REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

INQUIRY INTO COMMUNITY BASED SENTENCING OPTIONS

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At Sydney on Tuesday 27 September 2005

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. C. M. Robertson (Chair)

The Hon. D. Clarke
The Hon. R. H. Colless
Ms L. Rhiannon

Corrected

CHAIR: Welcome to the ninth public hearing of the Standing Committee on Law and Justice inquiry into community-based sentencing options. This inquiry has been very interesting and somewhat complex. We have extended the reporting date on the numerous occasions and these latest hearings, which are at the end of our public hearing process, have been structured for us to tidy up some of the information we have received in our field trips and also in public hearings in Sydney. One major issue has related to health, so your evidence today will be very important. The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines governing broadcast of the proceedings are available from the table by the door.

Witnesses, members and their staff are advised that any messages should be delivered through the attendance or the Committee clerks. I advise also that, under the standing orders of the Legislative Council, any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person. The Committee prefers to conduct its hearings in public. However, the Committee may decide to hear certain evidence in private if there is a need to do so. If such a case arises I will ask the public and media to leave the room for a short period.

If a witness gives evidence in camera following a resolution of the Committee, however, they get to be aware that following the giving of evidence that Committee may decide to publish some or all of the in-camera evidence. Likewise, the House may, at a future date, decide to publish part or all of the evidence even if the Committee has not done so. I ask everyone to turn off their mobile phones, not just turn them to silent.

RICHARD JOHN MATTHEWS, Medical Practitioner/Bureaucrat, NSW Health, Locked Bag 961, North Sydney, affirmed and examined:

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

Dr MATTHEWS: As the Chief Executive of Justice Health and as Acting Deputy Director-General for Strategic Development, NSW Health.

CHAIR: Are you conversant with the terms of reference for this inquiry?

Dr MATTHEWS: I am.

CHAIR: If you should consider at any stage that evidence you may wish to give or documents you may wish to table should be heard or seen only by the Committee please indicate that fact and the Committee will consider your request. If you take any questions on notice we would appreciate it if the response to those questions could be forwarded to the Secretariat by Friday 14 October 2005. Do you wish to make a short opening statement?

Dr MATTHEWS: I have been the chief executive in an acting and substantive capacity since 1999. The history of the service is, we would like to think, that we started with the four surgeons who came with the First Fleet. But it changed from a prison medical service, a small outreach of the Department of Health, into the Corrections Health Service in 1993, when it was formally constituted as a statutory corporation under the Health Services Act with a board reporting to the Minister. About two years ago, because their remit had spread beyond adult correctional centres, we had taken responsibility for juvenile detention centre health services, we had been given responsibility for the statewide forensic service and established the court liaison service and were establishing the community forensic liaison service, we thought it appropriate to change again to Justice Health, to reflect our role at the intersection between health and the criminal justice system. We are in adult centres, juvenile centres, police cells, courts, just about anywhere you find people in trouble, both before and after release as well.

CHAIR: The Committee heard quite a lot as we were in the field about the implementation of the mental health people attached to the courts. My question of the local people was had those people come from the mental health program in Health Services?

Dr MATTHEWS: Many of them are known to Health Services. I will backtrack a bit. As part of our remit we have done a lot of research about the socioeconomic and health deficit that people coming through the doors of prison suffer. In 2001 we administered an instrument called the National Mental Health Interview, using the acronym CIDI, which has also been used in the community on about 13,000 people across Australia to give the prevalence of mental illness in the community. We administered the same instrument to people coming through the front door of prisons, together with comparison between those people in the normal community.

We found that 10.7 per cent of males and 15.7 per cent of females had a 12-month prevalence of psychosis compared to about 0.4 per cent for both sexes in the community; its ratios were about 20:1 and 30:1. When we looked at those people and categorised them by offence type, we found that just over 50 per cent were charged with an offence which was potentially bailable, and about 45 per cent were charged with offences for which there was less likelihood of getting bail because of the nature of the offence.

