HALL: The focus is on what happens in the four walls of a treatment facility; that is what people think of as "treatment", rather than what goes on outside.

CHAIR: Should drug and alcohol services act more along the lines of community mental health teams?

Professor HALL: Yes, I do not know how widely implemented the model is in the mental health services. I know people still complain about the same gap in mental health services, as with addiction services, I do not want to hold that up as a model. It is certainly advocated more there as an aggressive outreach to involve people to follow-up, and not let them drop out of treatment or disengage without some sort of effort to follow-up.

CHAIR: The Committee spoke to a community health worker who, while focusing on mental health, was very conscious of people in her area with alcohol and drug problems and she was able to play some role in the follow-up and checking on how they were going. Should we continue a total separation between mental health and drug and alcohol within the health system?

Professor HALL: Yes, I think that is a larger underlying problem—the great divorce between the two sets of services. It has gradually evolved and certainly was very pronounced in the late 1970s when I was with the Health Commission. The Mental Health Act at that time, or sometime after, explicitly excluded people affected by drug and alcohol problems from the remit of the Act. I was evaluating the deinstitutionalisation of hospitals and we surveyed hospital staff on what sorts of patients were the most suitable or unsuitable for treatment in mental health services. At the top of the list of unsuitable were alcohol and drug dependent people; no-one wanted them in mental health services. I can understand that. If you are dealing with acutely psychotic people, having large numbers of people rotating through detoxification, presents challenges.

Extruding them from the mental health system and from the oversight that went on, and the rundown in mental health services—drug and alcohol services are the poor cousins of mental health services, which are not fabulously well resourced in our community—certainly presents problems. There are issues around how one would regulate, and what sort of oversight would exist if you were to go down the route of some form of compulsory treatment. Setting up a whole separate system seems a pretty expensive option, even if one were to allow that the number of people who would come under it would substantially increase if the services were properly resourced. It would make sense to use the Mental Health Act, although that would clearly present problems at the moment because very few people would meet the criteria under the Mental Health Act.

The Kirketon Road submission gave good examples of people who would. People with drug-induced psychoses or withdrawal delirium and serious medical complications of drug and alcohol dependence

would probably meet the criteria of the Mental Health Act. But that would warrant only very short-term treatment, probably days, even seven to 10 days. If you were to use the Mental Health Act you are probably looking at some sort of amendments to allow addiction to be a reason for hospitalisation. You would need a fair amount of retraining of psychiatric staff. Psychiatrists have not had a lot of experience in dealing with people with drug and alcohol dependence. It is part of their training but, because of the separation of services, their exposure to alcohol and drug dependence has been more often limited to people with mental illness and alcohol and drug problems, rather than drug and alcohol problems per se.

Magistrates and tribunal members and ward staff would need to be re-educated if we were to use psychiatric wards, and I do not think that is a great idea. From some of the submissions I have read that view is shared by people in psychiatric services. There would be real problems in doing that. But one could use the Mental Health Act as the architecture for oversight of the system and then specialist addiction services as the place where treatment might be provided. That would be an alternative.

CHAIR: Would that be your preference to keep the two systems separate?

Professor HALL: Given the difference in cultures. There are various proposals to reunite them. I would not hold my breath on that happening. That idea has been around ever since I have been in the addictions field. I do not imagine it happening easily. If it were forced, I do not know that it would work terribly well. That is probably a fact of the organisation of health services that you have to work with.

CHAIR: Yesterday the Committee was in Melbourne and we spent some considerable time talking to people from the non-government sector who either run an individual service or have knowledge across the field of the way in which the drug and alcohol centres compulsorily detain people. That is part of a separate non-government drug and alcohol service. Is that a model you can comment on?

Professor HALL: I do not know much about how it works. In principle, I would have no objection, as long as there is some independent oversight. It does not have to be government facility to provide the service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In Melbourne the question of oversight came up. People from Moreland Hall said rather bluntly that there was not enough oversight of what they were doing, they were not saying that they did a bad job. What model should there be for oversight of those services, particularly if you have to provide a fund that is split?

Professor HALL: I was involved in the evaluation of the legal representation of the Mental Health Act in 1977-78. That was not an issue we had to contend with; a funder-provider a split. It is in everyone's interest that there is some form of independent scrutiny, not least of all the people providing the treatment, so that there is some degree of protection and community sanction of what they are doing is appropriate as well as of the people who are receiving treatment. It has to be some form of quasi-judicial tribunal. In Queensland the mental health tribunals have three members; a lawyer, a medical practitioner and a community representative. That is not too heavily handed, and patients can have representation either legal or non-legal. Those opportunities are important. We do not want QCs and barristers, the wigs, the full adversarial system. That is not appropriate. But there ought to be some opportunity for independent parties to represent the interests of the individuals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My question, rather, was to the regulation of the providers. I take your point about regulation of clinicians in individual cases. Moreland Hall representatives said that there was not much regulation there; they had a contract for a quarter of Melbourne. There was not much competition in the sense that someone might say that they would lose a contract because there was another contractor ready to jump in tomorrow. In a sense, that is regulated. As there are 125 providers, that means in the small towns you could find another provider, but in a big facility you could not. You actually have a long-term contractor. Now they are talking about partnerships rather than contracts. That suggests they have to be in bed together. What model do you suggest for regulation of relativity providers, including NGOs? What are you aiming for?

Professor HALL: That issue had not occurred to me. Historically the private mental hospitals in the eighteenth century had the capacity to lockup people. There were all sorts of opportunities for exploitation for financial gain. Recently I attended a meeting of the World Health Organisation in Geneva. The accusation was made about detoxification services in China, which are run by the military, charge the families. That it is a profit-making enterprise. The same sort of operation occurs in Indonesia. One would have to be wary of the extent to which you provide an incentive for people to effectively incarcerate and compulsorily treat people, if there was a financial interest in doing so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the American system the mentally ill are committed until their insurance runs out. If you look at quality control, and have a facility that is predominantly publicly funded, what regulatory system would you suggest? What independent advice should the Government get to ensure that people are doing the right thing? Should that be separate from the department?

Professor HALL: I think it should, it has to be. It would have to be at arm's length, at the very least. I am not sure how you would set it up. That set of issues had not occurred to me until you raised them today. Clearly there are complications that arise from the privatisation of lots of public services.

CHAIR: The 1968 Victorian Act, which is in force, grew from an older Act. It has provision for an inspector.

Professor HALL: Yes, there used to be an inspector-general for the insane, and official visitors.

CHAIR: Official visitors, community visitors, but that was never implemented. There was an inspector for five years, then it lapsed. The official visitors never existed. Presumably those systems could operate, whether government or non-government?

Professor HALL: Yes. Certainly under the old Inebriates Act the system had become so routine, as it happened with the Mental Health Act, the form was filled in with the patient's name and six months on it and the magistrate just had to sign it. There was no examination of evidence, consideration of cases. It was a rubber stamp. That is the worry that often happens when our systems become so routine and large numbers of people are processed that it just becomes something that is not thought much about. Unless there is some major scandal you do not get much in the way of oversight.

CHAIR: Our question further down about a legislative framework gets onto some of these issues. For instance, whether you need a magistrate to sign the initial order? When we talked to people at Bloomfield, some people there felt very strongly that there should be a much more expert medical input into the initial decision-making rather than a magistrate. Perhaps it has become the practice that a police officer or a general practitioner signs a bit of paper and the magistrate signs a bit of paper and off the person goes.

Professor HALL: Yes, and certainly what we saw of the way magistrates operated under the Mental Health Act in the late 1970s, they were not a serious independent authority that checked that. I guess the system as it seems to be operating in Queensland—I have a bit of familiarity with that—it has a tribunal of three members, which does include a legal representative, someone who is familiar with the Act, a medical practitioner, and a community member provides a bit more because you have to get agreement from three people.

CHAIR: Is that a panel that operates after a person's initial admission or is it a panel that operates to make the decision?

Professor HALL: It is more of a review after the event, and in more contentious cases if an ECT is ordered against a patient's wishes there will be independent scrutiny of that or if a community treatment order is issued, or the renewal of a treatment order, there would be some discussion of that. They are the sorts of triggers the tribunal looks at.

CHAIR: The Chief Magistrate here has also expressed concern about magistrates with generally no background and no general knowledge and having a case brought before them. It would be fair to say that the Chief Magistrate does not think it is a proper system that operates.

Professor HALL: No. If the system is rarely used and magistrates rarely come across cases, they are not in a position to make an informed judgment. Historically there was the central Darlinghurst admission centre where all psychiatric cases went through a single court. It had magistrates with some familiarity, but centralising this sort of system defeats the purpose of it being reasonably micro-responsive to need. There has to be some sort of trade off. It is difficult. We have to accept whatever regulatory and oversight system we set up will be imperfect and there should be some other checks further along the way to monitor what goes on after the initial event.

CHAIR: That might even go hand in hand with data collection, which seems to be conspicuously absent everywhere at the moment?

Professor HALL: Yes.

CHAIR: I suppose that tells you something about how a non-systematic system operates. In New South Wales and Victoria and elsewhere there seems to be a gross lack of data.

Professor HALL: I think they are often using this sort of area. I would be a very strong advocate of some small-scale trials of any system that was advocated before being rolled out, and the more rigorous the design the better. What tends to happen in these sorts of areas, and it has happened in drug courts, there is an enthusiasm for the system because it looks to be working okay. Before there is a chance to evaluate it it is proliferating, it is all over the place, and then it is up and running and it becomes routine. As services and resources run down, and community interest and support to clients, so does the quality of what is provided to clients. It is not until we get some major scandal that it is re-examined. At the bare minimum we ought to be collecting reasonably timely data on the number of patients subject to this Act, the characteristics, age and sex, and the type of drug problem they are being treated for, how long they were kept and what sort of treatment was provided. It would not be hard to do that routinely.

The trickier things to look at, that probably requires more special-purpose research that might be built into a trial, would be looking at its impact on the voluntary treatment services. If they are provided within that setting. What effect is it having on that, the number of patients presenting voluntarily? What effect is it having on staff morale, attitude and turnover? I guess the other shorter-term outcome would be the extent to which patients are recycling through the system. One certainly used to see that with the Inebriates Act, people would be coming through again in a three-month period.

CHAIR: We had evidence in Melbourne yesterday of people coming through up to eight times a year, through their shorter—say seven-day—period.

Professor HALL: I am mindful of the comments made by the Hon. Dr Arthur Chesterfield-Evans. There may be circumstances in which they might regard that as not an unreasonable outcome if you are preventing harm and preventing more serious emergency hospitalisation for complications of alcohol or other drug dependence, but you would probably want to look at that if that became the norm, if there were a cohort of people recycling through fairly frequently. You would want to look at the benefits to them and to society.

CHAIR: But as such you would not necessarily object to that level of frequency?

Professor HALL: It depends. For alcohol dependency, where people are drinking fairly heavily and steadily, they accumulate substantial risks of dying from liver failure and other medical complications. I guess community attitudes may harden if they see the system coming to be exploited by alcohol and drug-dependent people. There would need to be some clearer reasonable expectations about the number of times people might cycle through within the year and what they might get by way of benefit from that.

The Hon. IAN WEST: My recollection of discussions we had with the drug courts was that there was an opportunity for there to be assessment, a little bit of carrot and stick, if you can describe it that way. In life things are voluntary but there is usually some outcome that you are after that causes you to be so enthusiastic about your voluntariness. I am asking whether or not you see any value in assisting by way of respite families in times of stress? Halfway between coercion and voluntary is some reward for certain behaviour. Do you see any ability to have in the system some reward for behaviour to assist the persons with the difficulties and their families?

Professor HALL: I mentioned and stressed the sort of medical complications, but you would clearly be wanting to do everything you could to persuade, encourage, cajole, exhort people to consider the options. You would make them aware of what is available, introduce them to some services, encourage people from services to visit some of these places to meet with and speak to people. Certainly I would have no objection. That would all be a legitimate part of a service of that type.

The Hon. IAN WEST: Would you see some form similar to an apprehended violence order, if you like, a person not being able to attend a place of abode without first being in a certain condition?

Professor HALL: Well, you could certainly try the orders. I do not know how you enforce them or what sort of penalties. That is the difficulty with the sort of clientele. There is certainly a case from the research and value of contingency management, as it is known in the jargon, the carrot and stick, but again it has to be implemented and followed up systematically. Where a lot of these programs fail is that the consequences are not there immediately if people do not comply. So, people get the idea you do not have to worry about these sorts of orders, they do not mean anything.

CHAIR: One specific question about the comments you made about the difficulties arising from putting involuntary with voluntary clients, and it also perhaps relates to Ian's question about the continuum from voluntary to involuntary, with a large group in the middle. Do the concerns you expressed apply when, for instance, you have a short—say, seven-day—detoxification period? Are they likely to apply then or are they more related to much longer terms, such as rehabilitation centres and so on?

Professor HALL: I do not know. It is a concern rather than something I can show evidence for. Mental health services have often used this and this is probably what the Hon. Ian West is talking about. There is the capacity to hold someone voluntarily if they are not compliant. We would often see people who would come into the hospital and want to leave. They would be told that if they left against medical advice they would be put on a schedule and retained. They would then say okay, they will stay. Is that the sort of thing you are talking about? I guess that could be used but I think you would find some civil libertarians would be less than enthralled with the use of the legislation in that way.

The Hon. IAN WEST: It would depend on how it was framed.

Professor HALL: Yes.

