REPORT OF PROCEEDINGS BEFORE

JOINT SELECT COMMITTEE ON SENTENCING OF CHILD SEXUAL ASSAULT OFFENDERS

INQUIRY INTO SENTENCING OF CHILD SEXUAL ASSAULT OFFENDERS

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At Sydney on Thursday 15 May 2014

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The Committee met at 4.30 p.m.

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PRESENT

The Hon. T. W. Grant (Chair)

Legislative Council
Reverend the Hon. F. J. Nile
The Hon. M. J. Pavey (Deputy Chair)
The Hon. H. Westwood

Legislative Assembly
Mr C. Casuscelli
Ms M. R. Gibbons

CHAIR: Thank you for attending this public hearing of the Joint Select Committee on Sentencing of Child Sexual Assault Offenders. The Committee is examining issues around whether the sentencing options for child sexual assault offenders are effective and the extent to which alternate sentencing options may improve public confidence in this area. Today the Committee will welcome witnesses from the Justice Health and Forensic Mental Health Network to discuss the treatment and rehabilitation of child sexual assault offenders.

JULIE BABINEAU, Chief Executive, Justice Health and Forensic Mental Health Network, and

TOBIAS MALCOLM MACKINNON, Statewide Clinical Director, Forensic Mental Health, Justice Health and Forensic Mental Health Network, affirmed and examined:

CHAIR: Thank you for appearing before the Committee. I draw your attention to the fact that your evidence is given under parliamentary privilege and you are protected from legal or administrative action that might otherwise result in relation to the information you provide. I also point out that any deliberate misleading of the Committee may constitute a contempt of the Parliament and an offence under the Parliamentary Evidence Act 1901. As time is limited today the Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions following today's hearing?

Ms BABINEAU: Yes.

Dr MACKINNON: Yes.

CHAIR: Would either of you like to make an opening statement?

Ms BABINEAU: I just wanted to confirm the fact that Justice Health is a statutory health corporation and we are part of the big Health family. Dr Mackinnon's and my areas of expertise are in the operation of the delivery of services for people in contact with the criminal justice system. It is a small area, but I think it is really important to state that for the record.

CHAIR: The Committee has had a number of private briefings with legal and medical representatives and victims advocacy groups. It has also conducted public hearings and taken evidence to provide Committee members with a range of options that we may consider as part of our recommendation process to Government. We are focusing on what recommendations can be made to help with the sentencing options that are before the courts to get a greater level of consistency and, more importantly, a greater level of public confidence. A lot of the information that has been provided to us concerns what happens in Health and potential models that we may look at. Are you aware of the drug court model?

Ms BABINEAU: Yes, I am.

CHAIR: Does Justice Health play a key role in that process?

Ms BABINEAU: It plays a role in the process absolutely, yes.

CHAIR: One idea that has been given to us is to consider a specialist court for child sex offenders that would operate in a similar way to a Drug Court. Do you have any views on how Health would perceive a role in that type of forum and would that be beneficial?

Ms BABINEAU: I really would not have a view on how Health would be provided in a specialist court for child sex offenders or on child sex offender cases. I can tell you that our role in the Drug Court currently is really an assisting role in helping to identify and to advise the court at times. When people are in custody we provide treatment and we will provide the monitoring of any of the illnesses that are associated with drug dependency or any other illnesses when people are in contact with the criminal justice system or in custody. I am not exactly sure what the court would be like for sex offenders but I can basically tell you that the role of Health in the Drug Court currently is really to look at the rehabilitative pathway of the offender who is drug dependent.

CHAIR: In relation to a potential specialised child sexual assault court we have heard evidence that a risk assessment from a psychiatric or psychological perspective is required. Then potential treatment options

would be available which may or may not include antiandrogenic medication, which would be a health-related issue, and/or ongoing counselling and psychological support. Would Justice Health play a role if that was part of a sexual assault court that was similar to a Drug Court?

