STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE INEBRIATES ACT 1912

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At Sydney on Thursday 8 April 2004

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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. Dr A. Chesterfield-Evans
The Hon. K. F. Griffin
The Hon. R. M. Parker
The Hon. I. W. West
The Hon. G. S. Pearce

RICHARD PHILLIP MATTICK, Professor of Drug and Alcohol Studies and Director of the National Drug and Alcohol Research Centre at the University of New South Wales, sworn and examined:

CHAIR: In what capacity are you appearing before the Committee today?

Professor MATTICK: I am appearing in my official capacity as Director of the Drug and Alcohol Research Centre.

CHAIR: I understand you are going to give us a presentation of maybe about 40 minutes in total, but you are happy for us to talk to you as you go through, within units, I think I should say?

Professor MATTICK: The presentation is probably 20 to 25 minutes, depending on the discussion. I can do it quite quickly and I can also do it more slowly.

CHAIR: But you are comfortable if we ask things as you go along?

Professor MATTICK: Yes.

CHAIR: Perhaps unusually for us I know you and Merrin have talked more about an outline of the points and issues you are going to address that will be helpful for us, with less emphasis than we usually have on specific questions. Obviously, we will have a lot of questions to ask you. I suppose your opening statement and your presentation is one thing, so if you would like to begin.

Professor MATTICK: I do have a presentation which addresses the issues raised in discussion prior to coming here today. I think it is important to understand the nature of addiction or dependence and the changes in its consideration over time. Alcohol-use disorders used to be simply considered as alcohol addiction or alcoholism. Over time there was a recognition that individuals can be dependent on alcohol at different levels—mildly, moderately or severely dependent—and that is true of other drugs as well. It is an important point to make because we still think of addiction as we did in the 1950s and even the 1930s. We still have that mindset. The criteria that are used to define, in this case, alcohol use and dependence are set out in the presentation. For alcohol abuse it is recurrent drinking. The emphasis there is on recurrent drinking, with failure to fulfil roles, or recurrent drinking in dangerous situations, recurrent legal problems or recurrent social and interpersonal problems. A lot of people miss the word "recurrent". It is not a one-off occasion, it is a repeated problem the individual has.

Alcohol dependence is a bit different because it invokes the notion of tolerance to the effects of alcohol, and withdrawal can be quite severe. You can suffer an organic brain syndrome called delirium tremens. Of all the drug dependencies, alcohol withdrawal is the only one that has the potential to cause death. A lot of people do not appreciate that either. The potential of opiate dependence or other dependencies to cause serious harm is minimal. They are very uncomfortable withdrawal states but they do not cause death. Along with the two physical criteria of tolerance and the effects of alcohol withdrawal are a set of other criteria that mark alcohol dependence. They are a strong desire to continue drinking, difficulty controlling drinking, neglect of interests, substantial time drinking or recovering from drinking and persistent drinking despite consequences—physical or psychological consequences. The individual can have a few of those or can have all of those—hence the notion of mild through to severe dependence. Severe dependence really is a chronic and relapsing disorder.

We have another problem when we think about drug dependence as a community. That is, that we would like to cure it. We do not think of curing necessarily other diseases such as diabetes, schizophrenia, depression or hypertension. Unless the community can get out of the notion that we will cure this disorder and only manage the other ones we will be left in a situation where we are always looking for a therapeutic ideal. It is a real problem in this area. We want cure and we are not going to get it. We have good methods of management as we do for other disorders. This has been said before, and you have probably heard it here before, but it is an important point. It is a subtle point that people miss—they slip back into it, but if we can only get them to stop.

If you move away from substance disorders to something like panic disorder, which is an anxiety disorder. We do not feel that we have failed if the panic attacks reduce but someone has one or two every month instead of one or two a day. We feel we have succeeded. With alcohol or other drug disorders if they return to drug use we feel we have failed. It is an issue of management more than cure. There is a need for repeated treatment episodes as there is for blood pressure problems and diabetes when people are not compliant with their medication. There is a need for the avoidance of unrealistic expectations of a therapeutic ideal of cure. That is not an ideal that is applied to other disorders. We are on an uneven playing field here. It actually has quite negative consequences in the drug and alcohol field because the area is criticised if we do not achieve the therapeutic ideal.

Whether the treatments are naltrexone, methadone for opiate dependence, or treatment for alcohol-use disorders, abstinence is the only appropriate goal for severe alcohol or other dependencies, in my opinion. You can get reductions of harm in the case of alcohol—and I am focusing here on alcohol—by good nutrition, dietary supplements and detoxification. Recently I had a discussion about controlled drinking with some people in the drug and alcohol area. The issue had been raised before the government advisory committee. Controlled drinking is rarely exercised as a therapeutic intervention in Australia. There are some interventions but they are for problem or excessive drinkers not for alcohol-dependant individuals. I think it would be wrong for any discussion to get railroaded along the issue of controlled drinking.

CHAIR: What would controlled drinking be?

Professor MATTICK: Controlled drinking is teaching people to continue to use alcohol but in a way that is not a problem. They may drink at an average social level rather than at an excessive level. It is potentially appropriate for people who are excessive drinkers but not dependant drinkers. I am just raising it because it has been raised in some senior groups over recent time.

The Hon. IAN WEST: But could it not be a step, especially attracting people to become participants in a goal down the track?

Professor MATTICK: I think it could. I think you are right. I was quite concerned. The only reason I am raising it here is that it started to take over a different process and was setting the agenda briefly. I think we need to be careful that we do not see it as the ultimate goal. Our centre and others in Australia did a study of 10,000 individuals with the Australian Bureau of Statistics on the prevalence of a number of emotional behavioural disorders, including alcohol-use disorders, which are alcohol abuse and alcohol dependence. The distribution is shown on the slide. Alcohol-use disorder is most prevalent among young males. They tend to improve or decrease across time. Young females also have high rates of alcohol disorders. Many of these individuals will only have mild problems but they do meet the criteria. But it is wrong for us to only focus on people who we characterise as end stage.