CHAIR: We skipped over question six because we dealt with a great deal of it anyway. Do you have any more comments about the sort of service system that would be required?

Professor HALL: No, I think we have covered that.

CHAIR: We have talked about the legislative framework and I think enough about the initial order and who is involved in that. The procedural safeguards, I think most people have talked to us about being happy with the sort of procedures the Mental Health Act contains, even though the majority of people who have spoken to us would not want their services coming under the Mental Health Act, but as a model for the review process and so on.

Professor HALL: I agree with that. I think you would be silly to try to duplicate the MHA system with a parallel system for addiction. We have had a lot of experience in running mental health systems that can be put to good use here.

CHAIR: I think Robyn talked earlier about the net widening if we were to recommend and the Government were to adopt some sort of new system. There are a couple of aspects to this. Since so few people in New South Wales seem to have heard of the Inebriates Act, there is the publicity factor. If more people knew about something it may be used a great deal more, but there is also the concern that we have discussed about the definition and limitations so that you do not suddenly find yourself with a system that drags in more clients who people had not initially envisaged being there. Do you have any further comments you want to make about that area?

Professor HALL: I think "diagnostic creep", as it is sometimes called, is an inevitability in this sort of system. I do not think it is a matter of people being dishonest. You have that opportunity, you can see someone who would benefit from being treated for a short period of time and there is a temptation to use it. The power is there. Certainly, the low numbers we have at the moment are not reflective of the potential application. As you said, people do not know the Act is there. If it were to be publicised and effort was put in, you would see a lot more people coming under it. I guess you would have to monitor the characteristics of people and review case records and files periodically to see that there had not been some sort of big shift in the way in which criteria were being implemented and interpreted. I think the bigger brake on this happening would be resourcing—whether you have the beds and services that people are prepared to accept. That offers a brake, as it does in the mental health area. There is probably a bit of a constraint on that getting out of hand. Under the Inebriates Act all we had to do was to be caught for drunkenness and come up before a magistrate more than a couple of times in a short period and you would find yourself on the end of an order.

CHAIR: Implicit in some of this discussion is an argument that there is probably a need for more people to be cared for than is actually happening at the moment. Just because only 10-20 or fewer people are being dealt with under the Inebriates Act and a similar number under the Victorian legislation does not suggest that that is all the people who need some kind of treatment?

Professor HALL: Yes, that is certainly true. The bigger question is the availability of treatment for people seeking it voluntarily for addiction. Although it has improved in recent times as a result of the Drug Summit, the Alcohol Summit and increased Federal funding, there is still plenty of room for improving access to existing treatment for people who want it. We have to remind ourselves when we are proposing to pull people off the streets and treat them for their own good that there are plenty of people who want to be treated who we are not accommodating.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there a problem of putting people in silos where they are institutionalised when what is really needed is greater community support?

Professor HALL: I would agree with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the key thing in mental health and drug and alcohol at the moment having a structure that you trust?

Professor HALL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People who work in the community are regarded as scruffy people who wander around having cups of tea with people whereas the people who work in hospitals work with very serious matters? There is almost a conceptual gap that people cannot control people in the community and they are not respected and resourced. That effectively means they are either in the silo or not. There are no gradations of support. Is that really an overall problem in drug and alcohol?

Professor HALL: I think it is an issue, yes. It is what goes on in the walls of an institution, a hospital, clinic, outpatients centre is defined as treatment. What goes on as support and follow-up is not regarded, as you say, in the same light with the same degree of professional prestige.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which is quite wrong as you either own a Rolls-Royce or nothing and you do not have bicycles which are cheaper and more widespread?

Professor HALL: Yes.

CHAIR: And they are not paid as the people who work within the walls. The committee has had quite a bit of evidence that general practitioners [GPs] are really not playing much role in this area. They are not playing the roles that most people who have raised this issue think they should for a whole variety of reasons, not necessarily unsympathetic to general practitioners. Do you have any comment on the role of GPs?

Professor HALL: Yes. That has certainly been a recurring complaint. If you look at it from the side of general practitioners [GPs] they do not know what goes on in drug and alcohol treatment services. There has not been a tendency to observe the standard medical etiquette of writing letters of referral and sending letters back to GPs about the results of referrals. GPs often report that they send people off and they do not know what happened to them and if there was any benefit from the intervention? There is no feedback of consequences. There is no effort to contact them and involve them in patient care so it is not surprising that they are not.

In cases where efforts have been made to do the job of that—I do not know whether it is still running as a service at Gosford on the Central Coast—there was a great deal of effort made to involve GPs in the care of people with alcohol and drug problems that showed it could be done with appropriate support. If GPs knew that there was specialist backup, that they could call a 24-hour telephone line to get assistance if they run into difficulties they were much more prepared to engage, I think. They are not that well-trained in treating addiction. There is opportunity to improve GP involvement and I think there are some models that have been shown to do that.

CHAIR: Are you talking about the Gosford model?

Professor HALL: Yes.

CHAIR: No-one else has referred to that lack of professional etiquette. Does that apply in the mental health area as well as the drug and alcohol area?

Professor HALL: I think less so, because you have psychiatrists much more involved in the mental health area. One of the other things that has tended to happen is with addiction services, apart from the hospitals which had often been staffed by gastroenterologists, there is not much medical involvement in drug and alcohol services. It has been nursing staff, social workers, psychologists and others and a lot fewer medical people in there so I think that is part of the reason why that sort of etiquette has not been observed. Whereas psychiatrists are much more involved in mental health services so it is more an expectation that if a GP refers a patient to you, you would write back to them and give them some sort of account of what you have done and what your advice would be on their management, and maybe some sort of follow-up.

The Hon. IAN WEST: I get the impression anecdotally that this passing parade concept with clients is right across the board and not just for GPs.

Professor HALL: With all medical practitioners?

The Hon. IAN WEST: We need to be careful not to single out GPs in this whole area.

Professor HALL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they are seen as scruffy unprofessional people?

Professor HALL: Not GPs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Particularly are the community-based drug and alcohol people because they are marginal seen as scruffy and unprofessional and almost like their clients in a sense?

Professor HALL: Yes, that is certainly true.

CHAIR: I said that some of the comments have not been unsympathetic to GPs. People have said that in terms of a Medicare item or provision for long consultation, it is very hard for a GP to deal with these sorts of clients to whom we are referring in the routine expected of a GP in a busy practice.

Professor HALL: I would agree.

CHAIR: In a sense the whole system is conspiring against proper medical assessment and thinking of options and so on, and it was not that the GPs were singled out for massive criticism. Perhaps in rural areas particularly the role of the GP—because of the shortage of specialist workers—becomes particularly crucial?

Professor HALL: The GP is the health professional that most people with a drug and alcohol problem would see. They do not go anywhere near a specialist unless they have got very serious complications. They are the group there for a lot of drug and alcohol affected people, whether GPs recognise it or not and whether parents volunteer it. They often do not inquire about drinking. In relation to getting doctors to ask people about what they drink, there has been an attitude very often that that it is a sort of infringement of privacy to actually ask how much alcohol a client consumes. That attitude is not confined to GPs but to a lot of health professionals.

The Hon. IAN WEST: Is the attitude that this is just another one of the many in the passing parade?

Professor HALL: Yes.

The Hon. IAN WEST: Is it not really a question of a terrible interference with the civil liberties and privacy, but they do not ask the question because they cannot deal with the answer?

Professor HALL: Yes.

CHAIR: In relation to evaluation, and your comments about the way programs and new systems are implemented, set in concrete and nothing happens until there is a scandal, do you have any specific advice in relation to evaluation and monitoring to avoid that?

Professor HALL: The Drug Court evaluation is a good model. I do not think there are many examples where an evaluation is built into the implementation of a program. I think often the difficulty is once a program is up and running, everybody wants it. The pressure on the clinical system to provide it and roll it out becomes pretty difficult to resist. The evaluation is often overtaken by the dissemination of a program before it has been evaluated and before we have had the chance to look at it. Then of course you get people who want to vary it in different places. There are local variations and so on. Evaluation would be desirable whether it is easily organised and has much impact at the end of the day is probably more the question.

CHAIR: Does that comment apply to the whole health system or this area?

Professor HALL: I do not know enough about the rest of the health care system. Certainly I have seen plenty of examples of this in the addiction and law enforcement area.

CHAIR: Do you have any views on the so-called Ulysses clause, living wills and so on?

Professor HALL: I think they are a good idea but I do not know how often they work. It is quite acceptable for people in advance to specify the conditions under which they want to be treated against their will. Certainly some people with some mental illnesses have said that with family members and it can work. It is the same as advanced directives in the event of serious illness and non resuscitation orders. Whether they are respected by medical practitioners or family members at the end of the day, I do not know enough about how they work. I do not have any problem with the idea. I think that would be reasonable.

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

Professor HALL: It is time to repeal the Act but you will not get away with doing that unless you have got some sort of alternative. I think some sort of time-limited, short-term involuntary treatment with some degree of protection under something like the Mental Health Act would be a reasonable thing, with some form of evaluation specifically built in to its implementation so that we can see how it works.

CHAIR: In general is it true to say that the broader problems, lack of resourcing, training or whatever in the whole area of alcohol and other drugs is such a major problem that this small part cannot be effectively addressed unless the broader issues are addressed?

Professor HALL: I think it has to be seen in the broader context. I think that there is a danger that we think that all the other problems are solved and there is just this small number of people who need treatment and are not getting it, and if we plug that gap we have solved the problem. We have to look at addressing the quality of treatment that is provided for people who want it and cannot get it as much as anything else.

(The witness withdrew)

DAVID ANTHONY McGRATH, Deputy Director, Centre for Drug and Alcohol, NSW Health, 73 Miller Street, North Sydney, and

MICHELLE NOORT, Director, Population Health Strategy and Drug and Alcohol, NSW Health, 73 Miller Street, North Sydney, sworn and examined:

CHAIR: Thank you both for appearing before the Committee today. Would either of you like to make an opening statement?

Mr McGRATH: We have nothing specific to say.

CHAIR: We have asked you some quite lengthy questions. I think it is true to say that almost everyone who has spoken to us has asked for some form of compulsory treatment for people with severe drug and alcohol dependence. I think everyone agrees that the current legislation should be repealed and that something should take its place. There is also the issue of how we limit the coverage of any such legislation involving compulsion. Do you have a view on that?

Ms NOORT: We agree with that. Our answer to this question would be yes. I guess the question that we would raise is: What is the problem we are trying to resolve here? One view could be that we are trying to resolve the problem of the health of the individuals for whom we are providing compulsory treatment. In addition, we are attempting to resolve the social and family issues that are a consequence of the behaviour of these individuals. How we construct the answer to the purpose of the program in some ways informs the answer to the rest of the questions because we will do it in different ways depending on what the ultimate goal is or goals are. David can comment from a clinical perspective.

Mr McGRATH: Definitively, there is a cohort of people who need compulsory treatment. Most likely these will be people with alcohol-related problems more so than illicit drug problems. But there will be a small cohort with illicit drug problems as well that definitively will need compulsory treatment.

CHAIR: Can you expand on that comment? Why do you say that it is much more likely with alcohol than with other drugs?

Mr McGRATH: It is because of the cognitive deficits that come from long-term alcohol abuse. More significant cognitive deficits and physical harm come from organ damage as a result of alcohol abuse. Plus there is a much higher prevalence of alcohol-related disorders than of drug-related disorders. So there is likely to be a much larger cohort of people with alcohol-related problems who will be appropriate for compulsory treatment.

CHAIR: In saying that, are you focusing on the risk of serious harm to the individual not the more family-community arguments?

Mr McGRATH: Yes, that is the context of the comments that I am making.

CHAIR: In talking about involuntary treatment many people have argued for a much more limited period than the Inebriates Act provides—more of a one- to two-week period along the lines of the Victorian legislation, which is also under review as you probably know, and therefore more related to an initial detoxification period. Do you have any views about that?

Ms NOORT: As an overall statement, we have concerns about the notion of a two-week limitation. We would probably be more interested in looking at a larger approach, which David will explain from a clinical perspective.

Mr McGRATH: We need a stepped approach. We need a range of different options. You will not get a single cohort—a single set of presentations—in this particular group. There is certainly more than one presentation that will occur amongst this particular group. We need a range of different options to provide responses when this particular approach fails. There needs to be a contingency for failure. People can come in for a two-week period as an initial alternative to people coming in for

compulsory treatment, with the option of longer-term treatments later for those who do not succeed within the two-week framework. I think that would be the ideal. Particularly for people with alcohol-related brain damage, it takes a significant period of time for the cognitive deficits that occur as a result of alcohol-related brain damage to rectify themselves. That is not to say that the damage to the cells can be repaired—that is not able to occur—but the actual function can be transferred to other components of the brain. However, it takes a period of time to do that and two weeks, for instance, may not be long enough to establish those particular changes.

CHAIR: But the question relates to compulsion. I do not think anyone would disagree with anything you have said about the need for other longer-term approaches and the various stages of rehabilitation, treatment and so on. I guess the issue that we are confronting is whether those stages—those more long-term approaches—should be subject to compulsory treatment orders.

Mr McGRATH: I guess the issue is the long-term outcomes for the patient. If we create a cycle whereby people come in for a range of two-week periods—if it is continually short term—they could cycle through what can be a reasonably expensive form of treatment without the ideal outcomes that we would prefer. An investment in this sort of approach probably requires a longer-term approach for a single cohort of patients in order to get the outcomes that are best for the investment made.

