REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At North Sydney on Thursday 4 March 2004

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The Committee met at 10.30 a.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)
The Hon. Dr A. Chesterfield-Evans
The Hon. R. M. Parker
The Hon. I. W. West

STEPHEN JURD, Area Medical Director, Drug and Alcohol Services and Addictions Psychiatrist, Herbert Street, Clinic, Royal North Shore Hospital,

TONINA HARVEY, Area Medical Director, Drug and Alcohol Services, Herbert Street Clinic, Royal North Shore Hospital,

DIANE PAUL, Manager, Detoxification Unit, Herbert Street Clinic, Royal North Shore Hospital, and

OWEN BRANNIGAN, Manager, Phoenix Unit Residential Rehabilitation Program, Manly Hospital, sworn and examined:

The witnesses elected to speak as individuals, not as representatives of any organisation.

CHAIR: Do you wish to make an opening statement?

Dr JURD: No.

Ms HARVEY: No.

Ms PAUL: No.

Mr BRANNIGAN: No.

Dr JURD: Before this meeting the Hon. Dr Arthur Chesterfield-Evans referred to some epidemiological background that he said is very relevant, and I think it is. Australia drinks a fair bit compared to most of other countries. We are among the heaviest drinking countries in the English-speaking world. The Mediterranean wine drinking countries tend to drink more than us, but not all that much. Alcohol consumption varies on a per capita basis on a 100-150-year cycle. That cycle peaked in 1980 at about 10 litres of absolute alcohol per capita per annum. It has come off about 20 per cent in the 20 years since then but that is a 100-year high. Generally you will expect the more drinking there is in the community, the more problems associated with alcohol there will be in the community. Equally, the sociologists tell me that as the consumption diminishes so people wake up to how high it was previously, and begin to do something about it. So now is the right time to act.

CHAIR: Are those figures affected by the age structure of the population? Would they also be affected by migration patterns given the drinking patterns of host countries? Have you learned some lessons or is it a factor of migration and an ageing population or baby boomers? Do you not know?

Dr JURD: The main thing I know is that we are drinking more wine which probably is an indication not only of the fact that we have had a very well functioning wine industry but also that we have had a lot of Mediterranean migrants. The proportion of the amount of alcohol that is drunk as wine has doubled across the past 20 years. We are drinking more wine now, and we are drinking a little bit less beer and a little bit less alcohol overall.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the extent to which other drugs have replaced alcohol? Drugs were a much lower problem in 1980 and are quite a big problem now. Presumably the extra drugs are a bigger problem than an improvement of 20 per cent drop in alcoholism?

Dr JURD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How much more are drug and alcohol a problem of total hospital effort, to put it that way, or some index of medical resources as opposed to what they were?

Dr JURD: It is really hard to capture illegal drugs, in particular, because understandably people are reluctant to give good information about that. From heroin overdose deaths in the 1960s my understanding is it was something like 50 per year for the whole of the country, but it peaked out in about 1999 or 2000 at 1,000 deaths per year, so there is a dramatic increase. That has come down

equally dramatically over the past three or four years. But again across this same period of time the fairly new phenomenon of the use of stimulants in clubs and the chemical MDMA—commonly known as ecstasy—as been highly popularised and there are complications of those.

Ms HARVEY: You need to recognise that we are talking about different cultures. We are talking about cultures of people who have grown up with the availability of illegal drugs versus cultures of people who have not. So there are different degrees of problems and different age groups and dimensions, depending on what substances of choice were around at the time. It is very unlikely to see a 45 year-old give up heroin for the first time. We need to think about that context.

CHAIR: We need that background to explain the different patterns for an Act as old as the Inebriates Act.

Dr JURD: Which goes back to just after the last peak in the second half of the nineteenth century.

The Hon. ROBYN PARKER: Would it be useful to define the pilot Linking Project that is established in the Newcastle area?

Dr JURD: I do not understanding the Linking Project.

The Hon. ROBYN PARKER: I am not very familiar with it, but they track people's contact with various drugs and alcohol. They then link that with an end outcome which is the behaviour for a lot of them. They just try to chart them as a pilot to start with.

Ms HARVEY: They are starting to roll that out in the Northern Sydney Area Health Service which is going to get alcohol link offices in police areas in the Northern Sydney. It is just about to be introduced.

Dr JURD: It is enforcement?

The Hon. ROBYN PARKER: Yes, it only affects those people who have come into contact with the police generally.

Ms HARVEY: Similar to a Magistrates Early Referral into Treatment [MERIT]-type program.

CHAIR: Can you define "severe alcohol dependence"? What is the relationship between severe dependence and mental illness as well as severe dependence and brain injury?

Dr JURD: There is an accepted definition of "alcohol dependence" that comes out of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, [DSM 4] produced by the American Psychiatric Association. That is the diagnostic bible pretty much throughout the world. If you want something published in the literature you will be asked "How did you come to the diagnosis?" If you say "I used DSM 4 diagnoses", they say "Fine". Alcohol and substance dependence is defined in that. When I looked at this question, I thought you were looking for something that was very practical and perhaps applicable. I thought in terms of the sum total of damage to an individual physically and mentally, to his or her family and to his or her reputation and job; that is, just how much damage there has been. That is an important measure of severity. A further necessary dimension is time—across what period has this been happening? If a person has been dependent on alcohol for 10 years, I would generally say that was severe. However, where one draws the line between severe and moderate dependence is almost arbitrary.

CHAIR: The reason we are grappling with this problem is that most people see the Inebriates Act as being limited to the severe end of the spectrum. It may be impossible to get a clear definition. However, we are trying to define the group for whom this extreme piece of legislation, as some would see it, is designed.

Dr JURD: One of the things not mentioned in the Inebriates Act is that dimension of time. So, theoretically I could get drunk for the next three weekends and I could go in under the Inebriates Act. I suggest that a time dimension might be useful.

CHAIR: There has to be a chronic or habitual situation.

Dr JURD: It would have to be occurring over years before we would consider treating people compulsorily. They must also meet diagnostic standards and there must be demonstrable and significant damage.

CHAIR: When looking at the relationship between mental illness and brain injury, is it sequential? If someone drinks enough, often enough for long enough he or she is likely to suffer those conditions. Is the relationship present from the beginning, or is that like asking how long is a piece of string?

Dr JURD: Yes, it is the last of those options. There are multiple, complex relationships depending upon the individual's response to alcohol, the intensity of their drinking at any particular time and their age. The younger someone is the more likely they are to be able to bounce back and to make good new cerebral connections.

Ms HARVEY: It also depends on people's ethnicity. The damage caused by alcohol in Australia's Aboriginal population is a lot more severe a lot sooner than in the white Caucasian population. There are different elements that need to come into play.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that relate to nutrition?

Ms HARVEY: It could.

Dr JURD: At least in part.

CHAIR: Or it could be inherent.

Ms HARVEY: Yes, it could be. There is evidence—I cannot quote it because I do not have access to it—that Aboriginal Torres Strait Islanders and Pacific Islanders have less ability to metabolise alcohol. Therefore, it causes more damage to them in the long term.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Many more British soldiers than Australian soldiers died on the Burma railroad. So the effect of childhood nutrition might well have a long-term metabolic effect.

Dr JURD: Yes.

Ms HARVEY: Yes.

CHAIR: Do you have anything else to add about the relationship? From the committee's point of view, that complex mix of issues is also related to the treatment regime, the issue of compulsion and whether brain injury or mental illness are present.

Ms HARVEY: It is fairly well documented that alcohol causes frontal lobe dysfunction to varying degrees, depending on the length of time people have been drinking. That is evident in people's lack of insight into their illness, their lack of planning and organisational skills, their inability to learn new tasks, decreased motivation and so on. We expect people with severe dependence to be motivated to change when physiologically that is impossible. That is very important.

Dr JURD: Alcohol, in particular, attacks the organ that we are trying to use to get them to change. It attacks the brain and, in particular, the frontal lobe. One of the things that the neuro-psychologists have been able to demonstrate with pen and paper tests is that people who have frontal lobe damage are less capable of learning from their errors.

The Hon. IAN WEST: Is there a correlation between people who have frontal lobe development difficulties in the first place and alcohol problems?

Dr JURD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that if a person has enough thiamine he or she will not get Wernicke-Korsakov's disease.

Dr JURD: That is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it the case that if you have enough thiamine you do not get the brain damage?

Dr JURD: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that brain damage is separate from the Wernicke-Korsakov's damage.

Dr JURD: It is two separate mechanisms. The frontal lobe damage is from direct toxicity and the Wernicke-Korsakov's damage is the result of thiamine deficiency. The blokes on the Burma railroad recovered much more of their cerebral functioning than the average alcoholic with Wernicke-Korsakov's disease.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that because they had reversible thiamine deficiency?

Dr JURD: It was because they had a thiamine deficiency rather than many years of predating direct toxic alcohol-related brain damage. The survivors of Changi and the Burma railroad are relevant because they are the only groups that have been written up as having Wernicke-Korsakov's disease that was not caused by alcohol. That reflects the impact of nutritional deficiencies on alcohol-dependent people who get Wernicke-Korsakov's disease.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is thiamine deficiency significant any more?