Magistrates told us that often a barrier to bail was the inability to get health services, homelessness, a whole range of issues. We had already established a pilot court liaison service in Central Local Court and Parramatta Court. The aim of the service is to provide magistrates with advice about whether people are suffering from mental illness. That is done by registered nurses in the court. Referrals to the service can be by the court, the defence, the prosecution, the police, the family, or the person. We have now expanded it; it is in 19 local courts, 16 run by Justice Health and three by the area health services. About 11 per cent of all custody is in those courts that we are in get referred to the service for assessment.

Of those who are referred, about 7 per cent of the total, not 7 per cent of the 11 per cent, are found to have mental illness. That advice is given to the court and as a result of that advice about 55 per cent are diverted from custody into care in the community. It is nice when one's research is backed up by findings, because that was almost the exact percentage we found in the original research were potentially divertible. Of those who are diverted, about 20 per cent go into a bed through section 32 or 33 and the other 80 per cent are diverted to community care. Most people have been known to mental health services, some are new diagnoses, but the majority are known. For one reason or another they have dropped out of treatment.

People with mental illness tend to be a fairly mobile group, they move around the State, they are often difficult to track down, particularly homeless people because they are difficult to follow up. They have a tendency to drop out of treatment, become non-compliant, and then commit crime of one kind or another. It has been an extremely successful program. We have just about saturated the courts where there is sufficient throughput to justify full-time nurses. We are now commencing a trial in two courts, Griffith and Broken Hill, of a telemedicine facility to see if we can provide an effective service when needed through the medium of telemedicine. That equipment has been installed and we are about to start in those courts.

Those nurses are all skilled mental health nurses and they are backed up by psychiatrists, who are on the phone. If the nurses have questions, they telephone the psychiatrist. They get straight through and, if necessary in some cases, particularly where there is a concern about risk and public safety, a psychiatrist will attend the court, see the person and give an opinion about that particular area which is beyond the competency of the registered nurse.

CHAIR: My question also related to rural communities where mental health nurses are few and far between. How many of the court nurses in those areas have come out of the mental health teams from the area health services?

Dr MATTHEWS: I would say that about 50 per cent of those courts are in regional or rural areas. I would have to take on notice where the nurses had actually been recruited from. I would think the majority from the local area, but some may have moved there. It is a desirable job for a number of reasons. It is a prestigious job. You become part of the court team; you give advice to the court; you work at a high level of independence and competence for a registered nurse; so for those reasons they are desirable jobs.

CHAIR: Is your research available?

Dr MATTHEWS: Yes, it is. I can make that available.

CHAIR: You will take that on notice?

Dr MATTHEWS: Yes.

CHAIR: Another comment we had from Bega was in relation to the Long Bay gaol psychiatric centre and the perception that it was a hopeless pit where no service was available when they got there.

Dr MATTHEWS: Long Bay is a complex of correctional centres. Depending on how you count them, there are about five or six different gaols at Long Bay. One of those is the prison hospital, which is a curious beast, in that it is both a maximum-security gaol and a level 5-6 gazetted psychiatric hospital. There is a very significant resource of mental health professionals available at Long Bay. The budget of Justice Health this year is round about $72 million of which about the $22.5 million goes on direct mental health services. A large part of that would be in the Long Bay hospital.

That hospital was built in the eighties when the prison population was probably about 3,500. The prison population is now hovering about 9,000, so obviously the number of beds is not adequate. We are about to build two new hospitals at Long Bay. One will be a 135-bed maximum secure forensic hospital on land, which will be degazetted as the prison, and that hospital will be entirely run by NSW Health. The other will be a 85-bed prison hospital for sick prisoners, including 40 mental health beds, which will take the total number of beds on the campus from 120 to 220. More important, it will bring the model of care for forensic patients—those found not guilty by reason of mental illness or unfit to plead—into line with the practice in other States in this country and other parts of the world.

CHAIR: The question came up in relation to community-based sentencing because people were terrified to go there through the psychiatric assessment at the courts.

Dr MATTHEWS: Certainly, I think it is fair to say that correctional centres can be terrifying places. I would probably be extremely unhappy about going to gaol.

CHAIR: But they actually would prefer to go to gaol. A lot of people out there were comfortable about going to gaol; they were more frightened of the Long Bay centre.