The message here is not just to bring your attention to it but where intervention should be becoming focussed. We think that is the important part, particularly if you want to stop the end stage later, to capture people early and deal with their drinking, reduce it, as part of a culture change in New South Wales and Australia. Then, recognising where the alcohol-use disorders are occurring becomes quite important. If the focus is not on trying to think into the future, but rather on dealing with the problem as it currently presents, you might ignore that part of the spectrum and focus only on those who are predicted problematic. My advice would be that we should try to do both; you have to deal with people who are currently presenting and also those who, in 20 or 30 years, will be presenting, and try to decrease their heavy drinking.

The Hon. KAYEE GRIFFIN: You said mild problems in the younger age group. How do you classify that?

Professor MATTICK: They would be reporting that they have symptoms of alcohol abuse or dependence, against standardised international diagnostic interviews, rather than developed by the World Health Organisation. They have symptoms, difficulty controlling drinking, neglect their other interests, may have tolerance effects of alcohol; they have to have three to meet criteria for alcohol dependence. Many have three of those criteria present, but they are reporting what is occurring for them. It is a problem for them and occurs regularly.

CHAIR: The classic binge-drinking by young people, maybe once a week or once a fortnight, who drink massively to excess and then may not drink during the following week, would that fit within your definitions of alcohol use disorders?

Professor MATTICK: It could. If it is a young man in Western Sydney who repeatedly has too much to drink and gets into fights outside the pub every week or fortnight or month, and comes to the attention of police, he is having recurrent problems because of drinking. That would certainly meet the criteria. If it was a person who failed to go to work repeatedly on a Monday morning, and that became a problem for them because of alcohol, that would fit. If there were a lot of interpersonal problems, such as yelling over the fence at the neighbour when one had had too many drinks at night, that would cause problems and create neighbourhood disturbance. The same is true with the criteria for alcohol dependence. The notion has to be that we start to see these things on a continuum, as we do with other problems. At the national centre we developed guidelines about 10 or 12 years ago for alcohol use disorders, we have updated them with the support of the Federal Government. Those guidelines are available to the Committee—

The Hon. IAN WEST: I apologise for interrupting you, but could you please speak up, I cannot hear you.

Professor MATTICK: Sorry, I do speak softly. About 12 years ago we developed some guidelines for the management of alcohol use disorders, alcohol abuse and alcohol dependence. New guidelines are available to the Committee. They are based on a review of the international evidence of what is effective to manage alcohol use disorders. Our centre has also been responsible for all major reviews of management of opiate dependence and other drug use disorders. The guidelines set out the ways in which the evidence base suggests that alcohol use disorders can be managed. They are evidence based and distributed throughout Australia to lots of health professionals through a large-scale dissemination project.

Withdrawal management, or detoxification, is not a treatment for alcohol dependence; it is a way of managing people when they need to detoxify. Some people characterise this as a 6,000 drink service. Another way of thinking about it is that we often provide treatment for sexually transmitted diseases, but we do not expect the individual to not engage in sexual activity again; they may need further treatment in future. It really is not a treatment that will stop heavy drinking, it is a way of managing, particularly for the severe end of alcohol withdrawal for epileptic seizures or delirium tremens, an organic brain syndrome that can eventually cause death. The thing that New South Wales and Australia lost over the last 15 years is that detoxification used to provide very good shelter and humane care. It gave people a place to have a shower, to get away from wet boarding houses or other environments for some time.

Systematically over the 1990s those detoxification facilities were not supported and some closed. Some have reopened. They play an important role in terms of shelter and humanitarian care. It can be provided on an outpatient and inpatient basis, medicated and non-medicated. The most important point that the Committee needs to understand is that the international literature is quite clear; providing detoxification does not change people's drug use or alcohol use. It provides some health gains, potentially, and may be an entree into further treatment. The episode of detoxification, per se, is not a treatment for altering drinking or drug use. It is the way of simply managing the individual for a brief time.

The Hon. ROBYN PARKER: Are you saying that proclaimed places do not have a valid role at all?

Professor MATTICK: No, quite the reverse.

The Hon. ROBYN PARKER: They have a valid role, but not as a treatment; they offer relief for a short period?

Professor MATTICK: Yes. This comes back to the unrealistic expectations. The notion that going into a detoxification facility or a proclaimed place will change a well-rehearsed long-standing habit is nonsense. Because we have this therapeutic ideal that we want to cure this problem, we ask what is a cure? People grasp at things. In the area there is a tendency for treatment providers to

overstate the effectiveness of their treatments from time to time. I think proclaimed places and detoxification are very important. That should be supported, but we have to recognise that it is not a treatment and then provide other treatments. That is my first point.

CHAIR: The Committee recently visited Moree and went to a centre that had been a proclaimed place. The people who had run that place said that it was a place for a shower and a bed, but basically they picked up people at 4 o'clock in the afternoon and had to empty the place at 8 o'clock the following morning. There is a considerable difference between that kind of proclaimed place and the detoxification units that used to operate in a variety of general and psychiatric hospitals, which might have kept people for a week or so.

Professor MATTICK: Yes, most detoxification facilities will keep individuals for between three to five days, possibly up to a week. Alcohol withdrawal takes three to five days; opiate withdrawal takes about five days. People will remain there as long as they want before they voluntarily leave. That is the notion, whereas proclaimed places can be as you have described, and similar shelters function throughout Australia. In Alice Springs, in the Northern Territory, buses go around and pick up people and provide them with somewhere safe to sleep. That is very important.

CHAIR: Recently the Committee went to the Herbert Street clinic at Royal North Shore Hospital. That facility is similar to the detoxification units you described, which have reduced in numbers.

Professor MATTICK: Yes. They have not been in favour. A lot of residential programs across the State have closed as a consequence of a belief that brief interventions were appropriate for alcohol use disorders and other disorders. That was a misunderstanding of the international literature. There are brief interventions that do not target, and should not target, people who are dependent drinkers. They should target people who are risky drinkers or excessive drinkers. They should just simply aim to alert drinkers to harmful drinking levels and encourage them to reduce consumption. They are relatively brief and can be from five minutes to 30 minutes in duration. They involve what is called motivational interviewing and counselling techniques. They are cost effective. They are being rolled out across Australia through a number of initiatives, including the Smoking, Nutrition, Alcohol and Physical Activity program, a collaborative project to general practitioners who are involved.