Dr JURD: It still happens; we still see Wernicke-Korsakov's disease. It is less common clinically for me; although I have not done any surveys. I have the clinician's gut feeling that it occurs less often than it did. It is important that this be on the record. I am aware of at least two published articles saying that since bakers' flour was augmented with thiamine the rate of Wernicke-Korsakov's disease has diminished. It is not down to zero; I think it has been cut in half or to one-third. There was a significant decrease. Clive Harper, a neuropathologist at the University of Sydney, is probably the world expert on structural brain damage caused by alcohol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At a public health level, is it worth revisiting the debate about whether thiamine should be included in spirits or wine?

Dr JURD: The cutting edge is whether it goes in beer, because beer has more calories. People are more likely to literally live on beer than on spirits. If someone is on spirits he or she will have something else that may contain a tincture of vitamin B1. However, if someone is drinking 20 or 30 schooners a day he or she is getting so many calories that that may drive out virtually all other eating. Dieticians were strongly against giving the beer companies the free kick of saying that their product was now fortified with vitamin B1.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some would think that that was silly of them.

Dr JURD: Yes, but that was how it was resolved 15 years ago.

CHAIR: In terms of dependence, are we talking about people drinking beer or other things?

Dr JURD: It applies across all types of liquor—it is alcohol.

CHAIR: When speaking about the most severely affected group, does beer become irrelevant because they have moved on to spirits or fortified wine?

Ms PAUL: Many of the presentations to the detoxification unit relate to wine. It is not that they move on to spirits because they get an effect more quickly. In fact, they tend to drink more wine.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because wine is cheaper in terms of absolute alcohol per dollar?

Ms PAUL: I guess so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was extensive argument when the Dawkins' budget was handed down about whether the tax should be on the alcohol content or on the sociological context of the consumption of the different types of beverage. Do you have an opinion?

Dr JURD: Yes. I would err on the side of alcohol content. If I was sitting on your side of the table, that is what I would be arguing for; that alcohol is a drug and that there are reliable consequences of it as a drug; and that that is the problem, and so the content of alcohol should be taxed. There is a difference now. Across my clinical career there is a difference. Now many more of the people presenting drink cask wine because that is the cheapest form of alcohol.

The Hon. IAN WEST: But would there be some demographic problems in your assessment in terms of where your catchment area is as opposed to a Kings Cross clinic or a Western Sydney clinic? I am having difficulty comprehending how the majority of people are presenting with wine.

Ms PAUL: No, a large percentage of wine, and beer. So what I am saying is that it is not all spirits.

Ms HARVEY: I have worked in the inner city and in Western Sydney, and it is the same because you can buy more volume.

Dr JURD: So the attraction is to be able to buy. You can have a days drinking for 10 bucks—30 standard drinks for $10, or four litres of wine, and that, I think, is the attraction. That is an indication of a step down the socioeconomic scale. For people who have got the money to be able to choose what they drink, there probably is a tendency to drink beer because it is just the most common drink in Australia, but I see beer alcoholics, wine alcoholics, spirits alcoholics and, not commonly, but even a few methylated spirits alcoholics.

CHAIR: When you say cask wine, we are not talking about the old tuppenny dark port, the cask of port, or the bottle of cheap port?

Dr JURD: No. Typically, just wine.

CHAIR: Just wine that anyone else would drink?

Dr JURD: Yes.

CHAIR: Do you want to put on the record for us the effective treatment approaches and the typical treatment pathway, if there is one, for people who have a severe dependency? What is the most effective?

Ms HARVEY: As far as I am concerned, I believe that abstinence is the only goal for severe dependance, at least in the first instance. Detoxification, followed by either residential rehabilitation or long-term follow-up on an outpatient basis. Some people, especially those with significant brain injury, may require supervised care in a structured environment and that is because it gives them boundaries by which to build their recovery. This can take the form of a facility or a long-term boarding accommodation, or may be able to be achieved within a supportive family environment. If

they have carers, the carers need to be very strongly supported to be able to cope with that. That would be my feeling.

Ms PAUL: I agree with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You agree with all abstinence at first?

Ms PAUL: I think so. I think that if someone has a severe dependency, you have to aim for abstinence.

Dr JURD: Yes. I think this is the time when I would have to quote Nick Heather, the world's most ardent advocate of controlled drinking. My favourite quote of his is that there is no doubt that the more severe the dependence, the less is the likelihood of controlled drinking. When you are looking at this end of the spectrum, even the most ardent controlled drinking advocates are saying that it is a bit hard. But the practical choice is abstinence. I agree with everything that has been said. Anti-craving medications, naltrexone and acamprosate probably deserve to be stirred into the mix somewhere. We have not really got on top of that—the best way to use them, which patients to use them with, and whether they should be used in combinations—and there are other anti-craving drugs that are on the boil. There will be another one that will be released perhaps next year or perhaps the year after. So this is an area that is going to increase, and the other thing that is important is tying people into Alcoholics Anonymous [AA]. There are varieties of things. AA is a voluntary movement that is community based and run by alcoholics for alcoholics, but there are lots of things that we can do in a treatment setting that can assist patients to understand it and better use it and better connect with it.

CHAIR: So you are broadly supportive of AA as a philosophy and as an organisation?

Ms HARVEY: Yes—for people with severe dependence, definitely.

CHAIR: I wonder if at this stage or later it is appropriate to talk separately about, for instance, Manly and the rehabilitation side of things, and the point at which the use of anti-craving drugs might come in, the detoxification and various stages in the treatment pathway. Do you want to add anything?

Mr BRANNIGAN: Yes. The other thing with the treatment pathway is that a lot of people get picked up from general hospitals through our consultation liaison services. We put a lot of emphasis in Northern Sydney, as do most area health services, on continuity of care, so it is recognised. It is not just being seen in a hospital, being withdrawn, being four weeks drug-free and things like that. I mean, it is a complex problem and there are challenges, for the person who is wishing to abstain or attempting to abstain, all the way along the line. So we try to accommodate that type of thing as much as we possibly can and we also put the general practitioners in the process as well. We try to link patients up with the GP in their local area so they get ongoing medical attention and they also get psychological attention from services.

Alcoholics Anonymous and Narcotics Anonymous, any of the self-help groups, can be a useful adjunct to our services because people who are severely dependent would rarely still be living in the world they used to live in, so they would have lost a great deal of things. They would have caused sometimes irreparable damage to their social and family relationships. They can experience a tremendous sense of isolation. So linking them into self-help groups to let them know that they are not the only person who has suffered from this problem, to let them know that there are people who have had to fight similar battles, that can be useful for those people and can benefit them greatly. At the Phoenix Unit, of which I am the manager, we have a consumer group.

A couple of weeks ago we had an annual reunion of former consumers, and that was such a nice occasion because if you are aware of how those people made their initial contact with you—where some of them were living on the street and some of them had parents who had kicked them out of the home or wives could not tolerate the violence any more and police intervened, et cetera—it is just a tremendous experience when the health services are being used with those other types of voluntary services like Alcoholics Anonymous to support the person in achieving their goal. I do not necessarily think that abstinence has to be the goal for the rest of their life. I think we all understand

that people do relapse, but I think the most critical period is actually that first three or four weeks when the patient is attempting to abstain, fighting their dependence, fighting their cravings, et cetera.

CHAIR: This is the first three or four weeks after they leave your unit, for instance?

Mr BRANNIGAN: The first three or four weeks when they enter treatment. I think that is the critical period, actually containing the person. This is where I think that something like the Inebriates Act needs to be brought into play.

The Hon. ROBYN PARKER: I have a couple of clarification points, and now that you have said that last sentence, I have another question. The first issue I wanted to clarify is that if abstinence is the goal, and you are talking about people you come in contact with who are coming in here, I wonder how that fits in with those that are on the methadone program? Do you have a policy here that you do not use that approach at all, or do you see that as a valid part of their clinical treatment?

Ms HARVEY: It is part of their treatment. If you talk about methadone you are talking about opiate dependent persons only. You are not talking about people who are affected by alcohol, and methadone is part of the treatment program. What we would be aiming for is for them to be abstinent from other drugs as well, including alcohol at that time.

The Hon. ROBYN PARKER: So you do not include methadone as part of that abstinence?

Ms HARVEY: No. There are clients on the methadone program who drink alcohol and probably drink at safe levels in terms of consumption. But we do have concurrent programs looking at the risks associated with continued alcohol use while you are on methadone as well.

Ms PAUL: You would still have a bed allocated in the methadone program for those clients that are using other substances on top of the methodone. We would want them to abstain from those, but they would stay on the methadone program while they are in our treatment centre.

The Hon. ROBYN PARKER: The second question was that I noticed when we were downstairs the number of referrals that were self-referrals. I think you made a comment at the time that that was an indication of not enough work coming from GPs. Could you elaborate on that?

Dr JURD: Happily. Addiction medicine in general is a new specialty. The College of Physicians has only recently organised a chapter of addiction medicine that is only 18 months or two years old. Drug and alcohol dependent people in the past have largely being treated as social, not really clinical. There were not many specific medications. When I started in drug and alcohol back in 1983, basically there were only two medications that were used and that was valium for withdrawal and methadone for people with opiate dependence, provided that you do not call vitamin B1 a medication. But now there is an increasing number of medications.