Dr MATTHEWS: When you say the Long Bay Centre, do you mean the complex as a whole or the hospital?

CHAIR: No, the hospital, the psychiatric centre?

Dr MATTHEWS: Many people would associate the hospital possibly with compulsory treatment. The Mental Health Act, as you know, allows for compulsory treatment. Many people with mental illness have very bad memories of compulsive treatment, both in community psychiatric hospitals and in the Long Bay hospital. Many people with mental illness are not accepting of their problem and the experience of having enforced treatment can be a very, very unhappy one, which is why we need to have more assertive and aggressive recognition of the first psychosis and early psychosis treated much earlier, so that we do not get these overwhelmingly negative feelings about treatment services that are felt by many people with mental illness.

The Hon. DAVID CLARKE: I understood you to say that some 10 per cent of the male prison population have mental health problems and 15 per cent of the female population, is that what you said in general terms?

Dr MATTHEWS: That was the 12-month prevalence of psychosis. That is one category of mental illness. There are many other categories, depending on how you define mental illness. Drug dependence, for instance, is a DSM4—that is the categorisation of mental illness diagnosis. If you accept drug dependence and drug abuse as a type of category of mental illness, you also accept all the

anxiety disorders and depression. Then you can argue that up to 90 per cent of the female population and 75 per cent to 80 per cent of the male population suffer from some form of mental illness. It is a question of definition.

The Hon. DAVID CLARKE: Taking that area of psychosis, why is there a 50 per cent higher rate with women held in custody? What special factors would be at work there?

Dr MATTHEWS: That is a very interesting question. Women make up about 6.2 per cent of the prison population. They are in every way a much more damaged, much more ill group than the men are—very high levels of mental illness; very, very high levels of substance abuse and dependence; very high levels of both physical and sexual abuse as children; and perhaps more abnormalities—10 times higher than the community rates. Hepatitis C positivity is about 60 per cent for women compared to about 1 per cent of adults in the community. In every possible parameter you can think of women who end up in prison are a very sick, very damaged group.

The Hon. DAVID CLARKE: That is a very disturbing and startling state of affairs to have women in the community who have suffered like that, for a variety reasons, such as sexual abuse and other factors. That is something that really needs to be looked at and is probably not realised.

Dr MATTHEWS: I think that particular picture would be painted in every other State and most Western countries. Traditionally, although there has been some change, women commit different kinds of crime to men. Their crimes are mostly those of mental illness and drug dependence; also personality disorder, because they often have quite damaged personalities because of the things that happen to them. Traditionally, they have come to gaol for more minor offences and they have come on multiple occasions for multiple relatively short periods. You do not get many gangsters, armed robbers, et cetera amongst the female population. They are crimes of desperation, in the main.

The Hon. DAVID CLARKE: Is it true to say that there is a growing percentage rate increase in mental illness in the community and, if there is, is that because of pressures of modern day living or is it because there is a greater detection rate of something that has always been there?

Dr MATTHEWS: That is another interesting question. There is a lot of debate about whether the prevalence of serious mental illness is increasing and there is no clear evidence at this stage that it is. If you take schizophrenia, manic depression, the rates at this stage do not appear to be increasing, although there are many academics and researchers who are predicting that they will. The etiology of schizophrenia is complex. They have now identified something like 37 different genes, which have an impact, but there is no question that environmental damage, if I can use that term, ranging from abuse of a physical and sexual kind, increasingly through to higher levels of stimulant drug use may be tipping people over the edge. There is no doubt in my mind that what we are seeing is an increase in the rate, severity and treatment of people who do suffer from this illness.

An individual will have more acute episodes that are more difficult to treat and require longer periods of treatment in hospital than previously. This in my mind is very closely linked to the phenomenon in the late 1990s and what we are now calling the "noughties" of an increase in not only stimulant drug use but an increase in the concentration of the drugs. So there is now a lot higher concentration of THC, marijuana, due to hydroponics and a whole lot of other agricultural improvement. The shift to methamphetamines and, in particular, high concentration of so-called Ice—crystal methamphetamine—is absolute dynamite for people who suffer from serious mental illness. The jury is out. Are those drugs actually causing it or are they precipitating it in those who are already prone to it is a matter of raging academic debate across the planet.