CHAIR: Could you please speak up, Hansard is having trouble hearing you. The microphones are directionally sensitive.

Professor MATTICK: These interventions are cost effective; they do work. There is good evidence from the Australia and internationally. A collaborative effort is underway throughout Australia with general practitioners that aims to increase general practitioner preventive activities in smoking, nutrition, alcohol and physical [SNAP] activity. They are brief interventions for the 28-year-old fellow who has a few too many beers after work and who does not realise the problem. When given sensible advice that he should not do that, he will change his behaviour. That is quite different from alcohol dependence. We have a range of cognitive behavioural therapies for alcohol dependence. They are essentially skills training and development of better communication methods and better relationships within the family. The social skills training involves behavioural self-management to set limits for alcohol consumption, cognitive restructuring, cue exposure—which helps people to cope with cravings for alcohol—and interventions for families and couples. There are also self-help guides and self-help materials.

The international literature is clear that these interventions reduce drinking. It is quite convincing. They are not unavailable in Australia, but they could be more available. Motivational interviewing is a more recent intervention. It introduces the notion of stages of change; that is, drinkers are at different stages in their desire to change their drinking. Some people are not really thinking about it and some people think they should but have not thought it through. Others are ready to change and some are trying to. The motivational interviewing process, which feeds back the health effects to the drinker, allows for the individual to engage in changing his or her motivation to stop drinking or using drugs.

Psychological interventions also deal with situations where a risk of relapse is high. This is an important area that also has a good evidence base in the international literature. It is called relapse

prevention. It recognises that alcohol and other drug-use disorders are chronic relapsing disorders and that these interventions identify factors likely to cause relapse and help people to develop strategies to overcome those situations. They can be used in a number of settings. More recently we have seen the introduction of two medications: naltrexone, which is also used in the treatment of opioid dependence; and acamprosate. They have been included in the Pharmaceutical Benefits Scheme [PBS]. Historically, we had a medication called disulfiram, which has gone out of favour. That and a community reinforcement approach—which is a very intensive treatment—were very effective in the treatment of alcohol and other drug-use problems. There are very good international reviews. It is not practised much around the world because it is very expensive to implement. There are three pharmacotherapies, two of which have become available recently and one which is older and not much used for a number of reasons.

Naltrexone has been the subject of 19 randomised clinical trials involving a couple of thousand patients in seven countries. The trials began in the 1980s. The Therapeutic Goods Authority [TGA] in Australia approved naltrexone in January 1999, and it was PBS listed in February 2000. Acamprosate has be the subject of 12 randomised clinical trials involving 3,800 patients in eight countries. The trials began in the 1980s and it was approved in 1999 and listed on the PBS in the same year. Our studies indicate that the uptake of these pharmacotherapies in the first period of their availability was very low at about 3 per cent of alcohol dependent individuals.

CHAIR: Is that of the known or estimated individuals with a severe disorder?

Professor MATTICK: With alcohol dependence.

CHAIR: Only 3 per cent?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not a drug company approach that they have another 97 per cent that they must catch? The implication is that everyone on alcohol ought to be on naltrexone at 50 times the cost.

Professor MATTICK: It certainly comes from a drug company. However, it also came from our centre and we are not aligned with any companies. If there is an intervention that could have a public health impact one might want it rolled out to more people. It does not mean that everyone who is alcohol dependent should receive medication. The benchmarking in respect of the goal is difficult.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems to me that everyone looks at the cost effectiveness of drugs and not the cost effectiveness of non-drug treatments.

Professor MATTICK: I agree.

The Hon. IAN WEST: That may be only one part of the exercise. Obviously, we must consider the delivery and willingness to update. I am assuming that you will address the reasons that the uptake was only 3 per cent.

Professor MATTICK: We know the reasons. The promotion of non-proprietary remedies around the world is extremely poor and it should be much better.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that personal interventions?

Professor MATTICK: I mean approaches that are not owned by companies, whether it be in psychiatry or in this area. We have very good treatments, but they are not promoted particularly effectively.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is because no-one makes a profit except the scattered individuals who are doing it.

Professor MATTICK: It is usually run through health services, so there is no profit. However, that is correct. Unfortunately, we have a mechanism in Australia that focuses on drug trials and then supports them. A good example of how that can go wrong is zyban, or bupropion, which is medication for the management of tobacco dependence. In fact, $200 million or 0.5 per cent of the

PBS budget was spent on that medication in the first year it was introduced. We have done some research in this area and shown that half the people who received the scripts did not use them. They received them, the Government paid for them and up to $100 million worth of the medication was left on bathroom shelves or bedside cabinets.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have written on this subject.

Professor MATTICK: I know.

The Hon. IAN WEST: We all know.

CHAIR: We have heard—frequently.

Professor MATTICK: We have seen. That is correct. Alcohol dependence problems have been marginalised in the community in terms of interventions. They have been left with a group of professionals who were disregarded for many years. A great deal of effort has been put into the management of these problems over the past 20 years, particularly in the past 15 years. There has been a real growth in our knowledge. The point made is correct. However, to say that we should not promote these pharmaceutical products is also wrong. We must recognise the notion of doing what has been suggested, but I will come to that.

We must get more doctors and others simply to screen and intervene in a general way for alcohol use disorders and not necessarily have them prescribe medication. In terms of the correct level of prescription, zyban reached 11 per cent of smokers in the first year it was available. The issue for doctors is that they do not feel confident or see it as their role to intervene. That is a cultural shift that governments can bring about. That is occurring, and that is why I referred to the SNAP initiative that is occurring through the College of General Practitioners and others. That can provide a vehicle for changing clinical behaviour.

Other important point of intervention is treatment retention and maintaining people in treatment. People will often come to treatment for two or three sessions and then disappear. That is because of their motivation and treatment variables and how useful they appear to be. There is a need for ongoing support after treatment, both through retaining people in contact with the agency but also through using groups such as Alcoholics Anonymous or Narcotics Anonymous. It should involve assertive and structured aftercare, which is not done particularly well in Australia for a number of reasons. It simply means keeping in contact with patients for long periods.