There are even other substitutes for opiates apart from methadone. There is buprenorphine that is available and there are a couple of anti-craving medications for alcohol. There is more on the market, and so now we are beginning to have a field that is more consistent with other fields, and so we are in a better position. Strategically it was a good time for the New South Wales Government to support GP liaison. When the Drug Summit came through, GP liaison officers were appointed in each of the area health services. We have made some progress, but we have a long way to go to get general practitioners to accept that this is a serious health problem that warrants their attention, and that is hard work.

General practitioners are very busy and there are lots of people competing for their time—lots of drug companies that want them to think about a particular drug and lots of other specialties that have got a longstanding connection with them that say "It is really important to take the blood pressure", and we are saying, "It is really important to take the alcohol history", and in a 6 or 10 minutes consultation, what you do? We have a hard row to hoe there. We are up for it, but it is something that is evolving. As drug and alcohol in general professionalise and as the medical end of it comes more up to stream, then we are up to the stage of saying, okay, we will go out there and give talks to GPs, like I have already done once this week, and we will develop workers within our field whose job it is to look after those GPs.

Ms HARVEY: And it is demographically different. It is different in northern Sydney from what it is in the rural sector, for instance. In some rural areas they may only have three GPs who are quite engaged in that process, but in northern Sydney we have 450 GPs. How we engage all those to take a role is a different strategy.

CHAIR: Is GP training and in-service beginning to reflect the pattern that you are talking about—newer GPs and that process? You said you were out talking to a group of GPs this week.

Dr JURD: I will respond about that. The number of GPs has been underestimated. It was said there are 450, but it is 1,450.

Ms HARVEY: It was 450 that we got from the survey.

Dr JURD: Yes, that is right. We have 1,400 GPs to relate to in this area. What is happening? At the medical school level we have made dramatic progress. We made enough progress there that we, being drug and alcohol—I was not involved in it myself—over at Royal Prince Alfred Hospital found in a study that knowledge about, skills in and attitudes towards the treatment of drug and alcohol dependent patients diminished across the intern year. They had less knowledge, less skills and worse attitudes at the end of their intern year than they did at the start. That is because they experience it as persecution. They think these people are getting drunk and they are ruining their shift. They have woken them up in the middle of the night, so the doctors experience it as a personal affront.

You talked about training general practitioners and at the university level I think we are pretty much on top of it and things are going pretty well. But at the post-graduate level in the early years of training attitudes are formed in old institutions like this that it is very hard to work on. This is another role for the consultation liaison service to infiltrate to try to get people to think that you can do something about this. It is not as negative as all that. Yes, we do see some who are pains in the neck but there are others who get well and do really well. We are not there yet. That early practical experience as a doctor often influences subsequent practice. We have got a long way to go yet.

CHAIR: What are the most appropriate and realistic outcomes to expect from treatment, given that addiction is now understood as a chronic relapsing condition?

Ms PAUL: The first thing is completion of the detoxification process, getting clients to a stage where they can actually make some decisions based on the choices they have in managing their addiction and providing education links to support networks so that they will have the resources to access support in the event of a relapse. I think that is the most important thing. Also having the opportunity to provide support for the family to help them gain a better understanding of what the addiction process is like for the client and how they can assist the client post-detoxification. Also to inform them about what community support is available for them, which is something, fortunately, we take time to do in this detoxification unit. We invite the families in to sit down with the client and look at some of the difficulties we have in managing the client's addiction and how they can actually help them when they leave. Ideally the end is to get the clients straight from detoxification into rehabilitation.

Ms HARVEY: It is important to recognise that relapse is part of the journey for a percentage of clients. What is important are the gains made in between those relapses and, hopefully, a realistic expectation is that the length of sobriety will extend over time. As clients build new skills in dealing with how they feel—other than using substances—there is an opportunity there for them to make significant life changes. We accept that it is part of the process.

CHAIR: How important is voluntary participation and motivation? What is the role of the family support and the community?

Ms PAUL: The main issue is to ensure that the client has got access to treatment. My experience is that a client's motivation can change so quickly that it often takes quite a few attempts at treatment for the time that is right for them. While staff are skilled in using strategies such as motivational interviewing and working with clients to assist them in making changes to their lifestyle this is not always successful. In fact, I found the most challenging group of clients to manage are those

who feel that they have been pressured into the treatment facility by others, such as family members, case managers or probation officers.

Their reluctance to be involved in the program can be detrimental to other clients in the treatment facility. Specific behaviours such as disrupting group program challenging in the motivation or commitment of others, and unfortunately taking one or more of the other clients with them as they leave to pursue their addiction. On the other hand, many clients who are initially lacking motivation for treatment do manage to complete the program and choose to go into rehabilitation post-detoxification. Our main challenge is to get clients through the first three days, get them through the withdrawal process so that we can actually have a chance to work with them.

Ms HARVEY: Having staff who are skilled in being able to use the catalyst for admission as a motivator and work with the client with that is one of the keys because you utilise any opportunity you can to help support somebody in treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People from the Drug Court say that the client's main motivation is to keep out of gaol. But within that framework they say they are still getting a much better result than the person going into gaol. You referred to those who have been pressured into treatment by family but are they also pressured into treatment to stay out of gaol?

Ms PAUL: The difference is that the MERIT clients are still making the choice. They are choosing treatment over gaol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do they get near the voluntary patient result or are they somewhere in the middle?

Ms PAUL: Since it started in 2002 we have had 20 MERIT clients come through the detoxification program, 15 of whom have successfully completed the program.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How does that compare?

Ms PAUL: I'd say it has about a 70-75 per cent success rate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you getting much the same result from the MERIT clients as the equivalent Drug Court voluntary patients?

Ms PAUL: Yes.

The Hon. IAN WEST: From a sample of 20.

Dr JURD: But that is 100 per cent of the MERIT cases.

Ms HARVEY: While they have been bonded to treatment, they choose to take that bond.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they are not bonded they might do worse? Do you have results of that?

Dr JURD: Not yet, no. Having said that I do not think any one of us this morning thought "It is a nice day. I am going to change today. I am going to change a whole bunch of my habits. I am going to be different today." People only want to change because of a variety of competing pressures on them. If you have woken up with a hangover for the seventy-fifth time, that is one of the things that is driving you but so is your boss and your wife et cetera. To go from that in the psychological lingo, external locus of control, that is, "They are making me do it" to internal "I want to do this" is a journey that typically happens across recovery. You go from saying "I suppose I have to stop drinking because you say so, doctor" to "I need to stop drinking because my liver is sick and I need to get on better with my wife."

The Hon. IAN WEST: In the initial stage of external control, are there any differences between a person's place of abode or the geography in which they live? Are there differences in that externalising in age groups or ethnicity et cetera?

Mr BRANNIGAN: I do not know those particular figures. But I know that one of the key factors would be the person something to go back to. For instance, the person who has a supportive environment, has a mother and father who wishes contact with them, or a wife or wishes contact would have a better outcome than the person who simply had nothing and had lost all.

Dr JURD: And they do not drink with them.

Mr BRANNIGAN: That is right.

Dr JURD: Sometimes it is fantastic that they have a nice safe place to go to, but some of the other ones think that their place is safe but they are going back to a husband who has been abusing them for the past 15 years and they think they are better off than the poor people who have to go to the half-way house. We want them to go to the half-way house.

Mr BRANNIGAN: That is why we put an emphasis on getting families involved as well so we can ascertain what is going on in their environment when they are not in the unit.

Ms HARVEY: There is also an element, when we are looking at family issues, that families need to be brought along that journey of treatment as well. Families are profoundly affected by other people's substance abuse and it can cause a high level of dysfunction within the family unit. Often the family thinks that if the client gets better then everything will be all right. The reality is that is not always the case. There are often many years of dysfunction within that family unit that the whole life change need to happen for everybody in that family unit. In context it is really important to engage the families if there are supportive carers in that process.

CHAIR: The committee has heard about individuals for whom an Inebriates Order has been sought but we do not have evidence of who they are. Do you have any evidence of clients who are subject to an Inebriates Order?

Mr BRANNIGAN: One of my duties as manager of the Phoenix Unit is intake officer which means ensuring people have good access to our service. I went through our records to answer this question. We have about 500 individuals who contact the services, we have 140 admissions to the service and over the past five years I have only had one experience of such an order.

CHAIR: Is that 140 over the five years?

Mr BRANNIGAN: No, each year. We have 500 individual contacts of which 140 are admitted and I can only recall one example of an Inebriates Orders for a retired 60-year-old man. He owned his own home at Manly with his wife and had adult children. Since retiring, according to him and his wife, he basically decided to go to the club during the day to play bowls and poker machines and that kind of thing. Not having a work structure in his life basically led him to increase his alcohol consumption dramatically. This also led to domestic violence where, after X-number of years of marriage he suddenly began assaulting his wife who was annoying him because she was challenging his drunken behaviour.