Ms LEE RHIANNON: How can co-ordination and co-operation between the Probation and Parole Service Mental Health Teams in area health services be improved?

Dr MATTHEWS: The next initiative of the statewide forensic service, now that the Court Liaison Service is established, is the establishment of the Community Forensic Teams under Justice Health. The first team was funded in the past financial year. This year it is being expanded in both the adult and established juveniles. We are talking to Catriona McComish and others in the Probation Service about establishing a referral service to assist with their most difficult clients, in particular, serious and serial sex offenders, a group we are particularly interested in setting up and offering an

expert advisory service on. Also, there does need to be a better linkage with mental health services established as well. How can it happen? We are going to work with Catriona to try to establish appropriate referral criteria. We have to start with the most serious ones and work our way down. We need to make certain that the referrals are appropriate, otherwise the services will be absolutely swamped with referrals they cannot manage.

Ms LEE RHIANNON: Are there sufficient resources to be able to do that intensive work?

Dr MATTHEWS: It is intensive work. The resources are being expanded. We were funded for $1 million to establish it last year. We have got an additional $1.3 million for the adults and $0.8 million for the juveniles this year and that will increase again next year.

CHAIR: Is that Justice Health?

Dr MATTHEWS: This is purely Justice Health, not the State. There are additional enhancements for other area health services but this is for a particular and specialised service which will have very special skills in the difficult area of risk assessment. By risk assessment I mean not just risk to the community but also risk to individuals who might harm themselves. It is a two-way street. I am often asked if mental health resources are adequate and the obvious answer is, of course they are not and it is hard to imagine how they will ever be.

Ms LEE RHIANNON: Why do you say that? Is it short-term frustration with the Government—maybe that is the wrong way to put it—or do you think the Government will not have the political will to do that? Do you have a bigger picture?

Dr MATTHEWS: Firstly, there are a couple of reasons: first, it is a very big problem. It is a bottomless pit of endless need. The second thing is that our ability to treat schizophrenia, for instance, is improving but still a long way from perfect. Professor Gavin Andrews at St Vincents" Hospital, for instance, who is advising the Commonwealth on what ideal mental health services should look like acknowledges that if the ideal service were introduced you would still only remove 40 per cent of the burden of schizophrenia as a disease with our current state of knowledge. There are many people for whom our treatments do not work; there are many people for whom our treatments have such severe side effects that they reject them.

The first reason I say that is that no matter how perfect your service you will still have people who are extremely difficult to treat and non-responsive to treatment. The second thing is that we have a significant work force problem in mental health. We have got an ageing mental health nursing work force, particularly in country areas. I think the average age of mental health nurses in the bush is approaching 50, with an average retirement age of 55. There is a lot of pressure on our work force. One of my greatest fears is that increasing scrutiny by media and others of some of our adverse events—bearing in mind that these assessments are subjective. When you have someone in front of you who is suffering from a severe mental illness and you are trying to make the decision about whether they need to be admitted or whether they can be cared for in the community, is a subjective and difficult decision to make and sometimes you are going to get it wrong; that is absolutely certain. It is not like diabetes where you take some blood and you get an absolute blood sugar and you adjust the insulin on that basis.

Very often circumstances change rapidly. You could do an assessment on a patient today, that patient could be fine. They could go out and take a drug or something else could happen and their clinical situation could change dramatically and they could do something terrible to themselves or to someone else. Too often the blame for that is being sheeted home to our clinicians and we need to protect them because people increasingly say to themselves "Why would you do it?" We do need to improve systems but we do need to get away—unless people are operating at a level of practise really right outside the norm—from blaming individuals around what are very subjective and difficult decisions.

Ms LEE RHIANNON: In the big picture, I am sure of you are aware of the ongoing criticism about the lack of resources post the Richmond report. Has Justice Health had to pick up the pieces since?

Dr MATTHEWS: Again I make two comments: the report of poor old David Richmond gets cited for a lot of things. If you look at the actual history the decrease in the resources in institutions actually started in 1942. In 1942 we had 400 beds per 100,000 of population and what happened after the war was that we started to develop treatments such as Largactil and others which were effective and the institutions started to decline. The majority of the decline in numbers of beds in institutions occurred prior to Richmond, if you actually look at the graph of decline.

