REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At Sydney on Thursday 11 December 2003

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. J. C. Burnswoods (Chair)

The Hon. C. E. Cusack
The Hon. K. F. Griffin
The Hon. R. M. Parker
The Hon. I. W. West

JOHN FENELEY, Assistant Director-General for Policy and Crime Prevention, Attorney General's Department, Goodsell Building, Sydney, and

GEOFFREY GREY BARNDEN, Director of Drug and Alcohol Policy, Cabinet Office, Level 37, Governor Macquarie Tower, Sydney, sworn and examined:

CHAIR: Mr Barnden, I understand that you wish to make an opening statement before we start going through the questions.

Mr BARNDEN: Yes, with the Committee's concurrence, I would like to make a brief statement to give some context to our fairly lengthy submission, which contains numerous attachments. The Inebriates Act provides for the care and control of compulsory treatment of persons who habitually use alcohol and drugs to excess and extends to both non-offenders and a limited group of offenders. The Government's submission to the Committee's inquiry into the Inebriates Act has been jointly prepared by the Office of Drug and Alcohol Policy, which I manage in the Cabinet Office, and the Attorney General's Department. The Office of Drug Policy was established in August 1999 in direct response to the recommendations of the New South Wales Drug Summit for whole-of-government co-ordination to tackle the drug problem.

Following the recent New South Wales Summit on Alcohol Abuse in August this year the office has been expanded to cover alcohol-related policy issues. The office is responsible for providing policy advice on alcohol and illicit drugs to both the Premier and the Special Minister of State, who has ministerial responsibility for drug and alcohol policy co-ordination across the Government. A review of the Inebriates Act was an important recommendation of the New South Wales Summit on Alcohol Abuse. The Office of Drug and Alcohol Policy is currently co-ordinating a Government response to the recommendations of the Summit.

My office has no direct operational experience with the Act, although I am aware that the Committee has already heard from, and is calling for, witnesses from such operational areas such as area health services, NSW Police and, of course, the Chief Magistrate. The Inebriates Act is administered by the Attorney General but it has implications for a wide range of government portfolios. The written Government submission provides a whole-of-government response to the inquiry. The role of my office, with the assistance of the Attorney General's Department, has been to co-ordinate the preparation of the submission based on advice from other relevant agencies. These include New South Wales Health, the Department of Corrective Services, the Department of Education and Training, the Department of Aboriginal Affairs, the Department of Community Services, NSW Police, the Department of Gaming and Racing, the Department of Housing and the Department of Women.

The submission addresses each item in the Committee's terms of reference but makes no specific recommendations. It does not reflect the conclusive views of government but provides information to assist the Committee. The compulsory assessment and treatment of any individual raises difficult cultural, ethical, legal and public policy issues. The Government has adopted an evidence-based approach to drug and alcohol policy and the submission includes information on this approach.

This inquiry provides an opportunity to gather evidence to support public policy on this matter through good research, stakeholder consultation and consideration of all views of clients, service providers and experts. The terms of reference include consideration of overseas and interstate models for compulsory treatment of persons with severe alcohol and/or drug dependence. The submission encourages the Committee to consider the experience of other jurisdictions and attaches copies of relevant Swedish legislation, papers on United States legislation and a discussion on the New Zealand Alcoholism and Drug Addiction Act 1966. The Government looks forward to considering the outcomes of the inquiry and will carefully consider the Committee's recommendations when it hands down its final report.

CHAIR: Thank you for your submission and the voluminous collection of attachments about practices in New South Wales and elsewhere. You have already touched on our first question. This inquiry arose out of the discussions at the Alcohol Summit. The Attorney General then formally

referred the matter. The Committee understands that the Cabinet Office also had some input into the terms of reference that we were given. Can you explain how this particular Act came to be of concern to both your agencies and what outcomes you seek from the inquiry?

Mr FENELEY: There is a fairly long record now of difficulties having been expressed by chief magistrates over a long period of time in terms of the difficulties magistrates have experienced in making orders in relation to the Act, finding that orders that were made were not being implemented and that proper facilities were not available to refer people to. That was one frustration. There have been ongoing discussions about the availability of appropriate facilities and the fact that Health has expressed the view that certainly mental health facilities are not appropriate facilities for people who are classed as inebriates to be referred to.

There are difficulties with the age of the legislation. It is 90 years old and much of it would not be appropriate to today's drafting. In particular, we are concerned about the lack of safeguards in the legislation and the fact that the definitions within the legislation lead to some difficulties because, at the moment, the definition of "inebriate" is fairly broad and leads to some uncertainty about what groups fall within it. Those concerns have been expressed for a long period of time and there is doubt about exactly where to go and what might happen if the legislation were not in place, which has probably led to your later question about why something has not happened until now. There has been uncertainty about what to do and no doubt this Committee will hear a lot of evidence and come up with some ideas about where we might go from here. That has been the history of it from our point of view. There have been a lot of concerns but not a lot of clarity about the alternatives.

CHAIR: We will come back to the question of possible outcomes. Mr Barnden, would you like to add anything?

Mr BARNDEN: I think I should say that the review, of course, has been prompted by the Summit on Alcohol Abuse and the concerns raised by individuals and families about treatment pathways for people in dire situations. It is also quite timely because the Government has been considering the development of a compulsory treatment correctional centre and in that context we examined legislation such as this and other overseas legislation relating to compulsory treatment. In looking at that, we also examined legislation such as the Inebriates Act and the legislation that exists in Victoria and how often it had been used. It came to notice in that particular context.

We were also aware when we were preparing this submission that the Act had been under consideration at various times by various governments. It had had no systematic examination and we thought this was a really effective method at looking at it from all aspects and ensuring that all stakeholder views were taken into consideration.

CHAIR: Can you outline for the Committee the key principles underpinning government policy in relation to alcohol and other drugs?

Mr BARNDEN: Yes. I have brought along a brief guide to evaluation for the New South Wales Drug Summit programs. As I said in our submission on page 6, the key approach that we have had in relation to drug programs, especially since 1999, has been one that is evidence-based. That is the overriding principle that we have adopted in relation to our programs; that there should be evidence of good outcomes and delivery against stated objectives

We produced a brief guide to evaluation of all programs so that agencies right across government, as well as non-government organisations [NGOs] funded by the Government, would be very much aware of the objectives that we have set in this area and the approaches that should be taken to consider the effectiveness, efficiency and outcomes of programs. I table this guide for the Committee members. At the outset it lists a very clear set of 10 objectives that we have in relation to illicit drugs. Whilst it does not cover alcohol at this stage, I think that is what we would be looking at doing in relation to alcohol as well. I suspect that many of the principles and approaches outlined here will be carried over into that area as well.

CHAIR: Do you have a formal document about your approach to illicit as distinct from licit drugs, including alcohol? Are there differences in your approach to a legal drug as compared to an illegal drug?

Mr BARNDEN: There may well be some differences in approaches, given that one is a legal drug and one is not. That is the sort of question we will be looking at over the next 12 months as we develop and finalise the Government's response to the summit on alcohol abuse. We will be taking advice on that sort of question.

CHAIR: Do you want to add anything, Mr Feneley?

Mr FENELEY: No.

CHAIR: I will hand over to other Committee members to run through the questions. We have divided them into questions dealing with non-offenders and offenders, given that the Inebriates Act applies to both groups. We are conscious that you cannot always answer along hard and fast lines, but as far as possible we will separate them. Some of the issues you have addressed in your submission. Would you outline the problems you are aware of in the provisions of the Act relating to non-offenders?

Mr FENELEY: The concern that the department would like to express is the fact that the possibility of a non-offender being the subject of a compulsory order is an extreme step. The department's starting position has been that we would like this Act repealed, and when we come to look at what might replace it we need to consider what regime, if there is to be one, might apply to non-offenders. We are also concerned that in the current legislation the definition of "inebriate" is a person who habitually uses intoxicating liquor or intoxicating narcotic drugs to excess. The definition does not really assist those who have to operate within the legislation as far as distinguishing between a temporarily intoxicated person and the person who might fall within that definition. It can lead in the short-term to the class of people being much broader than perhaps originally intended.

Also under the present Act, whilst medical evidence is required, it is only required to certify that a person is an inebriate. It does not address the broader issues such as whether people are incapable of taking care of their own affairs, whether their health problems in the short- and long-term may be a danger to themselves and bring about their likely death, and whether they are a danger to themselves in some other way or to family members. It really does not address in any holistic way the individual. The likelihood is that legislation that would allow a person's liberty to be affected could well bring in a whole class of people who are truly inebriates, if you were to properly describe them.

Another concern is that the legislation as currently framed does not provide for protection in terms of some form of review to ensure the person's rights are being protected. That seems to be a significant issue for us. We are concerned that in remote areas certain classes of people may be more likely to fall within the attention of the authorities. That is not through any malice. For instance, in remote Aboriginal communities, given the pressures that are on all communities to deal with what appears to be a problem in their local community, the pressure could be on to use legislation of this sort to deal with what are really problems of public order and the like. We think that much greater definition would be required to protect individuals to ensure that we have a concern for the individual, which is based on a concern for their wellbeing, that they might be a risk to themselves, or they might be a risk to others around them. That may well then justify some action being taken. None of that is factored into the existing legislation.

There are other aspects of the existing legislation that concern us, such as, the fact that it provides that an order might be made in relation to a person's assets to meet the costs associated with treatment. In this day and age I think that is something that could no longer stand. Fundamental to so much of this—and I know you will be hearing from Health—is that under the current provisions what will happen to the non-offenders? Where will they be sent if it is determined that some compulsory detention period is required? We have heard over and over again that, as things currently stand, appropriate facilities are not available, from the point of view of the offender or of people who are currently in mental health facilities. The two classes of people do not mix well, and it is not good for either of them in terms of their long-term treatment.

There are other options in terms of community-based treatment. We would say that should be the priority if we are going to take care of people. Ultimately, if we are concerned about their health and the Government determines that some form of compulsory order is the appropriate way to go, the

first priority should be focused on community-based treatment and any form of detention should be a last resort.

CHAIR: It sounds as though you are very committed to new legislation?

Mr FENELEY: Yes.

CHAIR: That includes a regime that deals with all of those broader issues?

Mr FENELEY: Yes.

The Hon. CATHERINE CUSACK: Do you see community-based treatment as being voluntary and detention as being involuntary treatment?

Mr FENELEY: There could quite possibly be a form of compulsory community-based treatment. Again, the difficulty in this area of non-offenders is the possibility you will ultimately criminalise their activity due to their failure to observe what are meant to be compulsory orders. We are a bit concerned about how to achieve the objective. Presumably, the objective is based on a true concern for the individual or those around them. We do not want to take non-offenders and turn them into offenders because of their failure to comply with what is meant to be compulsory treatment orders.

The Hon. CATHERINE CUSACK: Would you clarify your position on coercive treatment for non-offenders?

Mr FENELEY: We think that coercive treatment for non-offenders should be a last resort based on a concern either for their safety or for the safety of others. What that coercive treatment might ultimately be and whether it is effective, I believe Health is in a better position to address than I am, or the department is. It is a question of whether or not you think it is appropriate at all to require a person who has a health problem but is otherwise not an offender to be forced to do anything.

The Hon. CATHERINE CUSACK: Are you saying you do not like it but do not rule it out?