Ms NOORT: If I may expand on that a little, one of the difficulties we feel with the two-week compulsion component alone is that we will end up running a very expensive respite service. We need something that allows a longer period of time in relation to clinical progress—what we are talking about here—so that people can make a substantive attempt and/or decision to change in the context of whether we are trying to provide two weeks of respite because we are trying to deal with social and carer issues or trying to look at a level of rehabilitation. Logic suggests that you will probably find that you were looking at two issues any way. As with all people with addictive behaviour, some of those who come through will take the opportunity—sometimes they might have to come back seven times before they take that opportunity; we are not not acknowledging that—but we do not want to simply create an environment that has an incentive for respite care versus effectively encouraging people to move into rehabilitation. We may need to look at stepped compulsion as well when people are in a locked environment for two weeks. There is then another level of compulsion beyond that to be considered, which pushes us through another form of treatment—such as weekend release or whatever—in a treatment methodology that encourages or forces people to be involved in the program for a longer period of time.

The Hon. ROBYN PARKER: You mentioned a locked environment. Do you recommend that it is necessary to have a locked environment?

Ms NOORT: Our view is that if we are looking at coercive treatment we are looking at a secure environment. Perhaps I should have used the word "secure" rather than "locked" but I am working on the assumption that a secure environment will be locked. I do not see how we cannot have open-ward environments; I do not see how else it would work.

Mr McGRATH: I guess the issue is how the involuntary nature of the treatment is enforced and where the responsibility lies for the enforcement of the involuntary component.

The Hon. ROBYN PARKER: And who then supervises that treatment.

Mr McGRATH: Indeed.

The Hon. ROBYN PARKER: Do you envisage a situation where involuntary and voluntary patients are collocated or do you envisage separate facilities?

Mr McGRATH: The first point is to say that there is very limited evidence based around the outcomes of compulsory treatment and the best models for compulsory treatment. I have to make that statement before I say anything else. In an ideal world you would perhaps prefer a treatment model that has all involuntary patients getting a set treatment program based on the nature of their presentations so that they are getting consistent treatment. But there is no rationale for saying that involuntary patients could not be located with voluntary patients. We just do not know what the best

Ms NOORT: If I tried to think of a parallel I would think about the parallel of mainstreaming disabilities into education. You can see a level of advantage of having a mixed environment but how would you maintain that? Would you have these people behind a glass screen, which is what we have in the mental health unit, where you have actually got the secure clients locked up behind locked doors and the involuntary clients sort of wandering around in the other environments? So it is those sorts of issues as well.

CHAIR: What sort of sanctions might we have in that sort of later period you envisage after an initial perhaps locked period? What sort of sanctions would you have for someone who left, who just walked out? Do you then bring someone within the realm of the criminal law, for instance, because if it is going to be compulsory and you are not actually locking someone up, if they walk out then have they committed an offence? How do you basically make it compulsory?

Mr McGRATH: That is a very difficult question, not a question I think I have an answer for, to be honest.

Ms NOORT: I think it is worth investigating the mental health approach to it where they look at community orders and those sorts of things and whether we pursue models that are similar to that. But then who implements those and who runs with them?

Mr McGRATH: The difference being, I suppose, that drug and alcohol treatment, pharmacotherapies, particularly with alcohol related disorders, do not make up a significant proportion of the treatment base. You are often dealing with psychotherapeutic interventions, cognitive interventions. So it is a slightly different model to the mental health field.

Ms NOORT: And the other issue is that you are actually encouraging people to make an active behaviour change, which is inclusive of continuing to take medication and which is not the same in a mental health environment.

The Hon. IAN WEST: So unless you come to grips with all those particular issues that we have just been discussing, we do not know what the definition of success or failure is in determining funding.

Ms NOORT: I would probably take it back a step and I would say are we actually clear about what it is we want to achieve in the first place? If we know what it is we want to achieve we can say did we achieve it or not? So part of what we want is to provide some relief and support for carers and some comfort which may be paralleled by putting someone into respite, let us say, and potentially at the same time offering the kind of opportunity to then make a choice about a behaviour change. Parallel to that I think we would need to be offering a level of support to the family environment so that they are better able to cope with an individual's decision not to continue with rehabilitation. That is what will stop some of the revolving door.

So part of it is about that and then providing support for those individuals. Part of it is about the larger social agenda than simply removing them from the street; we will impact on some of that parallel with needing to deal with the issue of intoxicated individuals, which is a different cohort and another issue which needs to be dealt with in the context of your deliberations. Then, in addition to that, we can look at providing outcomes for the individual through some form of therapy, acknowledging that they may bounce back a few times.

The Hon. IAN WEST: Are you saying that that is what you think the outcome should be?

Ms NOORT: My view would be a comprehensive program would deal with that range of elements, yes.

CHAIR: We probably all agree with what you just said, and probably most people would agree we need more resources and more thought to all of this, but we have been given the job of working out the group that should be subject to compulsory treatment. You seem to be saying, correct me if I am wrong, that, say, respite for the family is part of a justification for compulsory treatment?

Ms NOORT: It seems to me that part of the reason that compulsory treatment came up at the Alcohol Summit was twofold: one about the absolute trauma that was experienced by family and relatives in observing this behaviour in their loved ones, which therefore cries out for respite so that they can draw a breath; and the second issue that was raised at the Alcohol Summit was the need to make them stop, which therefore is the treatment component of it. So I think both those issues were raised.

Mr McGRATH: I do not think it would be a primary selection criterion though for somebody to go into compulsory treatment, but it is certainly a consideration.

CHAIR: Our previous witness limited it much more to self harm, the actual danger to the individual, while aware of the need and importance of the family consideration on the specific issue of involuntary treatment. I am quoting that witness but we have had a range of witnesses with different views and we have tried to get clear just what criteria people want to impose.

Ms NOORT: Maybe I should clarify the points that I am making. I understand that what you are doing is looking at a particular component of a much larger system. What we are basically suggesting to you is that this component of the larger system is likely to fail if there is no consideration given to the other elements that have to be there. So in relation to this component, it should be people who are in danger of serious harm, absolutely.

CHAIR: We are conscious that the Inebriates Act is designed to cover a very small group and in practice at the moment so few people are under it each year that it covers even fewer than it was intended to. I guess the other issue that raises is that at the moment you would have to say—I think everyone would say—that the people who are compulsorily detained under the Inebriates Act are not really getting treatment. For instance, from the people that we spoke to and the case studies we heard at places like Bloomfield and Macquarie Hospital I do not think too many people in the alcohol and drug area would say that they were actually receiving treatment.

Mr McGRATH: I would agree with that, yes.

CHAIR: So the system we are talking about is one that should exist, not one that cannot be accessed yet?

Ms NOORT: Absolutely.

CHAIR: Coming to Question 3, regarding the sort of system that we might like to see, some people have said that a seven to 14 day detoxification and assessment period could be relatively easily integrated into the existing drug and alcohol system that operates across the State so that in terms of cost-effectiveness and in terms of access in the local areas and so on, the involuntary part could be integrated more. From your point of view is that a reasonable proposition for the services that exist across New South Wales?

Mr McGRATH: Functionally it is possible in terms of the clinical interventions that would be required for this group. They are certainly available in those particular services that you are identifying. It covers a couple of issues, I suppose; one is that those services are not functionally set up to enforce involuntary components. So drug and alcohol services across the State do not have the capacity to monitor and enforce people who may attempt to leave the units if they choose to act against the involuntary or compulsory treatment component.

The other point to make is one that I made before about the limited evidence base for the best approach for people under involuntary treatment orders, as to whether it is best to place them with clients that are in a voluntary treatment system or whether it is best to segregate them and treat them separately. We do not have a definitive answer to that, but the intuitive assumption would be that it would be better to segregate them. But it certainly would be possible to treat them in an environment where they were co-located with voluntary patients.

CHAIR: Obviously part of the issue is a concern for access in rural and regional areas to avoid a situation where two-thirds of the State is basically covered by Bloomfield Hospital in Orange, with all that that means in terms of isolating people from community and other significant people in

their lives. You would be concerned that the primary network that exists would need to have basically walls and gates if it were to deal with a larger number of involuntary clients?

Mr McGRATH: Possibly. It comes back to the question you asked earlier about sanctions, which I did not have an answer to. It is really a matter of what the repercussions are for people who choose to walk away from an involuntary treatment order and who has the responsibility for pursuing those repercussions and what relationships exist with other agencies that might have some of those responsibilities.

CHAIR: We were in Melbourne yesterday and we spoke to people, including people from the non-government services, that are responsible for some of the group we are talking about. They did not have walls and gates on the whole and they were basically arguing that the nature of the treatment, the nature of the staffing, the level of one-on-one engagement in the detoxification period and so on meant that while people were not physically locked up, most people actually stayed. They did not feel terribly fussed about the notion that involuntary or compulsory actually did mean locked gates.

Mr McGRATH: I guess you would find that there would be a proportion of people who would stay and a proportion of people who may choose to leave. I think the drive to absent yourself from compulsory treatment would grow the longer the period of compulsion that you put in place. Certainly within a short period of time there would be a proportion of people who would not feel the compulsion to leave, but I think it would be unrealistic to suggest that there would not be some individuals who would think that they would not want to be involved in that particular treatment methodology.

Ms NOORT: We currently have individuals who walk out in the middle of involuntary detoxification after they have sometimes waited a significant period of time for placement. So it actually happens in the involuntary environment as well. I think it brings us back to what is the purpose of the exercise? What is the range of purposes of the exercise and what is the expectation of the community? The community's expectation is that these people do not walk away, that the carers' or loved ones' expectations are that they know this person is locked up and safe, then we will not need that because inevitably, if there is not a secure environment, there would be people who choose to walk away.

CHAIR: Moving on, in relation to the longer term approach after that initial stage, and bearing in mind those unanswered questions, what are your comments on the view that if there is a longer term compulsory period that we would need a couple of purpose-built treatment facilities in New South Wales—new ones, basically?

Mr McGRATH: I think the answer to that question probably overlaps significantly with the answer to the previous question; the two are related. There are a lot of factors to take into account in terms of making a determination about what the appropriate treatment methodology is that you want to use, whether you do want to segregate this particular cohort from voluntary patients—that is probably the primary concern—what the sanctions are that are in place for the people who choose to walk away and, I guess, what sort of capital infrastructure might be required for those services that are currently out there providing long-term residential rehabilitation treatment, and whether they might be able to handle this particular cohort or not. There is no definitive answer to that question. The answer to the previous question overlaps with that one.

The Hon. IAN WEST: Is there not also a bit of a mix? If it is that you had some sort of sanction that caused a person to have over their head that they may end up in a locked and secure environment, cannot you mix those sorts of incentives with the locked environment so that you do not just put everyone in a locked environment; it may be a second, a third or a fourth step along the way?

Mr McGRATH: That is certainly a sensible approach.

Ms NOORT: I guess that depends whether you are thinking about a locked environment as providing a level of protection for the individual or as a punishment to the individual.

The Hon. IAN WEST: It may be that some individuals need that secure environment to save themselves from themselves in the first instance. Others may not need it in the first instance.

Ms NOORT: The question is what do you actually do with them while you are trying to go through that process of assessment, because that is not an assessment you will be able to make quickly. They are going to have to be somewhere while that assessment process is occurring. That is one of the tensions, too.

The Hon. IAN WEST: We have received some evidence that indicates that there are various levels of assessment also: that there is not a one size fits all assessment. It may be up front that there is some sort of screening exercise incorporated with some form of judicial structure in what form that might take—there may be various levels of that as well—that gives you an initial screening or an assessment that enables you to make an assessment as to whether or not that person may, in the first instance, be given some advice as to what decisions they should make and the ramifications of what decisions they make in terms of ongoing sanctions and possibly ending up in a secure environment.

Mr McGRATH: But the group we are talking about here is quite chronic; they are not in early stages of assessment.

The Hon. IAN WEST: We received evidence that in terms of alcoholics they are also people who take a very long time to do the final damage. It may well be that the person is at a stage where their damage is quite palpable, quite significant, but it may be that they are still going through a fair deal of time before they get to the final stage of doing themselves in. It may be that you do have plenty of time in certain cases to make assessments, even though they may, at this particular point in time on the night of 29 April, be in a gutter somewhere, completely and utterly inebriated. It may not be that they are at the stage where, unless they are in a secure environment, they are going to kill themselves. I assume there are as many various stages of the client you are dealing with as there are treatments. We do not seem to have a definition of treatment as yet.

Ms NOORT: I think we are quite clear about what we mean by treatment, and we think that there are a couple of levels of treatment. I am sitting here, struggling with your example, thinking how the client that you have just described in relation to the length of time and picking up on the point you make about being able to present them with some options and their making choices, how that would be any different to the normal process that we would use of intervention with an individual who has suffered from alcohol abuse when encouraging that individual to come into voluntary detox. Again, it is that stuff about who is the cohort we are talking about here and what are we trying to achieve? I need to preface this by saying that I have been involved in drug and alcohol for only the past 12 months and prior to that I have been in the New South Wales health system in a variety of managerial roles, which has also included acute care, mental health and that, so I am not drug and alcohol expert.