David produced a report which, if you like, described and codified what ought to happen and various people have acknowledged that there were not sufficient resources put into the community at that time. In my view this disinvestment has been going on for about 70 and not 20 years. From my perspective, having taken that historical view, we need to again move away from looking a governments, institutions and others to blame, and accept that we have got a problem, agree with the Commonwealth, I think this is a national issue, about what the models of care, the different kinds of packages of care for people with mental illness ought to be, and work out how much all this will cost. After we have done that in a room with our hats off, and we have agreed on what it ought be, then we should have a discussion about how it should be paid for.

Ms LEE RHIANNON: During the committee's visits the issue of the uneven distribution of services, particularly drug and alcohol, has been raised. What are the reasons for that? What could be done to improve the distribution of services across the State?

Dr MATTHEWS: Where have you been where they have felt that things were unfair in distribution?

Ms LEE RHIANNON: I remember the further we went west—

CHAIR: Although Inverell had a big issue.

Ms LEE RHIANNON: Yes, Brewarrina, Bourke and Inverell.

Dr MATTHEWS: These are issues that go beyond drug and alcohol in country towns of that size. They are right across health and, indeed, right across government. How do you provide effective and safe maternity services in those places, given the lack of skills of the clinicians and the fact that the throughput of patients in any particular discipline is often less than is needed to maintain the skills of clinicians, even if you have them? It is a sad and difficult fact that increasingly people who live in isolated communities have to travel to larger communities to get effective and safe health care. Outreach services are obviously one way to do it. Incentives to attract skilled clinicians to work in those places is another way but it is often said that a lot of it is about money, it is not just about money. It is about the lifestyle of clinicians—doctors, nurses or allied health—but one has also got to consider that other critical factor that if you spend a lot of time training to be very good in a relatively small area, you also want to have the throughput of patients with that particular problem to maintain your skills. That is true whether it is for drug and alcohol, mental health or delivering babies.

Ms LEE RHIANNON: Is it about half and half between money and organisation or is it tipped one way or the other?

Dr MATTHEWS: It is more about the package out there of all those things I talked about. The future has to be around embracing innovative technology. We are doing that to some extent with telemedicine. From memory, I can give you the detail, we have about 235 sites across the State that have telemedicine facilities for delivering a range of different kinds of clinical care. We have got quite increasingly sophisticated ways of assisting people in emergency departments. A couple of weeks ago I was at Penrith Hospital and the emergency department physician was in a room with telemedicine to the Blue Mountains Hospital at Katoomba guiding a less experienced clinician/doctor in treating a very seriously injured person and preparing them to be transported down, and doing that via telemedicine, and actually telling that person what to do.

We have got more and more diagnostics being delivered via improved technology. In Justice Health we have now got computerised radiography so our x-rays inside the gaol are sent down the wires to Prince of Wales Hospital where some radiologist will read them and give a report and it will all be done fairly quickly as opposed to somebody, five years ago, putting those x-rays in his car and

driving them to the Prince of Wales Hospital and then driving them back. It is going to have to be a combination of embracing and improving the different kinds of technology available to us and accepting that for whatever we do, for some forms of treatment to be safe and effective, people have to travel to get them.

The Hon. RICK COLLESS: The relationship between mental illness and the propensity to commit a crime, which comes first?

Dr MATTHEWS: You will remember I spoke about the research we did about people coming to gaol and we effectively divided the population into two groups; one with a 12-month prevalence of psychosis and the other who did not have that. We divided them into offence types. Essentially there was no difference. The idea that people with a mental illness commit crime particularly violent crime at a higher rate than the rest of us, is a myth—it is not true. The best predictor of the likelihood of a violent crime in our community is the use of alcohol. People with mental illness do not commit crime at a greater frequency, it is important to understand that.