Mr FENELEY: The only reason I do not rule it out is because it is very difficult to say to the community in the case of a person who is engaging in a course of activity which is clearly self-destructive that there will never be a circumstance in which the community would act. I can understand the community concern and desire to have some safety net mechanism. There is no doubt that the community will always act in times of crisis. A person found in an alcoholic coma will always be treated. The issues we are dealing with here much more complex. We are talking about a person who is considered to be at the extreme end of intoxication problems but is otherwise not in a medical crisis at the time. Should that person, because of concerns expressed by the family or others, be forced to undergo certain activities? That is the difficulty, the very reason why we are here today and why this legislation has not been addressed in the past. It is quite complex.

I do not rule out the possibility there may be extreme cases. It is much easier to deal with those extreme cases where there is evidence to suggest a person is a risk to themselves or to those around them. It is harder to justify from an ethical standpoint if all you are saying is that they are continuously intoxicated. Of course, that would not be good for them in the long run, but they are not in immediate risk of harm to themselves. That is a very difficult area to deal with.

The Hon. ROBYN PARKER: Do you think that government has a responsibility to act in cases of people who are only causing harm to themselves? Is that government's responsibility?

Mr FENELEY: From an ethical standpoint we know there are many people in our society who engage in risk-taking activity. We do not legislate necessarily to intervene in those cases. To pick a very common activity, people continue to smoke despite the fact they have been diagnosed as having throat cancer. We know that happens, but we do not intervene. When dealing with a person who otherwise has control of their own lives and may be managing their own affairs reasonably well but in the long run will probably kill themselves, ethically it is very difficult, unless you can see some other factor involved, to come up with a framework that allows you to intervene. It is entirely

understandable why families would want government to take some action. In many cases at the extreme end the easy answer is to say that the person is an immediate risk to himself and, therefore, there is some justification.

CHAIR: Mr Barnden, do you have any views on these matters? We got on to the appropriateness and effectiveness of compulsory treatment and the ethical issues.

Mr BARNDEN: When we look at this legislation we should bear in mind it is not widely used and has not been widely used. When we think about the appropriateness and effectiveness of the legislation, we should consider whether or not we want it to be widely used or narrowly used in situations described by my colleague. New Zealand has done a good discussion paper on this issue. I have attached a copy for the Committee. In New Zealand the legislation appears to be, dare I say, a little more modern than ours.

CHAIR: It would hard to be less, given that our legislation was formed in 1898.

Mr BARNDEN: The discussion paper raises a number of key questions, which are very good and sensible questions, and then addresses them. I have identified a number of the key questions on pages five and six of the Government's submission. Perhaps I could read them out for the Committee. The key questions that I think the Committee should address when considering the appropriateness and effectiveness of legislation are:

> Is dependence on alcohol and narcotic drugs a significant enough condition for society to intervene to remove people's liberty in order to legally enforce assessment, detoxification and treatment? If so, under what conditions should this happen?
>
> Should there be a minimum and/or maximum time for committal under any compulsory treatment legislation? If so, how should this be determined and what controls do we need to protect patients?
>
> Should legislation for the compulsory treatment of people who are addicted to alcohol and other drugs include additional provisions to protect the committed person? If so, what additional protections do these people need?

Many of the Acts in the United States of America have such protections, and I have also attached a report listing much of the legislation there. Continuing the key questions:

> Is it appropriate for people to be compulsorily detained in the interests of their relatives? If not, what should the rationale for compulsory detention be?

For example, in Pennsylvania there is now a new law which allows parents to request compulsory detention of their children, and I mentioned that in our submission as well.

> Should compulsory treatment apply to treatment in non-institutional settings such as community programs or day programs?

Which you just raised as well. In fact in New Zealand in some of the treatment programs that are referred to under the legislation there are Salvation Army programs.

> Should there continue to be a process of certifying institutions for the purpose of treatment under the Act or should any agency be able to provide compulsory treatment?

Again, that relates to your question.

> If it is decided that compulsory treatment should be continued should all drug and alcohol treatment organisations be required to accept people referred by the courts?

And not just simply designated or certified institutions such as psychiatric institutions, and how would this work in practice? I think they are very good questions. I think we would like to see the Committee provide us with some answers.

CHAIR: You are not going to give us any of your views?

Mr BARNDEN: We really are seeking your advice.

CHAIR: We thought we were seeking yours. We could go round and round.

The Hon. IAN WEST: Have there been any cost assessments done as to the ability to provide facilities and appropriate treatment for that preventative end, the non-offender's end?

Mr FENELEY: I must say I think this question in one sense may well be answered better by health. I think part of the difficulty at the moment is the extent to which people choose to access things that are available to them. I suppose this is the difficulty with the whole issue about whether at some point you need to have some compulsory regime because there are things available in the community—there are medical facilities available in the community—and perhaps people do not access them. There is no doubt that there is a real issue that if we were to ramp up, to an extent, the degree to which we were going to direct people to treatment, then a question always is whether or not the resources are going to be there to meet that demand.

So that if we just leave the non-offenders for a moment and just look at the offender end, there is no doubt that in all of those cases where we have had success, where we have had, say, the drug courts or the Magistrates Early Referral into Treatment [MERIT] program, a regime has been put in place to ensure that there are the appropriate resources to deal with the people who have been referred there. If there are not, then it is not going to be successful. So there is no doubt if you increase the level of referral by broadening the class of people who you think might need to go into compulsory treatment, you need to find better pathways—I think as Geoff was saying—to reach those services. There may be existing services and it may just be the pathway needs to be found, but to the extent that they are specialised services, and you are going to increase the number of clients seeking them, then you have to do some cost assessment of that. I think that is something that is yet to happen.

The Hon. IAN WEST: At this point in time if we were to just repeal the Inebriates Act what incentives would there be to have any replacement mechanism to deal with the non-offender end of the market, if you like?

Mr FENELEY: My short answer to that—and I know that Geoff no doubt will have something to say—is the fact that the Government has had an alcohol summit and that it is now looking at all of the possible responses to that, I think has flagged that there is going to be a significant move in New South Wales to look at the broad range of issues about the problems associated with alcohol. I think the Inebriates Act is not the catalyst here for making things happen, it is just that if it was not here tomorrow we would still be doing all of those other things that we are looking at. But I understand that there has often been concern that if you took away the Inebriates Act there would be nothing and, therefore, in those extreme cases what would people do?

The Hon. IAN WEST: You are saying that would not be the case?

Mr FENELEY: Yes.

CHAIR: Certainly the Chief Magistrate's figures and other figures tell us how few people are actually being dealt with under that Act.

Mr BARNDEN: It is difficult to establish exactly what the annual throughput under the legislation might be but I suspect it is under 50, which is not a huge number of people. But itmay be significantly less—

CHAIR: Just following on from the Hon. Ian West's question I guess you could say that costs are almost certainly being borne by Government, some borne by families perhaps, and in the community somewhere. Maybe if a wonderful regime was set up the cost would be technically borne by health. But one suspects, given the class of people that we are dealing with, that the costs are actually occurring in various parts of the system, whether it is in the community or a family, eventually in the corrective system, or by the police.

Mr BARNDEN: If you were to do a cost benefit assessment you would probably look at what are the existing costs now of having these people managed in perhaps a less effective way, but still perhaps going in and out of Government agencies, whether they be health services or perhaps correction services—that old revolving door issue about people going into treatment and failing, going out into a community organisation and failing, and going back in. I suppose it is important to bear in

mind that since the drug summit we have expanded our services across the State in the drug and alcohol area quite significantly in terms of detoxification, non-government agencies, rehabilitation, residential periods and counselling.

If we are talking about legislation which does not radically expand the number of people under the ambit of the legislation but it manages the process better and provides better pathways, it may be that we can truly accommodate these people by changing some of the processes in some of the existing services which perhaps could manage these people in a different way or under protocols between agencies which would ensure that there was much better case management around these people. It may require some augmentation of procedures and programs but the most expensive option is, of course, the old approach which was a standalone facility. But in this particular case with this number of people scattered across the State and looking at the situation on a needs basis, it may be that different approaches can accommodate these people. If it was truly assessed on a cost benefit basis, looking at the current cost of managing these people in a perhaps less organised way against the costs of case managing them in a better way which had more effective outcomes might actually be a positive outcome.

CHAIR: Catherine, did you want to continue on these questions or shall we move on?

The Hon. CATHERINE CUSACK: I wanted to ask again about non-offenders so I am happy to wait until the end.

The Hon. ROBYN PARKER: I think we have addressed question five fairly well but in the submission from the Attorney General's department you talked about three principles which came under the heading "New Legislation" concerning non-offenders. I wonder if you could outline those three principles that you see as being crucial?

Mr FENELEY: Again, the starting point here is obviously a concern that if someone is not an offender today and there is otherwise no reason for them to be brought to the attention of authorities, then anything that looks at denying them their liberty, even for a short period of time, needs to have some strict safeguards put around it. So we have said that involuntary admission should only be used as a last resort for the person's own protection from serious physical harm, or for the protection of others from serious physical harm. We have said that as a guiding principle the order should be the least restrictive alternative in terms of the type and duration of detention, and there should be appropriate safeguards for the rights of people who are involuntarily detained, for example, the right to an independent review of the involuntary restraint. And finally, a right to treatment and quality of treatment should be ensured, and there should be an evidence base to support the treatment provided.

I think the guiding principle, as in so many of these things, is that if we are going to act first we should do no harm. So we need to know that what we do is going to be beneficial. It may be that in the first instance, in that first principle where we look at the protection of others from serious physical harm, that what we are concerned with is the family or the broader community; we are not necessarily concerned principally about the individual. If we are going to put a person into some sort of custody, and it is going to be for any lengthy period of time, then we need to be offering them something; we need to be making the most of that opportunity. Therefore, we talk about the fact that there needs to be real treatment available and some sort of quality treatment which has a solid evidence base. There may be an argument, of course, as we have said, for short-term restraints and if that is the case it may well be that nothing much can effectively happen with that person in terms of treatment for that period of time, but there might be justification, nonetheless, in terms of the protection of others, and it is a preventative protection. If we are talking about a non-offender—they have not actually done anything—but there is a fear they might be a danger to others, then we would assume there would need to be a short-term order.

In this class of people we would assume that if you could actually define very clearly the sort of person that you are talking about, then we are not talking about a person who has had some other mental health problem, we are not talking about a person who has brain damage, because there are regimes in place for dealing with all of that, we are talking about a distinct class of people, and that class might be quite small but the circumstances in which they would be inclined to act would have to be fairly extreme and the sort of evidence that would be required to satisfy the person who is required

to make that decision would need to be adequate so that it justifies denying the person their liberty for even a short period of time.

The Hon. IAN WEST: Could I clarify two things in that answer? Firstly, you are assuming the definition stage as it is stated is in a very small, confined area. I took from your answer that you are assuming that because you are treating the person on behalf of someone other than the inebriate therefore you are not treating the inebriate for themselves. I do not make a distinction but if you are actually treating the person on behalf of who initiates the treatment, it does not mean that you are not at the same time treating the inebriate on behalf of both the inebriate and the people who are asking for the help. Is it not narrow to be making the assumption that you can only treat on behalf of one or the other?