He was actually a patient in Macquarie Hospital. He had been placed there under the Inebriates Act. He rang me as manager and intake officer of the Phoenix Unit to say "Please, get me out of here. I realise I have got a serious alcohol problem. I want to come into your drug and alcohol rehabilitation unit. This is not the place for me." This case was surprising because it was rare for the Inebriates Act to be mentioned. The man had a serious alcohol problem and he met the criteria for admission into the Phoenix Unit. He reported having a desire to abstain, et cetera, but I had to organise things to find out how does the Act work. He said he was there for 12 months. I could not keep him on the waiting list for 12 months so what was I to do?

His wife was very keen for him to receive treatment. On my instinct, I got the sense that his wife would have preferred him to stay in a secure environment like Macquarie Hospital. This man contacted me three Mondays in a row, as they do for intake to that facility. On the fourth Monday he basically reported that he had been discharged from Macquarie Hospital and he was now going to attend self-help groups. I tried to talk to him about this being a critical time for him and emphasised its

importance. I suggested that perhaps he and his wife should attend a drug and alcohol service. Failing that, he should attend. I told him I could keep him on the list, and he would not be the first person coming in after a short period of abstinence. He rejected all offers. As soon as he was released from Macquarie Hospital his attitude changed about everything.

CHAIR: Do you know what became of him?

Mr BRANNIGAN: No.

CHAIR: That was the end of the contact.

Mr BRANNIGAN: Yes. I know of only two people who have been admitted to the Phoenix Unit in the past two years who reported being previously subject to the Inebriates Act. That comes out when we do their history and things like that. That is only two people out of several hundred.

CHAIR: Obviously the numbers are small and that is why it has been hard to get a picture. We are visiting Macquarie Hospital and we have had a submission providing considerable detail on the history of one client. Obviously it is not the same one. It will be interesting to for us to talk to them.

Dr JURD: The Phoenix Unit's previous incarnation was Bridgeview House, which was a ward of Macquarie Hospital. It was closed and the Phoenix Unit opened at Manly. I was the director at Bridgeview House. A few patients subject to inebriates orders went through. A couple of them did adequately. I remember it was a little unsettling that one of the patients was a middle-aged Turramurra mother of three teenage children who had terrible trouble and had been to a few private hospitals. She kept relapsing and in his desperation her husband got an inebriates order. She stayed for two or three months in Bridgeview House and apparently did quite well in the program. It was an open facility at the time. She actively participated in the program and I had some hope that she would be okay on discharge.

CHAIR: The sample size is so small that no-one can give us an answer. Presumably the legislation has fallen into disrepute because it was not effective. We are cleaning up a legal hangover.

Dr JURD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are being forced to take stock of why the figure declined and ask why it was discarded.

CHAIR: Alternatively, we are asking whether it should be replaced.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the alternative?

Dr JURD: That is correct. It works more effectively when it is used as yet another method of getting people into voluntary treatment. People need to connect, but sometimes they need a push.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Effectively, we say that if people commit crimes the Drug Court will divert them. However, if they do not, no-one will divert them. The Inebriates Act then does the job. Is that what you are advocating?

Dr JURD: We are getting down to tin tacks. There is a role for it with people suffering alcohol-related brain damage who are locked in a circle that they cannot get out of and who are causing extraordinary damage to themselves and those around them. Under those circumstances there probably is a role for some compulsion for a period—that is, three or four weeks, not 12 months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there is a place for a short period of compulsion?

Dr JURD: Yes, for a small proportion of patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What time frame?

Dr JURD: I would use the Mental Health Act as the template.

CHAIR: Most people have suggested that.

Dr JURD: It is practical. The doctors are eager to say that someone is not gaining anything from being in their facility. They will then discharge people as necessary.

CHAIR: We need to be clear. Almost everyone agrees that the Mental Health Act could be a template. However, there also appears to be unanimous agreement that the people we are talking about should not be sent to mental health facilities. One of the problems is that the Inebriates Act sends them to the most inappropriate facilities.

Ms HARVEY: I have been working in the drug and alcohol arena for 19 years. During that time I have seen a change in the utilisation of the Inebriates Act and the resources available to support people who are subject to the Act. I worked at Roselle between 1983 and 1989 in drug and alcohol services as a nursing unit manager for the detoxification unit. We had two alcohol-related brain damage units dealing with people with mild to moderate damage. A high percentage of people going through the program were subject to inebriates orders. Often they were on an order for the first three months of treatment. Some left after three months of treatment and some stayed longer because they felt they needed to.

It was a highly effective program because there were options available for people to be managed according to their needs. They came into detoxification on an inebriates order, and if they were chaotic and absconding they would go to the acute admission ward for a short period and be dealt with by drug and alcohol liaison people. When they settled down in their withdrawal they had a mental state examination and it was determined whether they had any alcohol-related brain damage. A recovery program was then developed for them. I would argue that, while not a lot of people are subject to orders now, the resources are not available to support those placed on orders. They go into a mental health facility that is not tailored to their needs.

The Hon. IAN WEST: The program was calibrated at Rozelle.

Ms HARVEY: Yes.

The Hon. IAN WEST: It was associated with the geography of Rozelle, but these people may have started inside the acute ward.

Ms HARVEY: Yes, they could have been in an acute admission ward. Once they had been through withdrawal and the craziness was settled they were often moved voluntarily.

The Hon. IAN WEST: But they still went to the environs of Rozelle.

Ms HARVEY: Yes.

Dr JURD: Yes.

CHAIR: Is that not still the case? During the Alcohol Summit I went to the detoxification unit at Rozelle. It seems still to be true to some extent that while they are in the grounds they are not part of it. Some of it seems to be there because of a function of numbers and resources. If you have enough people in the drug and alcohol area you can keep them separate and devise appropriate treatment.

Ms HARVEY: The issue now is the availability of neuropsychiatric testing and the opportunity for people to go through programs to retrain memory and so on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That already exists.

Ms HARVEY: No, there are no formal programs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why?

Ms HARVEY: They were closed down.

Dr JURD: Because it is expensive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a blunt answer. Are you saying that the Rozelle programs worked?

Ms HARVEY: They were very good programs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were presumably reasonably expensive inpatient programs involving neuropsychiatric testing.

Ms HARVEY: There was an affiliation with the Royal Prince Alfred Hospital. RPA did the neuropsychiatric testing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a department that did that.

Dr JURD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has that been abolished?

Dr JURD: To the best of my knowledge, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that because it was shown to be ineffective? That has never stopped silly treatment before.

CHAIR: It was shown to be expensive.

Dr JURD: That is my understanding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We use expensive drugs all the time.

Dr JURD: Yes, but we do not spend that kind of money on alcohol-dependent people.

CHAIR: We spend it on more fashionable illnesses and on people in higher socioeconomic brackets.

The Hon. IAN WEST: They have very strong lobby groups.

Dr JURD: That is very relevant in this area.

CHAIR: As I said, I visited the detoxification unit at Rozelle and they said how effective it was in the 1980s. Without wanting to criticise, what has changed? They also obviously have grave problems.

Ms HARVEY: My experience is that there has been a massive shift of funding out of the alcohol arena into the illicit substance arena. That money had to come from somewhere, so it came from areas that were seen to be resource expensive.

CHAIR: Has some testing been abandoned? Do people stay for shorter periods? Is there fewer staff?

Ms HARVEY: I have not worked in the clinical area for a while, but I believe that if you want someone to undergo a neuropsychiatric test it can be done. However, there is no longer a system that supports that as a natural course of treatment. If Dr Jurd wanted patients tested, he could refer them.

Dr JURD: Yes.

Ms HARVEY: However, it is not seen as a normal course of treatment for people with alcohol-related brain damage.

Dr JURD: There is a resistance to it. It is arduous for both the person doing the testing and the person being tested. It can take three to five hours. It may not change the treatment much, but it specifies.

CHAIR: Why is it important?

Dr JURD: It documents the fact that this is not just a difficult person who is having trouble changing; this is a person who has demonstrable brain damage. Getting that fact on the treatment agenda is a powerful influence.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Many investigations simply confirm what people generally know. Are you taking a lot of time to document a fact that people around the wards or in the tearoom know, which is that you cannot do anything with a patient? They would say that they do not need to do a fancy test to establish that. Is not the judgment of the people who have worked with them enough?

Ms HARVEY: There are degrees of damage. We cannot make a blanket statement like that. If you can measure the degree of damage and work with a person's deficit it gives them something tangible to work with. I have seen significant life changes made by people who have been diagnosed with a brain injury who can say, "It is not just me; maybe there is something I can do." That is a big relief for the person and his or her family because often they blame the individual. That gives them something is hang it on and the ability to go forward.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of outcome, if the people in the tearoom said that a person could not be helped, what is the probability that the test would change the outcome?

Ms HARVEY: There is probably not a huge difference in terms of forecasting that outcome. However, the patient has tangible evidence rather than someone's opinion.

The Hon. IAN WEST: I would be so bold as to say that it is probably the opposite. The test might say that the person cannot be helped, but a family member or persistent person may be able to help.

CHAIR: I was going to say it is the opposite in another sense. It takes the moral dimension out of it. Instead of saying that someone is a bad person behaving badly, we are saying that that person cannot help himself.

Dr JURD: This person has specific deficits.

CHAIR: And with all the other services they go through, the label can actually mean that people feel more sympathetic.