But what I took away from the Alcohol Summit and what I have taken away from the analysis of the community issues that have been raised around drug and alcohol as a program area is they are looking for a level of immediacy of response in relation to this cohort. One of the things that will need to be managed, which again goes back to the fact that there are a couple of different dots on this system—and this is one of those dots—is the fact that no compulsion system is going to be able to respond immediately; there is going to be a break between the initial individual who is in trouble, whoever raises the flag, and some imposition of treatment, if we use that, or the beginning of some intervention. You make the suggestion later on yourself, when you talk about some sort of tribunal for individual's rights. There needs to be a process of making sure that natural justice is undertaken. Somewhere in that we also have to think about the immediacy of responses that people are expecting. I do not know if that answered that question. I took you off on a tangent.

The Hon. IAN WEST: Again, in trying to define success or failure, what seems to be coming out of the evidence is that people who go into the first stage, whether it is a secure environment or otherwise, for a short period of time—7 or 14 days, or whatever—they would not necessarily, as I understand it, be successful. They may come back a second, third or fourth time.

Mr McGRATH: Indeed.

Ms NOORT: Being clear that no-one will be successful in two weeks, if you measure success on the fact that they are rehabilitated—no-one.

CHAIR: We are probably a little bit at cross-purposes. The question we got to was meant to deal with the group after that 7 to 14 days if we take an approach under the current Inebriates Act where the three-month order is most common so that the questions Mr West is asking probably relates more to the early stage and the chronic lapsing condition issues. This particular question about purpose-built involuntary treatment facilities was more to do with whether we have a compulsory regime for the period between 7 and 14 days and, say, 3 months. I guess they are somewhat different questions.

Ms NOORT: Perhaps it would be useful to talk about what we think the elements would be. If we think about the chain of care, or whatever language we want to use, or how we describe the situation, it is that stuff up the front, which is about intoxication, that we need to think about how we manage, which is the assessment and referral phase. That might be the two weeks that you are talking about. It might be that the assessment and referral, in some instance—Mr McGrath will have to plug in the clinical details—with a level of detox going on there, you are not going to be feeding them alcohol while you are assessing and referring them. As you are not technically into detox at that stage: you are just beginning the pre-detox stage. You do a bit of assessment and referral, make a decision about what is the best option for this individual given family support, et cetera and then you make a decision about where they go onto the next treatment methodology. That first two weeks predominantly is an assessment and referral element, which probably would have some early intervention stuff happening around that.

Mr McGRATH: You certainly would be going through the detox phase in the first two weeks.

Ms NOORT: Yes, so you would be doing that sort of thing. This question, then, when we talk about long term, and I am assuming this is a lot of what you got back from the Victorians that they talked about non-secure environments, some of the models that you could look at here is some of the therapeutic community models, some of the recent rehab models that have run in the community sector and, yes, they are open environments, they are encouraging. What we have done is build someone's personal capacity to survive in that environment, and still build the family's personal environment to cope with the individual being in that environment. Again, it is that stuff if you are going to roll it out like that, and that looks slightly different.

Mr McGRATH: If the non-government sector, the rehab sector as it currently exists, has the capacity to integrate with whatever sanctions are put in place for this particular group and play their role in terms of enforcing those sanctions, we have no evidence base to suggest that they could not provide long-term treatment and that there is requirement for a purpose-built facility. That is just, again, reiterating the point that we do not have treatment outcomes for this particular group.

CHAIR: We are always conscious when we draft these questions that it is almost impossible to limit one. We have to keep an eye on where we are going and what we have already covered. Because it has come up maybe we should go to the question about the first instance decision making, which was our question 7 to which I have just referred. Many people, from the Chief Magistrate on, have expressed concern about the current system where the magistrate makes an order, often on very limited training and qualifications and with relatively limited input—perhaps a certificate from a general practitioner or a police officer. Some people are arguing that decisions, particularly about compulsory treatment, should have a much more clinical input, a much more in-depth assessment from the beginning. Can you comment on that? Obviously, it is an issue with practical implications as well as issues that are ethical and theoretical.

Mr McGRATH: Clinically, the answer is, clearly, yes. In principle, anyway, the answer is yes, it should be a clinical decision first and foremost. But there are some issues that raises, one of which is the immediacy question Ms Noort raised before. In many cases these people will come to the attention of the system when they are intoxicated, and I guess this goes on to some of the issues around question number 9 that we will get to later on about the expectation that the health system can respond immediately to an intoxicated presentation and make an assessment of an intoxicated presentation. In reality it is almost impossible to undertake an appropriate assessment of somebody

who is intoxicated. We cannot make any determinations about their cognitive damage or about their mental health stability or about their physical stability or their capacity for detoxification while they are intoxicated. I guess we will get to that issue when we get to number 9, but in principle, yes, it should be a clinical decision.

CHAIR: I guess that also relates to the Mental Health Act model tribunal, which many people speak highly of and suggest as a model for people with severe alcohol dependence although it really operates more as a reviewing mechanism after that initial period. In terms of the initial order that does not help us much because the tribunal, with its mix of representation and the civil liberties safeguards it provides, is coming into play after an initial 36 hours or so. But that timing does not really suit the group we are talking about, does it?

Ms NOORT: It does in the sense that if the tribunal is doing a review process in making sure that the individual's rights were considered in the context of this and to remove some of those rights was an appropriate decision in the context of clinical advice, et cetera, then I think that is fine. But with or without the tribunal there is no mechanism to answer the immediacy issue, other than letting them sober up because that is the only way that we can actually take the first step, which is trying to work out what is happening.

CHAIR: Does that mean that someone may come to a specialised drug and alcohol centre from a general hospital, from an accident and emergency centre, or are they going to come from a non-government agency that may look after homeless people and provides shelter?

Ms NOORT: Presentations occur with either police or family bringing individuals to accident and emergency. Accident and emergency will look after their physical complaints at that time, if they are cuts, or any of those sorts of things. They will look after those physical, life-threatening issues in relation to that and then the individual is discharged. There is no mechanism for that. It is not appropriate, once the immediate illness, if you like, has been dealt, with for an individual to remain in an expensive accident and emergency bed while they sober up. It is inappropriate because they cannot assess them. We do not know where to refer them to, so we do not know whether to refer them to mental health services, general ward services or a drug and alcohol service. The answer to your question is they do not come that way. They usually go back on the street or go out with the police, and that is a group that is completely non-serviced.

CHAIR: But within that group there are people who would be properly subject to compulsory orders because of the stage they have reached.

Ms NOORT: They would have to have gone through that process. They have to be sober up before we can actually decide whether or not they needed a compulsory order.

CHAIR: Part of the problem is that until you can assess and until you can get people into a relevant centre to do that you do not really know whether they are candidates for compulsory treatment of whether they are someone who has gone through an episode, they will go back to wherever they normally go back to and they may or may not appear again.

Ms NOORT: Yes.

Mr McGRATH: It takes 12 to 15 hours subsequent to the last drink to be able to make an appropriate assessment of the individual's status. So there is a significant period of time in which the individual needs to stabilise and sober up before we can make any judgments, and that period needs to be addressed in the thought process.

CHAIR: Some time ago we went to Royal North Shore Hospital and spoke to the people in the Herbert Street clinic. They described to us the kind of co-operative relationship they have with accident and emergency, where they are called in, they advise and monitor, both groups are aware of a particular person, and then at some point a decision is made as to whether the person will go from accident or emergency into the Herbert Street clinic. It is a simplistic way of putting it, but is that a workable model, bearing in mind the cost and inappropriateness of someone being in a hospital bed, even in accident or emergency?

Mr McGRATH: Only in theory. It depends very much on the local arrangements that are in place. The Herbert Street clinic at Royal North Shore Hospital has a designated consultation liaison team for drug and alcohol services that is rare in many drug and alcohol services around the State. It is just a decision that they have made about the way they have aligned their resource base at the Herbert Street clinic. In theory, the model can work, but teams like that do not exist in all drug and alcohol services across the State.

CHAIR: Is that an historical or geographical accident, because the clinic is located in the old nurses home?

Ms NOORT: No. I would like to make two statements about that. Firstly, there are direct parallels with that scenario you have just suggested and the need to rebuild the system process in relation to accident and emergency. Secondly, it is necessary to acknowledge the reality of the development of drug and alcohol services everywhere, not just in New South Wales. If you focus on New South Wales, which is a normal context for all other States, basically five, six or perhaps eight years ago drug and alcohol was a cottage industry. It was the Drug Summit that created the emphasis for a sophisticated clinical approach to drug and alcohol activity. Over the last five to six years there has been a growing professional approach to drug and alcohol servicing activity, which has grown some foundations. So those services are only starting to grow up. If you map the development of any clinical service in health—and let us take cardiology for example—that becomes a real service with a real infrastructure and real funding. When the medical school is created, that is when cardiologists are created, and so flow the rest.

In relation to drug and alcohol, a chapter of addiction medicine has only recently been created. So we recently have a specialisation called addiction medicine, which makes it real in the eyes of practitioners. This means that if you have a specialty you have a consultation liaison team to provide consultation liaison to the generalists. Prior to that, drug and alcohol was something that everybody dealt with in their day-to-day activity.

We need to acknowledge that what we are talking about here is the development of an infield in activity and the parallels with the development of mental health for the program area are absolutely significant. Resource investment in the drug and alcohol program area has not been as large as mental health resource investment. Currently mental health services across the State have only recently grown up consultation liaison services in all major hospitals, which work actively with accident and emergency, and that is because of the very problem you just raised. The same problem occurs: people arrive in accident and emergency, they have a mental health issue, and it is inappropriate for them to be in an emergency bed. So mechanisms have been put in place around managing that. Some of that funding has been Federal and some of it has been State-based. But it is that same sort of growing up stage.

CHAIR: Is that a model that we should be developing? Is that the model that you would recommend?

Ms NOORT: It was one of the recommendations of the Alcohol Summit that we develop consultation liaison services across all acute environments, which then enables specialist drug and alcohol beds to be used for specialist drug and alcohol clients, and generalist drug and alcohol clients to be maintained in ward beds, which is a much more efficient use of all health service resources. Unfortunately that recommendation, whilst endorsed, has been unable to attract any funding.

CHAIR: It is a very expensive recommendation, is it not?

Ms NOORT: It is, because we are talking about a series of hospitals and a minimum of three staff. But we are probably talking about saving a significant amount of money at the other end as well, and servicing a whole range of clients who have never been serviced before.

CHAIR: With that recommendation not having been implemented because of a lack of funding and other reasons, do we have a workable short-term alternative, or are we marking time?

Ms NOORT: I think it is different in each hospital, depending on the infrastructure that exists in those environments, and depending on availability and what medical staff are available. Co-

operative relationships exist between the mental health and drug and alcohol teams across most of the area health services, and they will do some co-supports with people, but there are gaps.

CHAIR: I suppose you are also implying that it does not have to be exactly the same model in every hospital?

Ms NOORT: No, absolutely not.

CHAIR: What works well in one area may work very differently in another area, because of metropolitan versus rural, historical practices, and so on?

Ms NOORT: Yes. The rural models are required to be different. There is a lot of telemedicine and group consultation, even within the context of one area health service. I can give you a really good example of where I have worked with the mental health service. There was a consultation liaison team in Nepean Hospital, which is a major teaching hospital, and that consultation liaison service was provided through telemedicine to Blue Mountains hospital, which was another hospital within the Wentworth Area Health Service. At the end of the day, it was one team that serviced three hospitals.

The Hon. ROBYN PARKER: With regard to the consultation liaison teams and the development of a world's best practice model, which is what we are aiming to do, is it your view that the Government needs to place adequate funding and resources behind the establishment of those sorts of teams across the board, as provided in the Alcohol Summit recommendations?

Mr McGRATH: It varies from area health service to area health service, depending on the prevalence of the presenting conditions and the resource basis of individual hospitals, what they provide in terms of acute services for drug and alcohol problems. I guess the short answer would be that in many cases consultation liaison provides a significant advantage for the way the hospital deals with its patient flows and the movement of patients from emergency departments into wards. In other cases it would not necessarily provide a significant advantage.

Historically it has been a decision that area health services have made to determine whether they need those resources to provide consultation liaison services, where it matches the patient flows that they have coming into that particular facility.

The Hon. ROBYN PARKER: Do you think that the decision making in terms of the resource distribution should be made by the area health board and not by the Government?

Mr McGRATH: No. The need for consultation liaison services within the resource base of that particular facility has historically been a decision made by the area health services.

Ms NOORT: In answer to your question about whether it should be a government priority, the detail of the activity depends on the opportunity cost of making that service a priority over another service. The Government has expressed a clear priority in relation to drug and alcohol, and in the context of available resources the drug and alcohol area in health is currently unable to attract any more resources to expand to a larger service.

It is appropriate for local planners and service managers who understand the networks and resources that are available to them locally to configure the models to most appropriately suit the needs of their client group and the infrastructure they have, but some form of consultation liaison would be available in every institution. To answer your question, it is a fundamental plank in a program area that is growing up, creating a link between generalists and specialists.

The Hon. ROBYN PARKER: I think that is consistent with your earlier comment, that if we do not set up appropriate structures we are destined to fail. What are your views about the skills and incentives for general practitioners to be involved in this process?

Ms NOORT: GPs are the front line of the health system and have a major impact in relation to the broader health of the community across a range of areas and across a range of topic areas. It would be fair to say that GPs are under a phenomenal amount of pressure at the moment, that they are

often seen as the saviour of all issues within the system, and there is a large requirement both federally and at the State level that we are actively attempting to encourage GPs to be involved in. That would cover areas like methadone prescription and providing front-line services for mental health assessment.