Dr MACKINNON: To take a step back and just think about the role of a specialist court for child sex offenders, it is important from our position to say that obviously the running of the courts and the implementation of the courts is outside our area of expertise. We could only talk about our involvement in that.

CHAIR: That is all I am asking for.

Dr MACKINNON: To contrast a Drug Court with a child sex offender court, there is a fundamental difference in the nature of the offender and the involvement of Health. That is to say that if you are talking about a drug offender almost invariably they are diagnosed to have a mental health condition, which is drug dependence, which then leads into the treatment and rehabilitation pathway.

With regard to child sex offenders, it is not the case that there is a clear association between the offence and mental illness; rather, it is a case of there being a subset of child sexual offenders who may well have a mental health diagnosis that warrants treatment. Additionally, Justice Health has a role in providing services to the custodial setting and the court setting, but not a clear role in providing treatment services to the community setting. With regard to where our organisation has a current remit or role, that is in the custodial setting and in the court setting in terms of potentially providing advice about the subset of child sexual offenders who might have those health care needs clearly identifiable.

Where we would face a difficulty in trying to assist that court is in the provision of community-based programs, which might include rehabilitative programs, for example, with psychological treatment, or which might include, as we have outlined, anti-androgenic treatment programs that I would recommend should be part of a comprehensive treatment program as well—what we sometimes call multidisciplinary or multiagency.

Reverend the Hon. FRED NILE: Just to clarify that, you are not involved with offenders who are in the community—those who have completed their sentence?

Dr MACKINNON: That is correct. Once an offender is released from custody setting, generally speaking involvement with them terminates. At that point, if they have a healthcare need, that is taken care of by one of the local health districts who operate both community mental health teams, which might provide ongoing support for their mental health needs, and general mental health facilities in the community setting—for example, inpatient psychiatric wards.

Reverend the Hon. FRED NILE: We have had some expert witnesses speak highly of the previous Cedar Cottage program. Do you have any knowledge of that or any view on that?

Dr MACKINNON: I only have read some of the evidence that the Committee already has received and some of the submissions. I cannot add anything from my knowledge about the Cedar Cottage program, except to delineate that it was never something that Justice Health directly was involved in.

The Hon. MELINDA PAVEY: I wish to follow up on that question by Reverend the Hon. Fred Nile. When the client leaves your facility and that is the end of it, unless they get some support in the local health district through mental health support, is there any file that is forwarded on to the police for the child register, or is a file passed on to anyone to give your view of the status of the safety of that client in terms of the general community?

Dr MACKINNON: Yes, there is. There are perhaps two processes to outline here. One process is a legal and correctional process. For example, all of the offending history and if the offender has been placed on the appropriate register is already present in the community.

The Hon. MELINDA PAVEY: When you say "in the community", what do you mean?

Dr MACKINNON: It would generally be with the police and parole.

The Hon. MELINDA PAVEY: That should appear on the child sex offence register that the police hold?

Dr MACKINNON: That is correct.

The Hon. MELINDA PAVEY: Does that happen well?

Dr MACKINNON: That is probably beyond my remit. That is not something that Justice Health has any involvement in.

The Hon. MELINDA PAVEY: In your experience?

Dr MACKINNON: In my experience, reasonably well.

The Hon. MELINDA PAVEY: Really.

Dr MACKINNON: There is a well-administered child protection register and offender register.

The Hon. MELINDA PAVEY: We have just had some evidence from the Police Association that is concerned about the complications and the bureaucracy around the register. We are just trying to get a handle on that particular issue and some recommendations we might need to make. Your testimony is that it works reasonably well?

Dr MACKINNON: But I would say that that is not an area in which we are involved. I was going to delineate two areas. The first is the corrections and, if you like, the police aspect of managing those registers or that information. The second is what I might term the health area.

Ms BABINEAU: Yes.

Dr MACKINNON: If someone has had an identified health need within the correctional setting that might include treatment recommendations. Then our custodial mental health service liaises with Local Health District's community mental health team to ensure that they are aware of this person being released, their health needs, and their recommended and current treatment.