Dr JURD: Yes. So in the first place they have specific deficits, and they are in the brain as distinct from, as it were, in the personality. This person is not merely being bloody-minded, they are not doing the same thing over and over again from some neurotic repetitive compulsion à la Freud but because they have damaged the part of the brain that helps them to initiate new behaviours. So that should alter treatment and you should be able to divide people into the slower stream and faster stream rehabilitation. You can have people with no problem with damage and you can give them more and more information and flood them with it because they incorporate it, but the people who are more damaged, you have to move more downmarket to clichés—such as, a day at a time, first things first.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You spoke earlier about alcohol causing frontal lobe damage with a loss of insight.

Dr JURD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is a mental state examination in which you say that this person is not able to make any headway in this area. The mental state examination is much criticised by the body doctors as opposed to the brain doctors, if I may make that distinction. But people in favour of the mental state examination say that you can test for insight. If you have a number of people who look for insight—or what I call the coffee room discussion test—how much more accurate is the neuropsychiatric test in terms of errors?

Dr JURD: Considerably. An example will suffice. I had a very highly paid international sales manager who came back to Australia to get treatment for his alcohol dependence. He was making poor progress in group therapy that he was involved in at a private hospital that I was working in at that time. I said, "I reckon he could have brain damage." The staff said, "Huh? What?" He was a 35 to 38-year-old man who drank heaps. The test came up positive on one particular thing, a complex clerical sorting task. This man, who was leading a company, who set up the Australian sales organisation and who was setting up the Singapore sales organisation scored at the ninth percentile on a clerical sorting task—the capacity to put the receipts with the bills and sort them in a stack and so on. When he was given that feedback he said, "I always tell all my sales managers to get their expenses in on time because we recompense them, but I never do it myself because I just can't."

It was quite a specific deficit of organisation and planning that this man had, so we had to tailor our treatment program to accommodate that. Having said that, the other thing that I should have said in my opening remarks is that the brain is no longer regarded as a hardwired black box. When we are talking about brain damage, it is no longer inevitably regarded as irreversible. I have seen pictures showing how new synapses form in mature brains across a 20-minute period. I have seen pictures showing how, in damaged rat brains, new brain cells grow. So the idea of being brain damaged, unfixable and gone forever, there is good physiological evidence to counter that now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the exact opposite. You are saying that the neuropsychiatric tests show that it can recover.

Dr JURD: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is less likely or more difficult, or what?

Dr JURD: Well, you have got a deficit and so it is more difficult. It needs stimulation, it needs treatment, and it needs accounting for in the short term, so you do not flood that person with information but there is an extra powerful reason for them to stop drinking.

Ms HARVEY: And you give them particular therapeutic aids or ways of dealing with things, just as you would with anyone who even has had a stroke—different ways of managing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why it worries me is that it must be the only high-powered technical test that has declined in use, and I find that hard to believe.

Dr JURD: And I would suggest that that is because it is in drug and alcohol. We, as the drug and alcohol doctors, are quite attracted to public health notions such as, "What is the value?" My understanding of the reason that Rozelle was closed down, despite the fact that there were documented good outcomes from it, was "Oh, yeah, you helped the people but, look, a lot of them just ended up sober and in hostels." Their lives were 100 per cent better and much less of a drain on resources in the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they were not employed.

Dr JURD: Yes, but they were not employed, and so some people were able to demean those outcomes. But they were fantastic.

The Hon. IAN WEST: The people making those value judgments probably were not the appropriate people.

Dr JURD: Yes.

CHAIR: Let us get onto the ethical issues. Question six is the hard part. You started to talk about this whole issue of compulsory treatment.

Dr JURD: Yes, I did.

CHAIR: We have tried to put it in slightly extreme terms because it is such a crucial decision in terms of the Inebriates Act in whatever form it survives. Do people have the right to drink themselves to death? We will come back to the brain injury point because it examines whether people have the capacity. Some people do not have the capacity because there is some question about the family or the community having rights that take precedence. The basic thing is that there are obviously a lot of ethical issues about compulsory treatment. What are your views?

Dr JURD: Yes. I think I got pushed into this one because I talk too much.

CHAIR: If the others have different views, or if they agree, we think it would be appropriate for them to say.

Dr JURD: Yes, absolutely.

Ms HARVEY: Just as a comment, I think we all agree with what Stephen is about to say but the reality is that there is a fine balance between neglect and ensuring that people have the capacity to make the right decisions. When there is evidence of brain injury and they have lost the capacity to make those decisions and they are harming themselves or other people in the community, I believe that intervention needs to be taken.

Dr JURD: Yes. We were chatting about this beforehand because they are fantastic questions. As I said in an email to Merrin, to every complex question there is a simple, straightforward answer that is wrong. I think the answer to the questions is yes, yes and yes, but they modify one another. No, we do not have the right to intrude into people's lives if they are quietly drinking themselves away and they say, "Look, I am 60 and I really like alcohol and I am not affecting anyone else's life. I just want to drink on. I have liver disease and I am going to die, and I would much rather do it now than later." That is fine; however, each liberty that we have has the capacity to impact in a variety of sectors in other people's lives and to be a drain on resources, and there is also the genuine capacity that we may not be able to understand the full impact or the full import of our actions, so I come back to the Mental Health Act and say that the same test applies as in psychotic illness, that is, first you need a diagnosis.

Is there in this case severe alcohol dependence? Then, is there going to be severe harm caused to that individual or to others in the community, or to the individual's reputation—brain damage being another factor that you might want to take into account? That is how I answer it. Sometimes the brain damage can make people say, "I want to drink myself to death", but you sort of say, "Well, let us sober you up for a month and see if you still want to make that decision."

CHAIR: What about the third part, which is perhaps more problematic—the rights of the family and that the community actually taking precedence?

Dr JURD: Yes. I can see that there would be times when that may well be the case. If a dad has decided that he is going to drink himself to death and he has decided that he is going to do that in his room alone, and somebody else can just keep looking after the kids who are 12, 14 and 16 and the house, and his position is that that would not have an effect on everybody else—I do not think so. That is a sort of thing for which there ought to be a forum in which that could be discussed.

The Hon. IAN WEST: How wide are you able to take that? What about the person who is operating quite successfully as the secretary of the ABC international company and everybody around him thinks that socially he is the greatest thing since sliced bread, but he is creating havoc with his family? Do you see a role for the Inebriates Act in that area, or is that too broad?

Dr JURD: Mostly not, but potentially. I think that, yes, people do have a right to drink to the point where it is destructive to them, but if it is causing lots of harm to the people around them, then

that is something that may need to be evaluated in a legal setting—which has nothing to do with us—where a judgment is made to say, okay, in this case with this evidence that is put before me, despite the fact that this man is a highly functioning executive, he is making such trauma in the lives of everybody in his family that I do decide that he has a period of compulsory care. But I think that that would rarely happen because he would have a row of lawyers to get him out of it.

CHAIR: The reality is that if somebody is being that harmful in the family environment, the chances are that they are having an effect in the work environment. The two cannot be separated because there are common difficulties.

The Hon. IAN WEST: I suppose that if they actually own the company, that might be different.

Dr JURD: Yes.

Ms HARVEY: It is very rare that you get that anyway.

CHAIR: Picking up from what you have said in submissions from yourselves and as well as people like yourselves, the real problem with a structure like the Inebriates Act is that a magistrate can make a decision on a call by police and the person turns up in a unit like yours and there has been no expert clinician input at all, so decisions are made by the legal people that make very little sense in medical terms or in terms of a positive outcome—basically, incarceration and compulsory care.

Dr JURD: Yes, that is right. That is why I said that there are a number of factors there, including making a diagnosis, and making a diagnosis is a medical thing.

CHAIR: It is not just a legal thing.

Dr JURD: That is right, because it is about treatment.

Ms HARVEY: There needs to be clinical assessment.

Dr JURD: There is a legal decision about the medical diagnosis to this effect: yes, this person has a medical diagnosis and might well benefit from detoxification and stabilisation on anti-craving drugs and some psychosocial input for their obvious alcohol dependence. They do not want it, but their family desperately does. That is a legal decision.

CHAIR: Then there is the review process, the tribunal-type process, and the Mental Health Act.

Dr JURD: Yes, that is right. That gets decided and then the person either comes into compulsory treatment, or not. The thing I wanted to say about compulsory treatment earlier that I did not say is that it could have been taken from where we got up to that I thought that there was no role for acute admission wards in this group. There may well be, for brief periods of time, but we may not need to develop a whole compulsory drug and alcohol treatment service. After somebody has been in an acute admission ward for three days and has been told, "Look, you have got an inebriate's order for three weeks. You can stay here or you can do go over to the Phoenix Unit or some nice place where the door is open and you get to go out to AA meetings", and that sort of thing, they might happily be able to engage in more voluntary treatment.

The Hon. IAN WEST: It may be a very effective tool in that transition from externalising to internalising?

Dr JURD: Yes.

The Hon. ROBYN PARKER: Who should take carriage of the pathway of using the Inebriates Act and making a diagnosis of the person presenting through the legal process into a caring environment?

