

REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

At Moree on 24 March 2004

The Committee met at 11.00 a.m.

PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr Arthur Chesterfield-Evans

The Hon. Kayee Griffin

The Hon. Greg Pearce

The Hon. Ian West

LOUISE PECKHAM, Aboriginal Health Education Officer, Alcohol and Other Drug Services, Community Health Centre, Moree, sworn

IAN JOSEPH KAMERMAN, General Practitioner, Bingara, Visiting Medical Officer in Addiction Medicine, New England Area Health Service, New South Wales Director of the Australian College of Rural and Remote Medicine,

BETH LORRAINE BURTON, Clinical Nurse Consultant, Alcohol and Other Drug Services, New England Area Health Service, Tamworth

TONI LORRAINE COLBY, MERIT Caseworker, Alcohol and Other Drug Services, New England Area Health Service, Tamworth, and

VI ISABEL HUNT, Area Co-ordinator and Registered Nurse, Alcohol and Other Drug Services, New England Area Health Service, Tamworth, affirmed and examined:

CHAIR: I declare this hearing open. I thank you all very much for attending, in particular, those witnesses who have come from Tamworth and Bingara. I also thank you for making the space available. It is great to be here, to get out of Sydney and to hear some of the views from the coalface. If there is anything you want to say that you do not want to be part of the official record, let us know and we can go into an in camera session. However, we hope that that will not be necessary. We also have ways of keeping names confidential, so you do not need to worry about that.

Do any of you want to make a statement before we commence questions? I know that you have all talked to Merrin about the questions. We might commence by asking questions. What is your current role and what is your experience in the field? You have already told us where you are from. You could link that up by expressing your views about the clear issues and challenges that you are facing as you seek to help people. We will also combine the first and second questions, if that is easier.

Ms COLBY: I have experience in alcohol and in the field of other drugs. I have worked in a drug and alcohol detoxification unit. I have worked in a alcohol-related brain damage unit. I have also been a caseworker in the community. I am now in the criminal diversion program of MERIT. The key issues and challenges that we face historically and currently are that we expect our clients to come to us. We expect them to be highly motivated to change, to have insight and to want to change. However, many of our clients have cognitive impairment. That means their ability to change, their ability to have insight and their ability to read the grey between the black and white is quite impaired.

Yet we continue to expect these clients to come to us and to want to seek treatment. At this point in time a lot of detoxification and rehabilitation units assess people on their willingness and motivation to change. But if they do not have that they are often told to go away, to think about it and to come back at another time when they might be more willing to seek treatment, even when we know full well that that is in direct contrast with the nature of a lot of our clients who have such impairment. That is a big issue for us. There is lack of local resources. Our access to detoxification and rehabilitation is limited.

There is a waiting list to get clients into rehabilitation and detoxification. There is also the geographical distance—four or five hour drives to these facilities. Obviously that incurs social isolation for clients, their families and their children. A lot of rehabilitation and detoxification services have strict rules about family visitations. Some of them are only on weekends. That is not viable for many of the families of our clients.

The Hon. GREG PEARCE: What facilities do you have?

Ms HUNT: Through the New England Area Health Drug and Alcohol Service we have five drug and alcohol teams across the area, all of which provide outreach services. So we do try to provide some services to most towns. As far as other drug and alcohol services are concerned, there is no detoxification unit as such. If clients wish to undergo inpatient detoxification they do it through the public hospitals. We have two non-government organisation [NGO] rehabilitation services—one in

Armidale and one in Moree. Some NGO facilities provide limited drug and alcohol services, such as the Salvation Army. They tend to be in places like Tamworth and also in Armidale. Once you get out into the smaller towns it is very limited. There are not a lot of services around.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I refer to a point that Toni made earlier. You were talking about the behavioural change model that resulted from tobacco—the pre-contemplative and the contemplative.

Ms COLBY: Yes, I believe that model is now quite outdated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not get cognitive impairment with tobacco.

Ms COLBY: It has been widely used in the drug and alcohol field for many years. It is under discussion.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that what you are attacking?

Ms COLBY: Not necessarily. I think it is a model to which many drug and alcohol facilities still ascribe. They ascribe to the view that a client has to be motivated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They use it for heroin as well, do they not, and addictive drugs?

Ms COLBY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With a number of drugs sometimes that impairment is not reversible.

Ms COLBY: Absolutely. It does not just relate to alcohol, it relates to drugs. We see chronic brain syndrome develop as well, which impairs a person's ability to want to change.

CHAIR: Can you put a figure on it? How many of your clients overall are at that more severe end and have cognitive impairment? Is it possible to put a figure on it?

Ms BURTON: That is extremely difficult. Not everybody in the community would come to the attention of drug and alcohol services. Some are going through aged care, some are going through the Aboriginal stream, some might be young people, and there are some concerns that young people are starting to slip across that line so we might not see them. They might end up in juvenile justice or in youth services and, therefore, on the street. So we find it very difficult. They might just come through the local medical officer, go into hospital, be stabilised for a short period of time and then go back out and fall back into that same dysfunctional state all over again. So I would not even hazard a guess.

Ms COLBY: It is important to remember that we are unable to assess someone's cognitive functioning when they are still using illicit drugs or alcohol. It is just impossible.

Ms BURTON: Even after a person has been through detoxification and the drug is out of his or her system, if we are to test correctly we still really need to look at another two weeks so that everything stabilises.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are saying that you never get two weeks to do the testing?

Ms BURTON: No, so we are always running behind all the time.

Ms COLBY: The next issue that we face is a lack of available general practitioners in our region. This has a great impact on our clientele. It means that, if I ring up to go to a general practitioner today, I might have a two-week to three-week wait before I am able to see my GP. Due to that shortage not many GPs bulk-bill. We do not have the medical centres that are provided in city

areas, so when our clients front up to most of these doctors they have to pay their fee up front and then claim at Medicare. This, of course, is not viable for most of our clientele.

Then, of course, that impacts on our emergency departments. You cannot get to the GP; therefore you go to the emergency department for minor complaints. If you go to the emergency department for a complaint related to substance abuse you would be triaged very lowly and, therefore, you would have a very long wait. People very often do not stay in an emergency department for a long time to see a doctor. The other issue is that we provide rural and remote services to outlying communities, maybe one day a week, one day a fortnight, or one day a month.

That is not adequate. Imagine a worker going out to Nundle one day a month. If I happen to be living in Nundle and I am seeing that worker that day and I cannot get child care, or I am sick, I cannot see that worker for another month. That is really quite inadequate for rural towns that do not have a good number of services to start with. So it is not a quality answer to have a drop-in service. The final issue that I wish to raise is that there is often an emphasis on non-government agencies. There has been a lot of talk about their involvement in the field of alcohol and other drugs.

Whilst they are very good in dealing with gambling problems, financial counselling and drought relief, we do not have a large involvement of non-government facilities in this area to assist with our clientele. They are good for handing out food vouchers. I will not say that they do not have their means of support, but we do not get support, counselling and follow-up services in those areas from non-government organisations that a lot of our city counterparts get.

CHAIR: Is that because it is not part of their role? They might not be funded to carry out that role. Do you think it has something to do with how thin they are on the ground?

Ms HUNT: It is probably a mixture of both. They are not necessarily funded to do that. I do not think it is that they do not want to do it; they recognise that there is a need, but they just do not have the ability, staff-wise or funding-wise to be able to carry it through.

CHAIR: So compared to some metropolitan areas, drug and alcohol services in this area are basically government services?

Ms HUNT: Basically, yes.

The Hon. IAN WEST: Are you talking about a lack of trained staff as opposed to willing staff, or is there just a lack of staff numbers?

Ms HUNT: Both—a lack of numbers but also a lack of trained staff. When we said they are willing, we mean we have been trying to do some things with training and frontline management issues, but generally they are not there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The non-government organisations [NGOs] do quite a lot of drug and alcohol work in the city.

Ms COLBY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is no particular reason that they could not do it out here, they just happen not to be here.

Ms HUNT: They are here, but they are not involved in the drug and alcohol field.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the Government were to call tenders it could find people to do it and that could change.

Ms COLBY: Absolutely.

The Hon. KAYEE GRIFFIN: I refer to the example of Nundle. If the NGOs were more involved in drug and alcohol work would that assist in getting assistance to those remote towns?

Ms HUNT: It would be limited because even the NGOs that are here are mainly in the bigger centres. Nundle is an hour and a half from Tamworth. It is a very small place and there is no NGO. We also have difficulties with travel and they have the same issues.

The Hon. KAYEE GRIFFIN: Are the staff in the NGOs you already have more specialised in the drug and alcohol work? You do not necessarily see that resolving some of the more isolated community issues.

Ms BURTON: Not with the topic of this inquiry, because we are looking at people who are damaged. We are trying to assess where they might need to go and what type of intervention we might need to provide. Nundle has a good nurse practitioner who refers quite readily back to our service. However, we run into the problems that Ms Colby alluded to. It is voluntary. If there is cognitive dysfunction, staff might travel to Nundle but when they get there the client is not there, he or she has forgotten.

CHAIR: Improved transport would not necessarily help the people we are talking about because they would have to be willing in the first place to go to a centre.

Ms BURTON: Yes.

Ms COLBY: We need to go to them. If they have to come to us it will not happen.

The Hon. GREG PEARCE: Why do you call them "clients"?

Ms COLBY: Because the word client suggests to me a quality service. If it is not provided they will not come back.

The Hon. GREG PEARCE: Is it also about your accountability?

Ms COLBY: Yes, and my respect for them.

CHAIR: I guess you all agreed that Toni Colby would go through key issues and challenges. Does anyone else want to add anything?

Ms PECKHAM: I travel out Toomelah, Boggabilla and Mungindi. There is nothing in place out there to help the Aboriginal community with AOD problems. Alcohol is a big issue out there. I present health education programs to the community. Something must be set up out there for the people because their alcohol intake is continual. Aboriginal life expectancy has been shortened. Over the years a lot of people Aboriginal people have died because of their involvement with alcohol. Before I came into this job I worked with a children's service and I saw the effects of drugs and alcohol. My heart is heavy and this issue must be addressed. Things must be put in place. I see the after effects. Who is caring for these people given the damage that alcohol has done to them? What can be done for them? It is not only Aboriginal people; it is across the board. That is my main area at this time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you suggest what should be done? People always talk about things being done, but I wonder whether it is better to have people running football teams to give the kids role models, to drive some industry or to put more money into the treatment side for the adults. If you could have some facilities what would you have? Most people ask for facilities in the area in which they work. If you could have any sort of facilities to help the community, which would you have?

Ms PECKHAM: I would go for training, educating them. It still blows me away when I go to the communities to talk about drug and alcohol issues and education. Many of them still have the idea that it only affects their liver. There were skills in the family when I was young and growing up. Our parents looked after us and taught us. But because the young ones are having babies at such a young age and the grandmothers are so young, skills in the household are not being handed on. Many of our people are going to TAFE in their 40s and 50s. I wish I knew the answer; I wish someone had the answer. But the alcohol problem needs to be addressed. There might be six in a group and they might get their Centrelink payments on different days. One person might get paid on Monday, another

on Tuesday and another on Wednesday. We provide education but, because they are able to nominate a day they want to be paid, they are intoxicated all week.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you prefer the payments all on Thursday so that you could start teaching them on Wednesday, the day before they get the money? You would have more bingeing, but at least there would be some dry days. You could run a soup kitchen.

Ms PECKHAM: I would like to see a lot of dry days. I do not know the answer.

Ms HUNT: It is part of the sharing culture. That is what we find when trying to provide interventions. If you are trying to deal with one person who has more of a problem than another person it is very difficult because of the sharing culture. You might have a person who is very willing and who wants help, but in their community there is an expectation that they will be a part of whatever is happening. When they go back to the community there is an expectation that they will spend their Centrelink payment today on the alcohol for everyone because it is someone else's turn the next day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I presume that gives you hope that if you change the whole community they will all change at once.

Ms BURTON: That is a possibility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When I tried to get people at the Water Board depots to stop smoking they laughed at me. When I got all of them doing lunch-time sport and banned smoking in the buildings everyone in the depots quit.

Ms BURTON: It opens up new possibilities if the payments are on a particular day, because you can work the interventions before that day and arrange the budget. It opens up possibilities. Ms Peckham is saying that the family is very important in the Aboriginal community. If you have one family member who is damaged and the family does not understand what that damage means they do not know how to help that member. They continue giving them alcohol and the damage continues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How do you provide the education? I presume that you do not take them into a classroom and sit them down.

Ms PECKHAM: I have worked with probation and parole clientele over ten weeks. I had to follow the department's guidelines. I go out into the community. When working with Aboriginal people we have to negotiate; we have to go with what they want. At Toomelah it is all Aboriginal; there are no Europeans. We can present the programs on their land. They have services like family support and Community Development Employment Projects [CDEP]. Whichever one they choose that is where the program takes place. The same occurs at Boggabilla.

CHAIR: It has a very large Aboriginal population.

Ms PECKHAM: TAFE will let also let us use their institutions. CDEP is also there. The facilities are there and they do come along. However, because I am going in all directions, when probation and parole have their programs they call me in. I am only a guest. I visit and tell them what services are available. I did a lot of doorknocking and wearing myself into the ground. Now I have told them that they have to take responsibility for themselves and ring me. I can then bring other people to offer education in budgeting, living skills, domestic violence and so on. I have had good feedback from drug and alcohol groups. I am working with girls now. Hopefully this group will continue on for 12 months. There are different services going there. An elder at Mungindi approached me. He was really concerned because alcohol is a big problem out there. We had to do a lot of negotiating. I had to go back out to Toomelah and negotiate, because the manager there oversees Mungindi CDEP. That is the only way I can get in to present programs. They are still at work and I can claim some time. I have tried setting up groups, but they are not willing to come along.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They will only come in work time?

Ms PECKHAM: Yes. In work time I am able to get some time there from going around negotiating because the Elder out there would like these people to understand what damage alcohol is doing to them.

CHAIR: We will come back to many of these issues later this morning and also this afternoon. I am conscious that this is an inquiry particularly about inebriates at the extreme end of the perspective. I think Ian was going to speak about drugs and alcohol from the general practitioner [GP] perspective—the key issues and challenges.

Dr KAMERMAN: Certainly from a general practice perspective the issues of drug and alcohol in rural areas are probably no different to other health issues. The issues generally are timeliness and providing services close to where people live. I think the area does an excellent job in providing services down to the small towns and the peripheries of the area. Before coming to this area I was down at Junee and in the Riverina and certainly their services were not as well spread out across the region. The issue of timeliness is certainly worthwhile bringing up because in my role as working in pharmacotherapy treatment I service Moree and Inverell on a fortnightly basis. That presents issues with getting people into treatment promptly at an appropriate time after an appropriate assessment. Those delays occasionally mean that people fall down the gaps and do not get onto appropriate treatments.