CHAIR: When you say it is not done particularly well in Australia, are there places in which it is done well?

Professor MATTICK: Probably not.

CHAIR: So we do not have a great model.

Professor MATTICK: The models exist. It is not a hard task. Our service structures are such that aftercare or follow-up are not necessarily part of the normal routine. They require a fair bit of support. If one is dealing with a chronic relapsing disorder, it makes sense to keep in contact with the patient. There are some examples from the United Kingdom and elsewhere in which individuals have been contracted and they have agreed to have further contact and follow-up. That has worked reasonably well. Service providers in Australia would have to shift their activities away from providing a response to someone who knocks on the door to trying to managing people.

CHAIR: In terms of the philosophy of treatment it is a problem that applies much more broadly in the Australian health system rather than simply to alcohol and other drugs.

Professor MATTICK: That is arguable for mental health disorders. People with schizophrenia or manic psychosis will turn up and be treated and disappear back into the community and will not be treated again until they reappear with problems. On that basis one might say that we should keep all areas equal. That is one way to deal with the health problem. It depends on resourcing. However, we know that aftercare improves outcomes for all kinds of disorders. It does work. Alcohol

abuse is ideally treated through simple screening and assessment, brief interventions and follow-up. The most likely outcome for low dependence is moderation. For severe alcohol dependence, psychosocial interventions, relapse intervention, pharmacotherapies and aftercare will most likely result in abstinence.

The committee is looking at other drug-use disorders. We know a fair bit about those. Methadone, buprenorphine and naltrexone are very effective for opioid dependence. Naltrexone is used for those who are keen to enter into a program. The same is true for the other two interventions. We have interventions for cannabis dependence—cognitive behavioural treatments. There are some treatments for cocaine and amphetamine dependence, but they are less well researched. They require some attention.

I will briefly deal with coercive treatment. I am sure the committee is aware of the historical arguments for this treatment. They include the over-representation of alcohol and drug dependent persons in prison populations; the causal role of alcohol and drugs in criminal acts; the high rates of relapse after incarceration; the need to divert people from prison; and the cost effectiveness of treatment versus prison. The arguments can be applied to deal with non-offenders with organic brain syndromes. I have a question mark against alcohol-related brain damage. Some important issues need to be thought through if the committee intends to include or consider those with alcohol-related brain damage who have not committed an offence as requiring management or treatment in an involuntary or coerced way. One must consider those with dementia and those who need to reduce serious life-threatening self-harm. However, there are problems of definition. One must also consider those with serious behavioural disturbances. Again, there are problems with definitions.

CHAIR: Do you wish to expand now on the question mark about alcohol-related brain damage?

Professor MATTICK: The centre at which I work has done a lot of work looking at cognitive functioning as a consequence of the use of alcohol, cannabis, amphetamines and ecstasy. The evidence is that these drugs affect cognitive functioning. If one talks about brain damage, one must consider how that is measured and how it would be operationalised. Individuals will frequently rely on psychometric tests, or tests of memory and other cognitive functions, conducted by psychologists to define the presence or absence of brain damage. That is not appropriate. First, one must use tests such as CT scans or MRIs to determine whether brain damage has occurred.

The second point is that one can have alcohol-related brain damage, just as people can after motor vehicle accidents or trauma, but they can still function quite well in the community. So there is an issue of definition as to how you define the level of brain damage which is the level at which you would intervene and whether it is behavioural, a structural change or a point on a memory test. Then if it explores less than this that is the point at which the person might be involved in coercive treatment.

I can see the argument quite well for the Wernicke-Korsakoff syndrome in that it is diagnostically defined and is quite clear usually. But if you are going to talk about brain damage I would think you will create significant problems with a definition. The problems of definition relate to other non-offenders with regard to self-harm and behavioural disturbances. How you would define those without, potentially with time, bringing others into coercive treatment is a problem—where it ends and how it is defined. Who defines it? Whether behaviour is determined by family, community or police and how that is operationalised in a reasonably objective way.

There are some caveats and cautions about coercive treatment. There are quite important ethical issues to do with extended treatment. It is one thing to bring somebody in to treatment to detoxify them, to even have them in a proclaimed place or to deal with some serious physical illness in a relatively brief way where they need it, but if you are talking about treatment for dependence, particularly, for instance, in a therapeutic community or in a residential facility, which can go on for many months, you will be withdrawing that person from the community where they live and have been earning money, but functioning otherwise, to have them involved in treatment. The same is true with methadone treatment. To involve individuals in methadone for long periods of time has a number of ethical issues.

The general sense that we have is that coercive treatment would be appropriate as an alternative to prison where there is demonstrable, diagnosable problems or where the individual chooses treatment rather than going to prison. The difficulty with introducing coercive treatment is that it is likely that over time it will not be particularly well run and if it is going to be introduced, it needs to be well resourced, implemented and humane. There are tensions between the criminal justice and health systems in terms of how they deal with individual who may not meet the expectations of treatment. But around the world there are examples of coercive treatments and they have tended to last for a number of years and then they gradually get rundown and disappear.

CHAIR: The Inebriates Act is probably a good example. It may never have worked properly but it hung around long after its use-by date: It should have expired.

Professor MATTICK: There was a civil program in California which ran for many years and got reasonable outcomes. It was coerced treatment: people had to enter treatment. People did improve, but individuals who did not go to that program who entered treatment elsewhere also improved. Gradually the program deteriorated and closed down. So if you enter into this you have to think about how into the next 20, 30 or 50 years such a program can be resourced and run and kept to be humane.

The other aspect is that we are going to have to have reasonable expectations of what can be achieved, and again avoidance of the unachievable, unrealistic goals of a therapeutic ideal. We will not cure these people. You may be able to manage them but you will not get them to be abstinent from all drugs. Related to the point of programs being resourced and well implemented is a need to monitor the program implementation and its effects to make sure that it is running well. These programs can become demoralised over time, as they become marginalised, as staffing becomes less enthusiastic about intervention, and as funding is not necessarily kept up to the requirements of the program. The danger is that if it is simply an alternative to gaol or if it is for offenders that they are simply a way of cost cutting rather than providing effective treatment.