Dr JURD: Essentially it is a clinical process so it should be a clinical decision. First you have to decide, have we got anything to offer this person? If they are just getting drunk every Friday night, they do not have physical dependence on alcohol, they are sobering up enough between times so probably do not have brain damage and you are able to see them on one of their sober days and talk to them, that is really their voluntary decision and there is not much our treatment can do for them. But if somebody has a chronic alcohol dependence, they are drinking every day, they have a physical dependence of alcohol, they have probably got at least a little bit of brain damage, you might be able to break that cycle and start them on medication and work with them psycho-socially, you have got something to offer them.

Ms HARVEY: You can draw some parallels to the changes to the Homeless Intoxicated Persons Act in which there is a care co-ordination element which is about stopping people falling through the gaps, which is what we are trying to do here. Whilst the Mental Health Act stands alone, it does not really bond people to a type of treatment or co-ordinated care. It just says that you need to be in a mental health facility. One of the key issues for people who are under an Inebriates Order is the lack of care co-ordination. That has not existed between even drug and alcohol services and mental health.

We have had multiple meetings, I have to tell you, with Mental Health about what do we do with people under Inebriates Orders. We say that we would love to be able to help them but they are not going to stay if they come to our facility: they are going to take off anyway. There are no structured programs. But there needs to be joint shared responsibility within health, the judicial system and the Department of Community Services to look at a systems approach to co-ordinating care for people under Inebriates Orders. You just need to have that system in place. It is not just the legal side of things.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Earlier you said that you would use the model of the Mental Health Act. Currently, the Mental Health Act is under review and this committee is looking into the Inebriates Act. Should the Mental Health Act, the psychotropic drugs Act or something similar say that people get a schedule 2 for a psychiatric disorder and a schedule 3 for what was an Inebriates Order—which is a drug treatment order—when they have not committed a crime yet, but are at risk and treated similar to the MERIT program by a court with some medical input rather than one where someone says "My wife is a drunk"? An order will be made by the court is similar to a schedule 2? Is that the model you suggest for both the inebriates and the Mental Act?

CHAIR: Would they be kept separate because of it being undesirable to put drug and alcohol under the label of mental illness?

Ms HARVEY: If you talk to our mental health counterparts they say that 80 per cent of clients within mental health facilities have drug and alcohol related issues.

CHAIR: I am thinking of stigmas and outcomes. Almost everyone agrees that the Mental Health Act is a good model but that is not the same as repealing the Inebriates Act and amending the Mental Health Act to include drug and alcohol.

Dr JURD: As an addiction psychiatrist I would be a unifier rather than a splitter. I would say that substance-use disorders are in the same manual as psychotic disorders in the DSM 4 and that what the Mental Health Act has done very well is to set an appropriate standard of civil liberties. It says that personal liberty is a highly prized commodity in our community and should be raised to a very high level, but it is not the be-all and end-all. There will be certain circumstances under which people might get hurt, they might hurt others and they might damage their reputation. There is already a group of people who understand that and come to that balance and make that a civil reality as well as a clinical reality. I would be on the side of saying "Yes, why not? Just fold them in together." We are talking about the same standards because now, more and more we are understanding that substance dependence is a bio-psycho-social disorder like most psychiatric disorders and that there is genetic input, toxicological concepts, and psychological and sociological influences as there are with most other psychiatric disorders.

The Hon. IAN WEST: However, in trying to get people to internalise their difficulties terminology is important.

Dr JURD: That is right.

Ms HARVEY: It is in the translation. It is really difficult to say are we talking about alcohol and the Inebriates Act or other drugs as well?

CHAIR: The Inebriates Act covers both.

Ms HARVEY: An out-of-control substance using person would not identify with being under an Inebriates Order, for instance. It is difficult trying to bring it into the twenty-first century.

CHAIR: There are also other models about balancing these issues of civil liberties, treatment and care. For instance, we will be talking to the Guardianship Board that deals mostly elderly people where there are all the same sorts of decisions to make about people who it has been decided cannot care for themselves. It is not only a mental health issue.

Dr JURD: Yes, the Guardianship Act is well placed to deal with old granny or with the early deteriorated "Uncle Steves"—money in the bank, own a house et cetera—but is much less well placed to organise treatment: The fact that a guy is in withdrawal and needs to treatment now. I have had dealings with the Guardianship Act, and good work is done with drug and alcohol dependent people now, but they are less well placed to organise acute treatment for 1-4 weeks which is what we are thinking of.

CHAIR: The Committee will ascertain their model of ethnical issues rather than specifically in relation to whether they can organise treatment. You have said that in certain circumstances there is a role for compulsory treatment of people with severe drug or alcohol dependence who are non-offenders. In what circumstances and with what purpose, for example, to save lives, to enable physical time out for the person or to provide respite? When should intervention occur and for how long?

Dr JURD: Particularly for those who are shown to have cognitive deficits which impair their capacity to completely comprehend the consequences of their continued drinking, that is the particular niche. Some people may truly not be able to understand the consequences of what they are doing. Across a relatively brief period of time, days or weeks, as their acute intoxification goes out of their brain, they will be in a much better position to be able to make that decision. That is the particular thing that I am concerned there might be a need for. I am also concerned that a particular deficit in the Inebriates Act is that the clinician cannot say "Your treatment has finished now". Some arbitrary six or nine months period has been put on it. That is the other thing, you need to allow the clinician the capacity to say "Times up, treatment is over".

Ms HARVEY: You need to recognise that in the early stages where the Mental Health Act might be for three days the reality is that somebody is in withdrawal from an acute brain syndrome for the whole period of their withdrawal. Their ability to make good judgments in that time is limited. You need to allow for at least the withdrawal period to be completed and then some extended time on top of that to ensure that they get engaged in treatment. It would be dependent on the substance that they have been using as to how long the withdrawal will be, and what is the appropriate treatment for a person with that history of addiction.

CHAIR: Mr Brannigan referred to a person in Macquarie Hospital where they should not have been. Do you think there should be flexibility in the degree of compulsion at that initial stage? Do you have some compulsion about moving through the pathway? Do you think that there is a short compulsory period and they must make their own decisions but the system has to allow the physical moving from one place to another?

Ms PAUL: People come into the detoxification unit for anything between five and 14 days so I think that period definitely has to be included. But also I think people need a bit of time, once their head is cleared, to actually make some choices about how they want to manage their addiction. I think you would be looking at approximately three months.

Ms HARVEY: I would say three months minimum.

Mr BRANNIGAN: I think there should be some compulsory aspect throughout whatever the process is legislated to be. I would envisage a compulsory period within a residential setting. Without doubt it would have to be in a safe environment and with appropriate intervention at that stage. Then either that time may need to be extended or if a clinician reviews them as suitable for returning to the community, a compulsory order for them to see someone in the community.

Ms HARVEY: There is no reason why whatever timeframe is set up that systems of review cannot be built in which are clinically sound and then taken up for recommendation to a tribunal, or wherever.

Dr JURD: Depending on the capacity of the individual to know what is going on so they can be repeatedly reassessed. They have a right to make a fully capable choice of telling us to rack off. But that is what I am concerned about—I am thinking shorter rather than longer. The vast majority of our clientele are treated voluntarily. We support voluntarism, and this is really a good thing, but we are looking at this exceptional group that would always be very small.

CHAIR: It would all be very small.

The Hon. IAN WEST: Am I right in assuming that if you can get to someone at that first relapse the chances of success are better?

Mr BRANNIGAN: That initial period is critical. It is well documented that good things can come out of a crisis. If you get people in that vulnerable situation when they recognise what they are about to lose or what they have lost they can be very receptive to an intervention.

The Hon. IAN WEST: The legislation could provide an ability to intervene after the initial treatment, perhaps for up to 12 months.

Ms HARVEY: A monitoring period.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a seminar sometime ago conducted by one of the mental health support groups that was very concerned about the civil liberties of mentally ill people. I have a correspondent who sends me emails about the issue every 10 minutes. There has also been a great deal of discussion about assertive treatment in terms community-based people and trying to avoid contact with the criminal justice system; that is, these people must take medication and someone ensures that they do.

CHAIR: That is the equivalent of the community treatment order.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. You are asking for a fairly aggressive Inebriates Act. Can you contextualise what you are saying in terms of the profession and opinions? Are you a relatively aggressive and optimistic group that wants to bring in these people to see how they go rather than a group that is too aggressive? Where are you in the spectrum of compulsory treatment versus civil liberties?

Dr JURD: I have not treated a patient compulsorily for a long time. Therefore, by behaviour, that is my position.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What you are advocating is to have the power to do so. A little while ago you said they could tell you where to go. You are still the one deciding whether they are sensible in making that decision. They can tell you to go to hell and but you can tell them whether they are capable of making that decision.

Mr BRANNIGAN: We would collectively agree that it is crucial to have the opportunity to engage a person in treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are asking for a paternalistic power, to put it in a civil libertarian context.

Dr JURD: We are asking for the opportunity to suggest that, to say that we have that opinion, and to ask what is an objective outsider's view. I might say that I think this man does not have the right to drink himself to death, but what does the magistrate say?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are asking to be able to put it into a legalistic context. It is your diagnostically-based, paternalistic and well-intentioned opinion as against the opinion of someone presenting a civil libertarian opinion and it is fought out in the legal context.