There are also issues with the number of pharmacists willing to take on dispensing of medications. There is only one pharmacy service in Moree privately and only one pharmacist in Inverell who is happy to dispense methadone. That lack of numbers on the ground is certainly an issue. From my point of view the people with the largest problems tend to be the ones who live very much on the periphery of our society. They are not so much where I live in Bingara, which is a town of about 1,200 people. I think we provide a very good service in general practice there but the smaller communities where I see the largest number of patients, a lot of patients come from Pallamallawa, which is a small community of 100-200 people some 20 or 30 kilometres east of here. If you look at Inverell, most of my clients come from areas such as Tingha or Stannifer, which are small communities, again some distance from the town. But I think a lot of that has to do with housing. As housing prices have crept up in Sydney, people move. They also increased in the provincial centres. People move into the much cheaper accommodation that they can afford. They can actually afford to buy a house there.

CHAIR: You are talking about people who have not lived for generations at Tingha or Pallamallawa? You are talking about people who have moved perhaps quite recently, possibly even from Sydney?

Dr KAMERMAN: Yes. I am seeing people who have moved out here from Sydney or moved from larger centres into smaller towns.

CHAIR: Into dying towns, because houses are cheap.

Dr KAMERMAN: From an alcohol and drugs point of view, the major thing that will get people off that sort of intoxicating substance is employment, and they are totally unable to find it.

CHAIR: And they are also lacking family support, I assume, because they have left where their relationships or links were.

Dr KAMERMAN: Or the other thing is that they have taken their family to those areas and have moved the family from the supports that they have had, and it is very difficult to provide services into those small towns. The area is looking at putting primary health care nurses in, but there are no GP services in those sort of towns, transport is lacking, and there is no infrastructure on the ground to actually get these people into services or to get specialist services into them.

CHAIR: So that is a nurse practitioner, or at best it will be an occasional visit?

Dr KAMERMAN: I think the area has a new program of primary health care nurses in some of these communities and having them stationed, if not full time, then it is looking at a part-time basis.

Ms HUNT: And they are particularly targeting the small towns that we are talking about. I think there will be 10 all up across the area, so they will be the front-line person and our job will be to build some referral systems in support of those people around particular areas, and ours will be drug and alcohol.

CHAIR: Presumably in these communities, there is a huge range of serious health issues and drug and alcohol is only part of it?

Ms HUNT: It is only one little bit, yes.

Ms BURTON: Plus we have often got, as Ian was saying, families so you are looking at the next generation, and the children are of concern as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say families, I suppose it is the concept of a nuclear family. Are you talking about two adults and a bunch of children?

Dr KAMERMAN: Largely, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the nuclear family moves down too. Did it have a drug and alcohol problem before it moved?

Dr KAMERMAN: More than likely. That is why they could not continue to live in places like cities or larger provincial cities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they are welfare dependent when they come up here?

Dr KAMERMAN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On welfare, you can still buy a house, is that the case?

Dr KAMERMAN: Especially if you had a family home in Sydney which you had sold.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or a forced sale, even?

Dr KAMERMAN: Or a forced sale. You are talking about housing you can get for \$30,000 or \$40,000. You can buy a house and a block of land.

CHAIR: These are communities like Tingha, which was tin mining, or whatever. There were a lot of houses there and in some places I think some of these towns have Department of Housing houses—or not?

Ms HUNT: Some do.

CHAIR: In relation to question 3, I think you have probably dealt with the range of services, although most certainly if one of you or many of you have prepared things, sing out and tell us. We can also take things from you later. Ian, I think you said you thought the New England Area Health Service was actually better than your previous experience in the Riverina. We have got that question about the extent to which you think the rather depressing picture you are painting is typical of the rural and remote New South Wales. Does anyone want to add a comment on that?

Ms HUNT: We have painted doom and gloom, but there are things out there. Like, I guess we cannot forget things like Alcoholics Anonymous [AA] and Narcotics Anonymous [NA], which certainly do use our services a lot. There are things like that we try and build around, such as 1 300 numbers, so at least if there is not a service, there is a phone number where people can ring. We are trying to use things like that. However there is, I guess, a bit of an aversion by some people to using a number that they do not know who is on the other end of, and it is not a local thing. Rural people tend to want to go into a centre where they know somebody. It is a bit of a double-edged sword because others want anonymity, which you cannot get in a small town, and that can also be a bit of a barrier to

seeking treatment. You have heard us say that there is a lack of transport, so when you have got people who do not necessarily want to access services at their local centre but do not have a capacity to move and seek it from elsewhere, you try to build things like phone services and that sort of thing. We have some good stuff come out of that. It is not all doom and gloom, but it is limited.

CHAIR: How do you think you compare with the situation in other places?

Ms HUNT: I think we are pretty much the same.

CHAIR: Does your picture reflect the situation in rural New South Wales.

Ms HUNT: Other rural areas that are not on the coast, if you are talking mid North Coast and Northern Rivers, which are still classed as rural, they are considerably better off than us. If you come inland, I think there would probably be some more.

CHAIR: So you would all agree that that is the case? Ian made a comment I think suggesting that perhaps the New England Area Health Service is perhaps doing a better job.

Dr KAMERMAN: That is certainly my experience. For a number of reasons I sought out particularly coming here, so I have to say that, I suppose.

CHAIR: The next questions were also designed for Ian about the role of GPs. We have heard criticism of GPs in the metropolitan area and the suggestion that in relation to inebriates, the service is right at the end of the problem, but GPs and others are not really there to provide the sort of services in a way that would actually prevent the problem becoming that extreme. Do you want to make some comments on whether you see that any differently in country New South Wales from the picture we have gained?

Dr KAMERMAN: I think it is probably a lot easier for doctors in the bush to handle looking after inebriates and people at the severe end of alcohol and other drug problems. For a start, most of us have access to hospitals where we have admitting rights so detoxification is very simple for all of us to arrange. We simply ring up our own hospitals and say, "I am putting someone in for a period of detoxification." The supports afterward can sometimes be somewhat problematic, booking them into a service once they are detoxified.

The Hon. GREG PEARCE: You do not really need specialist detoxification beds as such, as you sometimes talk about, particularly in the city?

Dr KAMERMAN: I just put them in hospital.

Ms COLBY: The hospital experience of detoxification is very unsatisfactory for a lot of our clients because most people can handle the physical withdrawal, but what about the social-psychological factors? We can detoxify our clients from drugs and alcohol but the issue is keeping them off them. It is very unsatisfactory to be put on the general ward of a hospital with other patients with numerous physical complaints and with nursing staff who may or may not have limited experience and expertise in dealing with these clients, and we are looking at a whole range of clinical specialist expertise in dealing with their cravings, their withdrawal symptoms, coming to terms with their grief, loss, remorse and guilt for their lifestyle. There are many multifaceted issues and I find that unsatisfactory when we put our patients in a public hospital in a normal bed. Having said that, some clients obviously do choose to stay in Tamworth, for example, and undertake detoxification in the Tamworth Base Hospital on one of the wards, so it is an individual choice. But a lot of our clients report it is quite unsatisfactory because there is no one to talk to.

Ms BURTON: I think Ian's situation is pretty unique because he can ring up the hospital and get a bed pretty quick but in most of our rural centres, getting a person into hospital is just not that easy; that is, getting people into hospital for detoxification. For example, at Tamworth Base Hospital, we have had people waiting for a bed for over two weeks. So it is that difficult at times.

CHAIR: Are you talking about Bingara specifically?

Dr KAMERMAN: They are beating me to it. I am talking about the smaller centres, the community hospital, because in the larger centres, those hospitals have 90 something per cent occupancy and to put somebody in for detoxification is generally probably a waste of resources because again, doing detoxification just for the sake of doing detoxification without booking them into a program afterwards that will maintain abstinence is just not worthwhile.

Ms HUNT: I guess my comments around that would be that I do not mind using public hospitals in rural areas for detoxification. However, there have to be some beds allocated to detoxification rather than just what is available. Especially in the larger hospitals, if there were some sort of allocated facilities there to do detoxification, that would be fine. The other comment I would make ties in what Ian said about support services afterwards. To my mind detoxification is the beginning of a treatment episode, so really we would hope that clients would be booked into a drug and alcohol service or whoever at the beginning so that detoxification becomes part of that client care and so that before you even bring them into hospital you have got things organised for after. That does not always happen with a lot of GPs.

CHAIR: Have you been able to, for instance, get one of the people you have been talking about—those you got into hospital at Bingara—into a rehabilitation centre in Tamworth or Moree later, or what has happened? I think everyone interrupted you before and you continued on the other things about GPs in the country.

Dr KAMERMAN: One of the major things is that people do not want to enter rehabilitation. They do not realise that detoxification is just the start of a step towards abstinence. They think that they are going to be in hospital for a week and they are going to come out clean and they will have the willpower to stay off the grog. It does work from time to time and that is why I do not say that it is a waste of time, but the issue is hopefully each time you try it and each time you are closer to actually hooking them into a program, that is, getting them to hook into AA or NA, or hooking them into the alcohol and other drug workers and coming to see you on an ongoing basis, and pharmacotherapies such as naltrexone and acamprosate for use in keeping people off alcohol. Certainly one of the changes that I have noticed in my practice is that people actually seem to stay off alcohol with fewer relapses and afterwards, just by a community program using the alcohol and other drug worker and the GP.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the community program is a huge success?

Dr KAMERMAN: I think you need many different ways of being able to treat people, from residential rehabilitation—and obviously we will talk about institutional treatment with the Inebriates Act at some stage—to community therapies. Community treatments are certainly quite successful.

CHAIR: We have probably covered question No. 4. I think we have dealt with the issue of strained and stretched systems. We should refer specifically now to inebriates. Do you have any experience of the Inebriates Act as such? Have people been placed under orders? If so, can you tell us anything about it, using a case study?

Ms HUNT: Yes. In the 12 years that I have been in the Alcohol and Other Drugs Service I have tried one person twice, so I can talk about that person. Obviously it is not something that we use frequently at all. The person who presented was a female in her early thirties. She had presented to the drug and alcohol service on numerous occasions. She also had a diagnosis of bipolar disorder. She had had a very high alcohol intake since the age of 18. When I say "high" I am talking about a cask of wine a day. She would go on a binge which would last four to six weeks. During that time there would be constant calls to drug and alcohol and mental health services. You would get her off the grog and you might get her into hospital for detoxification. She would go out and then we would start all over again.

She lived alone. She had two parents and a brother. She had contact with her father, but her mother and her brother would have absolutely nothing to do with her. So she was really quite isolated. As I said, she had numerous admissions for detoxification, but she never stayed very long. She had a number of stays in the mental health unit because sometimes when she was drinking she would become quite suicidal and depressed—another reason for her to be in there. I know that on two occasions we put her under the Inebriates Act. Her father actually initiated that process. We sent her

down to Wallsend hospital. On both occasions they had the Act revoked and they sent her on the next train home. So from my experience it was difficult. We could go through the process, get somebody under the Inebriates Act and into treatment, but when we got that person there, there was just not a capacity or a willingness to keep that person there.

CHAIR: Did you go through the process of getting an order from a magistrate?

Ms HUNT: Yes.

CHAIR: Even with that, which presumably was for a period, for example 28 days or three months—

Ms HUNT: It was for three months.

CHAIR: But the hospital basically ignored the order?

Ms HUNT: Yes.

CHAIR: We have heard from hospitals and others in the system. However, the criticism is almost the reverse. People turn up with an order but there is nothing they can do for them. They cannot release them because there is an order.

Ms BURTON: That is not correct. In the experience of this area ours have to go to Newcastle. So it involved a lot of transport and sometimes one or two staff. It got to the point where now it is basically not used.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because the hospital ignored it? You bust your gut to get her down there and it all evaporated?

Ms BURTON: Yes. They are sometimes isolated down there. We are talking about damaged people. We would not use the Act until they are quite damaged. You are in fear of their health, or their life in some cases.

Ms HUNT: Obviously it was for health reasons that we followed that path just to get this person in there. Who knows in the long term whether we would have got to abstinence because she is actually off the radar now. I think she has left the area. I do not know where she is.

CHAIR: But she was still alive?

Ms HUNT: She was still alive. Even just giving her three months out we could have tried to get her into detoxification and we could have done some work. As Ian said earlier, sometimes it is a process that you have to go through a number of times. If you can get a window of opportunity it is better than nothing.

CHAIR: How long ago was this? You said that you dealt with one person in a period of 12 years?

Ms HUNT: That would have been about 19 years ago. So it is a long time since I have ever thought about using the Act.

CHAIR: Why would you not think about using it now?

Ms HUNT: Where do you send them from here? I guess that is the issue.

CHAIR: We are going to Bloomfield tomorrow. People are still being sent to Bloomfield.

Ms HUNT: It is a difficult process from here. There are issues involved when you are taking somebody out of their area. Even though there might not be a lot of support for them you are still taking people out of their area.

Ms BURTON: If you are taking someone who is damaged out of their perceived comfort zone and you are putting them somewhere else, you can actually do more damage in a lot of ways. They have nothing familiar around them whatsoever.

Ms COLBY: We do not take all this lightly. We are talking about a huge invasion of civil liberties. If we are not going to have a treatment service that will make a difference we will not use it.

CHAIR: Has anyone else ever used or tried to use the Inebriates Act?

Ms BURTON: I was on the periphery. I have actually never used the Act. When I first came to the drug and alcohol service I certainly helped one of the existing staff. The process that person went through was very frustrating. The feedback that I got showed it was just not worth all the rigmarole—the doctor, the family and the magistrate's hearing. It just was not worth it in the end. If I may, I would like to share with you another case that was quite challenging. It will probably answer part of question No. 7. A few years ago I was asked to consult with community nurses out at Barraba. The girls asked me to see somebody. This lady was in her late fifties, perhaps early sixties. They were concerned about her because she was drinking. They were popping in and trying to do the bathing for her, looking after her and those community nurse type of activities.

They also had a key to this lady's house so they asked me if I would have a look at her and see what I could do, if anything. So I started visiting her at her home. You would have to stand nearly out on the street because of the smell that was coming out of the door. I never actually went into her home. I tried to build up a bit of a relationship over many weeks, just popping in whenever I could, trying to elicit what was going on with her, listening to her stories, and things like that. The longer I had contact with her—and the contact was at different times of the day—sometimes there was obviously the smell of alcohol on her breath and at other times there was no smell. At times she seemed to be a bit more together in relation to her dress and her behaviour. Then she would be talking about her husband who was due to come home when the information that we had received was that he had died many years before.

At other times she would talk about her husband and the domestic violence that she had lived through in that relationship. At times she would not talk to me at all; she would be too agitated or paranoid. Neighbours would complain that she was screaming at somebody at night-time, but when we conducted investigations there was nobody in the house. So there were all these types of behaviours. She was a smoker, so the community nurses were obviously very worried about her setting herself on fire. The bills were not being paid and there was nobody who seemed to be responsible. She had no family, so she was rather isolated. This was a very difficult case and we did not know what we were going to do.