When people who suffer from mental illness do commit a crime there are two mechanisms by which that can be dealt with. For serious indictable offences, the Mental Health (Criminal Procedures) Act, which belongs to the Attorney, is the means by which people can be found either unfit to plead—in other words, their mental condition is such that they are incapable of understanding the nature of the offence with which they have been charged—or they can be found not guilty by reason of insanity based on what are known as the M'Naghten's rules, which were established in the English courts in the 1850s. For serious offences in this State, and in other States, there is legislation that enables the courts to make that determination.

For less serious offences there are allowances under the Mental Health Act for magistrates, under section 33 or 32, to either send someone to hospital for treatment or dismiss the charge completely. We have legal mechanisms by which we deal with that. It is also important to say, and I may not be popular as saying this, that sometimes people with mental illness can commit a crime which has no relationship whatsoever to their mental illness. If that is the case, and that is what is decided by the court—which is the appropriate place, obviously—the appropriate penalty, whatever is prescribed by Parliament, ought to apply. It is the responsibility of Justice Health to make certain that those people get adequate services while in prison in the same way that it is our responsibility to make certain that people with diabetes get adequate health services.

If a person with severe mental illness who is sentenced becomes mentally ill, to the point where he or she needs compulsory treatment, the analogy is the same. They should be transferred out into the forensic hospital and treated and then transferred back, in exactly the same way that they would be transferred out to the Prince of Wales Hospital if they had appendicitis, had their appendix removed, and transferred back. The law makes the determination, Parliament prescribes the penalty, and people need to be dealt with on that basis and appropriately cared for.

The Hon. RICK COLLESS: Is that a satisfactory way to deal with it? You talked about a legal mechanism to deal with, essentially, a mental health problem. I find it a bit incongruous that the court decides whether a person is insane, obviously taking on board all the best advice it can get from the medical profession. Do you see any problem with the way it is dealt with as a legal issue rather than a mental health issue?

Dr MATTHEWS: Once an offence has been committed, the crime has been commissioned, then it has to be dealt with by the courts. There is no other mechanism. The responsibility of health authorities, in deed of the community—and it is the community issue—is to make certain that people with mental illness get the best possible treatment so they do not commit crime that is related to or caused by their mental illness. That is our responsibility, it is not just a health issue. As a community we need to do it better.

The Hon. RICK COLLESS: Do the statistics on mental illness have any hot spots in terms of regional distribution?

CHAIR: Who is madder than whom?

The Hon. RICK COLLESS: Yes. Which towns are madder than which towns? It is a very important issue, obviously for regional communities. Is there any particular ethnic group in which those problems are worse than in others?

Dr MATTHEWS: No, I do not think it is any ethnic group. However, people who come from parts of the world that a very troubled and who very often have had extremely troubled upbringing, an abnormal upbringing, are more likely to be damaged as human beings and people who come from very stable community. The prevalence of different kinds of mental illness seems to be fairly evenly spread across different ethnic groups and races, if you take out those other independent variables. In New South Wales, the highest prevalence is probably in areas that have a big homeless community, because a lot of people with long-term serious mental illness slowly lose contact with family support and community support. Large numbers of them, that reason, become homeless. So you get the biggest prevalence around the inner city. In regional areas, probably in a small place, a small number can be very obvious and very problematic within the community. But the prevalence is probably not any different.

The Hon. RICK COLLESS: I am interested to hear your comments in relation to drugs more than alcohol, although alcohol is probably a bigger problem, but what comes first, the mental illness or the dependency on the drugs?

Dr MATTHEWS: The silly answer is both. There is no doubt that many people who suffer from mental illness, whether severe such as schizophrenia, or depression, do not like the way they feel all the way their feelings are. Many people find that mood-altering substances, either legal or illegal, make them feel better. Marijuana is a good case in point. People with emerging psychosis have positive and negative symptoms and marijuana can heighten some of the positive ones; the kind of flight of ideas. It can blunt some of the negative ones. One of our biggest challenges is that we have a group of young people who we know that smoking high concentration THC keeps them over the edge but who actually like doing it. They are admitted, given compulsory treatment, and told over and over that smoking marijuana is very bad for them. But they get out and return to it, because they like it, and there is a lot of it about. That is a very significant problem for us, and it generates a lot of criticism. Very often when people are discharged from hospital or released on parole after appropriate consideration, they are okay; but it is the return to drug use the causes them to be not okay.