The Hon. MELINDA PAVEY: What if they move out of that local health district?

Dr MACKINNON: I guess that is a complex question and there are lots of complications to this. For example, one of the complications is sometimes it is not clear to our organisation—

The Hon. MELINDA PAVEY: Where they are going to?

Dr MACKINNON: —when they are going to be released and sometimes not even where they are going to be released to. Things can happen very rapidly. The court may decide to grant bail or the charges may be dismissed. Things can happen very quickly. There are difficulties in arranging, often, consistently for that sort of information to be appropriately passed on. Our custodial mental health service makes its best efforts to do that. I guessed the second part of your question is what happens if a released prisoner then moves from one Local Health District [LHD] to another. Again, there are two aspects to that. One is the issue like the judicial or correctional aspect, and I would not be the best-placed person to comment on that, I am sorry.

But the second is the issues to do with the health information and treatment. That would be a matter then for that LHD to communicate with the LHD that that offender in the community was moving on to. But, generally speaking—again, rather like our custodial mental health service—they would make their best efforts to liaise and advise the recipient LHD of the new patient coming to their area, subject to the same sort of difficulties I have outlined about whether they were informed that that move was going to happen and whether that person was under any obligation to report that move to the local health directorate's community mental health team, and so on in that vein.

The Hon. MELINDA PAVEY: What if they move to another State or territory?

Dr MACKINNON: I would not be in a position to comment on the cross-jurisdictional nature of those lists, I am afraid. It is not in the health remit.

The Hon. MELINDA PAVEY: If they move to Queensland after leaving a facility, what happens?

Ms BABINEAU: Health does not get involved when there are people who are on the register or when people change jurisdiction. Corrective Services has an area that is called the community correction monitoring group, which is the old probation and parole, and they are the ones, if people are on parole, who would follow up on them. Once people have basically served their sentence, then they are like everyone else in the community.

Just to add to what Dr Mackinnon was saying—Dr Mackinnon was giving you what happens with people with mental illness in the system—we have areas for people who, I would say, have chronic illnesses. Usually when people come in, we will ask them to sign a consent form so we already have an idea where the doctors are or where the doctors will be. For people who have chronic illnesses—people who are drug dependent, people who are on opioid substitution treatment [OST]—we will actually liaise back through the health provider. But more often what we will do is provide a discharge summary to the patient—the offender or the inmate—to take with them to make sure that the treatments that they are on continues. That is generally how it works, but we do not have any role responsibility when people are on parole and when they leave custody. We will look after the health side, but when they move jurisdiction, it is really for the police or Corrective Services.

Reverend the Hon. FRED NILE: Do you have any views on treatment such as anti-libidinal medication? Are you involved in any of that, Dr Mackinnon?

Dr MACKINNON: Yes. Largely, we do not have a great deal of involvement in that, and I can outline the reason for that. Generally speaking, our remit is to take care of the health needs of offenders while they are in the custodial environment. When they move on from the custodial environment, as I have outlined before, that is when the responsibility moves on to the Local Health District or onto the private sector, if the offender in the community chooses to pursue that.

When it comes to a decision about commencing an offender in custody on anti-libidinals, generally we are happy to consider that but it is a very difficult situation to consider starting an offender on an anti-libidinal if we cannot map out a pathway for them, post-release, to continue in an appropriate way both in terms of the prescription of the anti-libidinal but also the monitoring and management of that within a more comprehensive multidisciplinary setting that is focused not only on the biological treatment but also on the wider needs of that offender in the community to keep them safe.

The involvement of our service in anti-libidinal assessment and treatment is that at times an offender may be referred to Justice Health by Corrective Services and we could begin what is called a work-up for the appropriateness of anti-libidinal medication in the custodial setting and make recommendations about what should be made available to them in the community. Unfortunately, though, as we have no agency or power in the community, we cannot access any specific treatment for that offender post-release.

Reverend the Hon. FRED NILE: But while they are in custody, what percentage of prisoners would commence that treatment? It sounds like it would be small?