I was concerned that the community nurses also had a key to this woman's house, and how would they stand legally in relation to that. That was one of my concerns. The community nurses actually approached the Guardianship Board. We put it before the Guardianship Board. Of course, the Guardianship Board did not want to touch this case because it said that only alcohol was involved. We tried to put a case together. I suspected that she was no longer able to look after herself and there was dysfunction and alcohol-related brain damage. The Guardianship Board came to the party and actually made an order that we could put her into hospital and into detoxification. Then she was put into the confused and disturbed elderly [CADE] unit at Tamworth. She was put in there for a while after the detoxification.

While she was there we were able to achieve a comprehensive assessment. So she was able to be seen by our consultant, Michael Campbell-Smith in Tamworth. She was seen by an occupational therapist who determined her functioning ability. I think she was seen by a psychologist but I am not 100 per cent sure whether it was a clinical one. Consequently, we were able to obtain a diagnosis of dementia based on alcohol. They took her back before the Guardianship Board and the board was then able to act on that, once that diagnosis was there. They put her into a nursing home. I understand that she started improving quite well once she started to eat. Her house, which was a shack, was sold, so a little bit of money came back. Her bills were all fixed up and her quality of life was improved. That was a case of scratching our heads and working around it. When the Inebriates Act was raised as a possibility nobody really wanted to touch it. No doctor was involved. She had no doctor. Even back

then, which is a few years ago, it was very hard to get someone like this client in to see a doctor. So this was another approach which worked on that occasion.

CHAIR: We are talking to people from the Guardianship Board next week. We are aware that sometimes that is the way to go.

Ms BURTON: I think that, whatever happens as a result of these inquiries, that is another pathway that I would like to see somehow incorporated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: CADE units?

Ms BURTON: I was involved in another case. The aged care assessment team asked me to go with them to do a home visit. We looked at this gentleman who I think was about 64 years of age. He was not looking after himself. We did not go to the Guardianship Board, but he was more willing to go somewhere. So a drug and alcohol staff member escorted him to a place down on the South Coast. Within a week he was back, so there was no framework for protection, for holding him or for putting him in that environment. So he came back up to the Tamworth area and was soon back on the streets.

The CADE units, which have since been developed, are good for some of our clients because of their agitation. Anyone suffering from brain damage as a result of alcohol in particular is very quick to anger. Those people are very quick to become irritated, if you like. It is difficult to place people who are damaged into nursing homes if they are not aged and they do not have some kind of medical problem.

CHAIR: That means you need another diagnosis. Alcohol by itself is not enough?

Ms BURTON: Yes. You have to take into account in particular the fact that alcohol caused that brain damage. You can have it across the board. People as young as 20 might have this brain damage. They might improve in a place of safety where there is no alcohol, but when they get out and they go back to that alcohol again it will start that process all over again. I think Louise would probably agree that there are some damaged people in her community.

Ms PECKHAM: Yes.

CHAIR: Including very young people?

Ms PECKHAM: Yes, there is one person in this community that I had not seen for a while. I was a bit concerned about who was caring for this person. When I saw him last he was still speaking fluently, but it was difficult for him. He had changed quite drastically as a result of the alcohol abuse. He was walking sideways and his arm was out like that.

CHAIR: How old is this person?

Ms PECKHAM: He is about 53.

CHAIR: So no-one else has used or thought of using the Inebriates Act. The Committee has heard that the Act is often not used strictly to deal with a mix of the issues—medical and others—but because a person's behaviour has become so challenging that his or her family or the community see it as a way of getting the person concerned out of sight and out of mind. Some witnesses have suggested that that happens particularly in rural communities. You may not have an opinion given that you have not had much experience with the Act.

Ms HUNT: Not necessarily with the Inebriates Act, but we get a lot of phone calls from families who are probably at their wit's end and not sure how they will cope. It is very hard, especially if the client does not necessarily want help or to do something. We had a conversation about what happens if a person wants to continue drinking. If they are not hurting themselves or other people, have they got the right to choose? The family might be upset and might not be able to cope, but that is the issue with the Act and compulsory treatment.

Ms BURTON: It could become the easy line. We must ask whether this is all we have. We have to be able to give something to a person who is asking for help. Do we take advantage of that, turn it around and say everyone has the right to drink? We probably know that person and we know they are doing more damage, but we might have no other avenues or we might have tried them all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it worse than it was?

Ms BURTON: That is difficult to say. It is more widespread.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean less severe or more severe and more widespread?

Ms BURTON: More spread in that the alcohol and drug service does not see everyone. There are pockets of other people who see them; for example, aged care services or a general practitioner. The addict would know there is the GP to go to who might help. We might never see them. There are some we will never see who are still being supported by Alcoholics Anonymous [AA]. They will never come to our attention unless we get a referral from the hospital and we go in to see a sick person who is suffering from, for example, pancreatitis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought AA supported them in abstinence.

Ms BURTON: It does, but people go off the rails.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Most people in AA are functioning.

Ms BURTON: Yes.

CHAIR: Many families cope one way or another. No-one sees those people because their families are looking after them, hiding them away.

Ms BURTON: We have had cases like that. I remember one case I was involved in. I did not see the client personally the first time, but I went the second time he presented. In the first conversation he came across very well. He had a business and was running it and doing okay. His daughter telephoned frequently but did not live around here. It was only when I caught up with another worker that I found he was not running the business. He was drinking and had alcohol under his bed. He was not coping with the pressure and his bills.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was all about to collapse.

Ms BURTON: Yes, and it did. His daughter was quite happy to take him.

CHAIR: People have the right to drink themselves to death, but do we have the right to impose treatment? We have asked that question of everyone who has appeared before the Committee.

Ms COLBY: We could talk about it until the cows come home. Despite our differences and beliefs, it must be based on each individual case.

The Hon. IAN WEST: When you look at individual cases is there a point at which a person cannot make a rational decision?

Ms COLBY: There is and there are many different factors and components that we must consider. One is suicidal ideation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not a question of resources? You say that all people cannot be looked after like your lady. However, they could live in a confused and disturbed elderly [CADE] unit or supported accommodation. Presumably years ago they did and lived forever in a psychiatric hospital and tended the garden on their good days and the welfare system simply gave them board and lodging. They were chronic alcoholics if they got the opportunity, but they stayed there. Now we say we will not do that; we will provide x level of support in the

community and if they drink themselves to death, bad luck. There has been a huge change from the idea of supporting a fair number of people to supporting very few. Everyone talks about the ethical issues, but in a sense the point is whether we are going to have CADE units to meet demand. In which case, people who otherwise would have died in five years will now live for 20 years. Everyone likes talking about the ethical issues, but it is not a practical issue in terms of the extent of the welfare support we will provide?

Ms BURTON: The nurses at Barraba were putting themselves at risk each time they went into the house. Once they find that a person is not receptive should they withdraw the service and leave the person to his or her own devices? What legal protection is there for them in trying to give genuine assistance to a person who is not coping? They have a key, so if things go missing and she is paranoid and says that the nurses have taken her jewellery, she could decide to get legal aid. Where does that leave the nurses?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Without the lawyers making a mess of things—

Ms BURTON: Do you think you can do that?

Dr KAMERMAN: Please.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do my best. There are services like Meals On Wheels. If you feed people they live longer whatever mess they are in.

Ms BURTON: But they have to be cognitively functioning to recognise that they are hungry and to eat the meal.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you put the food there presumably sometimes they eat it and sometimes they do not.

Ms BURTON: I disagree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they reach the point where they do not surely they are on a slippery slope. They can either go into a long-term care unit or die.

Ms BURTON: If they are on a bender or a binge, they will not eat. Drinkers will not eat; they will go until they get sick, and that might stop them drinking. That is where the thiamine and vitamin deficiency comes into it. That is the situation that can lead to Korsakov's.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should the nurses be waiting until they are well and truly anaesthetised with alcohol and then jab some thiamine in their backside?

CHAIR: That is an informal way of asking our ethics question.

Ms HUNT: What would the lawyer say about that?

Ms BURTON: We could also put thiamine in their food from Meals On Wheels.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That should be done.

Ms BURTON: Before we get to that, we still have to be able to diagnose that someone is damaged from alcohol or substance abuse. We look at alcohol because it causes the most in terms of brain damage and other physical damage. There are other substances that cause damage as well. We are not seeing some of them yet.

CHAIR: Are you saying that in some more severe cases you almost need compulsion to make a diagnosis? It is not a matter of holding someone down and jabbing them.

Ms BURTON: Yes. As experienced as we are in terms of mental health assessment, I would not presume to continue to go to this woman and say that this is a definitive diagnosis because there

are too many factors. I suspect, and my hypothesis is, that this person has brain damage, but I would not dream of saying it is there until we have properly assessed her. We cannot do that until a person is dry or stable long enough to do it.

CHAIR: Most of the people we have talked to seem to accept compulsory treatment subject to a huge range of conditions, which probably vary depending on their background and experience. One side is obviously a framework like the guardianship set up or the Mental Health Act with all the legal and medical tribunals and concern for civil liberties. However, we felt it was important to ask witnesses, particularly people with experience like yourselves, whether you accept that there is a place for compulsory treatment. It is obviously fundamental to the Act or any replacement legislation. I guess there are all sorts of conditions.

Ms BURTON: Yes. I will speak for myself. Coming from a mental health background, I am aware that many people who ended up in mental health services were there because of their substance usage, not because they had a mental illness or disorder. There might have been a short-term crisis, but they might have a long history of abuse. I would have to say yes, because they are ending up in some compulsory treatment anyway. The added problem is that if they go into a mental health service, even though theirs is a substance usage problem, because their presentation has a mental health flavour they end up with a mental health diagnosis. That creates more problems.

Ms COLBY: Sometimes it means more services. If there is a mental health diagnosis such as schizo-effective or bipolar disorder, it means they can access good facilities and usually get a bed in a reasonable time. However, it is quite unpopular to be diagnosed with chronic alcoholism.

The Hon. IAN WEST: So the 30-year-old woman was better off with a bipolar diagnosis.

Ms COLBY: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would be a major step forward if all the Inebriates Act subjects came under the mental health model, because there would be a different mindset and more resources.

Ms COLBY: I know it is under review. However, much of the framework is working and many parallels could work with a new and improved version of the Inebriates Act.

CHAIR: We should make it clear that when we talk about the mental health model there are two aspects. One is the question of whether people whose fundamental issue is alcohol abuse should go into a mental health service. The other involves mental health legislation as a model with safeguards and tribunals. Obviously they can be quite separate. The question is whether the people we are talking about get the right kind of treatment if they are in a mental health service. Do they muck up the treatment for everyone else because of their condition? Do they create huge problems for other people seeking treatment?

Ms BURTON: I would probably be in favour of the legislation in terms of the safeguards, but I also would like the option of using the Confused and Disturbed Elderly [CADE] Program, if that is available, and I am not quite sure whether we need to think outside that box. You are right: There is a difference between a mental health person and a substance use person sharing the same space. There are no two ways about that.

CHAIR: Whereas are you suggesting, Toni, that the mental health service is an appropriate service?

Ms COLBY: I think it has been the most appropriate service that we have had up to date but I certainly think that there is room for improvement. I mean, I tend to think a confused and elderly unit or a similar unit would be quite appropriate. We have this traditional historical problem that nobody wants these people. We have an inebriate who is not really appropriate for mental health, we all know that, due to their frontal lobe impairment, they are annoying to psychotic people and there is aggression, et cetera. We know that. That is a fact. We want to send them to detoxification and to rehabilitation and, guess what, rehabilitation units do not like people who have motivation problems. These people do not want to be there. All their clientele are motivated to change. They do not want

them. So we have a really big issue, which is where we are we going to put these people. Where do they belong? That is the really hard question today. I do not think the question is whether we can come up with a culturally appropriate, easy to use new order or a new Act. The harder question and the more extensive question for you is: Where are you going to put these people?

The Hon. IAN WEST: Can you explain a bit further for us the difficulty of the mixing together with the substance abusers?

Ms BURTON: I think Toni has just mentioned it. If you have got somebody who is psychotic and who has had that frontal lobe damage, they are argumentative, they are very quick to be irritated, they are annoying people who have a mental illness and who are a bit more, shall I say, sedate in some ways. The other thing have got to look at is protecting other people as well in terms of bringing in drugs, to be quite honest.

The Hon. IAN WEST: They are described as manipulative, or are both of them?

Ms BURTON: Yes. Both of them can be manipulative; it just depends. It is a life skill, is it not—

The Hon. IAN WEST: A matter of survival, yes.

Ms BURTON: —"I have to have this substance."

Ms COLBY: If we are talking about confused adults—it usually is an adult we are talking about here—and if I am confused and you stick me in a unit with psychotic people who are talking to Jesus and Madonna that is not really going to help my mental state.

The Hon. IAN WEST: Are you suggesting that we should put them out in the desert?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What are you suggesting we do?

Ms COLBY: They are not suitable for a mental health unit where we have floridly psychotic patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I am not saying that the two should go together. We have had so much evidence about the dual diagnosis people and when you talk to the disabled, the incidence of mental disability and mental illness are two separate things, but they have a much bigger overlap than they do in non-mentally disabled people. I think it is 30 per cent, which is a relatively high number, that have dual problems. In drugs and alcohol, what are the percentages of the purely mentally ill, purely drug and alcohol [D&A] and the gap in the middle? Can you give us an idea of the percentages? Can you do that?

Ms BURTON: It is very difficult.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are going to set up two systems, you need to know how big each system is and how difficult the cases in the middle are going to be for the others to try to bridge the gap.

Ms BURTON: You have got to be very careful there of boxing that in too much. The rule of thumb that I always work on is that when anybody has a chronic substance issue, they are going to end up with mental health problems. A person that has a diagnosis of a mental health problem does not necessarily end up with a substance abuse problem, so your substance use problem is going to go towards mental ill health somewhere along the line. Now that might come from the drug itself, that might come from the chronic usage of drugs and it might come from a mixture of drugs, but somewhere along the line they are going to go there. When you are talking about dual diagnosis people, somewhere along the line that person, who might have started off as purely substance use, could end up in a dual diagnosis basket purely because of the fact that they have mental health problems. If they have got mental health problems which are seen and the community is looking at that challenging behaviour, and they are going to end up in a mental health facility. They are going to end up with a mental health diagnosis, so that is going to reinforce the dual diagnosis.

CHAIR: Arthur's question is that if Toni says these people should not be with those people—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many beds do we put in each house, you know?

CHAIR: —and let us say that the resources are there and all the rest of it and we can set up two systems, what do we do with this group, however large or small it is, that is essentially suffering from both problems?

Dr KAMERMAN: Your newly scheduled inebriate under your new model, these people will need a period of detoxification first. Putting them into a mental health facility is probably not going to be really safe for them, hence you would need to put them into a specialist detoxification unit with access to acute medical services. I presume at the end of that time there will be a reassessment at some stage and they will then go to another unit—a compulsory community treatment option or a compulsory residential option, and that is probably the unit that we need to think about—what type of unit that could be and whether that could overlap with a mental health facility or a CADE facility, or whether we need to invent another type. I do not know.