CHAIR: Your second point was a measurable brain injury with behavioural disturbances that are very severe in a non-offender. What about literally to save a life where the treatment is more a matter of, essentially, containment so that people have at least a short period in which they put on some weight, get treatment for a physical injury and so on?

Professor MATTICK: That is very sensible and there are examples where such containment in a number of ways occurs for disorders such as anorexia nervosa where individuals are at risk of death they may be contained in hospital. The rights of those individuals, and the way in which that is done, could be used to inform this area, and I think there are good examples. But once you step away from those short-lived crisis, if you are talking about the treatment of alcohol or drug dependence itself rather than the treatment of a physical illness or something which is an acute problem, then you enter a whole different realm of how you are going to deliver this and even think about it. If you are going to mandate that individuals who have not offended should enter treatment and they should go to a therapeutic community for three months, or in for methadone treatment for six months or a year, the consequences would be quite profound and the ability of the system to actually achieve it.

The Hon. IAN WEST: Where does the person who wishes to enter this treatment because of a trauma in a relationship with others who may not on this occasion be convicted of an offence fit in?

Professor MATTICK: If they are motivated to enter treatment then by and large treatment is available and generally accessible. There are some parts of New South Wales where that would be less true, but certainly in the major regional and urban centres treatment is available. I think they can get it if they require it.

The Hon. IAN WEST: Does it have a role as part of the court system?

Professor MATTICK: For a non-offender?

The Hon. IAN WEST: It may be that they have offended but have not been convicted.

CHAIR: The committee has heard of cases, for example, a solicitor in a country town has suggested to a magistrate an Inebriates Order approach as an alternative to a sentence.

Professor MATTICK: That is the most justifiable use of coercion where treatment should involve a constrained choice. You give the person a choice: you can go into gaol or you can go into treatment, and they make the choice. But you need to bring people into the process. The general opinion about this area is that people will do best if they have been given a choice and have some role in the process rather than being told "This is the treatment you will receive" absolutely.

The Hon. IAN WEST: In making that choice will that person be much more receptive if they have not been convicted of a crime? I am mindful of the need to ensure that there is not a brick wall between an offender and a non-offender.

Professor MATTICK: It is a difficult area. The only advice I can provide the committee is that if you mandate "you must enter treatment" particularly if they are non-offenders it will create significant problems. If you are mandating they should get help for acute physical or severe psychological problems where they need some management for a short period of time, I think that is fine. I believe that they should be given a constrained choice. That is the best option in terms of coercive treatment. Whether being convicted actually creates a brick wall, I am not sure. A person could be convicted and still feel that as a consequence of that they want to change their behaviour. But I think that is a harder discussion.

I think we should have the availability of detoxification for detoxification as such per se, and as a humanitarian care and shelter. There should be the availability of the other treatments outlined earlier. The treatment should be of length and intensity available to non-coerced persons. The most important thing I want to say is that there are no different treatments. There are no things to pull out of the hat and say "We can treat drug or alcohol dependence in this way if it were coerced". We are going to use the existing treatments and the risk is that they will be less effective in coerced individuals than in those who are not coerced. The number of people this is suitable for is unclear. It depends on the definition that is adopted.

Just going back briefly to the point of effectiveness, if a large system were put in place to deal with people in some way coerced into treatment, it could be that there is a net loss of treatment effectiveness, unless there are extra resources. If you stop treating people who are willing who might do marginally better than those who are unwilling or so, and you put it to those who are unwilling then you may find that overall the benefit to the community is less because the unwilling do not improve as much as those who would like to enter treatment. To do coerced treatment you actually have to resource a whole new sector of treatment provision which becomes quite difficult to achieve in the first place and in the second place to maintain with funding issues and budgets.

CHAIR: That point has been made to us in relation to the MERIT program because people under that program may, in effect, take beds or places that would otherwise have been available to those who are willing. So that net loss that you are talking about may well have occurred in places where people on the MERIT program go.

Professor MATTICK: I want to reinforce that point with regard to the provision of treatment, particularly for alcohol problems, and if we look at the burden of disease this is the attributable disability adjusted life years. Illicit drugs for males or females account for less harm in Australia than alcohol. That does not mean they are less important but it is noteworthy that the total harm from alcohol is greater than it is from lesser drugs. Then to place that into a further context—because I think you need that point to be made—we have seen the number of registered methadone patients increase from 2,000 in the mid-1980s to 6,000 in 1992, 9,000 in 1995 and 14,000 in 2001. I think that was appropriate as a response to the problems with heroin that were being experienced in Australia. I fully support that methadone is an important intervention to have available.

The Hon. ROBYN PARKER: Would you repeat what you said about the methadone program?

Professor MATTICK: I support methadone is a treatment which should be available in Australia. It is very important.

The Hon. ROBYN PARKER: Unlimited availability? Is a heroin drought and an increase in methadone a problem for you?

Professor MATTICK: It is a different discussion. It depends on the level of penetration into the opiate-dependent group that is desired. In some overseas countries, as you are probably aware, there are claims that 80 per cent of those who are heroin dependent are in contact with treatment agencies, or in treatment. In Australia we thought it has been around 40-45 per cent over the recent past. The heroin shortage has been documented by the centre where I work and we are currently preparing a report about that. It does appear that a number of people who are heroin dependent left heroin use because they could not afford it and could not get it. It does not mean that they did not go on and use other drugs.

Those who are in methadone treatment has stabilised, perhaps rising slightly, but those individuals, I believe, do require the treatment. If you have spent much time in methadone clinics you will know that they are not particularly attractive places, and people do not go there because of any benefits by and large apart from the fact that it helps them to keep their lives from being chaotic. There are other benefits to the community which Don Weatherburn and I have just completed a further analysis matching methadone patients with criminal charges. It has shown a clear decrease in criminal charges when people are in treatment. That will be available soon.

The benefits are not just the health of the individual, the prevention of HIV spread and a reduction in drug use. The community also benefits more broadly. The issues to do with methadone are very complex because of the way in which it has been demonised and championed by those who hate it and ones who love it. I believe it is a useful intervention and should be available for those who require it. You should also keep in mind that many of these people, who are on very marginal incomes, contribute to the $3,000 a year for their treatment. That is not the kind of impost that we place on other people who are disabled in the community. So the notion that they as a group are being favoured is wrong. I think they are a very difficult and unfortunate group who should be supported and we should aim for maximum penetration. That is the clear answer: I do support it, but it is a controversial area.