Mr FENELEY: No, because in many cases you may be doing both, but there may be cases in which you are not. So that if your only motivation is concern about the safety of others, and that might be a short-term thing, then you may well be seeking to detain this person simply for that reason only. There may be no prospects in that short-term to do other than have an order which keeps them in some safe place for whatever period it might be; we would say it should always be the shortest period that meets the needs. What I am saying is that if the only motivation is the well-being of the person, that is, that we are doing this simply because we think the person is a significant risk to themselves and, being an inebriate will bring all sorts of health problems to them, then everything would be just about treatment. I suppose we are acknowledging that in some cases the primary motivation might be something else. It just might be the fear of others.

I think later in your questions the question is asked about whether, for instance, respite care is a reason in itself. The notion that someone would be compulsorily detained only to provide a period of respite care for the families would certainly cause concern. Despite the fact that everyone knows that the families bear an enormous burden in caring for individuals, to move to a regime where families could simply apply for the order on the basis of having a break is a difficult concept in terms of compulsorily detaining individuals.

The Hon. CATHERINE CUSACK: This is not one of the written questions. It seems to me from your submission that the Act has never really been implemented—the committee has never been formed and they never proceeded to establish the inebriates institutions. Therefore, we can only speculate about what the problems and benefits might be in the Act, had it ever been implemented. We know that it is old-fashioned and the language is outdated. As to non-offenders, which is whom we are dealing with at this stage, I think it is difficult to be critical of the Act because it has never been implemented as it was intended—it is hard to imagine how it was intended. Non-offenders have not been convicted of any offence but their wives have broken arms and black eyes and their kids are terrified of them. Everybody's life is a mess but they are non-offenders, which is a subcategory of the group. Another subcategory of non-offenders could be people who desperately wish to access treatment but cannot. I believe if it were compulsory for them to be in treatment it would be compulsory for the State to provide the resources to enable them to have that treatment. Do you have any comments on those two subgroups, in which I think there is a more compelling case for coercive treatment?

Mr FENELEY: In terms of the broad area of domestic violence, you are probably familiar with the Government's commitment to establishing a domestic violence integrated court model, which essentially will bring all the relevant agencies together—the police, the Department of Community Services and the courts—to ramp up the current approach and to take a very action-oriented, pro-charge, pro-intervention approach in cases of domestic violence in order to address the very complex range of issues that we know confounds government when it tries to deal with this issue. As you say, in many cases all objective circumstances indicate that there is a domestic violence problem—a wife with injuries, children with injuries and so on—but we still have a non-offender. This integrated approach is intended to ramp up the Government's response and to ensure that all the agencies are acting appropriately in order to take the pressure off the victim and focus effort on the government agencies that are intervening so that it is not reliant—as it often has been—on whether the victim wants to participate or take some action.

Addressing the problem that you have talked about, inebriates are an extreme group—we are not talking about people who get drunk from time to time or misuse alcohol from time to time—and

they present a particular problem even for this type of government approach. Part of the new overall approach to dealing with domestic violence has within it a perpetrator program that is designed to focus on perpetrators and to raise their awareness of the damage that they are doing and so on. In that program it is sometimes quite difficult to work with people with extreme alcohol problems because you will not necessarily get a lot of insight. They add another level of complexity and difficulty in trying to deal with those issues. The answer to the problem that you identified is more that we need to lift our game in terms of how we respond to incidents of domestic violence.

That is what this entirely new program is all about. To some extent, it will take it out of the hands of the victim and make it more likely that the agencies will intervene. That may then identify people with other problems—perhaps a perpetrator will be identified as having anger management problems, alcohol abuse problems or drug abuse problems. They might then be picked up through the court system or other associated systems in terms of trying to deal with that person. However, I do not think we have any evidence about whether, of that class, many people would fall into the very extreme category with which we are currently dealing. I am sorry, I have forgotten the second part of your question.

The Hon. CATHERINE CUSACK: The second part related to making resources available and people seeking orders so that the Government would be obliged to take action.

Mr FENELEY: Are you focusing on a particular class?

The Hon. CATHERINE CUSACK: Yes. In terms of the Act, it is quite clear that services are not available. That is why we are still stuck with the seven listed institutions; they never proceeded down that track. We know that Mental Health is under dreadful strain in terms of resources and understandably could not even contemplate taking on a whole other category of problems—in fact, Mental Health seems to be defining many drug and alcohol issues out of its area. The question is: Where do they go? Are we, in complaining about legislation that has never had the chance to work, running around another problem, which might be that the programs and the approaches are not there on the ground? That is why everyone is too scared to get rid of the Act.

Mr FENELEY: Ultimately Health is better placed to answer your specific question. There is no doubt that everybody continually identifies the issue of the availability of appropriate services—not putting people with alcohol abuse problems with people who have mental health problems because they are the only facilities available; that is identified as being a problem. Assuming the services were available, yes, there is no doubt that people who come through the court process can be targeted and directed to an appropriate service. But the broad answer is that, through the Alcohol Summit and the Government's overall response, we must ensure that there are, from the lowest level of the community up, services that people can access rather than waiting until some extreme point when a person has become an offender and then we start saying, "Gee, we'd better make sure that you get the appropriate services you need."

The Hon. CATHERINE CUSACK: You would have to concede that that is a problem. In the Juvenile Justice area, I look at literacy levels among kids who have been truanting from school and the resources that are devoted at that stage compared with the resources devoted to literacy programs in juvenile detention centres. I think it is a pity that nothing could have been done earlier.

Mr FENELEY: In many cases there are services available; it is a question of whether people—particularly those with abuse problems—are prepared to access those services voluntarily. That is a conundrum.

Mr BARNDEN: I refer you to page 14 of our submission. In relation to your question, the Department of Community Services suggested that it would be of benefit to the department to be able to access treatment services for families and that, in doing so, the department had a statutory mandate to work with them, particularly in relation to the provision of child protection but when there is resistance to undertaking drug and alcohol treatment. I think they see this sort of legislation as providing an opportunity in some particular cases. Additionally, the Department for Women supports the need for an appropriate legal and health system to allow a person whose alcohol abuse is endangering their lives or the lives of others and/or where their mental health is being affected to receive appropriate care and treatment.

The Hon. CATHERINE CUSACK: I interpreted that as them saying that there is a need for additional services.

Mr BARNDEN: They are also saying that there may be a case for making appropriate statutory provision in relation to compulsory treatment as a way of ensuring that these people get into those services because there is resistance to entering services.

The Hon. ROBYN PARKER: What do you see as the linkages between Health and Justice in this process? You talked about the need for some sort of legal framework and compulsory process that protects domestic violence victims, for example. Where do you see Justice fitting in? Do you envisage that Justice will be involved at the beginning of the process or simply in a review of the whole framework?

Mr FENELEY: In relation to the Inebriates Act or some replacement of the Act and if we are talking about non-offenders, if there were to be a regime in which there was a class of orders available to deal with non-offenders the court could play a role not through the open courtroom process but by using the court as a way of checking applications and making initial orders—perhaps on the application of family or of others in the community, such as the police. If evidence is brought before a magistrate to show that there is a need to at least assess this person that does not need to happen in the body of the courtroom, where a person who has committed no offence is the subject of public scrutiny and the opprobrium that is attached whenever a person's name is mentioned in court. We could see that as the regime and we could see the court playing a role in terms of making safety mechanisms available for checking to ensure that there is a review—similarly, the Chief Magistrate outlined the role that magistrates play in mental health. We think that would be a very important part of the safeguard.

As far as offenders go, we have a very well developed jurisprudence in relation to the role that courts can play in directing and diverting people to appropriate care. Part of the department's view is that you do not need to have an Inebriates Act in relation to offenders because there is ample provision in the current law to deal with any offender who comes before the court and who can be referred to appropriate treatment as a condition of bail, a bond or whatever. The courts do that every single day; they are very well acquainted with it. We have some very sophisticated programs at the moment in terms of the youth and adult drug courts and the Magistrates Early Referral Into Treatment [MERIT] Program, which is a much more well-developed, program-based, multidisciplinary way of looking at these problems. That is yet another example of the court playing a direct role, with other government agencies, in taking the opportunity that is presented when someone comes before the court on a charge to look at them holistically and ask, "How can we reduce offending in the long run by dealing with a person's substance abuse problem?"

The Hon. ROBYN PARKER: Do you see the Inebriates Act applying to non-offenders? When someone offends everything is rolled out in terms of the process, the framework and the services.

Mr FENELEY: Yes. We believe any new provision following the Inebriates Act would need only to address non-offenders not offenders because there is ample scope within the existing system.

The Hon. ROBYN PARKER: It is pretty skewed, is it not—in order to get help you have to commit an offence?

Mr FENELEY: Help is available for people who need it; it is a question of whether people wish to access it. People with abuse problems often do not want to access help because they do not have the insight to know that they need assistance. We are saying that, when someone is offending, society has a direct interest in ensuring that anything that might reduce their likelihood of reoffending, and therefore causing more problems for society, is worthwhile and a justification for society's intervening and doing something. But as far as non-offenders go, if there is to be a regime—if ultimately the view that, having regard to all the considerations, there is a need for a compulsory regime in relation to non-offenders—it should have regard to all the safeguards that we have talked about. But it is not a case of getting treatment only by having a compulsory regime. If we are successful in the next so many years following the Alcohol Summit in all the approaches that we bring

to alcohol problems in the community, hopefully we will still only ever contemplate using compulsory legislation in an extreme case.

CHAIR: I refer to question 11. Can you tell us a little more about the evidence in relation to the models and outcomes that the policy is directed towards? You have mentioned the MERIT program, the Adult Drug Court, the Youth Drug Court, and the announcement about the establishment of a compulsory drug treatment correctional centre.

Mr FENELEY: Simply stated, the answer to the question why we go down that path at all is that, certainly with the drug crime diversion programs our aim is to prevent reoffending; we really want to do something to intervene to stop that cycle of reoffending. There is certainly evidence, in terms of what we are experiencing every day, that people who have drug abuse problems are likely to fall within this category of people who are offending and reoffending. Unless we break that cycle, we can expect to see them again and again. The overall aim is to make sure that there is a benefit to the community that flows from the fact that we have broken that cycle. Of course, that also means there is a benefit to the individual, because the individual then has some prospect of not spending a substantial part of the rest of their life inside the criminal justice system.

With regard to the specific models, I have brought along some material for the Committee in relation to MERIT, which is some general information about that program, and I have also brought along the evaluation for the Drug Court. The Government is currently considering the evaluation of MERIT itself, and also the evaluation of the Youth Drug Court.

Documents tabled.

My colleague may wish to say something about the proposal for the new compulsory treatment centre.

Mr BARNDEN: The Government has been looking at the establishment of a compulsory drug treatment correctional centre in relation to people with a very severe drug dependency, and at a class of offenders who would have demonstrated a very long history of recidivism, and probably also a history of failure in treatment programs, and possibly also some failures in other diversion programs.

We looked at overseas models when we were examining this, because this class of offenders often commits a great deal of the drug-related crime. That has been demonstrated in a recent report released by Dr Weatherburn yesterday in relation to heroin offences and robbery offences.