CHAIR: We do not know.

Dr KAMERMAN: But there needs to be a two-stage facility, one to get them actually detoxified and then a long-term solution.

CHAIR: And that needs to be out of the mental health area?

Dr KAMERMAN: Yes, certainly, or it would be really dangerous.

CHAIR: Could it be a general hospital? For instance, we went to the Royal North Shore hospital where the old nurses quarters function as a detoxification unit.

Ms COLBY: Absolutely—like a satellite unit, which a lot of mental health facilities now are. I mean, we cannot answer that question because we have a group of clients with very specific problems which do not really fit into any category. We do not have an answer for you.

The Hon. KAYEE GRIFFIN: One of the issues that you spoke about originally was the fact that, even after detoxification, whether or not that person actually gets to that next stage. That seems to be one that is missing or in lots of cases is missing because the person does not get to be assessed in terms of the alcohol damage and whether it has caused long term or permanent damage and where that person might go next. That is one of the issues you spoke about originally.

Ms COLBY: We have detoxification and we have an assessment stage because we want them to have some neurological-psychological testing so that we know what we are actually dealing with here, and then we can start to think, okay, where is the most appropriate place for this person. Maybe underlying that there is mental illness. A lot of people self-medicate with alcohol. There is no doubt about it. Maybe we do then send them to mental health, but we need a facility to allow us to assess this person to see where we put this person and what do we do with this person, and what is the most appropriate way to care for them.

The Hon. KAYEE GRIFFIN: That centre part is missing in lots of cases because the person might go through a detoxification program but not be around for another stage.

Ms COLBY: So that person has gone from detoxification straight to rehabilitation and have not been tested and no-one else knows what is going on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you want to do a detoxification assessment and rehabilitation, if they have not got frontal lobe impairment.

Ms COLBY: Possibly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably if they have got frontal lobe impairment, you want to support, and then of course support becomes the Confused and Disturbed Elderly [CADE] Program, or is it home support because institutionalisation under the Richmond report said it is cheaper and better to keep them out. I suppose I always think of keeping them out as feeding them and giving them thiamine, basically, and after that you do your best with accommodations.

CHAIR: Ian mentioned community treatment orders which is one thing that people obviously are exploring. I do not know whether you think that would work, instead of being in an institution. The other issue that I think we should address at some stage is that in this area with those two rehabilitation units, we have not talked about how successful they are with this group of people. What happens when people come out of them? Do they then fall into a big black hole or is there an effective community treatment or follow-up? Certainly if that does not work, the whole notion of effective community treatment that Arthur is talking about is not going to work either.

Ms HUNT: The rehabilitation unit that has been used in Armidale basically runs after-care support. They have some units. When people leave rehabilitation, if they choose, they go into these units and then they get assistance as an outpatient type of thing. Certainly from what they report, their success rates are quite high and they pull them in, too, because they have got a very AA focus. They are run by St Vincent De Paul, so their success rate is fine. Roy Thorne House tends to be mainly an Aboriginal rehabilitation unit here in Moree, but I am not sure. Usually people stay there longer. At Freeman House they stay there for three months. Here they stay anything up to 12 months.

Ms PECKHAM: No, only three months.

Ms HUNT: Three months, is it?

Ms PECKHAM: Yes.

Ms HUNT: Then, just looking at the difference in them where there is a structured support system, in after care, certainly they report that their people do better.

CHAIR: Of course the big issue for rural areas I guess, with these smaller and more scattered populations, is that a series of services that you can imagine working around the Royal North Shore Hospital may just be out of the question in an area like yours.

Ms HUNT: I think that we have got to—or certainly what we have tried to do—is work with other services. I think there has to be a mix and there has to be integration of services, whether they are non-government organisations [NGOs] or government. We certainly have to work together. I guess that is something that I would like to see come out of this—that there has to be no one person providing the answers. We have to work together. We have to have integrated services.

The Hon. IAN WEST: What role should the GP have in that integrated service?

Ms HUNT: A big role.

Dr KAMERMAN: I would have thought it would have to be a fairly central role because we are looking after all their other problems, as well as their drug and alcohol problem, apart from the simple things such as writing the scripts and making sure, hopefully, that they do not fall through the cracks.

The Hon. IAN WEST: Would you see that the GP would have a role in possibly being able, if there was some compulsory treatment, keep a handle on that person? If the incarceration, if you like, is not necessarily on the basis of bricks and mortar but on the basis of a combination of a period of control by yourself as to their mobility, where they are going to, is that too much of a role for a GP to be involved in?

Dr KAMERMAN: I do not think so because we are not talking about large numbers of people and ensuring that people maintain abstinence, ensuring that they are getting a supply of their

medication, and ensuring they are maintaining their nourishment. Those things are certainly quite within the realms of general practice.

CHAIR: How often would you have to see someone to be fairly confident that things are working?

Dr KAMERMAN: It depends on how large your community is and how well people confide in you, I presume. But thinking about other sorts of models, people who have come from psychiatric care, at a minimum you would look at them weekly if not twice weekly early on, and of course that time spreads out. But I would think that as part of a defined community treatment program, it will be cast in stone: thou shalt see your treating practitioner X number of times a week. So the choice, I would have thought would probably be within the Act or within some sort of judicial order.

The Hon. IAN WEST: So you would have a proclaimed doctor as opposed to a proclaimed place?

Dr KAMERMAN: Yes.

CHAIR: Would GPs in general be happy with that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a good question.

CHAIR: You may have noticed we also have a doctor in our midst.

Dr KAMERMAN: Yes, I realise this. I guess my feeling about this is that I think that if each GP looked after all their own patients' drug and alcohol problems, it probably would put a lot of us out of business. Some people tend to attract a clientele in. If you are interested in drug and alcohol, you tend to get those patients in, which tends to mean that at some stage you often get burnt out due to a particular presentation or whatever. We are talking about small numbers of clients really, and I would have thought that most GPs, provided that the paperwork and the red tape was not too onerous and provided that it was adequately remunerated—

CHAIR: There were several nods and noises when you made the comment that perhaps if GPs looked after people in the first place, they may not end up needing more severe services. I think that is one of our questions. Several people have made the point that if we had, through the community, a comprehensive series of services, maybe we would actually stop people getting to the point of needing the kind of treatment we were talking about earlier.

Dr KAMERMAN: The example I would have used would have been methadone prescribing. I do not believe that I should have to go to a particular clinic to prescribe methadone. That is a simple enough medication to be trained in its use. I think it should be standard general practice to do the training and to look after your own patients. Each GP would probably have one, two, three or no patients.

The Hon. IAN WEST: It would be helpful in overcoming the tyranny of distance, regional issues and also issues relating to the economy. If you had a proclaimed place somebody could go there for a short period and still keep in contact with his or her environment and family.

Dr KAMERMAN: The other issue is that you would also have to resource some sort of health worker to visit these people, and to do it safely. As I said earlier, a lot of them are in isolated communities.

Ms HUNT: We are talking about resources, which is an issue. You can throw money at places and rural areas, but getting staff is sometimes really difficult. So it might not be a matter of funding; it is bigger than funding. You might have the money but you cannot get staff. There are also the issues of training and maintaining staff.

CHAIR: Louise, I refer you to question No. 10. We have been told that many of the people who have been placed under inebriate orders are Aboriginal people. Do you think that the issues we

have been discussing are similar for Aboriginal people? How would the system work and how would it treat Aboriginal people?

Ms PECKHAM: The answer to the first part of that question is that I have absolutely no idea.

CHAIR: It is very hard to get or to attempt to get statistics about inebriate orders. The Chief Magistrate gave us some, but he mentioned that they were incomplete. Not all courts have been hooked into the central database, so that is a problem. But people certainly seem to agree that a higher number of Aboriginal people are under inebriate orders.

Ms PECKHAM: I did not realise that. I will have to look into that.

CHAIR: What do you think? Are the issues similar or different—all the issues that we have been talking about, such as treatment, compulsion and the kind of system that should be set up that would be culturally appropriate?

Ms PECKHAM: It is basically the same across the board for anyone who has an alcohol issue. If it is to be culturally appropriate there needs to be family involvement. You have to mediate with the person and give the family an understanding of what is contained in the Act. I see no problem with that. People who are not able to do things for themselves need help.

CHAIR: Would Aboriginal people be better off with specific Aboriginal services? Again, we have to bear in mind the population the centres that we are talking about.

Ms PECKHAM: We also have to bear in mind the people who would be trained in these areas to help them. You would not get too many Aboriginal people who are trained in these areas.

CHAIR: So you need one network of services as long as it is sensitively run for Aboriginal people and families?

Ms PECKHAM: As long as there is something in place for Aboriginal clientele.

Ms HUNT: I guess it would be similar to what we have done with positions like yours—having a community liaison and front-line community worker who can provide feedback to other mainstream services.

CHAIR: So someone in a position like yours, Louise? Your label is not specifically about alcohol and drugs, is it? It is a more general one.

Ms PECKHAM: I go beyond that.

CHAIR: But that is also part of it. We have to make sure that there are people with jobs like Louise who can deal with people and resolve a number of issues that might be affecting them.

Ms PECKHAM: Yes. I not only provide education for Aboriginal people; I provide services across the board. I am very flexible; I slot into a lot areas.

CHAIR: Looking at the questions that we have not touched on at all, we have mentioned other drugs on several occasions. Although people do tend to forget the Inebriates Act it covers all drugs and not just alcohol. Do you think the issues that we have talked about as being possible future legislation are the same or are they different for people across the board?

Ms BURTON: I think they are pretty much the same. However, there is one group of young people that probably need to be addressed a little differently. Last year one issue came to my attention as a result of the work of the community drug action teams. We had representations from a couple of Aboriginal elders. They expressed grave concerns about the youth in their community. When I refer to "youth" I am talking about children aged eight, nine and 10. At that time the drug that they were most concerned about was cannabis. They were grappling with what they could do in relation to the youth getting off track and getting involved.

Of course, they also expressed concern that the parents of some of these youth were encouraging them to smoke dope rather than drink alcohol because of the parents' past experiences with alcohol. Maybe their parents had alcohol in the home, so there was the violence and everything else. They might have had cannabis when they were young adults so they preferred their children to have cannabis to alcohol. So the children were getting this mixed message. Of course, it is very difficult to say, "Yes, we have something in place that can help all people."

That relates very much to a family perspective. You are talking about very young people. But you are also talking about very young people who are being influenced by a substance that could lead them into committing crime at a very young age. So we have this challenge: How do we help this community group? How can it be helped from within? How can it be helped in protecting young people? What is the role of families? That is a challenge.

Ms PECKHAM: People are aware of how much goes into the communities. They are aware of particular people within those communities—the dealers or whatever. They need to get together as a community and speak out and say something about it because everyone realises that it is happening.

CHAIR: It is a growing problem.

Ms PECKHAM: A lot more people need to speak out about it and start naming people. They have to do that if they want the problem to stop.

CHAIR: There is one last thing that we have not talked about at all. You just mentioned offenders. The Act applies to offenders and to non-offenders. We have not received nearly as much evidence about that because I think most people assume that, if someone is already part of the criminal justice system, the issues of compulsion, treatment and detoxification become a lot simpler. That may not necessarily be the case. Toni, we particularly wanted to ask you about the MERIT program and the plans to extend the MERIT program to include alcohol. Do you have any comments relating specifically to offenders rather than to the people we have been talking about so far?

Ms COLBY: There has been a bit of a flavour today. We talked about abstinence as being the only model. I do not think anyone has mentioned reduction or harm minimisation. When we started MERIT over 12 months ago we set our standards really high. We thought that, if we were to break the drug crime cycle, they had to stop using drugs. It was pretty clear very quickly that that was not going to occur. Somebody who was using \$200 worth of cannabis a day might have ended up using \$10 worth of cannabis a day after being on the MERIT program and probably was no longer breaking into my house to steal my money to pay for those drugs. One of the quick lessons that we learned was that we have to be really careful. I have heard that word abstinence, many times and it really scares me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Total abstinence?

Ms COLBY: Yes, because that is not achievable for a lot of people. A lot of people do not want it. If we promote it a lot of clients will not come near us. They do not want to know about it. I digress for one second. A health worker either in Broken Hill or out that way is trying to run some groups to get a lot of indigenous young people off volatile gases. None of them were really interested. Instead she ended up running a group. My memory is hazy, but the group was on the safe use of volatile gases. We all know, of course, that there is no such thing. However, the invitation was given to them and those young Aboriginal boys then decided that it sounded pretty cool and that they would attend the group. After a few sessions some of them came up to her afterwards and said, "Hey, Miss, I was thinking about giving up. Can you tell me a bit about it?" We have to be really careful about the invitation that we give our clients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did she receive a lot of criticism for that?

Ms COLBY: She did, but she got bums on seats. I will not criticise that at all. The other thing about MERIT that I find quite extraordinary is that people say they are voluntary. But when they walk in the door they are not voluntary. They sit there and they do not want to be there, but they will

be there. Most of them believe that they either have to go to gaol or they have to go to MERIT. Gaol is not the choice for most reasonable people, so MERIT is not voluntary. It is very rigid. There is no doubt that the compulsion is in the bail conditions. The extraordinary thing that has happened with MERIT is that when they come they are really cranky but, as a result of the process of therapeutic engagement—and because it is quite paradoxical that we are very rigid but we are also flexible within the MERIT context in the community—by about week five or six a lot of them are smiling when they walk through the door. They forget that they have to be there, which is quite extraordinary.

The unique thing about this criminal diversion program is that it is community based. Most of the previous programs and the ones from America that have been centred in correctional centres are similar to rehabilitation. In a rehabilitation service or in a correctional centre you do not deal with real life stresses. You never get to practice what you preach. The beauty of MERIT is that because it is community based we are dealing with real life issues. Yes, these people do relapse, but we also teach them how to deal with relapses and how to get back on track. We cannot do that in rehabilitation because of that artificial cocooned environment and so forth.

What I am trying to say is that I would really push for some form of compulsion in a community treatment order. There has to be a community treatment order. Up until today the treatment centres and the community staff have not been accountable for what they have done with people under an inebriates order. If we have some form of compulsion and we have a treatment order we must make treating staff accountable for what they are doing for those who are losing their civil liberties. I believe that MERIT does that very nicely. Throughout the three-month period we are accountable on a regular basis to the magistrate. We are accountable for the changes.

The Hon. IAN WEST: They are not losing their civil liberties; they are actually gaining some.

Ms COLBY: Yes, that is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have longitudinal data that shows just how effective MERIT is in your area?

Ms COLBY: No. It is very young. I think Lismore has been going two to three years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have the programs in place so you would be able to obtain that data?

Ms PECKHAM: We have a database in place.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are trying to get people out of gaol.