Turning back to alcohol, over time our centres have done a number of studies of clients treated in Australia—in this case, it is New South Wales. This is a client and treatment service agencies census done on four occasions from 1990 to 2001. It shows that the treatment of illicit drugs, separate from methadone—it is just the management of illicit drugs in these agencies—on a given day in New South Wales is either stable or increasing. But across time the treatment of alcohol-use disorders has been decreasing. We do not believe that is because alcohol-use disorders have decreased in the community. There has been a shift in emphasis that has taken all our attention. Drug summits and heroin overdose deaths have preoccupied us all and it is time to turn back and focus on where the burden of harm is, not to undo the good that has been done in terms of managing illicit drug problems but to recognise that there is a very significant continuing problem. If you look at the clients treated in New South Wales between 1990 and 2001 in terms of methadone treatment for heroin dependence, you will see that alcohol is gradually declining and illicit drugs, particularly heroin dependence, is increasing.

CHAIR: I think you said that you do not assume that that is because of a relative change in the use of alcohol—alcohol is not proportionately less of a problem than it used to be and illicit drugs are more of a problem.

Professor MATTICK: There is no evidence of that. In fact, the household and school surveys tend to show that there is an increase particularly in the number of young people who drink heavily. There has probably been an overall reduction in some drinking because of random breath testing, which has been a benefit to the community. But that reduction has probably not occurred in those who are having problems with alcohol; it is in people who decide, "Well, I won't have that extra glass of wine when I'm at the restaurant. I'll have a glass of water instead." We drink less per capita than we used to but I think that is largely amongst those who are non-problem drinkers.

A point I want to make is that we need to promote treatment. We need to promote knowledge of diagnoses of substance-use disorders in the population. Young men who play football and go to the

pub on Friday, Saturday and perhaps Sunday nights do not recognise or know the signs of dependence. This is not communicated to them; the health sector does not do this. If individuals could recognise that their drinking is getting a little out of control and have that information provided to them more clearly they might take action themselves before they developed further problems of dependence. It is not just the individual who has a problem but also their friends and relatives who may assist them. The simple point is that we do not promote knowledge of the signs and symptoms of alcohol and drug-use disorders very well in the community.

People also do not know about treatment options. If you ask people about treatment for alcohol-use disorders most of them would talk about Alcoholics Anonymous. They would not talk about the notion of speaking to a general practitioner [GP], getting some advice from the Internet or getting booklets on how to manage alcohol problems. I think it is important have that information available. We should have better screening in a range of settings—not just health settings. There is potential for better screening in a range of other settings, including tertiary education settings and TAFE colleges. Young people, where the burden of illness and the extent of use is occurring, are not provided with information about heavy drinking and drug use in a way that we could deliver it to them so that they could make sensible decisions about what they want to do. There should be better use of pharmacotherapies in GP settings and better referral from all management of individuals in GP settings. There are barriers to general practitioner involvement. One of them is financial incentive—GPs do not get paid to do this.

CHAIR: Is that because it is a lengthy process to embark upon?

Professor MATTICK: It is because there is no item under the CMBS to compensate for screening for tobacco, alcohol and other disorders or problems. Part of the joint initiative with the College of General Practitioners is to consider the value of a Medicare item not just for alcohol but to look across a range of physical health issues—smoking, nutrition and alcohol. This would allow a vehicle for screening. Say someone who smokes turns up at a general practitioner's surgery. The GP could also talk to that individual about his or her alcohol use and nutrition. That activity would have a lot of flow-on effects. Through that vehicle you also have the potential to get general practitioners to start to feel more confident about intervening.

The problem and one of the barriers for GPs is that if they intervene they tend to do so for people who are end stage in terms of their drug use. It does not necessarily go well for such people so GPs learn quite quickly not to bother. They do not recognise those at an earlier stage in the process so they do not get the sense of success. That is part of the cultural shift that we must achieve. Arthur Chesterfield-Evans said that we should promote not just propriety remedies such as pharmacotherapies but other interventions that are not currently well promoted.

I think we need some more specialist clinical services for alcohol. We have shifted towards illicits. I think coercive treatment is required for the few who need it and better treatment access is required for the many who do not fit into a coercive framework to stop them from progressing to more serious stages. Part of the discussion I had before coming here was whether the direction of focusing on coercive treatment is necessary but misses the other part of the discussion—which is if you intervene earlier and catch people earlier perhaps they will not need coercive treatment later because they will not progress to having severe problems. In considering that there is a need to look across a range of interventions throughout people's lives, not just at the end.

CHAIR: What sorts of services or systems would fit between that and a much better general practitioner [GP] model? I take the point you made earlier that treatments in a coercive setting would not be different from those for people who are there voluntarily. What kinds of settings would sit above the GP intervention?

Professor MATTICK: There is a range of ways of delivering interventions that we must come to grips with. It is partly to do with the changes in information flow, particularly Internet-based approaches, and making treatments easily available in all kinds of ways. I guess a trivial example of that is simply putting pamphlets in accessible points. But I think it must be more than that. It must be a promotion of what I just talked about: promoting the idea that there are signs and symptoms of these problems and getting the community to understand that. That leads people to think, "Well, I might

have a problem; I should do something about it." It becomes more accessible because people are actually thinking about it.

As for providing them with knowledge of the treatment services, there is a range of services where people can simply ring in to an agency and get advice over the telephone. As to the use of Internet intervention, I think the current younger generation will, certainly in the next 10, 20 or 30 years, look to the Internet for virtually all their information. I think we need to think that far into the future. Trying to set up interventions that will suit us now is appropriate but we must also think broadly about the range of ways in which people access information. Many people do not need heavy-handed intervention. They simply need some advice early on. If you ask people you know whether they know how many standard drinks are in a bottle of wine, a lot of them would not know the answer—some would but many would not.

The Hon. IAN WEST: It's the size of the glass.