Dr MACKINNON: I cannot give you the exact figure, I am sorry. I can return to the Committee with that percentage figure but it would be very low indeed.

Reverend the Hon. FRED NILE: Is that because the prisoners do not ask for it or do not want it?

Dr MACKINNON: I think it is multifactorial. It is not a treatment option that many offenders would be actively pursuing. It is not a treatment that has a particular role while someone is in a custodial setting. The very provision of a custodial sentence for that offender has managed their risk by incapacitation, so the rationale to give a treatment that has potentially very significant side effects in what is, to a degree, a coercive situation, is very poor. The rationale for anti-libidinal treatment only becomes clear when release is being contemplated, so that is in a community setting. As I mentioned before, there are difficulties about arranging that in the community.

The Hon. HELEN WESTWOOD: Do you manage other programs for offenders that are directed at treating their offending behaviour that are not anti-libidinal?

Dr MACKINNON: Yes, we do but it is worth saying that for most offenders the treatment programs that address their criminogenic offending behaviour are managed by Corrective Services.

The Hon. HELEN WESTWOOD: You do not oversee those?

Dr MACKINNON: We have no role in those.

CHAIR: Does that include the Custody-Based Intensive Treatment Program [CUBIT]?

Dr MACKINNON: That includes CUBIT but we have no role in CUBIT. The group of offenders for whom we do have a clear role and for whom we do run programs are those offenders who have a clearly defined mental illness. Generally that is a major, serious and enduring mental illness and at times those are offenders who have been found not guilty due to mental illness by the trial process, who are then given the status of a forensic patient.

"Forensic patient" is a clearly defined legal term that means that that patient then should not be in prison but should come out to what we call the forensic mental health network where not only are their mental health needs comprehensively addressed but also some of their other treatment needs are addressed, including programs to manage, for example, their anger issues and programs to manage their living skills. That subset of offenders—again, often found not guilty because they are partially decriminalised by that process—go through the forensic mental health system, which is separate to the correctional system.

Ms BABINEAU: And when I said we are not involved in the CUBIT program, the only time that we are involved is if the offender or the person that is in the program has any illnesses that need to be treated. Obviously, we have the role to look after them for anything else but we are not involved in the management of the program at all.

Mr CHARLES CASUSCELLI: Returning to what was discussed a little earlier, can I ask you both to consider the interface between your organisation and the custodial environment? I think earlier, Dr Mackinnon, you highlighted some issues where sometimes courts make decisions that make life hard for you in managing the offender in that environment or in delivering your services to the offender. Did I miss something?

Dr MACKINNON: Perhaps I misstated. I was talking more about decisions that the courts may make about the release of the offender to the community. That means that they go out of the environment where we have a remit to deliver health, to an environment where it is not our role or responsibility.

Mr CHARLES CASUSCELLI: Consider the interface between your organisation and the custodial environment. On the other side of that interface if instead of having all the courts that you deal with today you had specialist courts to replace some of those, would that make your task somewhat easier?

Ms BABINEAU: I do not think that it would make it easier because we look after them once they come in. Whatever pathway they come in by, once they are in we look after them, whether they come through a specialist court—the Drug Court is a specialist court—or whether they come from any court. We are a state-wide service, so I do not believe it would make a difference.

Mr CHARLES CASUSCELLI: In terms of the sheer quantity of advice transactions, if I might call it that, the courts come to you for advice and you do not see that quantity diminishing when dealing with specialists on the other side of the interface?

Ms BABINEAU: Asked in that way, I guess what works well with the Drug Court is that all agencies sit together. Every morning there is a meeting and they share a lot of information. There are advantages and disadvantages, like anything else but that is one advantage. We get asked to provide, and part of our role is to provide, a lot of reports to the courts. I do not know how many reports we have to provide for child sex offenders. I do not think that is the majority of the reports. I think that would be a low number. The majority of the reports we have to provide are for people with mental illness at Local and District courts.