The model envisages that by intervening with this significantly recidivist population we may be able to make a significant impact on their criminal behaviour and also provide them with an opportunity for longer-term rehabilitation and social reintegration. It is a model that is being trialled at the moment in the Netherlands, and I think they now have about four specific facilities, but they are very new so the outcomes are still being evaluated. Nevertheless, we understand that, for example, in the facility they have established in Amsterdam, all the offenders have committed more than 30 crimes in the last three years, so it is that sort of significant group.

The opportunity to intervene and case-manage these people in a compulsory treatment regime, followed up by a stage which is in the community as well, which provides you with pathways, case-management and intervention which would perhaps not otherwise be available, is a new approach in this area which we all hope will make a significant difference, but at this stage it only applies to people with a severe addiction to illicit drugs.

CHAIR: Presumably, broadly speaking, the most common crime committed by people using illicit drugs is overwhelmingly robbery, whereas the crimes committed by people particularly affected by alcohol are more likely to be violence offences. If you were thinking of any of these sorts of treatments for people at the more serious end of alcohol use, you might not necessarily treat these people together.

Mr BARNDEN: Absolutely.

CHAIR: Has any work been done to address the issues of different groups of people with different patterns of offending and different drugs of choice?

Mr BARNDEN: A lot of work has been done by Dr Weatherburn in relation to alcohol, violence and public amenity issues.

CHAIR: I am thinking more specifically about the proposed drug treatment correctional centre, and if you have one in New South Wales whether everyone goes in together.

Mr BARNDEN: I think we would take advice from our health colleagues. But I would say the treatment modalities and regimes would be very different and the issues would probably be very different. Although, of course, as we know, in all these areas there is a huge number of co-morbidity issues and the use of drugs right across the spectrum by people with these sorts of problems, and issues of dual diagnosis and multiple drug use are often interlinked. Whilst I am saying it is primarily focused on illicit drugs, many of these people, I imagine, also have alcohol-related issues. In recent studies conducted by the Department of Juvenile Justice it has been shown that many of their clients have both alcohol and illicit drug problems.

Mr FENELEY: The distinguishing factor with regard to this new proposal for a compulsory drug treatment prison, the MERIT program, the Youth Drug Court and the Adult Drug Court is that whilst they are commonly thought of as being court driven, they are not really; they are actually opt-in programs, in the sense that for the people who come to them there is an opportunity for them and it does require them to opt in and be part of that program. They may fail in that, and that might see them rejected from the program, but it is not really a case of them being compelled to do that. They have to initially elect to do it and they have to be assessed as being able to participate in the program. So that is a distinguishing factor, I suppose. One of the difficulties with all forms of treatment of substance abuse is the extent to which the person is prepared to co-operate beyond the detoxification stage in their recovery and rehabilitation.

Mr BARNDEN: On page 16 we have referred to the various drug diversion programs that my colleague has mentioned. You will note that the Attorney General's Department has also advised us that there are various sentencing options available under the Crimes (Sentencing Procedures) Act 1999. Of course, the programs that my colleague has referred to—the Drug Court, the MERIT program, the Youth Drug Court and the compulsory corrections treatment centre—tend to be specialist programs which are perhaps at the end of the spectrum of inappropriate conduct which needs to be addressed. The question might be: Can we make greater use of good behaviour bonds and perhaps greater use of the local courts in earlier referrals to appropriate treatment so that this problem is captured at a much earlier time in the offender's interaction with the justice system?

The Hon. CATHERINE CUSACK: Are you referring to the pre-conviction stage, as opposed to at the sentencing stage?

Mr FENELEY: The point there is that when people come before the court, whether they are young people or older people, and they are at the extreme end—in other words, the court is thinking of putting them into custody; there will not be another bond, or whatever—the specialist regimes that we have talked about here certainly come into play.

The question about the earlier points is: When the person came before the court on the first couple of occasions, and when the court really was not contemplating a custodial sentence, was there something more that could have been done to refer the person then? Whilst alcohol might be associated with a lot of criminal activity—particularly fights outside hotels, and people breaking windows and the like—the question is whether the person actually has, at that point, any problem with alcohol that can be treated at all. It is a subtle question about whether there is any appropriate referral that can be made at that point and whether the person is going to benefit at that early point from treatment that is focused on alcohol.

We are commonly seeing it in relation to drink-driving offences, that we are referring people off. From my limited perspective, the link between the factors is much closer. You really need the person to understand that they cannot be drinking and driving. But it is not always going to be the case that it is going to be obvious to a magistrate, or to anyone, that the person is going to benefit from

referral at an early stage. It might be that they are just being a naughty boy and that alcohol is yet another factor but it was not really the cause of the activity.

The Hon. CATHERINE CUSACK: I wanted to ask specifically about the drink-driving example, where the person has not killed anyone but they have clearly not learned from earlier appearances in court. To commit a person to 12 months of treatment is, according to the paper, potentially disproportionate to the offence that has been committed, and therefore the legal system seems to hesitate to do that. When you spoke about treating non-offenders as one group and offenders as another group, I wondered whether there was that overlap where, in trying to change behaviour, you needed to make an order for, say, a 12-month period of care, which seems disproportionate to the offence that has been committed.

Mr FENELEY: I am not sure whether you are taking evidence from the Roads and Traffic Authority during this hearing. However, we can provide the Committee with some evidence about the programs that are currently available for drink-drivers. We certainly participate with the RTA in the development of those programs. Some quite extensive programs are now available to deal with drink-driving.

I think you are concerned about the situation where the offence was really not that significant but suddenly the person is lumbered with treatment that seems to be disproportionate to the offence. I think that is a fine judgment about what is disproportionate. Certainly one of the difficulties under the Inebriates Act at the moment is that a person might get an order that sees them detained for a period of 12 months—although, I think in practice the experience has been that the orders are often shorter than that. The fact is that there are not many examples for us to go through in any event.

I would be very concerned that a person who has a health problem in being an inebriate had an order imposed on them for 12 months. That is why we stress that the use of any new legislation in this area should mean that the detention order is the shortest order that can be made, consistent with the needs of the individual. The idea of a blanket order for 12 months is a concern. But then again, if you have a regime in place which was regularly reviewing that, you would not be as concerned about it because you would be saying that once the person's needs have been met we can have it reviewed and they can be released.

An issue is raised, not uncommonly, before the courts where defence lawyers will say, "Frankly, we would prefer to cop the fine, rather than being forced to go down some long path of treatment." There is some subtlety in whether one or other option is appropriate. From the court perspective, if the person does not seem to be learning from the previous experience the fact you might require them to come back to some form of treatment is something that the system has to weigh, really.

The Hon. CATHERINE CUSACK: Is the court punishing them for their offence or trying to change their behaviour? They can be two different things.

Mr FENELEY: There is no doubt that that is a common theme both in juvenile crime and adult crime, that people often say I prefer to take the time rather than have to go through this process of rehabilitation or whatever it is, because they think the normal penalty will be over and done with a lot quicker. That is why sometimes defence lawyers resist, at both adult and juvenile levels, the court making orders that see their clients having to participate in drug or alcohol rehabilitation programs until the point where it is just too late. So, they have had a couple of opportunities, there seems to have been a problem, but basically they have opted out and said we want to be fined or just do a month in custody, and eventually they come back before the court with a significant problem and the court knows it has to intervene in more significant way, and says we think you should be going on to this particular program.

CHAIR: I think in one way or another you have dealt with all of the questions, but I would like to return to question 9, which was our last question in relation to non-offenders. We wanted to ask you about the progress being made in relation to the Alcohol Summit recommendation on the Intoxicated Persons Act and that that be reviewed, that we develop a workable definition and that the Government fast track the roll-out of intoxicated persons services.

Mr BARNDEN: The Government is presently examining all the recommendations of the Summit. There were 318 recommendations—a lot of recommendations—and our task is to provide the Government with a response by the end of March. This is quite a challenge, actually. Many of those recommendations are difficult and these are some of the most difficult ones. We are currently working with agencies across government in looking at those particular recommendations relating to the Intoxicated Persons Act and those definitions and recommendations around offences. A lot of issues have to be addressed there, and you can appreciate that different agencies have different views and there are a lot of challenges around definitional issues, but we are looking at that.

CHAIR: But the Intoxicated Persons Act has been under review in various ways, officially or unofficially, for a number of years now. Is there anything you or Mr Feneley can tell us about the relationship between that sort of legislation and the Inebriates Act? We are all aware that the Inebriates Act is at the extreme end of the spectrum. People argue that it is used sometimes because of gaps in other parts of the spectrum. The discussion has been going on for a while in different ways.

Mr FENELEY: All I could add is a word of caution more than anything else, that the Intoxicated Persons Act fulfils a specific need in how authorities can deal with intoxicated people in public places. There is a big gap between that and the concerns Parliament might have with inebriates and how to properly deal with inebriates. The caution is that we would not want to see the Intoxicated Persons Act as the pathway to the Inebriates Act because you could start confusing those two issues. It is something we need to bear in mind as we review it. While it is clearly understandable that there needs to be clear power for the authorities to be able to deal appropriately with people who are intoxicated, there is a capacity to use the information that comes from that process. The experience police have in dealing with intoxicated people might ultimately produce some evidence of how to deal with an inebriate, but we would say we need to be cautious about any direct link between those two things. The fact that someone may need to be dealt with for intoxication does not mean they might fall in the category of being an inebriate. One cannot make that jump too quickly.

The Hon. CATHERINE CUSACK: Only that you might mitigate some of the harm that the person affected by the Inebriates Act is doing through the Intoxicated Persons Act?

Mr FENELEY: You mean in terms of—

The Hon. CATHERINE CUSACK: You might relieve some of the pressure to commit somebody for 12 months if the actual crisis can be dealt with under the Intoxicated Persons Act.

Mr FENELEY: There is no doubt that you need to have a regime in place, as you do with the Intoxicated Persons Act, to make sure you can deal with those issues as they arise. It may even provide the authorities with evidence over time about whether a particular person is properly described as an inebriate, whatever that definition might ultimately be. You are right, the fact there is a mechanism there that allows something to happen might well mean, as we develop all of our systems, that fewer people might be falling into that category further down the path, if we are intervening at an earlier stage.

CHAIR: There are probably some issues in addition to the material you have provided to us about which we may need to get back to you to clarify. It is also possible that we may need to ask you to come back later. We often deal with the major agencies early in our inquiries and then find as we take evidence that it becomes important to put some things to you again. We will probably talk to you about that sometime next year.

(The witnesses withdrew)

RICHARD JOHN MATTHEWS, Acting Deputy Director-General, Strategic Development, New South Wales Health and Chief Executive Officer, Corrections Health Service, sworn and examined:

CHAIR: Do you want to say anything in an opening statement or shall we go straight into questions?

Dr MATTHEWS: No, I think you have provided such a splendid list of questions, I am happy to take those.

CHAIR: We asked you an easy, quick question to start with. Can you please give us the alcohol and other drug treatment and support systems in New South Wales, and your view of the key principles that underline them?

Dr MATTHEWS: It is actually a fairly complex question. There is a broad range of services available and not all, of course, are provided by New South Wales Health. The majority of people's primary care, from the general practitioner or community pharmacists, and through that measure or by other measures services provided by New South Wales Health can be accessed. They are provided through 17 geographic area health services plus the Corrections Health Service and the New Children's Hospital, each of which has a clinical service plan which includes a drug and alcohol section and is expected to offer a range of treatments from detoxification, assessment, pharmacotherapies, various cognitive and behavioural therapies and some in-patient detoxification and some residential treatment, either themselves or in partnership with non-government organisations.