CHAIR: The crucial issue is that you would not be the decision-makers. You would feed into the process. Instead of being such obviously nice people, you were a pack of power freaks. It would be okay in that sense.

Dr JURD: That is the check and balance.

Ms HARVEY: It also provides a degree of transparency.

Dr JURD: The Mental Health Advocacy Service would have the capacity to speak up for people who have been suggested as appropriate for an inebriates order. They would be able to advise them to say that they want to drink. The person involved may believe that he or she does not have brain damage or that it is only mild. The magistrate could make a decision about what is appropriate. The other view is: Do these people not really understand what they are doing to themselves as a result of their drinking? Our experience makes us absolutely unanimous in our belief that there are people who wake up after one week or four, suddenly find themselves sober and question what they have been doing to themselves. They realise that they did not care and were sliding down the slippery slide and enjoying the ride knowing that they would reach the bottom.

Ms HARVEY: There is an old saying: People choose to drink, but no-one chooses to be an alcoholic. That is classic in this situation. People do not pick up their first drink and decide to go down this path.

CHAIR: We have talked quite a bit about different aspects of what the service system required. Two particular things strike me, first, the role of government and non-government services and the mix. Secondly, we have not touched the extent to which good services in the city may create huge problems in regional and rural New South Wales. If you want to involve families, the community, general practitioners and so on, it is not so bad if you live in a heavily populated area like Sydney. It is very different for those living several hundred kilometres away. Is there any way that the Government can cope with that?

Ms HARVEY: I believe there should be an umbrella partnership between NSW Health, the judicial system and the Department of Community Services. Within NSW Health there should also be a formal agreement between acute service providers, mental health service providers and general practitioners covering the care coordination of clients. There should be some elements of a systematic approach to implementation of the Act.

CHAIR: You have mentioned only government bodies.

Ms HARVEY: Non-government bodies should also be involved. When inpatient services are required and absconding risks are high, obviously people need to be managed initially in a secure facility. We talked earlier about a short period during which someone must be in an acute admission ward in a mental health facility. Drug and alcohol services should liaise with those facilities to build programs within that framework to manage those people appropriately. I have some concerns about the application of that model to indigenous people and about locking them away involuntarily. That would need a lot more consultation with Aboriginal communities. Some of the programs in outback Australia should be examined. The committee should look at the safe elder-run programs for Aboriginals in Aboriginal communities. That is essential because of the cultural translation of being locked away for treatment.

CHAIR: I raised the regional and rural perspective because in relatively small population centres, which is the normal living environment for many Aboriginal people, there might be only one

patient at a time, so creating structures to provide the services we are talking about anywhere near home becomes very problematic.

Ms HARVEY: That is interesting in terms of the Intoxicated Persons Act, and the implementation of partnership agreements in area health services and their application in providing services on the ground for people who fall under that Act. The application of that Act was left to the area health services to define with NSW Police and the Department of Community Services. The committee could do a similar thing if it is considering that for rural and regional areas. Tennant Creek has a night patrol involving female elders keeping an eye on what is happening and taking people home. They have their own cultural system to handle the people who are out of control in their community. The legislation should allow opportunities for those communities to develop their own culturally appropriate responses. That is important; we cannot make this an all-Anglo approach. There must be some consideration of those issues.

CHAIR: We are going to Bloomfield at Orange in a couple of weeks. We have had evidence, current and historical, that two-thirds of the geographical extent of New South Wales has trucks that come into a special loading dock at Bloomfield. Again, it is a problem of small numbers. What you say makes sense perhaps for the broader spread of intoxicated persons, but whether we can effectively set up a service system for the small number of people at the severe end is another question.

Ms HARVEY: I believe that Aboriginal services could work with the committee to examine that.

CHAIR: What about non-Aboriginal people in rural areas?

Ms HARVEY: The committee would need to look at that too. It is tricky. The cultures are different, so we must look at it separately. We cannot put it under one umbrella and say that this is it for New South Wales and it will cover non-indigenous and indigenous people. That would be a big mistake.

Dr JURD: I was frantic about non-government organisations. We are talking about compulsory treatment for that small subset of the severely dependent people who probably have brain damage and who may have difficulties making decisions for themselves. That is very highly clinical work and it should largely fall within the realm of the public system, involving lots of registered nurses, registered medical practitioners and so on dealing with these small numbers. How many have been subject to an inebriates order each year? It is only 100 or 200.

CHAIR: It is 20 or 16.

Dr JURD: We are talking about small numbers of people. Of course, I do not hope that that number will increase; I hope that they will be dealt with more appropriately, that people will not be detained unnecessarily and that people who may benefit from such a measure will have that opportunity. I see that being done largely in a psychiatric rehabilitation setting, such as Rozelle. It would not fit well on a campus like this or other general hospitals. If it were in a psychiatric hospital setting, if patients were having trouble and needed to be contained, there might well be a locked area. Even though they were there compulsorily, hopefully they would be in an open area and would spend the minimum amount of time in an enclosed environment.

CHAIR: Would you see the Phoenix Unit as post compulsory? Many people would say that perhaps it could be run by a non-government organisation.

Dr JURD: Yes.

CHAIR: So, in a sense, you are saying that if we are talking about compulsory care, it is a responsibility of Government.

Dr JURD: Yes, that is right. That is how I see it—for good, or else. As I see it, you have stepped over a dangerous line where the non-government organisation, which is outside the Government, has got people contained compulsorily. In that way, if Hon. Dr Arthur Chesterfield-Evans does not like my attitudes and how I am containing people, there is something very direct that

can be done about it through Government lines, but if it is in a non-government organisation and you politicians think that we have been a bit too free and easy with it, I think it is a bit harder to get it back into the box.

Ms HARVEY: I want to play devil's advocate here because the non-government sector currently gets funding to run MERIT beds across the State. There are a lot of remote rural areas that do not have access to Government services, which means that people would have to be geographically removed from the less-supported systems. I think you need to be able to engage NGOs in the process because there are not the services out there at State level for people to be engaged in their communities.

CHAIR: In the early part, the diagnostic part, the detoxification part, the getting them far enough to the point where people can make their own decisions and the compulsory period ends, there is not much of the non-government role in the early part of the process, is there?

Ms HARVEY: In rural Australia, there is.

The Hon. ROBYN PARKER: And even in regional Australia.

Ms HARVEY: It would mean that at some places you would have to detoxify people in hospitals in rural Australia if you make it a totally Government response, which would mean another set of problems in terms of contained care.

CHAIR: And providing the resources?

Ms HARVEY: Absolutely.

CHAIR: One reason that the resources do not exist is because, the number of people being relatively small, there is not much public and political will to allocate the resources.

Dr JURD: Yes. If people are going to have neuropsychiatric testing—

The Hon. IAN WEST: It would have to be administered and co-ordinated by the Government, would it not?

Dr JURD: Yes.

Ms HARVEY: Sure.

Ms PAUL: For the rural areas, I am not so sure, but people need to be in a Government facility for that detoxification period, I think. Rehabilitation is already managing this group of people. They are not under an order, but they are already managing them, and they are managing them reasonably well. So I think what we need to do is just give the rehabilitation units a bit more support in doing that. I do not know how, or what form that would take, but I think we do need to use the NGOs.

CHAIR: I think that the Hon. Robyn Parker was going to say that even in regional areas the role of NGOs is proportionately higher than Government services?

The Hon. ROBYN PARKER: Significantly, because there are not the beds in the Government health system.

Ms HARVEY: So the only in-patient Government facilities would be hospitals. We are having trouble statewide getting hospitals to manage people for detoxification—just straightforward detoxification and nothing else.

The Hon. IAN WEST: But where they are physically, who is looking after them on a day-to-day basis is one thing, but the issue of who is responsible for co-ordination is another.

Ms HARVEY: Yes. It should be Government agencies, yes.

Dr JURD: On the vast majority of occasions, hopefully all treatment is going to be voluntary anyway, and that is my perspective. I might say that it is a very exceptional circumstance where you might want to get Farmer Brown to compulsorily detoxify, in which case it ought to be a big deal, it ought to be a palaver, and he ought to have a neuropsychiatric assessment and the lot. It is a big deal to deprive people of their liberty.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would say that all the inebriate candidates should have neuropsychiatric testing?

Dr JURD: Yes, I would say that. If it is only 20 or 30 a year, why not?

CHAIR: That was the other part in question 8 that we wanted to take up. How many people might require it? I know it is a bit of a stab in the dark.

Dr JURD: Absolutely.

CHAIR: The most recent figures are that there would be fewer than 20 a year under the Inebriates Act, and then we have had a lot of evidence from people saying, "I will not use the Inebriates Act because it is hopeless." Presumably it is more than 20 a year, then.

Dr JURD: Whether some of those are under an inebriates order currently, I am not sure. I made a stab in the dark I wrote down 100 to 200, and given that the majority of these people would not require special treatment beyond a brief period of compulsion and then would be plugged into the rest of the treatment as necessary, to accept or reject as they see fit, I would think that—if it was as simple as putting it in one place and starting up a unit—it would cost only $1 million to $2 million a year to run a facility like that.