I think there are opportunities for GPs who are interested to be involved in this. Is there a systematic approach that does not end up looking like a piece of Swiss cheese? I do not think so, because there are not enough of them.

Mr McGRATH: We are really talking about tertiary treatment interventions. This is a group that is going to require specialist intervention, who are likely to come to the attention of the system via their local GP because they will be having frequent contact, I assume. The actual treatment interventions will be provided by the specialist sector; GPs may have a role in the aftercare at the end of the process. But we are talking about a cohort of patients who are quite damaged by the definitions that were applying under the compulsory treatment approach.

The Hon. ROBYN PARKER: When we look at a new model for the Inebriates Act and the view that many people have presented to us, that it comes under the mental health model as opposed to a judicial structure, if we were to put it immediately under the Mental Health Act do you believe there is a capacity for the professionals involved in that system to be able to deal adequately with the clients we are speaking about?

Ms NOORT: First and foremost, this is a health issue and the health system is a total system. We are talking about two particular components of that system, that is mental health and drug and alcohol, and I would parallel that with things like cardiology and endocrinology. If you had someone with heart disease who also had diabetes, they would work on that client as a whole individual. Similarly, someone with a drug and alcohol issue who has a level of mental dysfunction can be jointly managed by those two service types. There is more than enough opportunity to do that, and there should be more than enough opportunity to do that.

If drug and alcohol clients are placed under the Mental Health Act, we are making the statement that drug and alcohol is a mental health issue rather than a social issue. Not all clients who are impacted on by drug and alcohol have a mental health disease. The drug and alcohol field has a growing capacity to manage this client case and increasing expertise. As I mentioned earlier, the creation of the chapter of addiction medicine strengthens that, and the chapter of psychiatry has expertise in psychiatry but not necessarily expertise in addiction medicine.

The Hon. KAYEE GRIFFIN: Currently there is some way of assessing people who present with a mental health problem at hospital accident and emergency units, to determine whether they have to go through some other part of the system that relates to mental health issues.

Ms NOORT: All mental health services and area health services have quick response to support clients presenting with suspected mental health illnesses. It is their consultation and accident teams. In some areas they are called slot teams, and they do the assessments.

The Hon. KAYEE GRIFFIN: Basically that happens at all hospitals, but it may be slightly different depending on how the hospital determines it should happen.

Ms NOORT: How big the hospital is.

Mr McGRATH: How many presentations they expect.

The Hon. KAYEE GRIFFIN: Currently, if someone presents with a drug and alcohol problem there may not be the same capacity to assess the person quickly in accident and emergency, or move them further into the hospital system, or move them to a specialist area that can deal with a drug and alcohol problem. Is that correct?

Ms NOORT: Not the same proportion that can be received for a mental health response, absolutely, if they present with a drug and alcohol issue. Turning up drunk at accident and emergency is not a drug and alcohol issue. That is a client group that no-one responds to.

The Hon. KAYEE GRIFFIN: How does it work if someone presents drunk at accident and emergency?

Ms NOORT: The emergency physicians will assess if there is any life-threatening injury, or whatever physically may need attention. Once that is done, there is a process of discharging them.

The Hon. KAYEE GRIFFIN: How does it work if the person with a severe drug or alcohol problem presents at accident and emergency and has a mental health issue?

Ms NOORT: The point raised earlier was that it is impossible to assess anyone who is drunk.

Mr McGRATH: For a mental health problem or a drug and alcohol problem.

Ms NOORT: Until the person can be assessed, we do not know that they have a drug and alcohol problem. We know they are drunk and they have a physical assessment. We can then fix their physical problem, but they need to be sober for us to do both the mental health and the drug and alcohol assessments.

The Hon. KAYEE GRIFFIN: Quite often they tend to fall through the cracks.

Ms NOORT: Absolutely.

The Hon. KAYEE GRIFFIN: They do not present with what is seen as a mental health issue, but rather with a drug and alcohol problem. The Chair referred to the Herbert Street clinic.

Ms NOORT: The Herbert Street clinic will not pick up drunk people from accident and emergency and mind them until they are sober. There is a mechanism and people need to sober up.

Mr McGRATH: There is no specific treatment for intoxication, other than the passage of time. You cannot make assessments for any other treatment until that time has elapsed.

CHAIR: This matter is raised in question 9. The Committee has been given the job of inquiring into the Inebriates Act and that small cohort of people. The Committee is aware that a new Act, with associated publicity and a net-widening effect, raises the issue of extra pressure on the health system, particularly the acute care system, in the absence of treatment for intoxicated people. The proclaimed places have gone; police rarely take someone to a cell, unless there is another reason to do so; there is no treatment; it is not appropriate to treat them in an accident and emergency facility. Yet, many of them are desperately in need of assessment. Many desperately need care. Are there any solutions to this conundrum?

Ms NOORT: Role delineation in health facilities is a problem. The facilities are to provide a level of acute care, and being drunk is not acute. To use clinical language, it is sub-acute. There is a variety of models that use the notion of sobering up. They are effectively and efficiently used within the context of a well-resourced NGO. In models there are specialist drug and alcohol teams and/or specialist mental health teams coming in and being part of the assessment with the NGO case-managing the individuals for the length of time it takes to sober up. They keep a professional eye on them to ensure they stay well. That is a much more cost-efficient way to do it. Also, it does not make being drunk an illness.

CHAIR: Administratively or clinically, who would put such a system together?

Ms NOORT: Salvation Army, NGOs often do that. It would be appropriate for the Government to use the same model it uses with illicit drugs, which is a partnership between the public sector and the non-government environment.

CHAIR: That means that a hospital would need to have mechanisms for rapid contact with the relevant NGO in the area?

Ms NOORT: Or role delineation with the police. There are local arrangements around illicit drug use and mental health problems and for people with complex diseases such as asthma. That is a partnership between the NGO and the public health sector with other environments, such as the Department of Community Services and Housing.

CHAIR: Those arrangements are less satisfactory, or less existent, in relation to drug and alcohol.

Ms NOORT: The available resource base across all sectors for drug and alcohol is less. The further out west you go, the NGO sector is very sparse, if not non-existent.

CHAIR: There is a stigma attached to people affected by drug and alcohol. There is a lack of esteem of people working in the area.

Ms NOORT: My experience from running a series of community consultations, as a CEO of an area health service, for the placement of methadone clinics versus placement of acute mental health institutions, clearly says we have a long way to go with community perceptions. The people require a level of support intervention and treatment.

The Hon. ROBYN PARKER: From your discussion with NGOs and the Victorian model, would you think that is the way New South Wales should head?

Ms NOORT: There is a partnership model. If you are asking me whether the health system should hand over the tertiary responsibility to non-statutory authorities I would say no. There is a balance between the two and everyone has a role to play. The problem is that with limited resources there is always a fight over whose role that is. If you get the role, you get the money. The issue is sorting it out. Who is the best person to provide it, what is the most efficient use of resources? There are a lot of opportunities to do that. There is the lot of experience in health working with a range of models. The women's health model is a really good one. Health provides basically the tertiary level and the NGO provides the community-based services.

There are many mixed models. For the drug and alcohol problem New South Wales already funds a series of NGOs to provide value-add services, not repetitive or duplicated services. NGOs no longer operate, or operate less and less, as small community environments. They are working on businesses that are required to operate as businesses.

CHAIR: Yesterday in Melbourne the Committee spoke with an NGO about the way it operates and its staffing. Essentially it had mostly part-time employees, mostly women, people with nursing background and welfare workers and youth workers. It had no medical personnel beyond the nurse level. It had access to local GPs of goodwill, certainly not all GPs. It had access to a certain amount of psychological support. Is that broadly sufficient for the kind of services we are talking about for the assessments, detoxification, et cetera

Ms NOORT: Probably it should be a broader range of mix. It is worth putting on the table that one of the arguments around pursuing the NGO sector is because they are cheaper. That will become less and less the case. There are a couple of reasons why the NGO sector is cheaper: One, they are paid less. At the moment there are award cases running for parity across those positions. With the exception of people who have major passion, it means that a lot of practitioners within the NGO sector could move to the public sector, so they can do a similar job for more money. There is a fair bit of movement back and forth. That is one reason why they are seeking job parity. Salaries and wages will eventually balance out, as they should.

Predominantly the NGOs are funded, either through fundraising and attract government funding to provide services. Increasingly all government agencies require NGOs to have an accreditation status in relation to quality of service and practice. That means that the NGO environment is now required to have the same costs that a range of public sector environments would have, because they need certain things in place such as fire restrictions. The difference in costing is getting narrower, and will continue to get narrower. Having said that, the other issue is about horses for courses. There is a role for the NGO sector, there is a role for the public health sector. Once you

come up with a total model, it is about who does what best, and putting a match. I do not think it belongs wholly in either the public or NGO. It belongs in both in a partnership model.

CHAIR: What about the specific issue of the level of skill or professional qualification required for the service we are talking about?

Mr McGRATH: During the sobering-up phase?

CHAIR: Yes.

Mr McGRATH: We need nursing staff who can make appropriate assessments about when people are going into a withdrawal state. That is the most crucial. Obviously the greatest danger is during withdrawal. You need nursing staff who are capable of making that assessment. Staff with psychological intervention skills—

CHAIR: Counsellors?

Mr McGRATH: Yes.

CHAIR: There is not a need for highly skilled, highly trained, medical personnel?

Ms NOORT: Except if the person starts to flip. If he does, there needs to be a direct line to a response team. That is why it should be a partnership.

Mr McGRATH: You need medical contingency of some sort.

CHAIR: That is relevant.

Ms NOORT: It would not be a local GP, the best friend, but an emergency team that could respond immediately.

CHAIR: That is relevant to both the partnership that might exist between an NGO and a government service and to a decentralised service in rural areas. There would be a likely need of rapid intervention.

Ms NOORT: And the way to resolve that is to look at where you might place the NGOs, geographically, in relation to its proximity to an accident and emergency place that would send out a resuscitation team.

CHAIR: We never did get your opinion on the suggestion that community treatment orders could be used as a less restrictive alternative to residential treatment but with the sanction, if you like, that if we are talking about an involuntary system if someone does not conform with a community treatment order they may be placed in a residential centre. Do you have a view on that?

Mr McGRATH: As part of a stepped approach it is a sensible component of a stepped approach and a sensible component of a menu or a range of treatment choices that have differing degrees of severity.

CHAIR: The other one we did not specifically talk about was the Committee's concern—it is questioned 8 basically—that new legislation might produce a degree of net widening to a much greater extent than anyone would want. Do you have any suggestions as to how we could cater for the people who need to be catered for, and most people would probably agree this Act does not do that at the moment, but not to a degree of undesirable net widening?

Ms NOORT: We would be looking at restricting the criteria in a strict assessment process, like looking at some sort of notion of an independent review. It is fair to suggest that if we are providing something that looks like two weeks of respite, a lot of people would be asking for it, both for their own loved ones and on behalf of loved ones, and there is potential for a high level of community representation for individuals to be placed, and we would be looking for rigid criteria.

CHAIR: Our previous witness, Professor Hall, referred to the concept of diagnostic creep, suggesting that in the profession itself there will be a gradual net widening.

Mr McGRATH: Possibly, yes.

Ms NOORT: One of the things that health practitioners are extremely good at doing is building a service base, and as a long-term bureaucrat who started off as a nurse, it is quite clear if you give someone $10 to run a service that cost $7, within a year they will need $15 because the service has just doubled. Yes, absolutely. That is why you need an independent review tribunal to do that. But I think there are also issues about the pressures put on practitioners and bureaucrats to admit people for a variety of different reasons, and there would need to be an independent mechanism to ensure that we maintained confidence.

CHAIR: Would that mechanism be the individual, civil liberty type safeguard like the Mental Health Review Tribunal or are you talking more about the monitoring, evaluation, quality control aspect of health, making sure that the services are performing properly?

Ms NOORT: Given my perceptions about who might be encouraging the acceptance of particular referrals, it would need to be an independent group.

CHAIR: You mean the tribunal?

Ms NOORT: It would have to be outside the health system.

CHAIR: So some new group would be set up but it would need to be a regulatory, monitoring group?

Ms NOORT: Yes.

CHAIR: Like community visitors? Inspectorate is probably the wrong word.

Ms NOORT: Yes, something like that. One of the mechanisms that was a case review process or something like that. For example, Health has a joint program with Juvenile Justice, and one of the mechanisms we are setting up at the moment, because we have shared clinical decision making and we have different views, there is a joint clinical review team from the two agencies which would then review the decisions or disputes or conflict resolutions. This is independent of the service structure. That is the sort of mechanism I am talking about.

CHAIR: When you said a joint clinical review team, does that imply its membership is totally medical?

Ms NOORT: In the instance between Health and Juvenile Justice it is. Well, not medical, that is wrong, I am talking about allied health in the broader sense of the term. I would suggest there would need to be some clinical advice on the tribunal but you would want social justice advice as well.

The Hon. IAN WEST: In assisting the assessment and definition of diagnostic creep, I am assuming you would want to make sure that that assessment was being done on the basis of what was best for the client as opposed to what was best for Treasury? That is an unfair question.

Ms NOORT: Health's priority is clinical effectiveness.

CHAIR: Question 10, an even smaller group, I think, amongst the cohort that we are dealing with is the group with a disability arising from substance use, whether we referred to brain damage or brain injury, and the suggestion that the system needs to be built or rebuilt to provide long-term care and support for that sort of group. Do you have a view on what should be done for these people?