We have another program, the court liaison program or the court diversion program, which is to divert people from mental illness. It is probably a hybrid between a regular court and specialist court. It is not a specialist court but we have an officer in a number of courts across the State that provides advice directly to the Magistrate. It is not a multi-agency team; we work by ourselves but we are in the same environment so there is

still a bit of shared information. But the majority of those are people with mental illness who can be diverted through the Mental Health Act, under sections 32 and 33.

CHAIR: If an offender got an extended supervision order, do you stay connected and involved during that period of time? Is your role only custodial?

Dr MACKINNON: We do not; it is only in the custodial setting. Returning to the earlier question about whether it would simplify proceedings if there were a specialist court. I can see how there might be a clarity about the source of referrals and there might be clearer procedures but I suppose that could happen even within the current court system. My understanding at the moment is that there is a fairly ad hoc arrangement in the courts about how evidence is gathered in these cases and that is that the defence may choose to commission an expert report from a psychologist or a psychiatrist and the prosecution, in opposition, may choose to do the same. But that does not necessarily have any involvement from Justice Health in that report writing process; those are independent psychiatrists who are commissioned by the prosecution and the defence.

CHAIR: Do you see a role there for Justice Health to provide a level of consistency of assessment and reporting?

Dr MACKINNON: I do, but I also foresee significant difficulties with that.

CHAIR: What are they?

Dr MACKINNON: For example, the current adversarial system relies on some discretion on the part of the defence lawyers, in terms of which expert they approach. Similarly, that discretion is allowed to the prosecution in choosing their source of evidence for the case. There are models—the mental health court, to think of another specialist court—where a clearer role is given to the State or State organisations in the provision of evidence. I am not an expert in the mental health courts—I know there is one that exists in Queensland—but there are similar difficulties or objections raised by lawyers about shifting away their ability to choose how to seek evidence.

CHAIR: We have heard evidence of the different scales of offenders from a psychiatric or psychological profile, from predatory paedophilia through to the opportunist sexual offenders and the like. Having a consistent way to evaluate that or a mechanism, do you think that would help judges be better informed when imposing sentences?

Dr MACKINNON: I think anything that helps the courts to be better informed about the scientific evidence put before them would be beneficial. From my point of view, that might have regard to the nature of psychiatric and psychological training and evidence giving, rather than necessarily the establishment of a specialist court.

Ms MELANIE GIBBONS: Moving from specialist courts and returning to treatment programs, you mentioned before that you were not involved in the management of the CUBIT program but you said that you do suggest that offenders undertake it on occasion, is that correct?

Ms BABINEAU: No.

Dr MACKINNON: We are not at all involved in the management of the CUBIT program. To explain again, where an offender is in a correctional setting and Corrective Services identifies that they have criminogenic or reoffending related needs, then generally Corrective Services is entirely responsible for the referral to, running of, and management of those programs.

The Hon. MELINDA PAVEY: And the funding of.

Dr MACKINNON: And the funding of, yes. Thank you. The only times we have a remit is when an offender in the custodial setting has a physical or mental health problem, and then our service becomes involved.

Ms MELANIE GIBBONS: So you do not suggest they attend, but you deal with the ones who do?

Ms BABINEAU: They become part of the population of the 10,900 inmates currently in jail for which we provide health services. Every jail has a clinic and we manage the clinics, wherever CUBIT is, and there are a few places. There are some clinics as well. So if they become unwell they will come to the clinic or we will go to them.

Ms MELANIE GIBBONS: Do you have any feedback on the CUBIT program?

Dr MACKINNON: As we have no direct responsibility or role in it, its management really would be beyond our remit. I suggest that be sought from Corrective Services.

Reverend the Hon. FRED NILE: Do you have any recommendations or suggestions about improving the system to benefit the persons charged with sexual assault or even to help in your role?