The Hon. RICK COLLESS: With marijuana, people who are recreational users, a social intercourse activity rather than someone who is dependent on it, per se, could that usage lead to mental problems?

Dr MATTHEWS: Put it this way: If you have a mental illness, you should not use marijuana at all, if you have any propensity. I come back to my alcohol analogy: If I give you a schooner of beer, it will have a certain effect on you. If I give you a schooner of Scotch, it will have a slightly different effect. It is the same drug, it is just a different dose. At least with the beer and the Scotch you know the dose of the drug you are taking. If you smoke marijuana or take something in a little foil that you have bought from someone, you are never certain of the dose, the purity, or indeed the substance. You cannot be certain, because it is illicit. It is very much also dose related and you cannot be certain of the dose. Anyone who has had a psychotic episode the advice would be you must not, should not, smoke marijuana or take any stimulant drugs.

The Hon. RICK COLLESS: You mentioned the 37 genes that contribute to schizophrenia. Of the general population that have those genes, how many develop a form of clinical schizophrenia?

Dr MATTHEWS: I think the prevalence is about 1 per cent. The genetic influence is that someone who is schizophrenic and who has a child, that child has a much higher likelihood of schizophrenia. If two schizophrenic have a child, the likelihood is approaching 50 per cent. So you see it is what is called multifactorial with variable expressivity. There is also a lot of environmental overlay. It is exactly the same as height: You have the genetic blueprint for height, but how tall you are depends on the diet you get as a kid. You can wind up within a range, so it is the effect of the environment on your genetic blueprint.

CHAIR: Do you have community-based sentence offenders accessing Justice Health services? That is people on bonds, et cetera.

Dr MATTHEWS: The vast majority of them would be accessing services from the geographic health services in which they live. We are setting up a very specialised statewide service for a small group of difficult folk.

CHAIR: That is good. Do you have any idea what effect that has on the ability for services such as the Magistrates Early Referral Into Treatment Program [MERIT], the Drug Court process?

Dr MATTHEWS: MERIT is expanding and is successful. I have some figures.

CHAIR: The problem we found is with mental health services on the ground in order for MERIT to function properly.

Dr MATTHEWS: MERIT is an early referral into drug and alcohol treatment. It has been extended to cover 53 Local Courts, which cover approximately 75 per cent of the volume of finalised Local Court criminal matters. People are referred into detoxification, pharmacotherapy, residential rehab, individual and group counselling, case management, welfare support and assistance. Given that the first one was established in Lismore in 2000, an extension to 53 courts with 75 per cent coverage over five years is a pretty reasonable expansion I would have thought.

CHAIR: The other area of sentencing that we found may be a problem is periodic detention. Does Justice Health have anything to do with periodic detention detainees?

Dr MATTHEWS: We do. We provide health services during the 48 hours in which they are in custody. We take the view that their primary care providers are in the community, so we would do an assessment, we administer legally and appropriately prescribed medication and we deal with emergencies, but because they are out five days a week, we take the view that their principal carers are in the community.

CHAIR: It would appear from evidence we have received that other organisations feel the same. Are you aware that they do not actually get access to probation and parole or any support programs?

Dr MATTHEWS: Yes, as I understand it, Parole certainly deals with people who have a minimum term greater than two years and who are released prior to their minimum term. So parole services are really for a group of people who are serving significant terms and then are released prior to their full term. If you are on remand and released, if you are doing short terms or periodic detention, or indeed, if you are released at full term, Parole has nothing to do with you. That is the way the system is. Probation is really different.

CHAIR: It is part of our terms of reference to ask about intensive supervision and a connection with periodic detention. We have come to the conclusion that there is not one.

Dr MATTHEWS: Periodic detention has to be seen purely in terms of it being a retribution. Again, there needs to be a kind of fundamental discussion and debate about what prisons and everything are for. If it is all about retribution, then that they are highly successful. If it is about rehabilitation and deterrence, then the success is arguable. It depends what you want from them.

CHAIR: Where are the area health service mental health teams that are doing the courts for you?

Dr MATTHEWS: I can take that question on notice and provide you with a full list of the 19 courts.