A number of other government agencies offer treatment services—the Department of Corrective Services, the Department of Juvenile Justice, the Department of Community Services—and increasingly education services through bodies like the Department of Education and Training and the Police. There is also a very large and complex relationship between Health and other agencies in the non-government sector, which has traditionally had a very big role to play in the provision of treatment and support services to people with drug and alcohol problems.

The treatment of illicit drugs received a major focus and impetus from the 1999 Drug Summit. There was specific funding targeted at illicit drugs as a result of that, which is co-ordinated across all the agencies through Mr Barnden's office within the Cabinet Office. Of course, recently we have had an Alcohol Summit, which has focused on one of the legally available, mood-altering drugs which causes some problems.

CHAIR: The key principles underpinning the system?

Dr MATTHEWS: I guess the key principles are that generally treatment is voluntary. I will add a caveat to that, that a great deal of drug and alcohol treatment is coerced in some way. When people come forward to seek services and you take a careful history, you will very often find that the family, a probation officer, a pending court appearance, problems at work or some crisis has precipitated the request for treatment services and that arguably there is some level of coercion when most people come forward.

CHAIR: Is that problematic for people in Health? The first principle you mentioned is that it is voluntary and then you immediately say that for many of them it is coercion. Is that a problem from the point of view of the health professional?

Dr MATTHEWS: No, I do not think it is a problem, but it is important to understand it. As a health professional should deal with any patient that comes before you, you should ask them yourself the question why this person, at this time, in this place, and the stated reason, which may be, "I want to give up drugs," is not necessarily the real reason for the presentation. It is terribly important in doing the assessment and formulating a treatment plan to make certain that you understand what the real reason is. That is true of any condition and is not confined to drug and alcohol.

The second principle, of course, is the principle of equity of access, which is a difficult principle to achieve across a state as diverse demographically and geographically as New South Wales. I think it is fair to say it is difficult to achieve equity of access across the whole range of

treatment services. The first principle would be generally the principle of harm reduction. That is an acceptance that as with any other condition, a cure, if indeed a cure is defined as abstinence, is not necessarily going to be achieved in the short term and possibly even in the long term. The underlying principle has to be that you need to reduce as much as possible the harm that the substance, either licit or illicit, is doing to the individual or to those around the individual or to the broad community.

CHAIR: Certainly they are the three principles that would be broadly accepted in the system.

Dr MATTHEWS: Yes.

CHAIR: Moving on to question two, we have found it hard to get a statistical picture either of the small number of people that we know are actually under an inebriates order or more broadly the proportion of the population that has a severe dependence on alcohol and other drugs. Can you throw some light on the dimensions of the issues that we are looking at?

Dr MATTHEWS: Probably more on the latter than the former. Data about the use of the Inebriates Act over the years seems to be somewhat scarce. I made an inquiry yesterday and we were able to locate only one person who is currently in a bed under an Inebriates Act order in the whole of New South Wales. The numbers have been quite small in recent years although they have been much higher back in the fifties and sixties, and indeed before the war. I think the reason for that is multiple: one, a recognition that it was not terribly effective; two, the place in which people were being confined, that is, the schedule 5 psychiatric hospital, was not the appropriate place. That is partly because the model of care provided in psychiatric hospitals has changed over the past 100 years. People being locked in wards is now a relatively rare event, apart from a small group of very, very mentally ill people in another subset of forensic patients. Most wards are open wards with relatively free access and egress for patients. The security required is simply not available.

As has been said before, mixing this particular group with people who are mentally ill is not very good for either. So we have essentially reached the point where we have got a custodial system imposed upon a non-custodial system and it simply does not work. That is why people stopped using it. There are problems with the health professionals: the fact that no-one in the health system had the power to discharge a patient—that required another order from a judicial officer; the fact that many people were able to leave and abscond; and the fact that many people were able to go out and drink and come back intoxicated. I think we also would have to say that the necessary skill sets to deal with the problems were not necessarily there because the skill sets that were provided were for dealing with mental illness, and they are quite different skill sets.

In terms of how big is the problem, we do have some reasonable data from the national mental health interview which was conducted with about 13,000 people across Australia—that is, 13,000 adults—and we can tell you from that group that with males it is around about 5.2 per cent dependent and about 4.3 per cent are abusers of alcohol. The figures are less in women—about 1.8 per cent for dependent and about the same, 1.8 per cent, for abuse. If you took the back of an envelope and said how many adult males are there in New South Wales, the answer is probably 1.5 to 2 million, then you are looking at about 70,000 adult males and probably about one-third of that number of adult females who are dependent on alcohol, and that is a very large cohort.

CHAIR: Can you tell us a little bit more about what dependence means, and I guess at what point legislation that is as draconian as the Inebriates Act cuts in for a group of, say, 70,000 males?

Dr MATTHEWS: Okay. I think that with any drug, licit or illicit, it is useful to divide the population into four separate groups. There are non-users of that drug, there are users of that drug, they are abusers and then there are dependents. Forgetting the first two for a moment, abuse is generally people who take the drug to a level which either causes them some physical damage and incapacity or causes them to behave in a manner which is unacceptable. With alcohol, of course, that is what you might call the id without the lid in that sometimes people who behave perfectly normally when sober become aggressive and violent under the influence of alcohol. They are actually quite reasonable people without it.

The difference between that group and dependents is that with the dependents, through mechanisms which have been poorly understood but are being increasingly understood, receptor sites

are permanently altered in the brain, in the central nervous system, so that when the drug is ceased, there are definite symptoms and signs of withdrawal from the drug. For instance, many people who might go to the pub on a Friday night and drink 12 schooners and bash everyone in sight do not exhibit any signs of withdrawal when they do not have the drug. The controversial subset of dependency is the group who have been dependent but have not had that particular drug for, say, five or 10 years but who arguably have permanent alteration of receptor sites so that continuation or recommencement of the drug immediately leads to dependency again. Perhaps I can explain that a bit better. Most people who commence using a drug—whether it is alcohol or heroin, though heroin is a good example—have a relatively long lead-in time of monthly, fortnightly, weekly use. At some point they cross the bridge where they are no longer using the drug for pleasurable effects; they are using the drug to prevent the effects of withdrawal, and that is when they become dependent.

Very often there is a very long lead-in. Once you have been dependent, almost universally even after five years if you start using again you will be immediately dependent again. In other words, that alteration in receptor sites appears to be permanent. People who are alcoholic will tell you that so-and-so within Alcoholics Anonymous [AA] has been sober for seven years and suddenly one day, for complicated reasons, he turns right and walks into a pub, has one beer, and wakes up three days later lying in a gutter somewhere. That appears to have a physiological basis but we are probably not at the point where we can accurately describe it to you.

The Hon. CATHERINE CUSACK: Is it potentially a mental illness?

Dr MATTHEWS: The psychiatric profession includes it in their DSM4 and ICD10 categories of diagnoses of mental illness. Others would probably—perhaps the neurologists and would argue that it is a disease or a disorder of the brain, a neurological disorder, because of its physiological basis. Others would argue that it is a societal or behavioural problem. It is a question of definition—who you ask.

CHAIR: Still trying to pin down the size of the problem that we are looking at with the Inebriates Act or a replacement Act, what are the views of NSW Health on the appropriateness and effectiveness of the current Act? I think we should also ask you your view of perhaps replacement legislation in dealing with people with severe drug and alcohol dependence.

Dr MATTHEWS: In relation to your current Act, I take the point that it has never been fully enacted in terms of its committees and control mechanisms. There is no evidence or evaluation that I am aware of or which has ever been conducted into its effectiveness. In other jurisdictions where similar legislation applies—and the most notable example would be Sweden—we have been unable to find through a literature search any scientific evaluation or research in relation to their legislation which I think has been in force since 1913 in a country where there are something like 4,000 secure beds for a population of 6 million. There is a very strong belief that it works, but no evidence.

We would argue I think that the current Act is ineffective but we might also say that it has been inappropriately applied. In looking at a new Act, I think we have to ask the question: What are we trying to achieve? In the previous discussion we have already divided the potential target group into offenders and non-offenders. I think we need to further divide them into abusers and dependent. We have to accept that within each of those groups there are a lot of people in those cohorts who are not causing any problem to the community but may be causing a problem to themselves. You have asked me an interesting question, "Do people have the right to drink themselves to death?" That is a terribly tricky question. I would probably duck it a bit by saying that we are all of us headed for death, and there are a range of activities that can slow down the progress—diet, exercise, keeping to the ideal weight, and not smoking—and there are a range of activities which can speed up the process and they would include cigarette smoking, being obese, not exercising and possibly hang-gliding, as well as partaking of alcohol to excess.

I guess my question back to the Committee would be: Why alcohol, within this range of activities which are illegal and which can hasten the process of getting to the grave? I think the answer is that because the sight of people drinking themselves to death distresses us immensely. We saw that at the Alcohol Summit. We feel that because of the distress to ourselves and to the relatives and everyone else, we would like to do something about it. That leads us to the question: Can we do anything about it? I think in broad terms the answer is yes but in specific individuals the answer is not

necessarily. If you gave me, as a drug and alcohol doctor, 100 people who were dependent on alcohol and continuing to drink at a level which was destructive to their health and said, "Here they are and here are as many resources that you want and whatever facility that you require and all the multidisciplinary teams that you need to change what is happening", I do not know that I would be able to bring you a great deal of success in terms of, at five years, the number of people who had been without alcohol for a considerable period of time. I could bring you some.

In looking at the problem I believe we need to look at it in the same way that we look at the treatment of cancer. It is an interesting analogy. We all accept that cancer occurs. We all hope that we do not get it. We all know that some of us will. We all hope that when we do or when our loved ones do get it, that there will be effective treatment that cures us, but we also accept that there will be a number of people where that will not be possible, and that they will die. We all accept that and we will fund various programs to improve the treatment of cancer so that the number of people who cannot be cured is less, but we know that it will never be zero. In fact, because we are all ageing, we know that it will probably be more.

Drug and alcohol dependency is no different. Young people will always experiment. A percentage will always become dependent. What they become dependent on will depend on the price, availability and peer pressure and to some but little extent of what is legal and what is illegal. A subset will become dependent and that will be based on a complicated series of genetic and environmental factors. We will be able to get some and we will be able to assist some of those people in stopping, but not all of them, and some of them will die as a result of their dependency.

The Hon. CATHERINE CUSACK: Can I ask you to elucidate. If somebody has cancer, they have a medical condition that requires specialist treatment.

Dr MATTHEWS: Yes.

The Hon. CATHERINE CUSACK: With a person who is drinking excessively we are, surely, looking at changing their behaviour. Behaviour modification is not a cure for cancer but it does improve the outcomes for people affected by the Inebriates Act. I see them as completely different problems.

Dr MATTHEWS: I would agree with you in the case of people who are abusing alcohol; the fellow who goes to the pub, drinks 12 schooners, becomes aggressive and wants to fight, I agree with you. But I would argue that dependency is, in fact, an illness, a disease, and requires the same approach. It requires a variety of approaches depending on the individual, the dependency and what past treatment failures have been. It is not the case that we are going to be successful in all cases because there is not a treatment that necessarily works and there is more to treating dependency than merely behavioural modification because it is an illness.