Ms NOORT: Yes, we do. I have to qualify this by saying that whilst I am representing New South Wales Health, I am also a member of the board of directors of the Spastic Centre. So some of my answers have been influenced by my experience there. The question is similar to the question you

asked about the mental health and drug and alcohol. The disability system is a disability system and people who have a drug and alcohol problem and a disability should have the disability managed within the context of the disability system, with specialist backup support from drug and alcohol. It is inappropriate to a disability drug and alcohol service, however you might think about it, that fractures a disability system which some could observe is already fractured enough.

CHAIR: We have certainly had evidence, not surprisingly I suppose, about some of the group we are talking about ending up, for want of better, in a nursing home—inappropriately placed in a nursing home because no-one has come up with anywhere else to put them.

Ms NOORT: The disability system has moved the same way as the mental health system has moved, with very little institutional care. That does not mean they should be part of the broader network in relation to the range of disability services available to them. The two messages, in my view, that the Drug Summit and Alcohol Summit tried to send are that drugs and alcohol are everybody's issue and specialist drug and alcohol workers are there to support other workers to meet their responsibility. That would be the same message I would give drug and alcohol disability.

CHAIR: Therefore, leaving out the need for extra funding or whatever it might be in the whole disability service system, you do not see any specific problem in building a system because you firmly believe that this group should be part of that system?

Ms NOORT: Yes.

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

Ms NOORT: We probably have three things. We would be hoping for a workable mechanism for dealing with this client group and their carers. We would be hoping for clear delineation between agencies and service providers, and we would be hoping that the prerequisites in some way, shape or form are addressed, highlighted or identified as needing to be considered.

CHAIR: Prerequisites for what?

Ms NOORT: What do we do with people who turn up to accident and emergency drunk? I guess the use of the word "prerequisites" is saying what is the value of filling in the third box if the first two boxes are empty?

(The witnesses withdrew)

(Short adjournment)

DUNCAN CHAPPELL, lawyer and President of the Mental Health Review Tribunal of New South Wales, sworn and examined:

CHAIR: In what capacity do you appear before this committee?

Professor CHAPPELL: Whilst I suspect I have been invited because of my present position, anything I do say in terms of my views are mine alone and not that of the tribunal.

CHAIR: Do you want to make an opening statement? Our first question invites you to tell the committee about your experience and expertise and the relevance particularly of the Mental Health Review Tribunal. The committee is aware that we have invited you because of that expertise but that does not mean we have a right to expect you to be on top of the issues about the Inebriates Act. Having said that, many people have talked to us about the Mental Health Act as a possible model so we are very interested in you talking about the tribunal.

Professor CHAPPELL: I have prepared some brief written remarks which I seek to table.

Leave granted.

Document tabled.

In preparing the remarks I sought to follow the challenging question list that was provided to me. I will summarise the opening and first question which is the one relating to my own experience and expertise and the role of the tribunal. My professional background is in law and criminology. For a number of years I was the director of the Australian Institute of Criminology a role which, among other things, involved directing and managing policy-related research on drug and alcohol issues, including two projects to which I should refer. One was a project conducted in association with the National Centre for Epidemiology and Population Health of the Australian National University for the development of a heroin maintenance trial, a trial which regrettably in my view did not proceed for a range of reasons with which I imagine this committee is familiar.

I also chaired a National committee on violence which was established by the Prime Minister in the late 1980s in the wake of the Hoddle and Queen streets massacres in Melbourne. As part of the committee's report entitled "Violence—Directions for Australia" which we produced the committee made wide-ranging recommendations for the adoption of a number of violence prevention measures which included many which related to drug and alcohol issues. Before I joined the Mental Health Review Tribunal—I have been in my present position as president for three years—I was for a number of years the Deputy President of the Federal Administrative Appeals Tribunal. I am also currently a member of the New South Wales Law Reform Commission.

Turning to the tribunal itself, the tribunal is a quasi judicial body constituted under the Mental Health Act 1990. I will refer to that Act as "the Act" since it is the one that tends to guide our activities. The tribunal has some 33 heads of jurisdiction but basically the jurisdiction falls into two principal areas, those of civil matters and those of forensic matters. In the civil area, persons who are being considered for involuntary treatment for their mental illness whether within the hospital or in the community must be brought before the tribunal or, as I will explain later, before a magistrate for review and determination whether or not that treatment should proceed and in what situation. I can speak more about the actual way in which we handle those reviews if you wish.

In 2003 we conducted some 8,700 hearings, 600 of which were forensic and the balance were civil. Most of our work is in that area. We, in the course of those reviews, considered both patients who were in the various gazetted psychiatric hospitals in the State as well as many others who were in the community and being considered for Community Treatment Orders. I understand that you do not probably wish me to say much about the forensic side of our jurisdiction since that is quite a specialised aspect of our work, but I would be very happy if you wish to answer questions on that as well.

CHAIR: Certainly there may be issues which you think are relevant for us in that respect, but in general most of our inquiry has focused on non-offenders.

Professor CHAPPELL: In general when the tribunal does sit it is obliged under the Act for the panel to comprise three people: a lawyer as the chair, a psychiatrist and another qualified member, usually someone with a specific experience in mental health issues who is there to represent the general community. There are three full-time members of the tribunal—I am one of those—and only full-time members can preside over forensic hearings. But in the civil area we rely principally on a part-time membership. We have more than 100 part-time members falling into the three categories I have just mentioned—lawyers, psychiatrists and other community members. They are the ones who adjudicate upon the applications that are brought to the tribunal.

The tribunal is not bound by the formal rules of evidence. It obviously though has to have regard constantly to the rules of natural justice and procedural fairness. Tribunal hearings are conducted as far as possible in an informal non-adversarial manner. We conduct wherever possible in the metropolitan areas of Sydney our hearings on a face-to-face basis with patients. We go to many hospitals around metropolitan Sydney, Newcastle and Wollongong as well as to various community health centres to conduct those hearings. Where we cannot do that—and that is a matter of cost principally—we conduct the hearings through the use of the tele-medicine video link or by telephone as a last resort. That is all I wish to say about the tribunal at this stage, but I can certainly answer any other questions you might have about it.

The Hon. GREG PEARCE: What proportion of those hearings result in an order for involuntary treatment?

Professor CHAPPELL: I would say that the overwhelming majority of hearings result in the tribunal supporting the application made by either the hospital or the community health agency. The hospital, for either a temporary patient order which can be given for up to three months and after a certain number of those orders have been made then the person becomes a continuing treatment patient if they remain in hospital or in the community. If it is a community treatment order which is the most frequent order made they can be kept on that order for six months. I would say that probably on average somewhere between only five to 10 per cent of applications would be refused by the tribunal.

CHAIR: Is it true to say that the tribunal always deals with cases where someone has been brought into the system? You do not deal with the initial bringing into a hospital or the issuing of a community treatment order, for example?

Professor CHAPPELL: That is quite correct. We do not have any responsibility for that aspect of the mental health process. One of your later questions asks about that and I can explain it now if you wish. In general, only when an application is made to the tribunal does jurisdiction get triggered and we then respond to that application—whether it be from a hospital or community health agency.

CHAIR: So in that sense you are really a review body or a second-stage agreeing body.

Professor CHAPPELL: We are. I should have said that we are a quasi-judicial body. In regard to the orders we make, I think we probably technically exercise judicial power—although obviously we are not judicial officers. I am a statutory officer on a term appointment as are my colleagues. The part-time members are appointed by the governor in council for a term period.

The Hon. GREG PEARCE: Are the patients represented in any way?

Professor CHAPPELL: Yes. There is a right of legal representation for all patients. All patients—unless there is some good reason, for example they may be so unwell that they cannot appear before the tribunal—are also obliged to be personally present. While there is a right to legal representation, only in matters where a patient is in hospital and a further period of involuntary treatment and detention in a hospital has been set are they able to get legal assistance through the Mental Health Advocacy Service, which provides that as a matter of right. There is no merit review. The service does an extremely good job. When a patient is in the community and a community treatment order is being extended or whatever there is no entitlement to Mental Health Advocacy Service representation. So quite a significant proportion of our client population are not legally

represented. I should say that the tribunal believes that is unsatisfactory, and so does the Mental Health Advocacy Service. We all wish to see an extension of the range of legal representation, but that is a resource issue.

CHAIR: I think you said you have 8,700 cases in the civil area. Roughly what percentage of those cases are in relation to community treatment orders? I presume that sometimes one patient will have both.

Professor CHAPPELL: Yes. More than half of the matters would be community treatment orders. They are the most frequent business that we conduct. I should perhaps have mentioned some of the other things that we look at. We have to consider electroconvulsive therapy [ECT] applications. We also have jurisdiction to give protected estate orders where a person is in hospital, and a few other areas like that.

CHAIR: But numerically it is a relatively small number.

Professor CHAPPELL: Yes, it is quite small—although, from memory, last year some 600 applications were made for ECT, which is quite a significant number.

CHAIR: You would be aware that many of the people who have taken part in this inquiry have pointed to the Mental Health Act as a good framework for involuntary detention for people with alcohol and drug dependence, if that is the path that we go along. They have said generally quite favourable things about the role of the tribunal, the safeguards and so on. We would like to know a little more about the principles you operate under and whether they are relevant or appropriate to the group that this inquiry is dealing with.

Professor CHAPPELL: The New South Wales Mental Health Act was, as you know, established in 1990. I believe it represents a very good statement of the principles that should apply to the treatment, care and detention of those people who have a mental illness. The Act is designed to safeguard the rights of those who are mentally ill and to ensure that the treatment they receive is given only in the least restrictive circumstance possible. The overarching criteria for compulsory treatment, which is one of the matters that we must consider as a tribunal, is whether there is a risk of serious harm either to the person involved or to others if that treatment is not given, and whether that person is suffering from a mental illness or a mental disorder. Those two concepts are defined in the legislation not by any prescriptive definition but rather by looking at what symptoms are present. I think the Committee has already been told that there are quite a number of specific exclusions from what is or what is not a mental illness, including merely taking drugs or alcohol. That alone does not constitute a mental illness.

In general, I think the Act has been well received over the more than a decade that it has been in effect. Parliament has only recently made a significant and extensive review of the whole mental health system, including the Act. I am sure that you are aware of the Legislative Council select committee report. It generally would have given a quite good mark to the success of this particular piece of legislation in, on the one hand, balancing the difficult competing interests of persons with a mental illness not being subjected to unnecessary, unreasonable or lengthy treatment in detention, or for that matter in the community, and, on the other hand, ensuring that if a person does have a mental illness and there are risks of harm to themselves or others there is a treatment mechanism available.

The review process that is put in place commences at the point that a person is identified as having a mental illness by, at the community level, perhaps a general practitioner who is treating that person, a family member, a police officer or a range of other people who can identify that there is a problem. A certificate may be issued for that person to be taken to a hospital and there the examination process is put in place, which is prescribed in the legislation. If that examination results in the finding that the person is mentally ill there is a next step that leads to that person being brought before a magistrate as soon as is practicable if they are to be kept in hospital. The magistrate must then make a decision whether to issue a temporary patient order, which can be for up to three months, to allow that person to be treated in hospital or, alternatively, the magistrate may issue a community treatment order, which can be made by the magistrate at that point if the hospital believes the person should be discharged but still have a form of treatment in the community.

The tribunal comes into the picture only after the initial examination and review. There is a right of appeal to the tribunal against a refusal by the medical superintendent to discharge someone from hospital. There is a right of appeal from a magistrate's order to the tribunal. But usually the tribunal will see the patient for the first time after the magistrate has made his or her order. The tribunal is then asked to look at whether, if an application has been made, the person should continue to be treated in the hospital or discharged on a community treatment order. In a nutshell that is the review mechanism that is in place. In the context of the mental health debate at that time, the Mental Health Act was introduced to seek to protect to the greatest degree possible the civil rights of the mentally ill and to ensure that, unlike in the past when largely unfettered medical discretion determined whether persons were held in hospital, for how long and what treatment they received, it would be a much more transparent and open process.

CHAIR: Do the magistrates involved have any special training or familiarity that the issues or is it essentially whichever magistrate happens to be on duty at a particular time and place?

Professor CHAPPELL: Perhaps in the past it might have been less specialised and magistrates were rostered to this particular aspect of their work on a general basis. I met only last week with the Chief Magistrate, Judge Price. There is now a cadre of largely retired magistrates who are available to do the initial reviews that I have mentioned. They are spread around the State. They see all patients face to face; they do not do any of the video and other types of links upon which the tribunal relies. I know as well that it is a resource-intensive aspect of their work. I think they saw nearly 8,000 patients during the initial review process last year, and there has been a quite dramatic rise in their workload.

It might also be relevant for the Committee to know that a review has been initiated of the Mental Health Act by the Minister for Health. As part of that review a discussion paper is in the process of final production. You may or may not have seen a draft of it. It contains quite a number of discussion points, including the question of whether the initial review by magistrates should continue at all, whether it should be taken over by the Mental Health Review Tribunal, or whether some other alternative might be put in place.

My own personal view is that it is very important to have as early as possible judicial or quasi-judicial review of the type that we have. I think New South Wales is ahead of other jurisdictions in this regard since it is not the situation in Victoria, which is the other largest comparative jurisdiction and only really when a patient appeals against their involuntary detention treatment to the equivalent of the Mental Health Review Tribunal of Victoria do they get that first review. I just mention that really as an issue which I think is of importance and certainly in a civil liberties context if there were to be an extension of this model to the area of alcohol and drug dependence I think it would be important to ensure there was a very prompt judicial intervention and review at the outset of any consideration of compulsory treatment.