Ms COLBY: We have a flagging system to establish whether people reoffend so we can see what is happening.

CHAIR: The Lismore evaluation of MERIT was circulated a couple of weeks ago. That was the first evaluation because the program is relatively new. You are saying it is relevant to designing systems for non-offenders. As you say, rehabilitation is like gaol. We talked earlier about rehabilitation facilities in this area and how successful they are. You are also supporting the use of community treatment orders.

Ms COLBY: There has to be that option, particularly for non-offenders. They deserve a chance to do community-based programs rather than being stuck immediately into a residential facility, which would be terrifying for anyone who does not want to be there. There is a big option that the Act has not had for some form of compulsion guided through a local governing body, such as the local magistrate. It should not be a visiting service. The Committee has talked about the Guardianship Board and it has looked at the Mental Health Act 1990 and the good features that may be useful. However, we feel strongly that the governing body must be local. Teleconferencing is not adequate for such an invasion of people's rights.

CHAIR: Have you had much experience of using teleconferencing and the Mental Health Act?

Ms COLBY: Yes.

CHAIR: Do you all agree that there are problems using it over long distances?

Ms COLBY: It is certainly not personal. The other feature is that if it is not a local community member we are less likely to ring up and say, "Why did you say that?", or "What went on here?" We lose that contact and grounding in local community issues.

The Hon. IAN WEST: Would it not allow the local community to have more influence over an individual if teleconferencing were used in an appropriate way, like bail orders and so on? I believe that video conferencing has a valuable role to play, even though I appreciate its weaknesses. Do you think it could help in overseeing the local role?

Ms COLBY: MERIT is only as good as the magistrate who uses it. The program has become very flexible and adaptable because the magistrate at Tamworth is a local and is aware of community issues. I know what you are saying, but I strongly believe that the governing body should be local.

Ms HUNT: That magistrate might cover surrounding areas. There is certainly a role for telehealth in that. We still have the local person but we are limiting the distance.

CHAIR: We have not asked our favourite question, but I think we have gained a sense of what you might like to see. Is there anything you really wanted to say that you have not said and that you must say?

Ms HUNT: Whatever comes out of this must be user friendly and easy for families, staff and a range of people who will use it to work their way through. It must also be flexible.

Ms BURTON: And it must stay within the drug and alcohol services framework.

CHAIR: Rather than, as some people have suggested, become part of mental health?

Dr KAMERMAN: Please evaluate it.

CHAIR: After however long it has been in place. Thank you very much for appearing.

(The witnesses withdrew)

(Luncheon adjournment)

CHAIR: I will begin by thanking everyone for a very nice barbecue lunch, especially the cook. We do not travel around as often as we should, and we certainly do not often have a nice lunch provided. As I guess you all know, we are doing an inquiry into the Inebriates Act, which is a very old Act—over 100 years old—and obviously very out of date. So we are talking mostly about people with really severe alcohol problems, but obviously some of the issues that relate to people with severe alcohol problems also relate to how they got that way and the range of services that exist. Sometimes it is hard to stick to just to one thing. Basically we are going to chat. We do not have particular questions, but Val has seen our headings and she had shown them to other people.

Ms VAL DAHLSTROM: Yes.

CHAIR: I particularly thank Val for organising so much of this and for giving Merrin so much information as we prepared to come here. Because there are a lot of us and because we are in the open air, it makes it a bit harder for *Hansard*. The evidence is being reported so that when we go back to Sydney and we want to recall in two or three weeks time or perhaps later, we will be able to remember what was said because we will have a record and we will be able to quote people. We will try to be as informal as possible, but please identify yourselves before you speak. Does anyone want to ask questions before we begin?

Mr FAULKNER MUNROE: Do the courts or the justice system still recognise the Act?

CHAIR: Yes. It is still in operation. In fact tomorrow we are going to Orange and we are going to the Bloomfield Hospital. Currently there are people at the Bloomfield Hospital who are under an order pursuant to the Inebriates Act. There are not very many. I think last year there were 20 and before there were about a dozen, but the statistics are not complete on that. It certainly still exists, even though it is very old. Are there any questions about procedure? You will know the best person to discuss certain areas, so we will basically just begin. The first heading concerns current issues about alcohol and other drugs because the Act deals with all drugs. We are interested in hearing your views about the extent of alcohol and other drug problems in Moree and all the towns around it and the main issues about alcohol and drugs bring up issues in the family and the need for services and so on, and the kind of services that there are in Moree and surrounding areas and whether there is enough of them, and what you think would help you as a community, particularly the Aboriginal community, to address these problems. If that is not enough to keep us going for two or three hours, I do not know what is. I will ask Val to begin.

Ms VAL DAHLSTROM: There are just a couple of things I have noticed over the years—not so much noticed, but things that have been identified over the years—as being needed, specifically in terms of alcohol services. First off, unfortunately we do not have anyone here from Roy Thorne House. I am not sure where Brian is at the moment. Even though Thorne House provides services for both males and females, I do not think there are enough services and enough accommodation to meet the extent of the problem. I think we need two separate units. It is not functioning the way rehabilitation services should because it is just one building and there is basically no dividing line between them. There are a lot of other issues that really should not be coming up, and they would not be coming up if there were two separate services.

Going on from that, I think that the other thing that is needed is a place so that you can finish at Thorne House after being there for three months, and then you have a halfway house before people go back into the community. I know they are old fashioned concepts that have been around for the past 20 or 30 years, but I have found that health services, to make a difference, have to go back to very basic services. We just have not made enough changes in the life expectancy levels and quality of life of Aboriginal people in particular with the way the services have been going. We need to go back to looking at basics. Places like Thorne House need to have separate accommodation for males and females, we need a halfway house, and we need people employed in the halfway house to help people integrate back into their communities. There just does not seem to be that type of thing available.

Going on from those kinds of things, the other issue that I have always been concerned about is the lack of community based or community controlled or community volunteer services for people: not exactly Alcoholics Anonymous [AA], but a community support network for families and for people who do want to get off alcohol, I guess, in particular. I do not really have a lot of experience with the drug side of it but I certainly have a lot of experience with the alcohol side. I just think we need to start looking at some community programs that build, say, up at Stanley, Mehi Crescent and Toomelah, where there is a defined Aboriginal community or there is a support network in the sense of the community: not just an AA program, but more of an Aboriginal support group. That is not to say that I do not support AA, which is a wonderful centre, but we need to look I think a bit further from that. From there you need hospital services. We really need to have more services that will provide a place for you, where you can dry out and where you have got some people there to help to look after you and get you through that trying time.

CHAIR: That is, a specialised detoxification unit as part of a hospital?

Ms VAL DAHLSTROM: The trouble with having it as part of the hospital system is that, unless it has changed drastically, we used to have one bed over there for detoxification and we did not have specialist nurses or anything who would be providing services for that person when they were in there. It was just a bed. I do not know whether it was kept empty specifically for that or whether it was used when it was empty, but we do not provide specialist detoxification services. I think at one stage they were looking at Thorne House providing those kinds of detoxification services, but the services which we do provide just are not enough. They just are not enough for the community.

Mr FAULKNER MUNROE: I just want to say that I agree with Val. We need detoxification services here in Moree, especially for Aboriginal people. Aboriginal people do not want to go away for detoxification. They want detoxification here, in their own home town. There are a lot of Aboriginal people here in Moree who do want to get off the grog but because there is no detoxification centre here, they cannot. They cannot access that facility. In the area of detoxification, I think that Moree is really, really lacking. The nearest detoxification centre to Moree a few years ago was Wallsend at Newcastle. We have taken a few of the Aboriginal people who did need detoxification down there, but it was really hard for them because they were so far away from home. There is a big gap here in Moree.

CHAIR: When you say local, are people from Toomelah or Boggabilla happy to come into Moree, do you think? Is Moree local enough?

Mr FAULKNER MUNROE: Basically, the way I see it, yes. Moree is part of Toomelah, and Toomelah is part of Moree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I just have a question about Thorne House. When you say there needs to be separate accommodation, male and female, it is needed for drugs and alcohol though—you have not got mental health in there as well?

Ms VAL DAHLSTROM: No, just the alcohol. It has not got mental health. It is just drug and alcohol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you need them to be separate?

Ms VAL DAHLSTROM: Yes, we do, and it actually needs to be a lot bigger than it is at the moment: but separate services and separate accommodation for both, yes.

CHAIR: How many beds does Thorne House have?

Ms VAL DAHLSTROM: I am not too sure.

Mr RICHARD SWAN: Thorne House has 12, eight for men and four for women.

Ms VAL DAHLSTROM: Unless the clientele at Thorne House has changed, we used to get a lot of out of town people into there. I think that one of the biggest problems we have with drug and alcohol and rehabilitation services is that the emphasis has gone away from going in there because you want to get sober to going in because the courts have said you have to because you have got to go and do a month or so, to get out of, you know, corrections or whatever.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Magistrates Early Referral into Treatment Program [MERIT] has taken it over.

Ms VAL DAHLSTROM: That is right. The problem with this is that you do not have committed people—people who are committed to getting sober. They do not stay for the three months, and that is the bureaucrats side of it. The figures that go back to the Aboriginal Health Information Strategy [AHIS] pale completely because you are just not getting the people who are committed to getting sober going through the program and staying sober for a set amount of time after that. They are only doing it because the courts have said that they have got to, so where is the commitment in that?

CHAIR: A lot of the evidence we heard this morning from the medical profession and the Aboriginal health service representatives referred to the importance of people choosing.

Ms VAL DAHLSTROM: That is right.

CHAIR: If you want to get off it, you have to make that decision yourself.

Ms VAL DAHLSTROM: Yes. Thorne House used to be called the Moree Aboriginal Sobriety House Corporation [MASHC]. One of the reasons that it eventually was liquidated and the

new organisation set up and put in its place was that suddenly the number of court referrals increased out of all proportion and the then administrator who was down there, John Kirk, really had a big problem with that because again that commitment was lost.

People just were not interested. So if you get someone referred from the courts and they go down for three weeks, what does that do to your statistics for three weeks? What does it do to the person who has gone in for three weeks? He has done the time the court has said he had to do, he has gone out and he is back on the grog.

Mr FAULKNER MUNROE: I agree with Val again. Magistrates think that MERIT means "magistrates early reinforcement into treatment", more so than early referral. That is what the MERIT program refers to. People who do go into the rehabilitation centres from the courthouse have an effect on the people who are there who genuinely want to sober up. They cannot. They find it very hard because of the people who are coming from the courts to the rehabilitation centres.

CHAIR: Part of the idea of MERIT is that people must want to get off the drugs or whatever it is. The magistrate does not send everyone into a MERIT program.

Mr FAULKNER MUNROE: No, that is right.

CHAIR: It is meant to be for people who really want to do it, but it does not work that way.

Mr FAULKNER MUNROE: That is exactly right. Which course would you take? You have to decide which way you want to go. If you were asked, "Do you want to go off drugs? You can do a three-month course at MASH or go to gaol", I would do that course.

CHAIR: Rather than go to gaol?

Ms VAL DAHLSTROM: So you go down there and get a report written after three weeks.

The Hon. IAN WEST: So you are suggesting that MERIT is not tough enough?

Ms VAL DAHLSTROM: In my opinion they should not be taking court referrals unless there is a guarantee that they want to get sober, or that they are committed to getting sober. This going in because it is going to save them from going to gaol just does not work. It is a waste of the system. I think it is an abuse of the system. It should not be allowed. It should not be supported by the magistrates.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is displacing people who are seeking treatment. It is queue jumping.

Ms VAL DAHLSTROM: That is right.

Mr RICHARD SWAN: It is jumping the queue. If someone wants to go to get help he cannot get it because he has to go from the court referrals. There are more court referrals than there are for alcohol.

CHAIR: Do any of you know people who have been to Thorne House for three months or whatever? Has it been a success? Do you think it works? Is it a good service?

Mr RICHARD SWAN: I used to work down there in MASH. It was not bad then.

Ms VAL DAHLSTROM: We all have relatives who have been there.

Ms JANE ADAMS: I was just wondering. You are talking about people that go down to MASH if they have been to the courthouse. Are they all Department of Community Services people, or are we talking about juveniles as well? I know that there are a lot of young people in town who have alcohol and drug problems. That is where the crime factor comes in for a lot of these kids. Are we just talking about adults?

CHAIR: Yes we are. MERIT is just for adults.

Ms JANE ADAMS: I think it is a waste of time with some of the adults. We should start focusing on our young people because they are the next generation. While ever they have drug and alcohol problems it will never go away.

CHAIR: What would be a good way of dealing with these young people?

Ms JANE ADAMS: I think we should have more educational programs for our young kids within the school system. We should have meetings and what have you for our youth because the kids in town as well as in Inverell are just running amok because of alcohol and drugs. They are getting themselves caught up in the justice system.

CHAIR: What sort of age group are you talking about?

Ms JANE ADAMS: I am talking about kids as young as 12 and maybe even younger. That is pretty sad because the cycle will never be broken.

Ms LEONA QUINNELL: Mine was focusing on adults.

CHAIR: That is okay. We can come backs to kids.

Ms LEONA QUINNELL: One of my concerns relates to the drug problems. I am from Inverell. As Jane just said, we have a large number of young offenders coming through as a result of drugs. A couple of things that we really do need is a support mechanism put into place for these kids. We also need counsellors who understand Aboriginal people, their needs and that sort of thing. We just do not have any mental health counsellors who are trained, for example, Aboriginal counsellors. There is real fall down in the support that is provided for our youth.

We have actually set up a bail house at Inverell. One of the things that I am concerned with is that the courts are not actually sending these kids, these first offenders. They are mainly sending them to Acmena. In order to give them a chance not to re-offend, places like these bail houses are being set up. It would be more supportive if the judges or whoever it is who is sentencing them uses these places first before they go to the detention centres at Acmena. If a lot of these kids had had that support in the first place maybe they would not have got to the point where they ended up being in the court system.

Ms JANE ADAMS: The other thing is that in Inverell at the moment we have an alcohol employee who only goes to Inverell five hours a week.

CHAIR: What do they do when they get there?

Ms JANE ADAMS: That is pretty poor, is it not?

CHAIR: What do they do with their five hours?

Ms JANE ADAMS: I have no idea. I do not go there. I do not consider myself an alcoholic. How would I know what she does?

Ms LEONA QUINNELL: Where does she come from, Jane?

Ms JANE ADAMS: How would I know? I do not know.

Ms DIANNE TIGHE: There are two women.

Mr RICHARD SWAN: I have got two. I have got Jane. She goes in on Tuesdays to see probation and parole and then she visits the hospital to see if anyone in the hospital has come in. The same thing happens with Mary. She does the same. I go to town on Thursdays to the community development education projects [CDEPs] and to Jellicoe Park and I have a yarn with the boys and I

talk to them about the problem. That is about it. I want to get to the bail house. I cannot get out there. I get lost.