Dr MACKINNON: Thank you for the very open question. I suppose it is difficult to know where to start. I really echo the submission from the Royal College of Psychiatrists. I would say that the best approach to reducing the risk of recidivism and making the community safer is one that may not necessarily be the immediately obvious one to the community that is often driven by populist fears and notions. The sort of efforts in improving access and availability of rehabilitation programs both in the custodial setting and in the community setting would be comprehensive rehabilitation programs that adopt a multidisciplinary approach using a variety of disciplines as well as a comprehensive, what we call in medicine, biosocial approach—looking at the body, the mind and the society. For example, not just relying on an anti-libidinal approach purely but considering, where appropriate and consensual, looking at a comprehensive psychological program based on best evidence.

I believe the Committee already has heard about the current shift in evidence-based practice in treating sex offenders with psychological programs to cognitive behavioural therapy-based programs and having well-trained and well-informed multidisciplinary teams of workers who can manage that group of patients in the community or in the custodial setting. If those sorts of comprehensive treatment programs were available in both of those settings, that would go some way to reducing, but certainly not eliminating, the risk of reoffending. I suppose the other area that would be of benefit to the community is a greater understanding of the nature of the risk presented by these offenders. Although there is a lot of heightened public awareness and concern about this group, and rightly so, nevertheless, when appropriately managed, the risks are comparatively low compared to some other offender groups.

Reverend the Hon. FRED NILE: Would that management mean constant interaction between some medical services and those individuals on a weekly basis?

Dr MACKINNON: It would be. It would mean that they were both in the custody and community setting and that there most probably were dedicated or at least properly trained multidisciplinary teams that could deliver that kind of overall therapy care and monitoring.

The Hon. MELINDA PAVEY: Can you explain to me the difference between anti-libidinal medication and anti-androgenic medication? Is there a medical difference?

Dr MACKINNON: They are synonyms really. The libido is the sex drive. So anti-libidinal simply means anti-sex drive. An androgen is a hormone that produces androgenic or masculinising effects. So anti-androgen generally is an anti-testosterone medication. That also has the effect of reducing libido. So essentially they are synonymous.

The Hon. MELINDA PAVEY: At the risk of being a populist, given some of the evidence we have received from the other side of the face of child sexual assault, did you read Mr Andrew Tink's evidence?

Dr MACKINNON: I did read the evidence from Mr Tink.

The Hon. MELINDA PAVEY: Have you studied the Oregon experience?

Dr MACKINNON: I have not studied it. I am aware of it, but that was a small study that showed a very good effect from the provision of anti-androgenic treatment, yes.

The Hon. MELINDA PAVEY: In your evidence you suggested ramifications and difficulties associated with anti-libidinal medication. It was interesting to hear from Andrew Tink, who also is on that medication, that the medication is a new standard that does not have the severe side effects or consequences. It seems that there is a medical view and another view. I suppose Mr Tink put to us that if you have an offender who cannot control those urges and is approaching parole or release stage and they agree to put up their hand to take medication and they can be monitored and tested to ensure the medication is being taken on a quarterly basis, is it not a good option for the community and for that offender?

Dr MACKINNON: I certainly do not disagree with that. I hope that none of my evidence can be construed that I am opposed to anti-libidinal medication. I am simply trying to explain that should anti-libidinal medication be considered an option, and I agree that it should, it should be considered in the appropriate setting with the appropriate team about it in a consensual fashion and so on and so forth. Might I take the opportunity to put my position as a scientist as well and say that when it comes to considering a recommendation for an individual patient, certainly you want to take into account individual patient characteristics. But, most importantly, you want to take into account what the evidence suggests is the most appropriate, statistically correct way to proceed.

Unfortunately, in medicine we found that generally anecdote, that is, a case sample of one, is not the most reliable indicator of future success. Rather, we found that the best evidence comes from larger studies of multiple people and sometimes even with more complicated research methodology that I am sure you will be familiar with called the randomised trial control, which attempts to manage some of the difficulties that anecdotal evidence has about people's hopes, expectations and sometimes misattributions of success. Without wishing to take anything away from what Mr Tink offered in his testimony, I would say that in my position as a scientist and doctor I would prefer to focus on the largest evidence base with the most robust scientific methodology possible.