CHAIR: So would it be true to say that you see these principles as being appropriate for the clients that we are talking about?

Professor CHAPPELL: I think I do. I know I have jumped a little ahead of the sequencing of the questions but I should say that in general in relation to compulsory treatment for your particular population of drug and seriously dependent drug and alcohol persons, I found quite compelling the evidence of Professor Ian Webster about the need for treatment for people who face severe threats to their own safety of their lives. My own view would be that I would only favour compulsory treatment for persons who were in life-threatening situations. I would restrict it to that. Also, on the basis particularly of the evidence that I have also had the benefit of reading from Professor Terry Carney, I stress the need to look at the capacity of a person to consent or not to whatever treatment is concerned. But within that framework, if there is to be compulsory treatment for this particular group of people then I do think the principles that apply in the mental health legislation could readily be translated to this area.

CHAIR: And the framework for implementing those principles?

Professor CHAPPELL: And the framework, yes. I think I was asked also whether I felt that if this were to happen the legislation that should be put in place should be incorporated in the Mental

Health Act or should it be separate legislation. On that issue I am a little equivocal but, on balance, I would feel that it would not be appropriate to mix these two groups in with the mental health patients group, if only to avoid what I think is the real risk in this area, and that is net widening, because I think if you did the risks of net widening could be increased rather than controlled. I have some ideas about net widening as well but that is one of the things I should mention.

The Hon. IAN WEST: Could I clarify that? You are only saying net widening. You do not see any stigma problems?

Professor CHAPPELL: I do see stigma problems as well, yes. I have not mentioned that but I think that there is now a much greater understanding in the community of the great suffering that people who have mental illness go through and an understanding of the nature of that illness even though there is still, I am sure, stigma in some sectors from being labelled a person with a mental illness and treated under it. I think probably it would be the same though if you had separate legislation. I just think that separate legislation would clarify the boundaries between the different types of dependency and I do not believe that it would be appropriate to try to bring together all of these patients into one particular piece of legislation.

CHAIR: In Question 3 we asked you about the key ethical issues in relation to compulsory treatment for substance dependence. I guess you have already started answering that in a sense by the stress you have put on the principles in the Mental Health Act and it overlaps to some extent with the specific questions we have asked in Question 4 that if we are going to have some sort of compulsory treatment then in practical terms who do we have it for, in what circumstances, what criteria, et cetera? I know you have prepared answers.

Professor CHAPPELL: In terms of the justification for compulsory treatment I have already mentioned that I thought that the views that were expressed by Professor Webster were quite compelling, also Professor Carney who I thought eloquently put the points about the need to consider autonomy of the person and the capacity of the person to make decisions, that basically personal autonomy, as I understand it, is the key feature of any consideration of when or when not to apply compulsory treatment and that a person should have the right basically to make their own decisions about their fate if they have the capacity to do it.

I think that the philosophy underlying what is being put forward by Professor Webster is probably that of John Stuart Mill and Jeremy Bentham—utilitarian philosophy—and I think I probably would share that but only, as I said, would I personally feel justified in consenting to compulsory treatment for life-threatening situations and I would fairly carefully specify that for people with drug and alcohol dependence.

CHAIR: To get into Question 4, for instance, physical timeout, respite for family, rehabilitation, are not areas that you would see as ethnically justifying compulsory treatment?

Professor CHAPPELL: I would not. I mention in more detail in my written statements that I also have serious doubts about the effectiveness of any compulsory treatment that could be applied. I am sure the tribunal has already been made aware of the scientific literature on this issue and I am afraid it does not give much support for the effectiveness of this, especially, for example, in areas such as Sweden, which has had quite a long experience of these forms of compulsion without, it would seem, good outcomes. I can also remember myself personally visiting a wonderfully run treatment program in Singapore some years ago where people marched around in uniforms and were put through various forms of rigorous therapy. I believe that the outcomes of that were not, unfortunately, very promising either.

I think California also went through a phase of having quite extensive compulsory treatment, although there was obviously an overlap between the civil system there and the criminal justice system. I am talking only now about civil patients, not those who have been involved in crime. But in Singapore, as I recall, it was a crime just to be an addict, so it made it easy to impose compulsory treatment on that basis.

CHAIR: Since we gave you these questions some of them have been clarified in our minds by our discussions in Melbourne yesterday, as I mentioned to you earlier before we started about the

Victorian legislation limiting the compulsory aspect to the generally seven-day assessment and detoxification period, as compared to the Inebriates Act where, from what we can gather, the most common order is a three-month order. So it is a very different pair of Acts that we are dealing with. I mention this because the other questions about the circumstances, the criteria and how long detention should occur, I guess we had a lot of discussions yesterday that are very interesting in relation to all of those. What are your views?

Professor CHAPPELL: Before I get to that I would like to say that in terms of justifying any compulsory treatment program I think one of my other concerns is, apart from the effectiveness, that it not in any way draw attention away from or harm the harm minimisation philosophy which Australia has now espoused for a significant number of years in relation to drug policies at large. I strongly endorse the philosophy and I would hate to see us move in any way from it as part of a compulsory treatment regime. I think it is a core philosophy and any examination of countries which have gone other routes, and especially our great neighbour North America, would realise that we have been very fortunate that we have had this approach in Australia.

As far as the actual form of compulsory detention that might be applied, I would limit it to the seven-day or more, around that period of compulsory detoxification and assessment as apparently applies in Victoria. It might be that there might not need to be a specific time period or a maximum period set for that to take place. I am not qualified to know really what is appropriate in this situation. I think that the question of what happens after that is perhaps more contentious and I know of the suggestion that perhaps community treatment should then become part of the compulsion, but that is something that would have to be fully justified, in my view, and I am not comfortable with it and the terms of the effectiveness of what could be provided. On the other hand, it may be that people who are faced with basically death if they do not have the dependency at least assessed and treated immediately, will need some recuperation period and the community would just obviously do that in the setting of the least restrictive environment rather than requiring them to be in some form of facility.

I have to say I am not clear what the community has been told about the types of facility that might be doing this type of work, but from just a historical side, the tribunal has its new premises in Gladesville Hospital, which is an old site of psychiatric hospitals and one of the oldest in this State. Indeed, the actual courtyard and wards that we now occupy were in fact, I understand, formerly a place where inebriates were treated and there were several hundred who were housed in this one building. So in the past at least clearly there were many who spent long periods of time in these facilities. This is something that we would all wish to avoid in any type of resurrection of this type of compulsion.

The other matter I perhaps should mention is the leakages between the sort of treatment that might be envisaged for those who are suffering from severe drug and alcohol dependence and mental illness. In my experience as a member of the tribunal and having sat on hundreds of matters now, there is a strong relationship often between mental illness and drug dependency and, perhaps to a lesser degree, alcohol dependency. There is much debate in the professional literature about cause and effect in terms of much of this but in terms of treatment many of those who are in both hospital or in the community require treatment not only for their mental illness but also reference to rehabilitation in the form of access to adequate drug and alcohol dependency programs.

The reality, I am afraid, is that all too often those programs are not available to people with a mental illness and very often relapse occurs because of renewed drug use and poor alcohol use, and then the cycle of re-entry to hospital back into the community occurs. I do not think that the resolution is to compel the treatment; rather it is to ensure that there are adequate facilities in the first place and resources available in the community for people with mental illness to access so far as their drug and alcohol dependency is concerned. I am jumping ahead again here, because it is very relevant if people in the community are on a community treatment order. Orders are really intended to ensure that they have a regular assessment of their mental state, that they see a psychiatrist, that they go to a case manager who helps them with their rehabilitation, which may include employment, referrals to drug and alcohol, but it is not intended under the Mental Health Act that as part of the community treatment order there should also be compulsion to go to these forms of drug and alcohol treatment.

That is simply because if it is a condition under the order then if they fail to go to the drug or alcohol program they could then be returned to hospital, which makes no sense in terms of the objectives, at least, of the Mental Health Act. In a sense it would also produce compulsion through the back door for treating drug and alcohol dependency if this were the case. But there is still in contention, I have to say, among some members of my own tribunal about this issue as well as, I am sure, in the hospital and the community treatment setting. On occasions when we have applications for a community treatment order there is an attempt to include compulsory treatment at the time I have just been mentioning for drug and alcohol dependency, and the tribunal should and will refuse to accept that that is an appropriate part of the compulsion and reachable target for an order that is made.

CHAIR: Is that a fundamental principle that guides the tribunal, when you say that people keep trying to make is part of the order?

Professor CHAPPELL: Sometimes it can be difficult because the plans are often vaguely drawn, they are not specific enough, it is not clear what is to be done in real terms in asking the patient to go to a particular rehabilitation program for their drug or alcohol dependency. In that way the odd one sneaks through. I am sure there are many workers in the community who are desperate, in a sense, to find a way to try to resolve these severe dependencies because the linkages between the mental illness that the person is suffering and their drug use is often quite distinct and there is quite compelling evidence that people who continue to use many of these drugs and still are being medicated, that the medication itself will become ineffective or will not work at all if they continue to use the other drugs. Obviously, there is a strong interest in trying to keep them free of these things. I suspect there is always a temptation if they continue to use them to use the device of them, say, relapsing to get them back into hospital when really it is the drug and alcohol matters that are perhaps predominant. I think it is frustrating for everyone that that is the case, but we are not there to compulsorily treat people for these things: we are there to treat their mental illness.

CHAIR: Having said everything you have just said, are you being philosophically slightly inconsistent in supporting community treatment orders in the mental health area to make people see their psychologist, to make them do a variety of things, but not support them in the severe drug and alcohol dependency area?

Professor CHAPPELL: If there is inconsistency I think it is because of the objectives of the Act, and the Act is clear that it is the mental illness of the person that is to be seen as the predominant treatable aspect associated with the order.

CHAIR: But if there were a properly written Act for the group that this inquiry is dealing with that had the right safeguards and a tribunal, if all of those conditions were satisfied is there some inconsistency in your view?

Professor CHAPPELL: I think not because I would only agree with the compulsion, certainly as far as drug and alcohol dependency is concerned, as I said, for where there were life-threatening situations. In terms of the treatment of the mental illness, the test is much less than that: it is severe or significant harm to the person or to others, which includes reputation of the person. To also compel this form of treatment would really, as I said earlier, be part of the net widening aspect that one could easily have. If you say that everyone with a mental illness who also had drug dependency, whether it be of alcohol or other types of drugs, also could be compelled to be treated under community treatment orders as part of the mental illness I think you would find that you would very rapidly have a very big extension of the net of the people who would be subjected to these forms of treatment. I am not sure from my reading, at least of the evidence that has been presented so far, how many people generally are thought to have drug or alcohol dependency independent of mental illness who may fit within the parameters of whatever compulsory regime is put in place. Certainly, the Kirketon Road Centre submission says that only about two people, in their view, would have satisfied the criteria. I do not know whether any other of the witnesses have suggested bigger numbers than that.

CHAIR: We wish they had. We have been given estimates of percentages of people with severe alcohol and drug dependence compared to mental illness, compared to dual diagnosis and so on, but no-one has even come close to making a stab at the number of people who might be suitable for compulsory treatment for drug and alcohol who might be suitable for treatment for drug and

alcohol dependence, and that is part of the reason we have asked about net widening criteria and so on because we are very conscious that the numbers are really small at the moment and no-one seems to have a clue what they "should" be. Everyone seems to be quite in the dark.

Professor CHAPPELL: Again, because so often the effectiveness of the sort of treatment that can be afforded, even to people in the mental illness category, is questionable you could see a very large number of people who might be caught in this net if you were to make it compulsory as part of the mental treatment illness regime.

CHAIR: Because we hopped a bit we have probably dealt with question 6. It is that bit about the process of examination and decision making that occurs for detention under the Mental Health Act. I am not sure whether you want to say more about your views on whether the process that you have described might be suitable for those with severe alcohol and drug dependence.

Professor CHAPPELL: It would depend very much upon the actual regime that was established, but if there were a short period for detox and assessment I would have thought that it was very important that decision, whether or not to keep the person in for that period, should be subjected to some form of independent review and that that might either be through a tribunal or a magistrate, or both, if there were a right of appeal as well, and that equally if you were intending to keep people for a longer period under some form of order in the community that that, too, should be only through application to a tribunal, which would again affect very much the framework of the Mental Health Act. I was also reflecting, as I was looking at the mental health regime and the possibility of its application elsewhere, that I imagined with a very small number, if that is what is intended, of compulsory treatment orders in this area I think someone might have said 100 or something like that perhaps maximum a year, that it would be quite feasible to make the Mental Health Review Tribunal, also the tribunal that reviewed these matters as a matter of cost effectiveness. The panels I have described have expertise pretty much in the area now of dealing with people with dual diagnosis, and I do not think it would be very much different the consideration of the sorts of questions that would need to be looked at for the compulsory detention or treatment of people with severe drug dependency.

CHAIR: If we were to do that, would it create any problems for the Mental Health Act if some drug and alcohol service specialists were added to the panel?

Professor CHAPPELL: No, not at all. I was going to say that I think it might well be wise to have at least a requirement that one of the panel members should have some specific expertise in drug and alcohol dependency. I have said, I think, probably that that would not really require any variation to our existing membership because quite a number of our community members, as well as, I think, some of us are quite familiar with some of these areas and work across both mental illness and drug dependency issues. However, I would also add that it would require, obviously, some more resourcing for the tribunal if it were to have extended jurisdiction of this nature.