Ms VAL DAHLSTROM: Two months to three months ago the drug and alcohol services that were provided through the health system were changed. We were not happy with it and we kicked up a fuss. I am talking about Aboriginal health. At the time we kicked up a fuss about it but we were not really given any choice about how the services were extracted. Richard actually goes up there. I object to the amount of travelling that Richard has to do. Basically I object to the amount of driving that is involved.

CHAIR: Can you explain to us briefly what changes were made to the system?

Ms VAL DAHLSTROM: Richard might have to clarify it for you. Richard was actually going to Toomelah, Mungindi and Boggabilla. So his services were here and out there. Then suddenly he started to go to Inverell and Tingha and he was told not to go to Toomelah and Boggabilla.

Mr RICHARD SWAN: I go to Inverell on Tuesdays or Tingha on Thursdays.

CHAIR: Has someone else replaced Richard in those towns?

Mr RICHARD SWAN: Not that I know of. I think only the two girls from mental health.

Ms VAL DAHLSTROM: When we did the service plan for Tingha not very long ago I suggested to the area health service that we should try to get a partnership with the CDEP at Tingha. As you probably know, the Aboriginal and Torres Strait Islander Commission [ATSIC] actually had 1,000 participant places nationally specifically to work in Aboriginal communities in the areas of violence, domestic violence and those kinds of things. Only one town took up that offer. I have asked ATSIC to send the information to me and I will approach the CDEP at Tingha and the CDEP at Toomelah and try to get participants from those two areas under that specific funding to do the training and to provide services there. It is a good option, but I feel that we should have more employees in the health system in those towns. We should not have to travel 180 kilometres one way on the same day. It is ridiculous.

CHAIR: Was this change in health services made essentially to save money?

Ms VAL DAHLSTROM: I do not think so. What happened up there to the drug and alcohol services?

Ms LEONA QUINNELL: Because of funding they could not put anybody else on. That is when they decided to combine the services at Moree.

CHAIR: Is it hard in this area to get trained and qualified people to do the job? Is that part of the problem?

Ms LEONA QUINNELL: It is part of the problem. The other thing is that there is no support for those people either when they come into the unit. Because there are not very many positions throughout the region they do not have any support mechanism, so they burn out as well. That becomes a major problem with the whole position. They do not pay terribly well.

CHAIR: Does that mean that a lot of drug and alcohol workers do not stay very long?

Ms LEONA QUINNELL: That is right.

CHAIR: So you get a big turnover?

Ms LEONA QUINNELL: There is a very big turnover. It is the same with mental health counsellors. They have a big turnover in that area as well.

Ms VAL DAHLSTROM: We were talking earlier about community support networks. Talk about showing your age! About 20 years ago in the Australian Capital Territory there was a program

called CAPAD—the Community Action Plan Against Drugs. I think alcohol was sort of in there. That was a community support network that received no funding or anything along those lines, but it actually built a support network for people who were having problems with drugs or alcohol. It was very successful. If we are going to make any changes in small towns in particular we will never be able to provide the services. There is just not the amount of money, the resources and those kinds of things. So we have to start looking at building up a support network in those towns. Leona is quite right. Richard is lucky. I reckon Richard is lucky because he has all of us to support him. We are always here to argue the point with him. But other people are not that lucky. They are on their own.

CHAIR: Do any of you know anyone who has been placed under an inebriates order under the Inebriates Act? Has anyone any experience in this area, or has anyone tried to do that?

Mr FAULKNER MUNROE: Yes, we have. I cannot say who was the person that we knew. What do you want to know?

CHAIR: Because the Act is not used very much—and we talked earlier about the figures—this Committee has been asked to give its judgment on whether the Act should be thrown out, or whether it should be replaced by something else. One of the things that we are trying to collect is evidence. A lot of people say we need an Act to deal with the most severe alcohol dependence, but people have a lot of criticisms about the way in which this Act works. So we are really keen to hear from anyone who has had experience with it.

Mr FAULKNER MUNROE: The experience we have had is with people who have drunk themselves to the point where they cannot manage themselves, their affairs or their money. We have placed people under the Act because we saw them being robbed without their knowledge—people would go to the bank and take their money—and they had to be picked up every night in an inebriated state in a park and brought to a refuge. I was working with the proclaimed police. We saw a lot of cases where we tried to put people under the Act, and we did.

CHAIR: Where were they sent?

Mr FAULKNER MUNROE: Morisset, Mortdale and Roselle.

CHAIR: And Macquarie Hospital.

Mr FAULKNER MUNROE: Yes.

CHAIR: How long is it since someone was sent?

Mr FAULKNER MUNROE: Eight or nine years.

CHAIR: Have you not used it recently?

Mr FAULKNER MUNROE: No.

CHAIR: Why?

Mr FAULKNER MUNROE: We have not seen the need to do so, and that is a really good thing. I hope it stays like that. I do not know about anyone else, but I do not know of anyone in town who would need to be put under an order.

CHAIR: Is that because it is used for the most severe cases?

Mr FAULKNER MUNROE: Yes.

CHAIR: Mr McLaughlan, have you had to cope with the issue of someone who is a danger to themselves or their family?

Mr DENNIS McLAUGHLAN: The MERIT program was mentioned. I understand that the solicitors ring up and book people in prior to coming to court. If someone is to be treated for two or

three weeks they have to ring and ask whether they will be accepted. Nine times out of ten they are and they do the two or three weeks and then they are back on the streets. The magistrate makes the order, but the solicitors and the people at these places set it up. It is a shame that they are mucking up the system for the ones trying to do the right thing. That is what happens. They are trying to do the right thing but they use and abuse the system to stop going to gaol. A couple of years ago a non-local was assaulted and robbed. We ended up making arrangements ourselves to get him into a house because he could not look after himself.

CHAIR: What sort of house?

Mr DENNIS McLAUGHLAN: We got him into a program in Wagga. We organised a bus ticket and we got him back to his area and he was comfortable. I do not know whether he used Faulkner's place.

CHAIR: Would you have arranged for him to be met Wagga?

Mr DENNIS McLAUGHLAN: We made sure he got there and we rang to make sure everything was fine when did. I have been here three and a half years and I have not seen it to the same extent. We used to notice drunks more in public areas; it is not as bad these days. It is not commonplace to find people inebriated in the streets or parks.

CHAIR: Does that mean the problem is not as bad as it was, or is it more hidden?

Mr DAVID ROBERTS: It is more hidden.

CHAIR: Are people drinking at home?

Mr DAVID ROBERTS: They are not socialising any more in the parks. They congregate in one area, usually in someone's flat or house and sit there all day and drink.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think there is less drinking?

Mr DAVID ROBERTS: No. It is just hidden more.

Mr BILL GROSE: I worked in the proclaimed place here in Moree for 19 years, but we have been closed for 12 months. Our building was situated across from Jellicoe Park. Before we started 40, 50 or more people would be drinking in the park. We started the service to stop people from going to gaol just for being intoxicated. Then we got into putting up homeless people as well. About 18 months ago we had a bus that would come to the park and we would give them a lift home. We might take up to 24 or 25 people home a night, as well as the people we were putting into the proclaimed place. When we stopped the bus service people stopped coming to the park. Most of them go home or to a friend's place. We seldom see anyone drinking in Jellicoe Park now. There used to be 50 people and sometimes more and they would be fighting and going on.

CHAIR: Why was the bus service stopped?

Mr BILL GROSE: Because of the abuse of the drivers. That was part of it. Stopping the bus was given a trial run just to see how it would go. Most of the people were pretty good, but certain people had no regard for anyone and were even threatening the drivers. After a short time people stopped coming to the park. They would go elsewhere. Tourists and other people could not go there, now they can.

CHAIR: The problem has not gone away, it has just moved somewhere else.

Mr BILL GROSE: Yes. It is probably better in a way that they are drinking at home, especially the older people because they are less likely to be attacked. There were quite a few bashings and a couple of people were killed.

CHAIR: There might now be more violence at home though.

Mr BILL GROSE: There could be.

Ms THERESE STACEY: Moree is an alcohol-free zone now. That might have cleared it up a bit. Many of the people who used to drink have passed on and the others have lost their drinking mates. They are not there, but they are at home. As Jane said, there is another generation coming up, but they are drinking at home. It will keep going and going.

CHAIR: Are the younger ones using drugs more than alcohol?

Ms THERESE STACEY: Elderly people are afraid of drinking.

Ms JANE ADAMS: The young ones attack them and they also drink. They may never have used drugs but someone might say, "Try this cousin." They might have had a bit of alcohol already and they think they are invincible, so they try it. They start and then move to other drugs and keep going; they cannot stop. That is when domestic violence and crime come into it. They start breaking and entering, stealing motor vehicles and assaulting people—you name it. I do not think we should be focusing on the elderly. We should be focusing on the young people, because they are the next generation. I do not see the cycle being broken.

Mr LLOYD DUNCAN: We live in a world where drugs are taking over everything as far as old people are concerned. Aboriginals only live to 40; there are not too many over 50. Drugs are taking over. That is it. It is all through schools and everywhere else. Alcohol is the entree.

CHAIR: Do you agree with what Jane said?

Mr LLOYD DUNCAN: Drugs are killing us.

Mr DENNIS McLAUGHLAN: We are unique in Moree. We have the Child Protection Act, which I have addressed with our magistrate and the solicitors in town. There are two parts to the Act. First, the police have the power to take kids off the street and take them home if we think they will be a victim of crime or commit a crime. We cannot take them to the police station; we must take them to someone responsible. That has been very successful. Secondly, our magistrate can order parents to provide a safe place for their children. They cannot provide a place where everyone drinks. Often these kids do not want to go home; their problem is not in the street and the town, it is at home. There might be 10 people drinking there for a week. If one person has money he will supply the drink and they will all drink at one place. There is no safe place for some of the children to go. We are trying to put it back on the parents; they have to take responsibility and provide a safe place. That comes back to education.

The Department of Health has one worker at Tamworth who services Moree. How can she do that? She provides education for parents and kids about alcohol, drugs and so on. She has a massive area to cover. I went to a lecture she gave this week and it was amazing the figures she had. The community attitude to drugs has changed. Cannabis is very popular, but there is ecstasy and things like that. Parents are misinformed about them and what they can do. That comes back to alcohol and adults. They have to understand what it does to kids. That is the way to break the cycle.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The second part is for the magistrates to make the houses safe. That would be a hard ask if the house is full of alcohol. If the magistrate makes an order, who enforces it?

Mr DENNIS McLAUGHLAN: The magistrate can enforce it. He has fines and if they break the order there might be Department of Community Service [DOCS] involvement. If there is no safe environment, DOCS should be informed. The police inform DOCS and it is then in the department's hands.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have to police it and DOCS enforces it in terms of taking kids away.

Mr DENNIS McLAUGHLAN: It serves no purpose to lock a child in a correction centre. But there is also no point in putting them into a house with drugs and alcohol; it is not safe. We tell

the parents that if they do not want their child to go to a correction centre they must provide a safe place. If they fail, they will answer to the magistrate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that work?

Mr DENNIS McLAUGHLAN: We have not done it yet, but that is the way to break the cycle. If we can say, "Look, these are the support services we can provide. We can send you to a MERIT course for three months to sober yourself up and that will make you a better parent, hopefully", there are plenty of opportunities and there are plenty of organisations in Moree. At the last count there were 130 different organisations in Moree that they can use for support. It is just getting them all to work together to solve the problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But do you think that the magistrate can tell people what to do about drugs and alcohol in their own home?

Mr DENNIS McLAUGHLAN: I think they can.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can they do it successfully? What does the Aboriginal community think about that?

Mr DENNIS McLAUGHLAN: I will open it to the floor.

Mr DAVID ROBERTS: It is not only just for Aboriginal people. This for everyone, right across the board.

Mr DENNIS McLAUGHLAN: Yes.

Mr DAVID ROBERTS: The aim behind it all is to make sure that the child is safe. That is the bottom line. If the child is not safe, the kid is out on the street and his going to get himself back into trouble again and back before the courts again.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The kid has made a decision, though, that he or she is safer out of the house. The magistrate can sit there on the bench and say, "Change the house", and enforce that either through the police or the Department of Community Services [DOCS].

Mr DENNIS McLAUGHLAN: Yes, that is another option.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But is that really a practical proposition, do you reckon?

Mr DENNIS McLAUGHLAN: It is a start.

Ms THERESE STACEY: No.

CHAIR: Someone over here said "No".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let us find out what everyone else thinks about that.

Ms THERESE STACEY: I do not know, but I do not just reckon that that is a good thing, that sort of thing.

CHAIR: Because it will not work?

Ms THERESE STACEY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not think it is a goer?

Ms THERESE STACEY: That is just my personal opinion. I do not know about these other kids with police and DOCS. Police and DOCS is just a big thing on its own. Plus they are housing us

all together, and that is another big thing, too, when they see your paper and whatever. If you go down to south Moree there, they are just all together and they are just all walking the streets and what not. It is the same thing.

CHAIR: So if DOCS turned up, there is suspicion and anger?

Mr RICHARD SWAN: How do we know that DOCS can put them in a safe place? You can work in a job for 20 years, right, and you knock off at five o'clock. We know all about you in the eight hours you work there, but after five o'clock we do not know what you do. You could be anyone. He could be Mr Hyde after he has knocked off work.

Mr FAULKNER MUNROE: There are a lot of things that go against the people here in Moree—unemployment, people being on the dole—and there are the parents who go down to the TAB at the corner every now and there and try to make 50¢ into a dollar. The kids come home from school each day and there are no cookies in the jar and there is no milk in the fridge, so they go out and throw stones at a truck or a car. There are a lot of things in Moree that accumulate to bring it to what it is today. I also see kids and wonder whether they are going out and vandalising the town and are they doing it out of fun for themselves. There is that as well that comes into it, not only the parents. There are some parents who are giving it a very good go to try and keep their kids in line but there are also the kids that are not because of some reason. I do not know what the reason is.

CHAIR: Are you saying that we really have to look at the economic problems and the social problems and concentrate on those, and that things like alcohol and drugs are the end product?

Mr FAULKNER MUNROE: I think they are the end product of an accumulation of a lot of things, yes. Dennis was saying that there are a lot of organisations. The Aboriginal Employment Strategy [AES] is one of them that has just begun. That is a fantastic initiative for unemployment in Moree for the Aboriginal people. So things can be worked out along those issues. There could be some improvement, but it is hard. It is very hard.

Mr RICHARD SWAN: It is not only the Aboriginal communities that are unemployed. What about the other communities? The Moree community has more Aborigines employed on the Nindethana, the Community Development Employment Program [CDEP] and the AES. They have all got jobs so it is all across the board as far as unemployment goes and all that. It is not just out in the Aborigine communities. It is across the board and affects all communities—white, black, brindle or whatever you want to call them.