The Hon. MELINDA PAVEY: It is hard to have an evidence base if the world-leading experience at this point is only Oregon and you have seen it but have not studied that example. Is that right?

Dr MACKINNON: That is correct.

The Hon. MELINDA PAVEY: Maybe it is a treatment that we should be studying so that it is not just anecdotal from Mr Tink and we can ensure that we view things properly through the scientific window, such as what happened at Oregon?

Dr MACKINNON: I absolutely agree.

The Hon. MELINDA PAVEY: Maybe we need to do that?

Dr MACKINNON: That would be excellent.

CHAIR: We heard evidence about the number of psychologists and psychiatrists available. From a health point of view, what recommendations or advice could you give the Committee to help build that resource and how would it be utilised most effectively?

Ms BABINEAU: I would be happy to take that question on notice because it is about training and it is a much bigger area because you start now and have outcomes probably for six or eight years. I certainly would be happy to take that question on notice.

CHAIR: We have heard that it is not the most pleasant type of work and obviously, that is one of its most detracting features. We certainly understand that. It is the same in police, Joint Investigation Response Teams [JIRT] and the like.

Ms BABINEAU: It is very specialty.

Dr MACKINNON: There are things we could say that could be helpful. As you say, it can be very difficult work. There is the potential also for it to be, in its own odd way, rewarding in keeping the community safer. I think one of the big risk areas for practitioners would be to feel that they are practising solo, unsupported and with no clear guidelines. Their perception of their accountability, should something bad happen, would be very concerning. I think the previous comments I made about the need for this to be done in structured,

multidisciplinary settings would be an aspect of the development of these sort of services that would be encouraging to practitioners to work in that field.

CHAIR: Do you have a view on whether they would be best employed by the State or resourced and accessed from the private sector?

Dr MACKINNON: As a worker for the State, that is a question beyond my remit.

CHAIR: By "the State", you are talking about the level of support and things of that sort, which is something we could control, whereas if it is in private practice we have less control.

Dr MACKINNON: If you are looking at creating multidisciplinary services that link agencies that is more effectively done within the public setting.

The Hon. HELEN WESTWOOD: Is the principle behind not treating or working with offenders on diversionary programs or on programs to treat their offending behaviour because that is part of their sentence, and the role of Justice Health is purely to look at an inmate's or offender's health and their health needs? As the politician perhaps I should know that.

Ms BABINEAU: Our current remit is really about the treatment, advice, monitoring and assessment of health problems. The rehabilitative pathway or the custody-based intensive treatment program is a remit that is with Corrective Services. We have no involvement inside for any of these rehabilitative programs. It is not our role to play. It has nothing to do with who they are. We believe it is really important to have health separate from Corrective Services. We believe it is important because we are there for treatment. We are not there to know why they are in, who they are, what they have done. We are there to assess them and treat them. It is a different role for both organisations.

The Hon. HELEN WESTWOOD: If they had to be given drugs or something else as part of their sentence, and I do not know if people are referred to you from the Drug Court, do you have any role in assessing the appropriateness of those inmates having medication without there being any serious side effects?

Ms BABINEAU: Corrective Services actually hire psychologists. We do not have psychologists in the correctional environment because Corrective Services is funded to hire them. Most of these programs are provided by Corrective Services. You gave the example of drug dependency. Justice Health will provide the medication, the pills, the assessment, the doctors, but Corrective Services will provide the counselling because they have the psychologists. To answer your question, it is not about who they are and why they are there. We have two different roles that we complement. In some areas it works well. People who come in with drug addiction, we treat the illness, the withdrawal, we give them pills, but we work well with Corrective Services because they provide the counselling.

The Hon. HELEN WESTWOOD: You would monitor that and then advise if there were some problems with the treatment that they were on for their drug addiction?

Ms BABINEAU: Yes, we would deal with it. If someone comes in who is withdrawing, they will need medication and we would have them in a safe cell. We work with Corrective Services because they are responsible for the placement. We would be monitoring them. If things go wrong, we might recommend that they go to a local hospital, because we are not a hospital. We have community clinics. We manage the illness but we do not necessarily advise Corrective Services on what they are doing with the counselling. We work with them. They do a lot of group programs, which we do not do. Our remit is to provide health services to the inmates.