CHAIR: One of the issues that was raised with us by some witnesses in relation to the Inebriates Act and its processes was the need for clinical assessment to be carried out as early as possible and to be virtually a prerequisite for an order, which raises the concern about early stage where the magistrate, at this stage, issues an order sometimes on pretty cursory statements from a police officer and a general practitioner. That is partly, obviously, to do with a range of expertise around in the drug and alcohol area. There is probably more expertise or more clear-cut room for decision making in relation to mental illness. I am not sure, with our lack of expertise.

CHAPPELL: It might be that it would be preferable to have the initial review by the tribunal rather than by a magistrate. If the numbers are small I do not think that would be a difficulty. The only question would be, I suppose, that our own hearing capacity outside metropolitan areas is only for video and video link; whether that would be viewed as satisfactory, I do not know. It is widely used, of course, in the health system and that is what we get ourselves. Perhaps with the initial order it would be possible to do that. Then a detailed assessment, I assume, would have to be made, at the time of the detoxification order, or whatever one would call it. I think that those are issues that could be worked out, and I certainly do not think it would make very much sense to set up a separate tribunal for process or review process. I think it could be incorporated in the way I have suggested.

CHAIR: You have made a number of comments about regional and rural areas. Videoconferencing provides a mechanism to overcome disadvantages of small, scattered populations with very few specialist health workers, and all of those problems are magnified if we are assuming we have group of perhaps 100 a year.

Professor CHAPPELL: One of the things I wondered about was whether in some of the rural areas that might be perhaps the most likely catchment area the compulsory treatment might be sought and where we would not necessarily be able to have any physical presence, but again with the video linkage it could be possible to do so.

CHAIR: Do you have any other comments on question 7?

Professor CHAPPELL: I think one of the questions was about how promptly we would be able to provide review. As I said earlier, we work always on the basis of an application made to us by a hospital or health agency. I assume that if it were to be a drug dependency issue it would come from one or other of those sources when it matters immediately for hearing, usually within a day or two since there is often urgency in that an order may be about to expire or it is necessary to see someone in a very short time frame.

We also have regular visits to most of the larger psychiatric hospitals and the larger community facilities, in some cases once or even twice weekly. We can always put people on at very short notice before our video panels. We have three hearing rooms at Gladesville which are totally equipped for this, and there we deal with hearings all around the State on a daily basis. So I think we provide a very immediate service.

CHAIR: Within 24 hours?

Professor CHAPPELL: I would say so, yes. Obviously, we do not sit at weekends, but otherwise we sit all the time and we can always get together a panel.

CHAIR: If your tribunal were to be extended to the drug and alcohol area and it was properly resourced, the same speed and reaction would be in place?

Professor CHAPPELL: Yes. The structure is there to provide such a service.

The Hon. IAN WEST: I do not know whether the Committee has received any information on outcomes from the Mental Health Tribunal? Are you able to provide the Committee with material on the outcomes of tribunal decisions and client case studies? I am having difficulty comprehending exactly what you do. I get the impression that it is like being hit over the wrist with a wet rag.

CHAIR: Earlier in the hearing the Hon. Greg Pearce asked about the number of cases approved by the tribunal, and I think you said it was 95 per cent, is that correct?

Professor CHAPPELL: Yes, around 95 per cent.

The Hon. IAN WEST: From what I can gather, you do not have any compulsion. In other words, if they do it, they do it; if they do not, so what.

Professor CHAPPELL: The compulsion is there. Let us take the case of a person who has schizophrenia. Their GP issues a certificate, they are taken to a hospital, they are examined by two medical practitioners, one of whom is a psychiatrist, and it is decided that the person has a mental illness which requires treatment in a hospital setting. That person would be brought before a magistrate as soon as practicable, and the magistrate would have to make a decision whether that treatment was necessary, whether it was the least restrictive environment to have it in a hospital, and also whether there was a serious risk of harm to that person or to others if that treatment was not provided.

Once the order is made by the magistrate, or later on if the tribunal comes into the picture, there is certainly a compulsion in the sense that if the person escapes from a hospital or leaves the hospital without permission, they can be returned by the police, and there are powers under the Act for

the police to apprehend people. Equally, a person who breaches community treatment orders can also be returned to hospital, utilising if necessary the power of the Police Force. So there is compulsion. They are serious orders; obviously they have a vital effect on the liberties of the person. Once that person is in the hospital or in the community, they are also required to receive whatever treatment is deemed to be necessary in that situation, and that is left to the discretion of the treating team.

CHAIR: We are literally talking about locked wards?

Professor CHAPPELL: We are talking about locked wards. They are not totally locked, in the sense that obviously we have people who leave.

It is certainly not a matter of a wet towel; it is a pretty severe and intrusive form of intervention in a person's life. Obviously, it can only be justified, in my view, with the most stringent checks and balances of the type that I think we have, in general, in New South Wales. In the past we did not, but we saw the outcome of that.

CHAIR: You referred to your concern about net widening, a concern that we share, as you know. Do you have further comments about how that could be prevented in the drug and alcohol dependency scenario?

Professor CHAPPELL: Yes. I have four general points as to how you might avert net widening. The first is to prescribe a very tight definition of the circumstances in which compulsory treatment could be ordered. I have already indicated that I would limit that treatment only to life-threatening situations and for a short-term detoxification period, with perhaps some follow up in the community if that is justifiable. Secondly, I would require a comprehensive review process of the type I have already explained, which would be based upon the Mental Health Act system. Thirdly, I would set a sunset clause in the new legislation, which would require an external and objective appraisal of the outcomes of any new Act for deciding whether or not to extend its lifespan. Finally, I would subject any compulsory treatment programs to rigorous scientific examination to determine their effectiveness.

CHAIR: I cannot resist, as I could not resist with the previous group of witnesses, quoting Professor Hall, who in his evidence this morning also referred to diagnostic creep as an issue in medical circles in general, but particularly in drug and alcohol and mental health services. Essentially, it suggests that the profession is likely to increase the numbers one way or another.

Professor CHAPPELL: As a lawyer, perhaps I should not comment on what my medical colleagues may or may not do. But that is, I am sure, a risk.

CHAIR: Professor Hall was quite serious in making the point.

Professor CHAPPELL: Yes. I think that is an issue.

CHAIR: Has that been a problem regarding the Mental Health Act? Has the tribunal found itself addressing in any way a tendency for net widening under the 1990 Act?

Professor CHAPPELL: It is a very good question. I would say that at the moment the general problem is not so much net widening as a real lack of resources available to mental health practitioners in the form of beds for treatment in hospital settings rather than in the community.

Very often people who probably should spend more time in a hospital setting or a secure setting are released back into the community because there is such pressure for beds. It means that they relapse perhaps more rapidly because they have not had sufficient stabilisation of their mental illness, and they then go back into hospital.

I suppose you could, in a sense, declare that as net widening, because it means that if you kept people locked up for a longer term you might be able to successfully stop them having to go back in. I see that as the main problem.

CHAIR: So the lack of resources is a major control?

Professor CHAPPELL: It is a major control. But it often means that people who probably would benefit from the more intrusive and restrictive hospital setting treatment environment are not able to do so, and instead have to be treated in the community. In the community there are often inadequate resources, as I am sure you have probably been told by other witnesses, and certainly as very clearly made out by the Legislative Council report that I referred to earlier.

There is also what has been described by one expert in this area, Professor Beverley Raphael, the Director of the Centre for Mental Health, as an epidemic of mental illness at the moment. There is certainly a significant rise in the number of admissions in hospital, even with the caveat I have just mentioned. Last year we had a 14 per cent increase in the hearing load, and this year we look like having a similar increase. Why this is so, I am not qualified to say. These are people who are acutely unwell in the main and do need treatment, and often we are not able to offer it in adequate terms. But it would appear that for some reason there is an increase in morbidity, if that is the right term, in the community as far as mental illness is concerned.

The Hon. IAN WEST: You spoke about the life-threatening situation, and you also spoke about harm minimisation. I am trying to understand how you bring the two issues together and what you define as life-threatening, in the sense that some of these people may be threatening their lives over a long period. Are you speaking about imminent life-threatening situations, in the sense that they are going to die in a couple of hours, or about their activities that are life-threatening over a period of time?

Professor CHAPPELL: I am thinking much more of imminent threat. The sort of examples that were given by the Kirketon Road Centre, I feel, are very good ones and very illustrative of the sorts of problems I would be addressing if there were to be compulsive treatment. I am not talking about people who, regrettably, have a severe dependency on drugs. They are obviously doing themselves significant harm, but I do not think that the compulsion can be justified in those circumstances.

CHAIR: Since we have mentioned the Kirketon Road Centre, you would be familiar with the example they gave of the young woman with the short-lived but repeated psychosis from cocaine use and their comment that she really did not fit within the Mental Health Act and she would have been a suitable case for the Inebriates Act. Do you have any comment on that kind of situation?

Professor CHAPPELL: Yes. Firstly, I thought there was a possibility under the Mental Health Act to describe this as a mental disorder, which would have justified detention on a limited basis. The provisions of the Mental Health Act only allow for periods of three days at a time for detention of a person who is mentally disordered, up to a maximum of, I think, three times each month.

There is a general feeling that perhaps that is not an adequate provision and that perhaps a longer period should be allowed for these sorts of situations. But I would certainly have thought that the example given by the Kirketon Road Centre of the cocaine psychosis would amount to a mental disorder and that therefore they could have been detained under that part of the Act. I also felt that the case illustrated the lack of desire of different treatment groups to accept responsibility for the situation.

The Hon. IAN WEST: "Desire" may be an unfair assessment. It may be a question of ability—

Professor CHAPPELL: Ability, and also having adequate resources to deal with it. I do not think they probably have the secure facility that would be required, as well as other types of facilities. It is a very significant problem in emergency rooms in hospitals around New South Wales, where people present with dual diagnosis problems and where they may be quite violent and aggressive in the initial stages, as would occur with a psychosis of the type we are talking about with this young woman in the example. How you cope with that is a matter that I know is very much in the minds of mental health practitioners at the moment.

CHAIR: Just before you arrived we were taking evidence from the drug and alcohol centre of the Health Department, who spoke about how accident and emergency relates to mental health experts and others, hospital by hospital.

Professor CHAPPELL: It is a very big and real problem. Often it puts health workers at some risk of injury.

CHAIR: You would be inclined to deal with that kind of case by either an amendment to the Mental Health Act to extend periods, or by making sure that people working within the ambit of the Mental Health Act accepted that that was the sort of case that came within their territory.

Professor CHAPPELL: I would, yes. At the same time I recognise that they need to have the resources to cope, and at the moment they do not have those.

CHAIR: The Committee has spoken a lot about your expertise in the safeguards, the review for the individual. The Committee is interested also in safeguards and mechanisms for service monitoring to make sure that a psychiatric facility or centre is adequate. Do you know enough to tell us whether they are successful in the mental health area? Can you comment on the safeguards in the drug and alcohol area?

Professor CHAPPELL: I really am not qualified to talk about service monitoring. I can say that members of the tribunal would contend that we have a responsibility to monitor service delivery indirectly through the review mechanism. That is probably true. But if we see poor examples of service, or have views about that, it is a little difficult to know what to do with that information, and what are our responsibilities. Clearly, if we see a gross breach that requires reporting to the Health Care Complaints Commission, whatever its status may be, that is one matter. But we are not there to second-guess clinicians or the treatment options that they have.

We are there to make an order on the basis of evidence that we receive. I would not see a tribunal as being the primary monitoring service. That requires a quality-based assurance program of some sort, and should come from within the expert delivery services that are in place.

CHAIR: It goes without saying that if we are dealing with involuntary treatment, the quality assurance and other issues are even more important than they are in voluntary treatment.

Professor CHAPPELL: Absolutely.

CHAIR: That was addressed yesterday in Victoria, partly because the services we are talking about are provided by the non-government sector.

Professor CHAPPELL: Yes. Victoria has moved very much in that area with prisoners as well, with the privatisation of the prison system. How you assure quality in that area is germane to this area as well.

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

Professor CHAPPELL: I would like to see a removal from the statute book of the present Inebriates Act. Whatever service it has done is long gone, and it needs to be replaced by new modern legislation. I think it should be stand-alone legislation, as I have said before, not part of the Mental Health Act. A case can be made out for compulsory treatment, but only on a very limited basis, as I have already suggested, for severe drug dependence. I would hope that that comes from this inquiry. I hope that whatever model is put forward it looks at what is best practice in the areas and continues to espouse the harm minimisation approach. That needs to guide us in this area.

CHAIR: Given what you said earlier, you would want whatever legislation or regime to have a sunset clause and rigorous evaluation.

Professor CHAPPELL: Yes, certainly I would make those part of it.

CHAIR: We should not have another Act that lasts for more than 100 years. It was introduced in 1899, although it has 1912 in its title. It has lasted well over 100 years. We asked a lot of you to talk about this Act, which is way outside your area of responsibility or expertise. Your contribution is very useful for the Committee.

Professor CHAPPELL: I have not trespassed too heavily on other areas of acknowledged expertise.

CHAIR: Many people have suggested the Mental Health Act as a model, and few have suggested bringing the group that we are talking about under it. Thank your for giving us your perspective.

(The witness withdrew)

(The Committee adjourned at 1.37 p.m.)