Ms JANE ADAMS: I disagree with Faulkner on the point that it is just Moree that this is happening to. It is not just Moree. It is communities wherever—in New South Wales, Queensland and all over Australia that have a lot of Aboriginal people that live in the town. At the end of the day a lot of the parents are responsible for their students and the responsibility comes back to the parents, but then again a lot of the parents do not know how to be a parent. They have got no parenting skills so therefore their kids are running on the street and they are drinking and what have you, and they do not know how to manage their finances and so forth. I think that maybe a good idea is that all the organisations in town get together and go down one tunnel instead of going through all different tunnels to help the youth in this town and everybody else.

It is not just black. It is black and white. The community has got to work as a community. I mean, you were saying that unemployment is a big thing, and it is a big thing. If you go to Inverell there are hardly any Aboriginal people employed in the shopping or CBD area. If you come here to Moree you see lots of black people, black faces, in Coles, Woollies and so forth. I just honestly think that all the services need to get together and sort some stuff out. Do not blame the police for doing their job and do not blame DOCS for doing their job. At the end of the day if your kids are out on the street doing the wrong thing, then it is the parents responsibility.

CHAIR: Do other people think that there is a lack of co-ordination in Government and non-governance services in Moree?

Ms JANE ADAMS: I think all over the place there is a lack of co-ordination.

CHAIR: Yes, we have certainly heard the same comments.

Ms JANE ADAMS: It is lacking everywhere. It does not matter whether it is Moree, Inverell or Wee Waa. All services are going in different directions.

CHAIR: Agreeing completely about the need to start off addressing the basic problems, I think that the underlying problems need to be addressed. Because we cannot be here all day, can I ask you what you think about the idea of compulsory treatment? As I said, our job is to inquire into the Inebriates Act which actually means that people can be ordered by a magistrate to go off to a hospital or a mental health institution and be locked up for three months, six months or 12 months. Do people think that if someone has got severe alcohol problems, perhaps life threatening, that it is okay to get them compulsory treatment? Do you think it is the person's own business?

Ms JANE ADAMS: Yes, up to a point.

Mr LLOYD DUNCAN: Yes. My word. I totally agree. I think it should be compulsory.

CHAIR: Is that for the sake of the person?

Mr LLOYD DUNCAN: For the sake of the person and for the sake of the family because you cannot beat treatment. You must get treatment.

Ms JANE ADAMS: Yes.

Ms LEONA QUINNELL: I think that Lloyd is absolutely right as far as that goes because in a lot of our circumstances we do need people who really need to be away to have that compulsory treatment, and it makes it very hard for a family member to have to do that to one of their own family members. If it is actually done through the court or whatever, I think it relieves a lot of that responsibility from the families as such.

Mr LLOYD DUNCAN: Yes.

Ms LEONA QUINNELL: We do know of people who should have been sent away before they got themselves into such a dreadful state that they end up in gaol.

CHAIR: At the moment, the way the system works is that usually it is a family member or perhaps the police who start the process and they need a doctor to sign something. Then they go before a magistrate, so there is a little bit of a safeguard, but not much safeguard perhaps for the person concerned.

Ms LEONA QUINNELL: Maybe they can arrange it that if it comes through the courts, the person has to do this. I know that if we have a lot of people who are scheduled, they can be down there and beat the police back, or whoever has taken them. It just does not work, unfortunately.

Mr BILL GROSE: I was just going to say that there are certain people about who need to be sent away for help. They refuse to be helped themselves. They become a burden on their family and other people. But I am dead set against people being sent away, placed in places like Roy Thorne House with people who have gone there voluntarily. People who are trying to do something for themselves should not have to put up with people who have been sent there through the courts. I have lived in Moree all my life and I know a lot of people who have been to the Moree Aboriginal Sobriety House Corporation [MASHC], which is Roy Thorne House, and who have gone down there and stayed a short period and they have gone there voluntarily. They have come out and said, "I cannot stay there. I want to stay, but there are people sent their through the courts that are standing over me for my couple of bob or my tobacco", whatever.

They are there because they want to be there. The people who have been sent there should not be sent there with people who are willing to go through and do it on their own. There has got to be a separate area somewhere. If you are going to have court referrals, they go there; voluntary people, they go here, and they should not be forced in together. Most of the people who go there voluntarily are pretty ill from alcohol or drugs or something else, and they cannot put up with these young people

standing over them and trying to make them do what they want and taking things off them. They have got to be kept apart. If someone wants to do something voluntarily, they should be given the chance, not subjected to the whims of people who have been sent there by the courts.

CHAIR: Other people have made that same comment about what is happening. The other issue that is similar to that is that at the moment the institutions that the people under an inebriates order can be sent to are mostly the old mental health services such as Bloomfield, Macquarie Hospital and Rozelle. The same sort of argument is made that actually putting in one place people who have a severe alcohol problem and people who have all kinds of different mental health issues is not suitable because they have very different problems. Very different behaviour in one group sets the other group off.

Mr BILL GROSE: Yes.

CHAIR: So there is a really an issue about what sort of service should be set up. I guess we would like you to tell us. In a way, that is not so hard in Sydney because the population in Sydney is big enough to have one service here, another one there, and another one there. They have that, but I am not sure they solve the problem of people, say in Moree, having to go a long way away because you cannot get all these different services with very few people in them. I do not know whether you have any ideas on how we can address that question.

Mr DENNIS McLAUGHLAN: Just on that, what are the percentages? Is the Inebriates Act used more in the city?

CHAIR: At the moment the Inebriates Act is hardly used at all. The official figure for last year was only 20, but we know it is a bit bigger than that.

Mr DENNIS McLAUGHLAN: Was that in the city or the country?

CHAIR: Bloomfield I think gets more than anyone else gets, but these days it is basically Bloomfield, Macquarie, Rozelle and a couple of others. There are very few places left because the places where people can be sent are listed in the Act. We are thinking that if there is a new Act, this committee might recommend how we grapple with this problem with separate services for perhaps very small numbers.

Mr FAULKNER MUNROE: Would you know of any statistics of persons who died while they were under the Inebriates Act?

CHAIR: We have had quite a bit of evidence about people who have died very soon after being released. Usually I guess a sense of failure comes over everyone. When we have talked to people in hospitals, they have said, "We had someone here for three months and it did not really work, and they died a few weeks later"—that sort of thing. I do not think we had any evidence of anyone dying in the hospital.

Mr FAULKNER MUNROE: I am fifty-fifty with the Inebriates Act. The Inebriates Act helps the family of the person who needs that treatment. The person that needs the treatment does not know what is going on. The person that needs the treatment is also happy when he has his grog. But if he dies whilst he is under the Inebriates Act he is dying a very unhappy person. I am of two minds in relation to enforcing people into treatment.

CHAIR: We would have to enforce proper rules. As we have in the mental health system we could have a tribunal with two doctors or two lawyers signing and checking things.

Mr FAULKNER MUNROE: I am talking about these people. They do not want to change.

CHAIR: So people should have the right to drink themselves to death if they want to do so?

Mr FAULKNER MUNROE: I am fifty-fifty there. I am halfway there and halfway not. They need to be treated, sure, but they are happy while they are drinking. It was a concept that proclaimed places actually took on. That is why the proclaimed places lasted so long here in Moree.

CHAIR: So you think the proclaimed places should be brought back?

Mr FAULKNER MUNROE: No, I am not saying that. There probably are some people who do think that proclaimed places should be brought back. Since the proclaimed places left Moree a lot of good things have happened. But I am saying that the person who is forced to go into treatment is happy drinking.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are saying it is not much use sending them there?

Mr DENNIS McLAUGHLAN: Faulkner is trying to say: How can you help someone if they do not want to help themselves? Is that not what you are trying to say?

Mr FAULKNER MUNROE: If they do not want to help themselves they do not want help. They want to stay drinking. They want to drink their lives away. They are happy to do that. We come along and we say, "Listen, we are going to put you away. We will get one of your family members and the doctor to sign something and you will go away for six months." He goes away for six months and he is an unhappy fellow. He might and die whilst he is under the Act. That is why I asked whether there were any statistics on how many people have died whilst they have been under the Inebriates Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have had experience, working as a doctor, of trying to help people who did not want to stop drinking. My view was just to give them as much beer as they wanted and to let them go. If you try to stop them you get nowhere. It wears out the treatment people and it uses a lot of resources. That is my view, but I admit that it is prejudiced. That was my experience. If they did not want to stop drinking you really were wasting your time. You might make them a little healthier and keep them alive a bit longer, but in the medium term you were wasting your time. As we have a limited amount of resources we should be using those resources to help people who do want to give up, even if we achieve only a one-third success. Something is still better than nothing.

Mr BILL GROSE: There is no risk. You have got to want to stop, or it is a waste of time. If you are forced to do something you will rebel against it. You will not get people to stop drinking by forcing them. They have got to want to do it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That has been my experience.

Mr BILL GROSE: I have had 19 years of it. Over the last 19 years I have worked with intoxicated people. It is no good trying to force them to stop drinking if they do not want to. You can suggest to them that maybe they ought to ease off or seek help. If they are willing to go along with it then well and good. But if you stand there and say, "You have got to stop drinking", they will say, "I am too old now. I have done this all my life. If I die, I have had a good innings." They do not want to stop. It is only the people that want to stop that will. As you just said, you can put people away and you might add a few more months or a couple of years to their lives and make their quality of life a bit better.

We have had some successes over the years. People have come to us and we have helped them to stop drinking and they are going really well. But some of it was through the fear of dying if they kept on drinking. For others there are many reasons why they do not want to stop, or why they do want to stop. I do not really think that you can say, "All right, I am going to send you away and you are going to stop drinking. You are going away for three months, six months or whatever, and when you come out you will never have another drink." Nine times out of 10 those people would come back and have another drink. If they do not want to do it they will not do it. They will not stop. They have to want to.

The Hon. IAN WEST: Do you find that there are those who would love to stop but they do not know how to do that? Their bravado tells them to tell you that they do not want to stop, whereas they need that help? Do you find that there are people like that?

Mr BILL GROSE: Definitely, yes.

Ms LEONA QUINNELL: Absolutely. If we got to the stage where we said, "If it is up to you to do it yourself", it would be a small world. These things take time to happen. I have been in circumstances where I have had to deal with people. I could quite easily have said to them, "The choice is yours. You either give it up or whatever." We always have to be there to help them through the process. That is where things fall down because we do not have that support mechanism for people who want to do it. Some people do need some encouraging along the way. I know that the choice is theirs, but a little bit of encouragement and incentive towards it can help a lot too. I just do not think that we should say, wholly and solely, "It is your decision." There has to be something else in place to support people in these circumstances.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that, as part of helping them along, we should provide compulsory treatment? You said that you wanted to help them along. I do not have a problem with that idea. Do you think that helping them along includes the inebriates-type forced treatment? That is really the nub of the matter with which this Committee has to deal.

Ms LEONA QUINNELL: I suppose that it depends on the circumstances. I do not know.

Mr DENNIS McLAUGHLAN: Do these people get assessed? If you are going to make a court order should they be assessed by a psychologist or someone else?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It varies. The complaint from Macquarie hospital was that they get an order from the court and the person turns up with an order. That person, who has not been assessed by a psychiatrist or psychologist, just arrives on their doorstep. The person does not want to be there, the hospital does not want that person to be there and the success rate was poor. It disrupted everything else that the hospital was doing with all its other mental health patients. Those are the practical consequences of non-compulsory treatment without an assessment by someone who could say whether or not it was likely to be successful.

CHAIR: A doctor has to sign a form before the magistrate will grant the order. The evidence suggests that it is a fairly perfunctory thing. There is no requirement for any assessment by a trained drug and alcohol person, or a psychologist.

Ms LEONA QUINNELL: With this compulsory sentencing, where are they going to send the people? Apart from gaol, what else is there?

CHAIR: That is something that we have to grapple with. We want your opinion on it because it comes back to the question that I asked earlier. In theory, you could establish a fantastic place in Sydney for people with severe alcohol problems, but that would not be of much help to someone in Moree.

Ms JANE ADAMS: That is right. Most rehabilitation centres around here are all full.

Ms LEONA QUINNELL: There are hardly any around, apart from those at Moree, Bendalong and those places. There is nowhere. It does not help our people if you send them away to these places. When they come back home again they are in the same environment as when they left. It makes it very difficult. It is hard because there is no support right then and there for them.

CHAIR: There are other options. We are listening to what people are suggesting. Some people think that you could continue to use the mental health system and that you could use some ordinary hospitals. Some people have also talked about a community treatment order. It would be a little like a parole order. You would make certain sorts of treatment compulsory, but it would be supervised in the local community, perhaps by a general practitioner or by a drug and alcohol service. Of course, that might be the second stage. You might have a kind of locking away or detoxification stage and then you would have a rehabilitation stage. So there are all sorts of different ways in which you could do it. But we are interested in your views. You are saying that it will not work if they come back and just revert to their old behaviour. That implies that, if anything is going to work, it has to be based in this community.

Mr RICHARD SWAN: We need a halfway house.

Ms LEONA QUINNELL: That sounds good, but I think the Government has to look at making money available to train people to work in these fields. We have very few Aboriginal people working in the types of positions that are needed to support these people. Until we can get some of our own people trained to work in these places we really do not understand the needs and the problems that people go through just to end up in this type of position. We need to look at training Aboriginal people in positions as counsellors in drug and alcohol services, or wherever.

The Hon. GREG PEARCE: When everyone was asked earlier whether they favoured compulsory treatment—in other words, locking them up—almost everyone said, "Yes, at some stage." What stage is that?

Ms JANE ADAMS: That makes it difficult because a lot of our people go to court because of domestic violence. When they are asked, "Why was that committed?" they say, "Because I was under the influence of alcohol or drugs." Whenever they go to the courthouse, nine times out of 10 it will be, first, because they were intoxicated or, second, because they were using drugs. If someone goes to court under this Act they are there because they have also committed a crime. It is not just because they were drunk; they have also committed a crime.

Mr FAULKNER MUNROE: That is not so with the Inebriates Act though, is it?

Ms JANE ADAMS: I guess so.

The Hon. GREG PEARCE: So your test is not so much that they are drinking themselves to death but that they are causing trouble in the community for which they should be punished? You are really looking at it as a punishment issue?

Ms JANE ADAMS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You take them out of the loop anyway?

Ms JANE ADAMS: Yes, that is right; but when they come back they are still going to be in the same cycle. It is still going to be the same cycle.

The Hon. GREG PEARCE: That is different from the health issues that we were talking about this morning. People were saying that once you got to the stage where you had brain damage or something that was when you got locked up.

Mr FAULKNER MUNROE: The only trouble that an inebriate is going to cause is being a menace to society or the town. I do not think an inebriate can cause trouble, get into trouble or do something that is against the law.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that they would be too far gone anyway? They are almost pathetic figures?

Mr FAULKNER MUNROE: Yes. That is why we put them under the Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are talking about different people from those that Jane is talking about.

Mr FAULKNER MUNROE: I am talking about people who fit under the Inebriates Act.