The Hon. HELEN WESTWOOD: If someone was incarcerated and they were on a treatment program, let us say for drug addiction, and you are monitoring or caring for their health needs, when they move into the community, to whom do you hand the management of their healthcare needs, including their pharmacological treatment, whether it is methadone or something else? How does it transfer from Justice Health to someone in the community?

Ms BABINEAU: We will be transferring the care as much as possible because it depends on the resources. There are different areas. If you are on an opioid substitution drug or you are on methadone in custody and you are going to St Hilliers, you might not have a public methadone prescriber. We work with them

as much as possible. Our method will be that we will try to get that person to bring down their dosage to be able to deal with it differently when they go back, if they decide to go home, which is St Hilliers, as an example. You picked a good example. Because it was an issue, we have developed a program called "Connections". People who are drug dependent can be on that program. We help them; not people on bail. Those people who will go out because they have finished their sentence, we will work with them for one month when they are inside and we will work with them for a month or two when they leave custody. Basically we provide the health services, we provide the linkages and we will coordinate other services. It is an intensive program. It is a different program. We have piloted it and we have been doing this program now for 10 years where we help a certain number of people.

CHAIR: What is the name of the program?

Ms BABINEAU: Connections. The whole principle with these programs—and the Drug Court is the same—if you treat the illness then chances are you will reduce recidivism. A lot of people, especially those who are drug dependent, will come back in because when they are outside in the same environment and they will use again, so they will come back inside. Where there has been a lot of evaluation of both programs, the evidence demonstrates that it has reduced recidivism for the people we have been working with.

The Hon. HELEN WESTWOOD: Is there a reason why that model would not work if an offender was, as part of their sentence, required to use anti-libidinal medication?

Ms BABINEAU: Before Dr Mackinnon answers I will say that we do not provide the health treatment when they are outside. We connect them.

The Hon. HELEN WESTWOOD: Yes.

Ms BABINEAU: That is important because the principle of these programs only works when there are places to connect them. There is the odd one that is typical. So far as anti-libidinal medication, as Dr Mackinnon said earlier, the issue is in the community. It has to be continued and there is a lack of people who provide it. There are a lot of other reasons, looking at the whole environment, so we have never been involved because of those reasons.

The Hon. MELINDA PAVEY: Do you have a percentage figure for the number of clients/patients that you see in your facilities who are in custody for child sexual assault offences?

Ms BABINEAU: I do not have that. Corrective Services would have that. We would not because we—

The Hon. MELINDA PAVEY: You see them as a patient.

Ms BABINEAU: Yes. We make that quite clear when we hire people. It is not about the history, it is about the treatment.

CHAIR: Any final questions?

Reverend the Hon. FRED NILE: As you get to know that person and you are treating their health needs, do you ever get asked to give advice about their release, whether they would possibly reoffend or so on?

Ms BABINEAU: We would not give advice on reoffending. I will leave the mental health arena to Dr Mackinnon. The way we have been working is that we would transfer the care, if they need care, to a clinician in the community or work with them to find a clinician in the community, people who are at high risk of chronic illness, or things like that. Our role would not be to comment on reoffending.

Reverend the Hon. FRED NILE: You do not make recommendations.

CHAIR: Any final questions? Is there anything you would like to say in conclusion?

Ms BABINEAU: I do not, thank you.

Dr MACKINNON: Thank you very much for having us.

CHAIR: On behalf of the Committee, we thank you for appearing today and for the evidence you have provided.

The Hon. MELINDA PAVEY: You are coming back to us with some figures?

CHAIR: You took one on notice.

Ms BABINEAU: I took one on what could be done for training of that specialty area. Yes, the secretariat will give it to us.

CHAIR: Thank you very much.

(The witnesses withdrew)

The Committee adjourned at 5.18 p.m.