CHAIR: Including the area health service ones?

Dr MATTHEWS: Yes.

CHAIR: It is expected that area health services, particularly in the country areas, carry a fairly high level of support for people on community-based sentencing. Anger management courses, et

cetera, seem to be in favour at the moment and there is a perception that it is very important for those to exist. It would appear that the one or two mental health or drug and alcohol people who work in a particular area are expected to deliver those courses.

Dr MATTHEWS: Firstly, I am not sure of the evidence around anger management courses and, secondly, I think with mental health services we need to define what our business is. We cannot be all things to all people. There is somewhat of a perception that we ought to be. We do not have the resources, nor should we be involved with people who are intensely unhappy; we have no cure for that. But there is an expectation on the part of a lot of people who are unhappy that they will access mental health services. I think we have a lot of other priorities than running anger management courses, quite frankly.

CHAIR: The telehealth and web cam facilities program. Did you say that they are trialling them in two places attached to the courts?

Dr MATTHEWS: Yes, we are trialling them in Griffith and Broken Hill. Across the State Health broadly has 235 different facilities.

CHAIR: Would you take on notice and provide us with a list of those facilities that are running telehealth?

Dr MATTHEWS: The 235?

CHAIR: Yes?

Dr MATTHEWS: Yes, we can do that.

CHAIR: Aboriginal persons have become a major part of our terms of reference, not necessarily because they were included in the beginning but because the majority of them are in rural areas and they are a disadvantaged population. Also, the proportion of them in gaol is very high. A lot of work has been done with communities to improve the structures within communities. Some of the issues relate to health structures, particularly in relation to area health services and AMSs, although they are not called that any more, working together and perhaps sharing resources.

Dr MATTHEWS: Yes, we have about 12 of the community-controlled organisations—the AMSs—that we have partnership agreements with who come into correctional centres to see people prior to release. Aboriginal people who come to gaol are a marginalised group within a marginalised group. They do not tend to access health services very well. Again, we are dealing with a problem of social determinants and we are dealing with a problem of antecedents.

Part of the reason that Aboriginal people are more likely to be sentenced with a given offence is because of the antecedents that start as juveniles. Many young Aboriginal people will have two or three episodes of what is known as the trifecta—offensive behaviour, assault police, resist arrest—before they have any other offence. There is not a health solution to this problem. Health is part of the solution. This is a problem, which is about jobs, about education, about housing standards and about improving a whole raft of social determinants of abnormal behaviour and health. It is a four-generational solution.

CHAIR: We did find that there was a perception from a lot of people that health could solve a lot of these problems.

Dr MATTHEWS: Health is a big part of it but you cannot put in place a health or treatment program that is going to solve this problem by itself. It is a whole-of-government broad societal problem. It starts with jobs.

CHAIR: With respect to our terms of reference to look at inequities in the community-based sentencing process—and I accept that for community-based sentencing to increase, the community itself has to be able to deal with it—do you have any ideas on how Health could be a participant in that process?

Dr MATTHEWS: Yes. If I can use an analogy, my view is that we need to put the nets further upstream. In our service we started with adults and we put out some nets. Now we are going to the juveniles. Our aim with the Adolescent Forensic Service is to provide an assessment service to the Department of Juvenile Justice the first time that young kids get into trouble in order to determine what their health needs are and what their broader needs are. We should leave the nets up the stream but we should also move them further up.

The Attorney General—and you may have taken evidence on it—is involved in a very innovative program with a community group outside Wagga Wagga where they are actually getting referrals from kids who are only very slightly in trouble, and if I can use that expression. They are young; they have not been charged but they are identified as being at risk and in trouble. We have one of our staff on the steering committee for that initiative and it might be worth your while getting evidence from the Attorney General about that. The further we move the nets up the stream, the earlier we pick people up, and the more services we provide for them and their families, the more people we are going to prevent winding up downstream in adult correctional centres.

CHAIR: Was there anything further you wished to tell the Committee?

Dr MATTHEWS: No, I do not think so.

(The witness withdrew)

(The Committee adjourned at 10.40 a.m.)

(The hearing continued with in-camera evidence at the Holy Family Centre, Emerton)