The Hon. ROBYN PARKER: You talk about a variety of treatments. Do you see a role for compulsory rehabilitative treatment?

Dr MATTHEWS: Yes.

The Hon. ROBYN PARKER: What should the aims be in that case?

Dr MATTHEWS: I think we need to look at the two groups: the offenders and the non-offenders. With the offenders there is definitely a role. In my view, the most effective role is an alternative to incarceration and, as has been said by previous speakers, we have some models such as the magistrates' early referral and treatment scheme and the adult and youth drug courts. A very considerable number of offenders are convicted of offences, which are potentially bailable or potentially dealt with by a non-custodial option. Those people ought to have the option or the availability of a non-custodial court-mandated treatment program.

There is, of course, a group of offenders where, because of the nature of the offenders, they are never going to get bail and, in fact, they are always going to get a custodial sentence and that group of offenders needs access to appropriate treatment programs within the custodial setting and, most important, the appropriate follow-up after release, because it is actually possible to effect change

within a custodial setting which is not necessarily continued when you return to your own environment.

In the case of non-offenders, we are in far more tricky territory philosophically, ethically and in terms of actually enforcing it. Whether we do it or not, I would argue is probably a decision for the people of New South Wales through the Parliament of New South Wales. We have some current provisions for compulsory treatment in other Acts—the Public Health Act allows for some—and compulsory treatment was an extremely important part of eradicating tuberculosis in this State. The difficult problem with alcohol as opposed to other drugs, say nicotine or, indeed, heroin, is that because it is a central nervous system poison, if you drink it at a certain level you gradually begin to get cognitive impairment and a considerable number of people who are dependent are moving down that continuum towards a point where they cease to be competent.

So you have an individual who, at one point, when sober says, "Thank you very much for your advice, doctor, but I am really not interested and I wish to continue drinking; that is my lifestyle choice." At another point, perhaps in two or three years, that same individual now has a level of brain damage where he or she is unable to articulate that particular argument and that is the point at which we tend to step in through guardianship Acts, et cetera. I can understand the argument that this is somewhat of a paradox when, in many individuals, we can confidently predict at that early point that this is going to happen. The argument is that where we feel that we can confidently predict that this damage is being done and will continue to be done, we should step in, in some legislative way, then depends on an analysis of whether, in stepping in, we can actually make any difference to the course of events.

We do not have any evidence that putting people in a locked ward for 30 days, six months or 12 months will make any difference to the behaviour of people when they are ultimately released. In my mind, and I guess this is what I am coming to—

The Hon. CATHERINE CUSACK: Are you suggesting locked up with a program or without a program just locked up?

Dr MATTHEWS: No. It would be pointless to lock anyone up without any treatment program. Let us take the Swedish model. You are taken before a civil court by a combination of police and social workers. They argue before the court that your level of use of the drug is damaging your health and that society has a duty to step in. The court can then send you to a secure unit run by their equivalent, I guess, of the Department of Community Services for a period of 12 months—and they are fairly secure. The treatment programs that are offered there are cognitive and behavioural treatment programs generally conducted by social workers and psychologists.

Unfortunately, we do not have any evidence as to whether when people are released after the six months they actually behave any differently. When we visited there the Swedes were convinced of the model and convinced that it did make a difference, but there never has been a real trial to evaluate what they do. I guess the point I am getting to is that if we have a belief that this is something that we, as a community, ought to do, then we ought to set it up as a trial, do it properly and evaluate it properly so that we know whether, in fact, it is an intervention that makes a difference.

CHAIR: Do you have a view on the Swedish system and whether or not their conviction that it works is soundly based?

Dr MATTHEWS: I have to comment that Swedish society is somewhat different to ours. They, as a community, have accepted that the State has a degree of responsibility for the individuals that we, as a nation of somewhat rugged individualists, possibly would not accept. So there is a difference in philosophy within the community in Sweden. In answer to your question, no, I do not really have any basis on which I can make an assessment. Until fairly recent times they have also been one of the most homogenous communities on the planet and that is another factor. Within our society as well, we have a great number and growing difference in cultural views about alcohol that would also need to be taken into account in relation to treatment programs and that, in itself, is a tricky issue.

The Hon. CATHERINE CUSACK: The Cabinet Office has given us a document entitled "The Effectiveness of Coerced Treatment for Drug-abusing Offenders". It was an attachment to the Government's submission. Are you familiar with that document?

Dr MATTHEWS: Yes, I think I have it here. Who is the author?

The Hon. CATHERINE CUSACK: Anglin, Prendergast and Farabee. It is an American one.

Dr MATTHEWS: Yes.

The Hon. CATHERINE CUSACK: Do you have any information, maybe not from Sweden but other places, about the effectiveness of programs in a custodial setting and a community-based program where your attendance is compulsory? Does it actually make a difference?

Dr MATTHEWS: There is, unfortunately, very little evidence. The best article that I have seen that summarises the evidence—and I have brought everything we could find from our literature review about the role of coercion—is from Professor Wayne Hall, who was the Head of the National Drug and Alcohol Centre, entitled "The Role of Legal Coercion in the Treatment of Offenders with Alcohol and Heroin Problems". That article discusses these very issues, the ethical justification, and it reviews all the evidence of effectiveness. To my mind that is the best summary of what is out there but, unfortunately, there is not very much out there.

The Hon. CATHERINE CUSACK: What did the evidence suggest? Are there programs that work? Is there any difference between heroin-affected people and alcohol-affected people as to whether a program is likely to succeed?

Dr MATTHEWS: At the risk of being difficult—and I do not want you to think I am a difficult—we need to define "success". If success is abstinence, then there are fairly poor results for most types of dependence and if you look at those who have been successful in becoming abstinent, it is extremely difficult to find any common pathway. If you take a large group of heroin addicts or alcoholics and you follow them for 10 or 20 years, and you then look at those who have been abstinent or sober for a period, you cannot find a common pathway. They have got there by different means. With abstinence, firstly, the results are poor and, secondly, there is no common pathway. If you take a harm reduction model—

The Hon. CATHERINE CUSACK: Is this the evidence of Professor Hall?

Dr MATTHEWS: He was looking–

CHAIR: Are we getting Dr Matthews' view or Professor Hall's view, is that what you mean?

The Hon. CATHERINE CUSACK: I am asking him about the research, yes.

CHAIR: We have a copy of the document.

Dr MATTHEWS: You have a copy. There is good evidence, for instance, about the effectiveness of methadone maintenance in reducing crime, reducing seroconversion and reducing death, if they are your outcome measures. But if abstinence is your outcome measure, there is not terribly good evidence around about anything much. It is a question of the definition of success.

CHAIR: If other things are the agreed goal—for instance, prevention of short-term harm or death?

Dr MATTHEWS: In relation to alcohol?

CHAIR: Yes.

Dr MATTHEWS: With alcohol-dependent people, the greatest risk of short-term harm is in withdrawal where delirium tremors can be a life-threatening condition. When looking at how we

handle intoxicated persons, it is very difficult to examine a person who is intoxicated unless you know them or have some past history, and form any view about whether they are dependent or whether they are an abuser and about what is likely to happen. It is when people go into withdrawal that you start to see the signs and that, as I say, can be a life-threatening condition. The other harm reduction measures can be fairly simple things like the provision of adequate amounts of vitamin B1 and vitamin B12 to reduce the amount of central nervous system damage that is being done, as well as adequate diet.

This is where the Inebriates Act probably functioned as a harm reduction measure in the past because individuals went into the schedule 5 hospitals for a period where they had no alcohol and they got an adequate diet and some care. Over the period they were in there that actually improved their health. Providing those sorts of beds for that sort of thing to happen is something that we should importantly be doing.

CHAIR: Some people would say that is the way the corrections system works these days.

Dr MATTHEWS: To some extent, to provide a service in a public hospital for those who have offended is a very expensive way of providing it. That is a service that should ideally be provided by the non-government sector through very clear memoranda of understanding and agreements and should be funded by government. That is a much more effective way of providing that particular intervention.

The Hon. ROBYN PARKER: Almost everyone we have heard from so far, including you, has talked about the need for follow-up and the absence of good follow-up processes. Using best practice, what do you believe is an appropriate follow-up mechanism? What do you see are the roles of Health and the justice system?

Dr MATTHEWS: Best practice health care is provided through general practitioners. Perhaps I should say I was a general practitioner for 20 years, so I am probably biased. Best practice care is provided by having a general practitioner who is the primary person who refers the patient to and helps the patient to access a range of treatment services, both in the private and public sectors and, if you like, brokers those. Unfortunately, abusers and those dependent on alcohol, particularly offenders, are marginalised and are not traditional accessors of that system. They need to be followed up in community health outpatient, if you like, drug and alcohol facilities, which do exist across the State. At the same time they need to be encouraged into a normal relationship with a general practitioner to look at all aspects of their health care, because it is extremely likely that other parts will require attention.

The Hon. CATHERINE CUSACK: Is it fair to say that approach is not working at the moment?

Dr MATTHEWS: Yes, it is fair to say for many individuals it does not work. One of the principal difficulties, of course, is that it is difficult, in fact impossible, to coerce people into actually attending and doing it. You can make attendance at treatment programs part of conditions of probation and parole orders, but where offenders are released without any orders there is no power to make people attend.

The Hon. CATHERINE CUSACK: What should be done in those situations? This is the opportunity to improve on that.

Dr MATTHEWS: That is an extremely difficult question. It is easy for me to say extend the scope and limits of those orders. The problem is that the only default mechanism is to the Parole Board and back into custody. We reluctantly have to accept that there are a lot of people who do not want treatment or who manifestly and definitely say that they do and then behave in a contrary manner. That is one of the greatest difficulties. Many of the cries of the heart that you hear are: "If only I had had access to this or that something would not have happened". You need to sit down, drill down and take a history and you will very often find that, in fact, that person has over the years accessed a lot of treatment services but they have not been successful.

My message would be, and this is what makes it really difficult, that each person who is using or abusing or is dependent, whether an offender or not, is an individual with an individual

history of periods of compliance and non-compliance with various different kinds of treatment and of incarceration. Each person needs to be appropriately assessed and get the appropriate treatment plan. Having done all that, we have to accept that very many of them will not follow that plan. They will not turn up for their counselling session. They will not turn up to pick up their methadone. They will not turn up for their naltrexone. They will simply be non-compliant with treatment. We have to be very careful we do not make the correctional system the default bucket for people who are non-compliant with treatment.

The Hon. CATHERINE CUSACK: We are saying by definition that they are impaired in their judgment, which contributes perhaps to their non-compliance with treatment. It is a bit tough, particularly in cases of family violence, where a group of people disproportionately bear the consequences of their failure to comply with treatment.

Dr MATTHEWS: Absolutely. I take the point you made with the previous speakers about the wives and children with the broken limbs. My view would be that whilst technically they are non-offenders, in fact they are offenders. It is just that we have not been able, for a variety of reasons, to get the evidence that leads to conviction. If I could perhaps bore you with another one of my analogies, when treating diabetes you will have a normal distribution curve of patients. At one end you will have people who manage the illness, check their sugars, take their insulin, turn up and are perfect patients. At the other end you will have people who dislike being diabetics. They are covered in tattoos, drink lots of alcohol, do not follow their treatment regime, constantly have hypoglycaemic attacks and are carted off to hospital casualty departments and generally create an enormous amount of nuisance and inconvenience. When those people come in you do not give up on them; you keep treating them.