Professor MATTICK: Indeed. The point is that even those interventions that were achieved—our sister centre in Perth, the National Drug Research Institute, championed that—have no impact on drinking, I suspect. People do not take any notice of it. It is about trying to get those messages out there in a broad way rather than thinking we will have treatment services available. Many people respond quickly and easily to simple advice.

Document tabled.

The Hon. ROBYN PARKER: My question about preventative measures and early intervention is probably not within the realm of what we are trying to achieve but arises from what you have said. Alcohol is promoted to the community, particularly to young people. We recognised that it was appropriate to remove tobacco advertising yet alcohol seems to be marketed more and more. Any time I watch television I see a series of alcohol advertisements that target young people. What is your view about the impact of those advertisements and your solution to that problem?

Professor MATTICK: These issues were touched on in the Alcohol Summit by Minister Della Bosca and Trish Worth, the Federal Parliamentary Secretary for Health.

The Hon. ROBYN PARKER: I think it is a Federal jurisdiction.

Professor MATTICK: The issues are very complex because of a number of aspects: the legality of the product and also the power of the lobby involved—the alcohol industry and its different parts. An interesting phenomenon has occurred—it is a very controversial area in which the alcohol industry has expressed strong views—in that we are now marketing drinks that look and taste much different from traditional alcoholic drinks. That is the major concern and the major change that people have identified as a problem. Drinks do not taste bitter and unpleasant to the younger palate; they taste sweet and quite palatable. I think the alcohol industry needs to think through that promotion. In terms of intervention, because of the issues that I have pointed to about legality and the role of the alcohol industry in the Australian economy there are tensions that must be recognised. But I think the industry needs to be accountable for the way in which it promotes its products. I think that will gradually occur. I think there is a sense that what is perceived to be a problem needs to be understood, better documented and addressed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think it should be addressed by the alcohol industry or the marketing industry?

Professor MATTICK: That is a fair point but marketing approaches are driven by the alcohol industry's desire to sell its products. We saw the other day a different event with Streets promoting alcohol-flavoured ice cream. As to the appropriateness of that, I think these events will cause society, Parliaments and various pressure groups in society to say, "This is not something that we think is appropriate." The alcohol industry produces the products and they are driven partly by the marketers, but they are trying to expand their sales. My understanding is that the industry would argue that they are not targeting young people, they are targeting individuals who are 18 to 25 with many of these ready-to-drink preparations and that there is no evidence that the general people are more likely to drink because of it. So what we need to do is to gather that evidence in a reasonable way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should we not reverse the paradigm so that they should prove something? This is the argument that we had before two decades ago.

Professor MATTICK: I would not disagree with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why do we have to provide the evidence to stop them? Why should they not provide the evidence that they are not doing any harm, like they do with other drugs?

Professor MATTICK: I agree. Currently my understanding of the response is that the evidence is not clear that more young people are being drawn into drinking and that that absence of evidence leaves a void in terms of discussion. But I think both groups have a role to play in a responsible process, and having some independent research about this would be quite useful.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does anybody actually compile research systematically about different treatment modalities? It seems to me that there is no data that general practitioners [GPs] do more or less with certain treatments. So that the pharmaceutical benefits assessment committee, is it?

Professor MATTICK: The Pharmaceutical Benefits Advisory Committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It does not compare drugs with non-drugs and there does not seem to be a budget to provide the data so they could do that, therefore they are perpetually working in a void in comparing a drug with a drug. If one drug is on there then there is of course a benchmark for any other drug and you then have data instantly—not instantly but certainly available data.

Professor MATTICK: With regard to which drugs?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am talking about non-drugs really. I thought Zyban was the example par excellence: they would not give it to you over-the-counter but you could have Zyban at 10 times the cost. You could not possibly have a national quit campaign which could have got a lower percentage but from a much higher pool and which would have meant much more quit per dollar than you are ever going to get from Zyban. Yet there is no method of evaluation and a very strong lobby to do what I thought was fundamentally obviously the wrong thing. It seems that that problem is either a generic problem and it would seem to me that if you are carrying out the national evaluation that people like you should be looking at this problem.

Professor MATTICK: We are currently. We are preparing a report for the Federal Government on the impact of Zyban and on the impact of nicotine replacement therapies [NRTs] and their availability on the Pharmaceutical Benefits Scheme [PBS] or otherwise. The issue you are pointing to is a much harder one, that is the availability of non-proprietary, non-owned, non-registered trademark interventions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably if you standardise on a few you could then evaluate those and probably extrapolate to others, could you not? Or if a GP did not stick perfectly to the script of some preferred program it would still have a similar effect and you could compare that effect per dollar GP wage, if you want to put it that way, to the effect of the two drugs you were suggesting?

Professor MATTICK: We are doing that currently as well as part of this effort for the Federal Government. We are looking at general practitioners providing brief advice for alcohol and for nicotine separately, and general practitioners providing brief advice with some further follow-up. We are actually costing it and looking at the likely impact of alcohol and tobacco use in the future for patients. 20 years ago Professor Gavin Andrews from St Vincent's hospital wrote in the British Medical Journal [BMJ] about the failure of the system to promote non-proprietary, that is non-owned, interventions and that these points are not much discussed but they are well-recognised by some. But altering the PBS to allow for non-proprietary interventions to be considered is something which has not occurred. It could be that a group like this could consider that as a recommendation.

CHAIR: I am conscious that we have to get back to the severe end. This inquiry is quite limited in its terms of reference. We might continue the broader conversation over morning tea, although I am also conscious of the point you have stressed that intervention needs to occur before people reach the extreme end. Could I just ask a couple of questions arising out of your presentation that I think we are still not clear on your views about? One is the role of motivation where, realistically, in relation to severe alcohol dependence, you can force a person to change or they basically have to want to change?

Professor MATTICK: I think the answer is that people are disinterested in altering their drug use behaviour—they won't. What you can do, however, is deal with their physical problems and then, through that process, I think it is very important to capture that you can actually get those individuals to become more motivated. The motivational interview approach relies on personalising the health effects of the behaviour and trying to get individuals to recognise the problems that are accruing from their drinking—this terrible pancreatitis which we are going to have to deal with—and to look at their life generally. So I think engaging people that way is likely to be helpful. Diverting resources from the health care sector to deal with people who do not want to be in treatment and trying to make them change is likely to get less good outcomes than leaving the money where it is.