CHAIR: So they would be almost all coming to one site, except that obviously creates problems if you are living in Bourke, Broken Hill or Wagga Wagga.

Dr JURD: Yes, that is right. And with the area set-ups, even co-operation across the harbour is sometimes difficult.

CHAIR: Question 10 has really been addressed. People have a right to say, "No, I do not want treatment", or "The treatment will fail", and that the system has tried and therefore had done its duty. I think we have covered that. We touched on question 11 briefly earlier. I think we have all agreed about the gap. What we have not talked about directly, particularly in relation to community-based services, is that everyone seems to agree there is a gross failure in post-treatment. People leave your rehabilitation treatment, for instance, and then who is looking after not only the health side of it but the house and everything they need in terms of family and community support, and so on? Do you have any comments to make about the various gaps that exist?

Ms PAUL: I just want to say that the gaps actually exist before the clients make it to the rehabilitation unit after people go through the detoxification program. One problem they might have is that there is not a rehabilitation bed available for a couple of weeks. Being an acute service, we cannot hold them in a detoxification unit for that period of time, so they get sent home. Often they do not have the support at home. The other problem is actually getting them to the rehabilitation unit without them relapsing on the way. You know, they have to pass the bottle shop to get to the train station and they have to work out how to catch the train up to Armidale or wherever they are going to. So there are a few gaps that need to be addressed. Also those clients often have to go home to sort out their house and home before they actually get to the rehabilitation units. They have to collect their belongings and sort out their bills etc. There does not seem to be any welfare support. We rely on the fellowship and any AA members to assist the clients in doing that.

Ms HARVEY: Also it does not mean that we cannot create a system. I think if you are looking at the individual care management of a client, you need to have some defined case management processes around which incorporate looking at all those issues. If I go back to my experience at Rozelle, the way patients were managed in the Alcohol Related Brain Damage [ARBD] units was that there was a multidisciplinary team which consisted of psychiatrists, registered nurses,

nurses' assistants, welfare officers and occupational therapists. There was a whole-team approach to supporting people through the transition and to look at all those different aspects, so I cannot stress enough the importance of co-ordinated care.

CHAIR: Again, thinking of the relatively small numbers, those people would not only be working with drug and alcohol clients?

Ms HARVEY: Yes they were, but they were not all inebriates, all the clients.

CHAIR: Is the drug and alcohol side of things big enough to employ that multidisciplinary team on various sites that we are talking about?

Ms HARVEY: With appropriate resources, yes.

Dr JURD: Not currently. Currently we are exploding at the seams with voluntary clientele. As Diane and Owen have both indicated, getting people who want to go to rehabilitation and who we think are appropriate to go to rehabilitation and getting them from detoxification to rehabilitation is quite difficult. For every one person who gets into our rehabilitation, we reject three.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You could have four times the quantity of facilities and still use them on the existing demand without going to find more demand?

Dr JURD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You think that there is more demand to be found, presumably?

Dr JURD: Yes.

CHAIR: So what becomes of those people?

Ms PAUL: They come back into detoxification.

Dr JURD: The mortality figures related to alcohol and other substances are pretty impressive. Every year, 3,000 Australians die as a result of alcohol.

CHAIR: And some of them would be your former clients?

Dr JURD: And some of them are people who have never ever received treatment and did not ever know that it was relevant for them.

CHAIR: Do you have anything to say on the gaps? There is a question on the issue of whether people could go through compulsory treatment while remaining at the community by having medication and by undergoing treatment under a community treatment order. That is a slightly different question, but I guess it is also related to the issue of resources and the issue of the geographical spread of people.

Ms HARVEY: And also the support that people have to stay at home, if they have a home. That is the other question.

CHAIR: Yes. Is it expected that could be done in community treatment types of places?

Ms HARVEY: I think you need to assume, like I said before, that people with severe dependence have created quite a dysfunctional environment in terms of their family supports, et cetera. For someone to travel well on a community treatment order and function well within the community on that order, they need strong support around them. I do not know that that is always available.

Ms PAUL: No.

CHAIR: I guess to some extent that relates to a question about a mix of Government and non-government services, and whether the partnerships with NSW Health, the Department of Community Services [DOCS] and police and anyone else who has to be involved means that enough resources can be pulled together, particularly in regional and rural areas. That also obviously has implications.

Ms HARVEY: I have my indigenous hat on again, but thinking of indigenous communities and compulsory treatment orders which engage the community to be part of that, that may well work and that may well be a model which is translatable to those environments because there is a whole community of Elders which will hold up the communal lore around those sorts of things. So in certain aspects, it might work.

Mr BRANNIGAN: I think that area health services are very aware of the gaps and we are constantly trying to plug them in different ways. When we identify something, we attempt to do something about it with the resources that we have, but it simply is not possible to be able to provide everything to everyone.

CHAIR: And plugging the gaps means that you have to go outside the drug and alcohol services.

Mr BRANNIGAN: Yes.

CHAIR: You have to try to draw all sorts of people together to co-operate.

Mr BRANNIGAN: Yes. I think we have good relationships with non-government organisations in this particular area. There is a place for homeless men, the Fairlight centre, and a lot of people who come through the rehabilitation unit have come from there, so we have good working relationships with NGOs in this particular area, but the demand is really so high. In the discussions we have had so far the focus has been on the severely alcohol dependent, but if you then introduce the chaotic drug user into the equation, your numbers go from low to very high in a moment.

CHAIR: Question 15 discusses the issue of severe dependence of alcohol and other drugs and whether they are similar or different. We have covered that already?

Dr JURD: Pretty much. The specific thing is that mostly substances other than alcohol do not cause direct brain damage, but occasionally they are complicated by brain damage from overdoses and falls and this, that and the other. It is reasonable to presume that most people with severe alcohol dependence have at least a little bit of alcohol-related brain damage.

CHAIR: Which in turn means that the issue of compulsion is actually much more related to alcohol than to other drugs.

Dr JURD: Yes.

CHAIR: We have reached the last question: What would you like to see come out of this inquiry? We do not know whether we can do it, but tell us.

Mr BRANNIGAN: I am pleased that this inquiry has taken place. I have read through the material that came forward about how there have been several attempts to address the Inebriates Act which, for a multitude of reasons, has not progressed. I am firmly of the belief that compulsory treatment should be a very last resort. I am also convinced that compulsory treatment needs to take place in a residential setting where there are fairly specific drug and alcohol interventions and medical interventions taking place as well. I would view the length of time as a minimum of one month and that would be reviewed by the appropriate medical officer. I would also like the young drug abuser who is at serious risk to all types of things to also be included in some way under some type of an Act

CHAIR: The compulsion?

Mr BRANNIGAN: Yes, because they are at tremendous risk from their drug taking behaviour. Potentially they could have serious psychiatric complications because of their drug use and

the fact that they also clog up mental health systems as well. About 80 per cent of admissions have drug and alcohol problems.

Ms HARVEY: I would like the Act abolished, as it currently stands, because of the ineffective general nature of the Act. Whether a decision is made to redefine the Mental Health Act to umbrella some of those conditions probably is a good suggestion. I would like a system of co-ordinated care built in as compulsory for service providers as well. We need to take ownership of these people as a whole of health approach, working with the judicial system as well as the Department of Community Services and non-government providers. In essence I want some clear statewide guidelines for management of people under an Inebriates Order. I know that is not in the terms of reference but I think it might be a good recommendation and a good step forward to come from this Committee.

CHAIR: These would be guidelines for everybody involved?

Ms HARVEY: Yes, just a recommendation to government that guidelines need to be established for the care and management of people under Inebriates orders and their families and carers because I believe they get left out of the equation a lot. They certainly need to be supported through this process if the aim is to make these patients voluntary and to have them supported within a home environment, I think we need to address those issues.

Dr JURD: The three things on my wish list for this committee are: One, repeal the Inebriates Act. Two, create a workable alternative with twenty-first century ethical standards and, three, fund it.

Ms PAUL: I seek easier access to treatment for people in crisis. I do not think they have good access at the moment. In the past 12 months we have had something like 1,200 calls through the unit and we have managed to capture just more than 700 of those. A lot of people out there are not accessing the service. One of the problems is that we do not have a mobile service to go out and see those people who cannot actually get to the service. The second outcome would be easier access to support systems for families who I feel have got limited support currently.

CHAIR: Two of you have stressed families, is that a means to their own end or for their own sake or both?

Ms PAUL: Both.

Ms HARVEY: Yes.

CHAIR: If families are looked after then the client has most hope?

Ms HARVEY: People from whom we get the most calls are family members saying "My father is out of control." "My daughter is out of control." "My son is out of control." "What do I do?"

Ms PAUL: They stress that there is no support for them out there and they do not know where to turn because the drug and alcohol services are busy enough dealing with the actual client. There are not a lot of services for the families, and I think that needs to be addressed.

Dr JURD: I have printed my answers. To get them printed up I had to send an email from my computer which is not attached to a printer to my wife whose computer is attached to the printer. At midnight last night I received an email from a distressed woman who has just found her separated husband in a parlous state in his flat at home. "What do I do?" That is on the agenda all the time.

(The witnesses withdrew)

(The Committee adjourned at 12.50 p.m.)