You will generally find that the non-compliant group are in the lower socioeconomic groups with a poor amount of education and come from poverty backgrounds, et cetera. When you are in the business of treating drug and alcohol people, the normal distribution curve is skewed in that the majority, not all, of the people you are treating come from those kinds of difficult backgrounds. They are, therefore, far more difficult to treat. As we do for the diabetic who does not look after his illness, we should keep trying. We should keep offering more treatment, but we should accept that there will be failures. If in the course of not complying with their treatment they offend—commit what the Dutch now call nuisance—it is a matter for the criminal justice system, of course. But we need to be as compassionate as we can in the management of them both by diverting the minor offenders and compassionately treating the more serious offenders within the criminal justice system. But there is no easy answer.

CHAIR: When harm is caused to other people in domestic violence or there are acts of vandalism, such as the breaking of windows or pub brawls, should that be an indicator to take more coercive action in terms of compulsory treatment? Is that the point at which the corrections system becomes more relevant rather than trying again and again with health treatment?

Dr MATTHEWS: I take the view it is the nature of the offence that is committed that determines whether the correctional system has a role.

CHAIR: Let us say that a person is now in the corrections system. Should the nature of the offence affect the type of treatment that is offered and the long-term program that is embarked on?

Dr MATTHEWS: Unfortunately, with this group who are generally abusers of alcohol and behave badly under the influence of alcohol—and often well without alcohol—the nature of the offence is often random. If you get into a fight in public it can result in assault, assault occasioning grievous bodily harm, manslaughter, murder. Which one of those is the outcome can be a random event, depending on whether the broken glass pierces the carotid artery or merely lacerates the face. I do not think with this group that the nature of the offence is so relevant; it is, again, the history. How long have you had this problem? What has been done about it in the past? Are you interested in doing anything about it? As a drug and alcohol doctor I would probably push for a trial of some of the new pharmacotherapies for this group of people, with the coercion being if they fail to turn up to pick up their medication they will go into the default bucket of the correctional system. In other words, you offer a coercion that this treatment is an alternative to incarceration. We do some trials on that and see whether these treatments work.

The Hon. IAN WEST: Does the default bucket have to be part of the correctional system? Could the default bucket remain for a time within the non-custodial area?

Dr MATTHEWS: Again, that would depend on the nature of the offence. Are you asking me whether we ought to set up a secure system within the health system or somewhere-else for this group?

The Hon. IAN WEST: A halfway house, for want of a better term, where they are not automatically going from the non-custodial to the custodial systems. Then there is some flexibility to enable people to have a few defaults before they end up in the correctional system. There would still have to be a system to implement the default, but not automatically into the correctional system.

Dr MATTHEWS: I think that NSW Health would be very reluctant to be in the non-correctional/correctional business, if you know what I mean.

CHAIR: That is what the Inebriates Act was.

The Hon. CATHERINE CUSACK: Exactly. It seems to me that 100 years ago the Parliament tried to set up a framework and asked the Department of Health to do so but the department did not co-operate. I do not ask you to account for the sins of the department 100 years ago. But we find we are in the same situation 100 years later. We do not want to treat people as criminals because they drink too much, but we are trying to prevent offences before they are committed. We are trying to get the Department of Health to play a role, but the department does not really want to be involved.

CHAIR: Originally the Inebriates Act sent people to places such as Shaftesbury Reformatory.

Dr MATTHEWS: And the prison.

CHAIR: And the prisons. It was later in 1929 when the hospitals, particularly the psychiatric hospitals, were made the repository. At the time the Act was codified people with an alcohol problem were sent to places such as Shaftesbury Reformatory.

Dr MATTHEWS: And Darlinghurst gaol and the Comptroller-General of Prisoners was the responsible person. It was only, as you say, in the 1920s that it was deemed inappropriate to put people with purely an alcohol problem into gaol. It was widely held at the time that the schedule 5 was inappropriate and many argued against it. They were the only other facilities available that had locked or secure facilities. So the Department of Health did get the responsibility, but over time the model of care within psychiatric hospitals has changed dramatically.

The Hon. IAN WEST: But again we appear to have to make a distinction between one or the other, we cannot seem to come to grips with a mix. I would be interested to hear of any case study you might have where someone dealt with under the Inebriates Act did not have some associated mental difficulties.

Dr MATTHEWS: You mean are there some people who drink to excess who are not suffering from mental illness?

The Hon. IAN WEST: No doubt there are but I am asking is there not also a mix of people who have both problems?

Dr MATTHEWS: Absolutely, and I think what is happening now is that, particularly with the group of mentally ill people who are, if you like, on the fringe and in the streets, there are very few of those who are now not abusing some substance. So certainly the increase in the range of drugs available which has occurred since the late sixties has had a dramatic impact on many mentally ill people and through the nineties it is certain that the rapid increase in the use of amphetamines and marijuana has led to more frequent exacerbations of, more treatment resistance and longer admissions for serious mental illness.

Alcohol has a more complex relationship with mental illness than, I think, elicits, particularly stimulants. Certainly many people with all forms of mental illness take alcohol to excess but there is over here a very very big subset who abuse and are dependent on drugs who do not suffer from any other form of mental illness.

The Hon. IAN WEST: Of the 70,000 that you talked about I understood that figure to be dependent as opposed to abuser?

Dr MATTHEWS: Yes.

The Hon. IAN WEST: Of that 70,000 what percentage do you think would have no other problem than dependency on alcohol?

Dr MATTHEWS: I will have to take that question on notice and talk to Professor Gavin Andrews and see if that analysis had been done. There would be very large numbers who did not have serious mental illness. If you included anxiety disorders and personality disorders of course the number would be far less.

The Hon. IAN WEST: Finally, would you hazard a guess as to the number of those that come into that category of abuser?

Dr MATTHEWS: No, I probably would not hazard a guess.

CHAIR: Do you want to take that on notice or is it impossible?

Dr MATTHEWS: I will take it on notice. I must add that on that figure of 70,000 I am quoting from a study that has been done across the country on 13,000 people and I came up with that very quick back-of-the-envelope calculation, so I would not want that to be read onto the record as definite.

The Hon. IAN WEST: We understand the numbers are flexible.

CHAIR: You gave us very precise percentages and then I think you worked it out quickly on the New South Wales population, but we should stick to the percentage from the health and medical research.

Dr MATTHEWS: The percentages from the national mental health interview give an indication, and I think this is historically the case and probably the case across the western world, that around about 10 per cent of the population develops some sort of problem with some sort of drug.

CHAIR: There is a group of questions which are questions 12, 13 and 14, which you have dealt with in part, but I just wanted to come back to them. They all relate to what are the best sorts of settings or the possible settings for treating people with severe problems, assuming we should not use psychiatric settings and, as you said before, the cost of treating people in public hospitals, for instance is inappropriate. So we have asked questions about the most appropriate setting for treatment, about the suggestion from some people about the shortage of longer term care and accommodation in addition to treatment and, more recently, people have talked to us quite a bit about community-based treatment, involuntary community-based treatment for non-offenders.

I wonder if we could get your views on that and specifically about the shortage of services in rural areas, which also brings up the question of shortages of services for many Aboriginal communities. I know you have seen the questions but it seems that that is a whole group of questions relating to desirable settings for treatment, perhaps areas we have not tried yet.

Dr MATTHEWS: Looking at the broader strategic view, I think that the model that we have adopted for elicits and the model that we are adopting in relation to mental health, if this is really a whole-of-government problem almost all the human service agencies and the justice agencies have a role and we need to work together. All people with drug and alcohol problems require a range of psychosocial interventions to assist them: some of them require pharmacotherapies, some of them can

be treated in an outpatient setting and some of them will require a period of inpatient detoxification and assessment and some long-term rehabilitative follow-up. So that needs to be done as a partnership between the human service agencies and the non-government sector. That is the kind of model that we need.

In terms of rural areas, capacity building for health services, and indeed all the human services is, for obvious reasons, difficult in the rural setting and there are particular difficulties in relation to Aboriginal people for cultural reasons. Again, in my view, the future for the delivery of services to Aboriginal people lies very strongly in partnerships between health and the other agencies and the community controlled organisations. The Aboriginal medical services and the land councils need to be heavily involved otherwise we will fail. The long-term workforce plan to build capacity within the Aboriginal workforce is vital. Unless we can achieve across the full range of health and other professionals a significant workforce which is itself indigenous, we will fail.

To me, for that group, the partnership with the community controlled organisations and the development of a workforce are vital in getting treatment programs that work. There has been some progress made. My substantive organisation has partnerships with 12 Aboriginal medical services [AMSs] across New South Wales who come into correctional centres and who, in partnership with us, provide culturally appropriate services, and the people who leave are linked into those AMSs when they leave. That is the sort of model we need in every health service for Aboriginal people.

The Hon. CATHERINE CUSACK: We should be the lead agency in a whole-of-government approach?

Dr MATTHEWS: Well, the model in relation to elicits was that the Office of Drug Policy was set up in the Cabinet Office. The model which has emerged in response to another inquiry in this House is that the Cabinet Office, again at Deputy Director-general level, will have responsibility for a group of human service and justice chief executive officers who will co-ordinate the whole-of-government response to mental health. Given the model that we have for elicits, I would argue that a similar sort of model would be appropriate for alcohol.

The Hon. CATHERINE CUSACK: Do you see a stronger role for community services in partnership with health in addressing some of these issues?

Dr MATTHEWS: Yes, the role of the Department of Community Services and other Government agencies is vital, as is the role of the probation and parole service for a particular group, and there is a large network in the community within juvenile justice that provides treatment services for young people who have come into contact with the criminal justice system but who are not in custody. There is a need to link these agencies.

CHAIR: You have briefly mentioned the review of the Mental Health Act and we have a couple of questions about the review and what is now happening in relation to the provision of services, and the extent to which the issues are relevant to the Inebriates Act will be included have been addressed in the review process so far, and then what is going to happen following the recent announcements from the Department about change and funding and so on for the mental health system. Can you tell us whether there is much there that is relevant to us or whether it is more specifically a mental illness area?

Dr MATTHEWS: The review, as you know, has been announced. The process will be that the department will produce a series of discussion papers around specific aspects such as information sharing, transport, forensic patients, et cetera, and they will go out for consultation with a range of community and other groups. Then the changes to the Act will be drafted. The Mental Health Act, of course, deals specifically with mental illness. There have been some suggestions, arising out of the Legislative Council inquiry, that other matters, such as intellectual disability and cognitive impairment, should be included and that will be the subject of discussion.

So in terms of this discussion, it may be that those who have become impaired and are no longer competent will certainly be part of the discussion, but I obviously cannot comment on what the outcome will be at this stage. In terms of the other group that you are vitally interested in, which is the group who are obviously damaging themselves but who are still competent, I do not think they will be

picked up by the Mental Health Act and they would need, if that were the decision of Government, to be picked up by a separate piece of legislation.

CHAIR: So the review process is expected to be complete by when?

Dr MATTHEWS: I would say that it will probably take until towards the end of next year.