CHAIR: One of the confusing things about the Inebriates Act is that it applies both to people who have committed a criminal offence and to those who have not. In fact, it is used primarily for people who have not committed an offence. That is what Mr Munroe is talking about.

Ms JANE ADAMS: My mother was an alcoholic. If I wanted to put her under this Act would I have been able to do that?

CHAIR: Yes.

Ms JANE ADAMS: Even though she did not want my help?

CHAIR: Yes.

Ms JANE ADAMS: She was an alcoholic and drank 24/7.

CHAIR: As long as the paper was signed by the police, a doctor and a magistrate you could have done that.

Ms JANE ADAMS: Someone in the family would have had to say my mother was an alcoholic.

CHAIR: Yes.

Ms JANE ADAMS: You would not find many Aboriginals doing that.

Mr LLOYD DUNCAN: A lot would not because they do not have the money. They will not sign their family away because they know they get the pension. Bill, Faulkner and I worked in proclaimed places for 20 years. I do not like seeing it, but families will not look after each other today. As long as they get your money that is all they worry about.

CHAIR: You have different views.

Ms JANE ADAMS: I have an uncle who is an alcoholic in a small country town. We know he is alcoholic and he does not want to get signed away. He thinks he is invincible. He drinks 24/7. I do not know where he gets the money from. That is his life. We have asked him to go to my father's place in Sydney, but he will not leave the town.

The Hon. GREG PEARCE: Do you think you should have the right to get a doctor to sign him away?

Ms JANE ADAMS: That is what he wants to do and that is his business. We love him regardless and we will take care of him regardless, and our family does. If he came and said he wanted help, of course we would help him, even using this Act.

CHAIR: Is he hurting anyone else?

Ms JANE ADAMS: Yes, his family.

CHAIR: But not directly by using violence.

Ms JANE ADAMS: No, because he lives on his own. No-one would have him.

CHAIR: The evidence seems to be that people use compulsory treatment usually because the person with the alcohol problem is hurting the family.

Ms JANE ADAMS: I see how it can work, but you have to get the strong members of the family to do the signing away under this Act. But if you do, the rest of the family will come down on you.

CHAIR: It must be a very strong family to make such a decision. Does everyone else agree?

Mr LLOYD DUNCAN: No.

Ms LEONA QUINNELL: Yes.

Ms VAL DAHLSTROM: I do. If I had been able to I would have signed any form to help my family.

CHAIR: This is one of the difficulties with this issue; that is, people have strong beliefs. Some Aboriginal people have been subject to inebriate orders and their family has taken the first step. There may not be many of them, but it has happened.

Ms JANE ADAMS: It is almost like putting an elder in an old people's home.

Mr LLOYD DUNCAN: People have pulled me up in the street and asked me to sign their uncle or brother away.

CHAIR: But you would not do it.

Mr LLOYD DUNCAN: They would ask me what they had to do. Many people have asked me, at home, in the street, everywhere. I tell them they have to go to the courthouse.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did they go?

Mr LLOYD DUNCAN: No. I suppose they did not want to do the paperwork. I told them if they wanted to sign anyone away they would have to go to the courthouse. Now the people that I knew are all dead.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Signing is away is a low point and you want to give people hope. The success of the compulsory system is only 10 per cent.

Ms VAL DAHLSTROM: It depends on what you see as success. If putting them in there meant they got off the grog, even in the short term, and they sobered up and got well, that would be success. I am not talking about living another 12 years. I have seen people who were put away for a week or so and it was the difference between life and death. In this case your perception of success is probably not ours.

The Hon. IAN WEST: A success rate of 10 per cent is better than nothing.

Ms VAL DAHLSTROM: That is right, particularly if it is a family member you care for.

CHAIR: We must measure success by how much longer the person lives and how much respite the family gets from a difficult situation. We must then add all the different factors together. It would still be better to do all this without sending someone away. It could be done with the right mix of services located, say, in Moree.

Mr LLOYD DUNCAN: It would be good if we did not have to send people away. It would be good if the treatment was provided in Moree. There are no places to send them.

CHAIR: Would there be enough customers in Moree?

Mr LLOYD DUNCAN: We used to take them to Newcastle, but they stopped that. When they came back they would be fat. We must have put six or seven years on their lives. They came back fat and healthy.

CHAIR: Did they stay off the grog?

Mr LLOYD DUNCAN: No.

Ms LEONA QUINNELL: It gave them time to rejuvenate themselves.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you feed people up they live longer.

Mr LLOYD DUNCAN: Going away was not right.

CHAIR: Could you see it working if the Aboriginal health service had someone under a compulsory treatment order? I am talking about a community treatment order rather than focusing on locking people up. Can you see a way in which that could work? There would still be compulsion, which presumably would mean that if they did not turn up twice or three times a week the punishment would be imprisonment.

Ms VAL DAHLSTROM: It would only work with support networks in place to help. We would have to have enough support people in the community to ensure that they had someone to talk to and something to do during the period before they had to report back. If the only people they saw were mates from the pub it would be a problem. You have to do away with all outside temptation and provide something in the gap so people do not think they might just slip down to the pub. They might think, "I wonder what Faulkner is doing. We could get drunk."

CHAIR: Would it be better to move them out of town a bit?

Ms VAL DAHLSTROM: Yes, but not stuck out in the wilderness. When Roy Thorne House was first set up we looked at a place on the highway towards Narrabri, about 20 kilometres out of town, but it was not big enough. That was well outside the town limits.

CHAIR: Would there be an advantage in having something in Tamworth? It would not be like being sent to Morisset, but it would be away from the local area.

Ms VAL DAHLSTROM: I do not know. Tamworth and Orange and a couple of other towns are the old settlement towns. Many Tamworth people are from Boggabilla and other towns. Moree Housing Commission tenants asked to be transferred because there were better houses and opportunities for their kids in Tamworth and Orange. I come from Tingah and many members of my family are down there. It would be very difficult to go to town and avoid them.

CHAIR: That temptation will always be there.

Ms VAL DAHLSTROM: Yes.

CHAIR: Does everyone agree? You are saying that with enough workers and funds the Aboriginal Health Service would be able to do it.

Ms VAL DAHLSTROM: I would not like to see us having to do it. It must have enough funds. I had a brother go through MASH and I firmly believe the only way to make a change is to get community support, not cash.

CHAIR: Does that mean the elders have to take charge?

Ms VAL DAHLSTROM: Not necessarily. It depends on the people you are in there with, the workers who support you, the people going through the process at the same time and the family mainly.

CHAIR: What about the health professionals and general practitioners?

Ms VAL DAHLSTROM: You have to have them. Again, I am not sure where drug and alcohol services are going now. They used to use AA. A lot of what Richard does is involved with AA at Roy Thorne House.

Mr RICHARD SWAN: We have AA meetings on Monday morning and Monday night.

Ms VAL DAHLSTROM: I have seen a lot of people go through that and get sober. It is a support network. It may not be the flavour of the month.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Howard likes it.

CHAIR: Most of the rehabilitation services around the State use AA a lot. We are talking about Aboriginal and non-Aboriginal people. It seems to be a very important part of the process. Could Aboriginal medical services here and elsewhere run a service with the GPs? Would that be a good idea?

Ms VAL DAHLSTROM: I feel we should have specific places. This is a personal opinion. Rehabilitation services should not be attached to other services; they should stand alone. They can develop all those other things they need to be successful.

CHAIR: Which means a committee to run drug and alcohol services.

Ms VAL DAHLSTROM: Yes. It would have to be a committee committed to that ideal, not to a whole spectrum of things. It would also have to have responsibility for and have people interested in that aspect, concentrating on it and knowing what it is about.

CHAIR: Would they then run community-based programs that followed the rehabilitation period?

Ms VAL DAHLSTROM: Yes. That is why I think it should go further. If you have a community organisation it should have rehabilitation programs, a halfway house and a community support network built around a community house. There are places like where Faulkner and the others were working and homeless shelters. Those are the kinds of networks that should be available for them. I just cannot see them tied up with everything else.

CHAIR: How does that sound to you, Faulkner?

Mr FAULKNER MUNROE: I am for that, for sure.

CHAIR: But that would put an extra strain on the resources of the halfway house, would it not?

Mr FAULKNER MUNROE: Are you talking specifically of our halfway house?

CHAIR: Yes.

Mr FAULKNER MUNROE: I think if there was the option of that from our halfway house, yes—whatever it requires. The idea of what Val is talking about is great.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think the point that Val has made is one that has come out of a number of committee inquiries, namely, what is needed in a lot of areas is graded community support. The system has always evolved to institutions and rehabilitation has always been an add-on to something else. Because of that, it has always been a bit starved of funds—because it is an add-on. If I understand you correctly, you are saying that it should not be an add-on to anything. Let it be the centre. Let it bring an institution, the halfway house, into a community-based organisation rather than have the rehabilitation as an outreach from the institution. You are basically putting the horse in front of the cart instead of the other way round, as it were. In other words, you are putting the community ahead of an institution, which it never usually is. That is what you are saying, is it not?

Ms VAL DAHLSTROM: That is right, and that is the only way I reckon it is going to work because I can never see the Government—Commonwealth or State—putting enough money into it so that you have got stacks of staff everywhere, whereas if you get community involvement in a halfway house and community support and everything else, you will be able to get help.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the thing is based in the community and the institutions are being created in accordance with the need of the community, you will get the right size institutions, as opposed to the other way round.

Ms VAL DAHLSTROM: Yes, exactly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I can see that model for a lot of stuff we have been doing.

The Hon. IAN WEST: Where does the GP fit into that? Where does the doctor fit into that?

Ms VAL DAHLSTROM: You would have to have some kind of a detoxification service in there. I never have supported the idea of having a medical detoxification unit in a rehabilitation centre because of the type of staff you would have to employ. I think that you should have quite specific detoxification services, not a bit here that nobody is using. You have a hospital but you have a unit within that which is set aside for detoxification and the people from the rehabilitation centre and the halfway house also are involved in getting involved with that person as they go through. But the way it is at the moment is that if the bed is available, you can go in and get detoxified. Theoretically anyway, you would be able to go down to Thorne House and start the process there. I do not think it always works that way. I would not have the detoxification unit in the rehabilitation centre. I think you need a medical model over there and let us keep it there, otherwise you have to employ a doctor and a nurse and God only those that you are not going to get the funds. You have to be practical.

The Hon. IAN WEST: I am trying to comprehend who is what I am describing as the proclaimed person, if you like, who actually takes the lead agency role in co-ordination of looking after that person's rehabilitation through the system.

Ms VAL DAHLSTROM: Okay. Once they go through the detoxification—and this is the way I understand that it works although I am not too sure because I have not had a lot to do with AA or anything like that for a long time—my understanding is that they go into the hospital and they undergo their detoxification. Then someone down at Thorne House is contacted and then they take responsibility for getting them into the service and all the rest of it.

The Hon. IAN WEST: Who contacts Thorne House?

Ms VAL DAHLSTROM: The person who is in charge of the detoxification unit.

The Hon. IAN WEST: And that would be?

Ms VAL DAHLSTROM: Probably a clinical nurse or someone along those lines.

CHAIR: And that person would be employed in drug and alcohol?

Mr RICHARD SWAN: Yes.

Ms VAL DAHLSTROM: It would be a person employed in hospital specifically in relation to that detoxification unit. Given the numbers and things, I cannot see them being employed full time, but it would be part and parcel of the role of the person in charge of the ward or the detoxification unit. That is the way I think it works at the moment. Whoever is in charge or whoever is on duty at night when someone goes in or in the day, they contact Thorne House.

Mr RICHARD SWAN: Yes. Jan Hannaford, she is the drug and alcohol nurse over there, and Mary Maguire—they contact Roy Thorne House, and someone from Roy Thorne House will come up and see them in hospital.

The Hon. IAN WEST: If you are going to localise it, the only way I can visualise it is that there has to be a person who co-ordinates all the services, such as non-government, bricks and mortar or whatever it is, and is looking to implement a court's decision or someone's decision as to the future of this particular individual.

Ms VAL DAHLSTROM: At the moment, that is the person in charge—the administrator or the chief executive officer [CEO] of the rehabilitation centre. Because we have never had a halfway house there, I would see the house family, or whatever you want to call it, who would be living in the halfway house looking after people as they are going through and helping them to make sure that they do all things that they are supposed to do. I would see those two people there as being the persons who would make any other arrangements for the person after that person got out of, say, the rehabilitation

centre or into the halfway house. You would not be able to have the person in charge of the rehabilitation centre in charge, every step along the way.

Mr BILL GROSE: I will see you good people later.

Mr LLOYD DUNCAN: I will see you all again.

(The witnesses withdrew)

CHAIR: Actually, I think we have probably almost wrapped it up. We had allowed more time. Is there anything we have missed or anything else to discuss? You have given us an awful lot to think about. We will have to check up on some of the details over the proclaimed places and other things, but is there anything else that anyone wants to add that has not yet been covered?

Mr FAULKNER MUNROE: Changes are going to be made to the Act? Is that what you are doing?

CHAIR: We are a parliamentary committee so we do a report with recommendations to the Government. We do not have power to make changes ourselves. We make the recommendations.

Mr FAULKNER MUNROE: So you are recommending for a change?

CHAIR: We have not yet started on our report, but I have no doubt: we have heard nothing but criticism of the Act as it stands. We have not spoken to a soul who wants the Inebriates Act kept as it is. Basically most people would probably agree that there needs to be something in place because most people we have spoken to agree that there should be some role for compulsory treatment.

Mr FAULKNER MUNROE: Are you covering all of New South Wales?

CHAIR: Yes.

Mr FAULKNER MUNROE: Or a big part. Are you going to all places or selected places?

CHAIR: No. At the moment we have done quite a few hearings in Sydney and we have visited different hospitals. We will go to Orange tomorrow and there we will talk to doctors from different places. We are also going to Bloomfield where there are actually people under the Act. Then we have more hearings coming up. We are going down to Melbourne next month to talk to them about what they are doing because Victoria is doing a major review of a similar Act that we have got.

Mr FAULKNER MUNROE: That is very good.

CHAIR: We hope to do a report by no later than August. We started last year after the Alcohol Summit.

Mr FAULKNER MUNROE: Is there a general consensus so far?

CHAIR: I should ask the committee members that. I think there probably is, broadly speaking. We need to talk to a number of people about whether we should have a new Act and, if so, how it may work. Then there is also the big issue of how we attach what the current Act calls dealing with inebriates to the rest of the alcohol and drug services. There are different views on that. We are talking it through as we go. We are trying to keep an open mind as we listen to people's opinions. We always try not to make up our minds too early because our job is to find out what other people are thinking.

Mr FAULKNER MUNROE: Certainly. That is very good.

CHAIR: In doing that, you have all been very helpful, and I thank you. If there is anything else you wish to say, you may contact us later or we will contact you, possibly through Val, Richard or Faulkner.

(The witnesses withdrew)

The Committee adjourned at 3.25 p.m.