CHAIR: We are hoping to wrap-up this inquiry about the middle of the year. A couple of questions we passed over earlier also relate to the Mental Health Act. Suggestions have been made by a number of people that that should be a model for new legislation in relation to inebriates in terms of the safeguards and protection of the rights of people and so on, not in terms of putting inebriates within the mental health system but using that Act as a model in terms of balancing the rights of the different players. Can you give us your views on that?

Dr MATTHEWS: The Mental Health Act is a very obviously well-developed Act which does have built-in safeguards to protect the rights of individuals, particularly those individuals who are being subjected to a restrictive regime and/or compulsory treatment, but they are largely restricted to those who are incompetent because of their illness or who are a danger to themselves or others. A danger to themselves or others has generally been taken as seriously suicidal or likely to very seriously harm someone. There has been some debate about whether the provisions for compulsory treatment are broad enough and it is fair to say that opinions differ and there will be a fairly rigorous debate about that. Again, I think the safeguards will give you a model in terms of what you might suggest. But you are still left with the very difficult problem that in this area you are looking at forcing treatment on someone who is competent and who may say no.

The Hon. CATHERINE CUSACK: Is that any different from a mental health patient refusing to take his or her medication?

Dr MATTHEWS: The only circumstances in which you can enforce treatment is when, in the opinion of a psychiatrist, a second psychiatrist assigned by the Chief Health Officer, that as a result of the illness the person lacks the capacity to make a competent decision. If someone is a voluntary patient and they refuse their medication it cannot be forced. So we return to the issue of someone who is damaging himself or herself but who is still competent and may say to you, "Thank you for your advice but no thank you for your treatment."

CHAIR: What if it is an involuntary patient?

Dr MATTHEWS: If it is an involuntary patient scheduled under the Mental Health Act he or she can receive compulsory treatment.

CHAIR: I am thinking of an involuntary patient under whatever might replace the Inebriates Act. I guess there would also be issues about safeguards in relation to how long a person's stay might be and the various locations—there might be a short-term stay in a more secure facility and a longer period in community-based treatment.

Dr MATTHEWS: When a person is not competent because of cognitive impairment I think the ethical dilemmas are fairly straightforward and you could argue strongly that compulsory treatment, or in some cases compulsory confinement, has an ethical justification. When the person is competent there is a significant ethical difficulty.

The Hon. CATHERINE CUSACK: Is extending the provisions of the Mental Health Act to cover those people theoretically covered by the Inebriates Act an option of this inquiry?

CHAIR: We have every option before us I suppose, but this question is more that people have suggested that the safeguards in the Mental Health Act are suitable for inclusion in an Act that replaces the Inebriates Act. We are not saying that there should be one system but a lot of work has been done on that Act and the Chief Magistrate, for instance, said that he felt quite happy with the range of safeguards it contained.

Dr MATTHEWS: If you are committed for compulsory treatment you must be put before a magistrate as soon as practically possible so that you, as the patient, can argue the case, if you wish, that this compulsory treatment is not justified. Forensic patients have the same right to appear before the Mental Health Review Tribunal—and have done so. The individual can argue before a magistrate—if necessary, or if they wish, with legal representation—that this compulsion is not justified. That is the safeguard.

CHAIR: You have drawn a distinction regarding people who are competent. Do you believe most of the people whom we would classify as dependent—I know that you are going to come back to us with some more developed views on the statistics—would also be competent?

Dr MATTHEWS: I think the majority would, yes. During their periods of sobriety the vast majority would not be cognitively impaired to the point where they could not understand the arguments. A significant minority would be cognitively impaired.

CHAIR: Can you give us any indication of the size of those groups?

Dr MATTHEWS: I doubt it but I will try.

CHAIR: The other question is whether there is a standard period of intoxication and withdrawal. What is the maximum period of days for which a person would be incompetent?

Dr MATTHEWS: It depends on the drug. With alcohol, the withdrawal can take up to five days. During the withdrawal period the symptoms of withdrawal might be such that it is arguable that the person cannot make good, rational decisions.

CHAIR: Would that vary from individual to individual?

Dr MATTHEWS: Yes.

The Hon. CATHERINE CUSACK: Is there an objective test of that?

Dr MATTHEWS: No, not a simple, objective test in the way that you can do a blood test. It requires either a competent clinical psychologist trained in testing for cognitive impairment, a neurologist or someone fairly skilled, possibly with or without diagnostic tests such as CT scans, to make a really good judgement as to competence. Lawyers often become involved at that point.

The Hon. CATHERINE CUSACK: In the old days the police used to administer the walk-the-straight-line test. I am not saying that that should be the system now. It is a big question: What does competent mean?

Dr MATTHEWS: That was the test for intoxication. In terms of the law, at the moment it happens under the Mental Health Act and the Guardianship Act. When guardianship orders are sought some evidence must be presented as to the why they are necessary. If there is brain damage there are generally expert reports from a clinical psychologist, neurologist, psychiatrist and other relevant clinicians.

The Hon. CATHERINE CUSACK: Is there any practical, easily available testing?

Dr MATTHEWS: No.

The Hon. ROBYN PARKER: Over many years there have been many attempts to review and amend the Act, or at least there has been a recognition that it is not working. Each of those attempts has failed. Why is that so and where do we go from here?

Dr MATTHEWS: Reading the paper before you, it seems to me that various Attorneys General started reviews on a number of occasions but then they seemed to falter and never came up with a set of conclusions. Ministers wrote to each other and people started reviews but I could not find any evidence that a review ever went from beginning to end and came up with a set of conclusions and recommendations. Why did that happen? It is a very difficult area and other priorities got in the

way. Nobody looking at the problems could see their way to any obvious solution. I think that is probably the answer.

The Hon. ROBYN PARKER: You know that I will now ask what you believe this inquiry should achieve and what solutions it should recommend.

Dr MATTHEWS: I think there should be a fairly clear set of principles around offenders that I believe would be pretty much based on what we are doing because I think we are at least starting to get that right. In relation to non-offenders, where there is a clear lack of competence and cognitive impairment, the State's duty is clear: to assist the family and carers in looking after that person. We need a mechanism to do that. Some mechanisms exist through Health and other government agencies. In terms of the other rather tricky group of non-offenders—

The Hon. CATHERINE CUSACK: Technical non-offenders.

Dr MATTHEWS: I guess there are two groups: your technical non-offenders, who we know are damaging others but we cannot necessarily prove it; and the group who are simply sitting quietly at home and drinking scotch. I want to duck that one. I honestly believe that is not a decision for either a government department or an individual; it is a decision for the Parliament of New South Wales, after careful consultation with the community.

CHAIR: My family had a close friend who basically sat at home drinking scotch. He was a World War II veteran. The general practitioner intervened at a certain point and sent him to a veteran's hospital, where he got over the acute stage. He was then sent to another facility in the veterans system, which was basically a rehabilitation facility. I suspect that that was done if not illegally then not according to most of the existing guidelines. I guess it provides respite for the family. From what I can gather, many veterans' establishments dealt with a large number of exactly those sorts of people.

Dr MATTHEWS: Did it work?

CHAIR: The family got some respite. The man did not die until he was about 70.

Dr MATTHEWS: Respite is important.

CHAIR: I guess it kept him alive and gave the family some respite.

Dr MATTHEWS: That brings us back to harm reduction: we reduce the harm to the family and to the individual, both of which are desirable outcomes, but we do not necessarily cure the dependency. A system that does that would be a good system.

CHAIR: It was made possible by a certain amount of creative form filling in that somehow related his condition to war service.

Dr MATTHEWS: Yes.

The Hon. CATHERINE CUSACK: You might have heard the witness from Attorney General's Department say that he felt that offenders are catered for at present and that there are enough options in the system and that we should focus on non-offenders. Is your area of expertise in Health with offenders?

Dr MATTHEWS: Substantively, but not in my current position or the capacity in which I appear before the Committee.

The Hon. CATHERINE CUSACK: Do you endorse the view that offenders are being catered for by existing legislation and that we should focus on non-offenders?

Dr MATTHEWS: I think the legislation caters for offenders. The Drug Court, for instance, has only one catchment area at the moment so we do not have full implementation. The other thing that militates against doing much with offenders is the very short stay within the correctional system

of many people with these problems. You might accept that you need six months to make a difference but they are not there for that long—although they might be there very often.

The Hon. CATHERINE CUSACK: Do you believe Corrections health has adequate powers in terms of doing the work it needs to do with offenders? What about juveniles? Are the consent issues different?

Dr MATTHEWS: In terms of adequate powers, it is not really a question of power but a question of resources to offer appropriate treatment modalities. That is the "When did you stop beating your wife?" question. On the one hand you can never have enough resources but on the other hand we are very well resourced and our resources have been greatly increased over the past 10 years. In February this year we assumed responsibility for delivering health care in juvenile detention centres. We received additional resources in order to do that, and we have already employed an adolescent decision and we will seek to employ at least a part-time adolescent psychiatrist to augment their services.

The Hon. CATHERINE CUSACK: Is the legislation okay? Is it doing the job?

Dr MATTHEWS: Yes, the legislation is fine.

CHAIR: In answering the Hon. Robyn Parker's rounding-out questions in relation to non-offenders, you said we can look at getting the various mechanisms in place. It is always going to be difficult, particularly outside Sydney, to provide enough services of whatever kind, government or non-government, because of the relative sparsity of the population. The question we have not asked you is whether the services we are talking about need to be kept separate from other kinds of services. Obviously, one way of making sure that there are enough services in areas more sparsely populated is to combine a whole lot of quite different things together. Is it more desirable to have drug and alcohol services operating quite separately from other services?

Dr MATTHEWS: I think they need to be very closely linked to other services, because we need to avoid the creation of silos and we need to recognise that people with drug and alcohol problems are going to have a higher prevalence of other physical disorders than the general population, so they need access to, for example, hepatitis services and a whole range of primary health services. So the drug and alcohol services have to be very carefully linked to the other services, and much better linked to general practice.

CHAIR: So the distinction we are drawing is that everyone seems to agree that drug and alcohol services, and the other services we are talking about, should not be located within a psychiatric hospital. Other than that, you are quite happy for services to be co-located, or even run as part of one service?

Dr MATTHEWS: In terms of saying they should not be in a psychiatric hospital, if you set up a service within a psychiatric hospital in a particular ward and that ward or facility is appropriately staffed, the fact that it is physically part of a schedule five service does not matter; it is a question of not mixing the two groups in the same ward.

CHAIR: In terms of freedom to enter and leave, for a lot of the people there, setting up a separate ward within the grounds of a psychiatric hospital has implications for the involuntary part of the argument?

Dr MATTHEWS: If it were a separate facility, the rules and means of security would be different within that building. The current problem is that there is no separate facility so they are put in that ordinary ward.

CHAIR: You have the question on notice in relation to the figures about dependency and so on. If we need further information from you, particularly with regard to the mental health review, I hope we can contact you.

Dr MATTHEWS: Yes.

(The witness withdrew)

CHAIR: For Committee members, we need a motion to publish the submissions received. Given the holiday period and the fact that the Committee will not hold hearings for a while, we thought it was sensible to publish the submissions received to date, except for those that are confidential. We also need a motion to publish submissions 15 and 20 whilst suppressing the names referred to in those submissions.

Motion agreed to.

(The Committee adjourned at 12.18 p.m.)