CHAIR: Yesterday we had evidence from a behavioural scientist who argued that the concept of motivation is essentially meaningless when a person has a severe dependence and an extreme compulsion to drink or use cocaine, for instance; they simply do not have good volition. Would you agree with that?

Professor MATTICK: I agree to some extent. I think another way to think about that is that many emotional disorders are averse, even unpleasant, but drug use disorders are repetitive, that is, people have an appetite for them and they want to do it. If you are anxious and depressed or you feel unhappy and miserable and you want to get rid of your symptoms, if you like using cocaine or heroin you want to use it. So there is a very fundamental difference the way in which people are operating with regard to the problem they have got. But I think it is a little bit black-and-white to say that there cannot be motivation. People do change their drug use patterns; people do go into methadone and they do do well; people do go in and accept treatment and they do well; people give up smoking and drinking excessively. So I do not agree with the black-and-white version. I think there is a correct point there, that the motivation is mixed.

The Hon. IAN WEST: But their motivation would be intermittent, depending upon the time of day and the actual environment?

Professor MATTICK: Yes, that occurs for all kinds of behaviours, such as going jogging to keep fit.

The Hon. IAN WEST: So it is not usually exclusive. You can be very dependent and still have motivations at particular points in time?

Professor MATTICK: Yes, but you can also build motivation. If you take that as a black-and-white view, because that is the way it presents itself, there is no volition, firstly, it is not true because people do voluntarily change their behaviour and, secondly, you can build motivation. The good example comes from the area of smoking where individuals who have the health effects of smoking personalised to them by doctors, by general practitioners, have three times the successful quit rate than those who simply get advice that they should cut back.

The Hon. IAN WEST: I had the opposite. When I was speaking to the doctor I was less motivated to give up smoking than other times. The first thing I did when I left the doctor's office was to have a smoke.

Professor MATTICK: It depends on how it is delivered. If it is delivered in a confronting way, it could. That is the other thing about motivation that the general consensus now is that you should not tell people they should stop because they are doing something wrong, rather it is to draw them into realising that, "well, these are the costs that are occurring for me". So I think motivation can

be built. I understand the behavioural scientist's view and I think there are mixed motivations but it is wrong to characterise that motivation cannot be increased.

CHAIR: Just a couple more questions which are still about motivation broadly. Some witnesses earlier in our inquiry, in looking at the issue of compulsory treatment, suggested maybe there would not be a perceived need for compulsion if there was a better and more successful system of voluntary services and treatments available. What do you think of that? In other words, do we actually need more voluntary services for severe problems? Would they pick people up? What do we need in an area of compulsion that might be quite small but which we should give our thoughts and our resources to the more voluntary aspects?

Professor MATTICK: Those kinds of ideas are consistent with what I was presenting about the need to recognise that people enter a drug use career and they go through many years before they end up coming to attention. But the notion that you expand the voluntary system and that people will necessarily get caught is nonsense. You need to recognise that you will be faced with these very people, and that society has to have a way of dealing with them humanely and appropriately. So I think that both are true rather than just one or the other.

CHAIR: Do we know much from the research about who actually does seek treatment at the moment? Still on this issue of motivation and the different groups, the different stages in a person, are there particular groups who are more or less likely to seek treatment—a particular age-group?

Professor MATTICK: Young people do not seek treatment. They do not see they have got a problem.

CHAIR: Regardless of its severity?

Professor MATTICK: By and large that is true, yes. It tends to be individuals who have over the years accrued various kinds of consequences where they have had repeated charges of drug and under the influence of alcohol, or whether they have just come to attention. The other aspect of this is that young people have not had time to come to attention because they have not had that exposure to a health system to be detected by it. You see this in the Vietnam veterans who had heavy drinking for a very long period of time and who have come to attention and are receiving treatment for their alcohol use disorders. They have been drinking heavily for 30 or 40 years.

CHAIR: Is there an important difference between men and women in respect to seeking treatment or coming to attention?

Professor MATTICK: Women are generally more willing to seek treatment and volunteer symptoms than men. Women tend to do somewhat better in treatment for alcohol use disorders than men. If you wanted to look at a broad brush approach, young people do not go into treatment. As they progress through their career and as the consequences accrue—they can occur with people who are quite young, you can have charges, you can have problems with family and friends—as that builds across time, people start to recognise the need to have some assistance. Many of them also in some ways are coerce. There are not a lot of people who enter treatment in Australia for alcohol or drug use disorders where there is not some coercion, whether it is from family or from some problem, perhaps work—an employer who tells them that they should improve their behaviour.

CHAIR: Or else?

Professor MATTICK: Yes.

CHAIR: There is usually a kind of a threat.

Professor MATTICK: To answer your question generally the only distinction one can draw is that young people do not interact—and there is an important point there—and that is the group we should be trying to target—not to pathologise their drinking or drug use necessarily, but rather to simply say that these are the signs and symptoms of alcohol abuse; these are the interventions which you could use; these are the opportunities to reduce your drinking to a way that is healthy. Those messages are not out there; they are not provided.

CHAIR: It comes back to the questions asked by Robyn and Arthur about the message that young people are being sent by the industry and so on?

Professor MATTICK: I think this is a very controversial area and it will continue to be so for the next decade or so. I think that the appropriate response is to ask for the evidence as has to whether young people are drawn into drinking by the way in which the products are marketed and, armed with that evidence, to then respond.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that quid pro quo being allowed to advertise should pay for nuclear research as to the effect of that advertising?

Professor MATTICK: I think that would be a great idea. It is notable that there is not research currently supportive to show there is no drawing in of younger people to drinking and it leaves governments and others rather impotent. You cannot convincingly decide anything because there is no evidence and that situation should change.

CHAIR: What do you want to see come out of this inquiry?

Professor MATTICK: A review of the Act is very important. As I said to somebody prior to the presentations, the Act has been reviewed and considered for quite a long time but there has never been any closure. There is a need to have a workable Act. I think that having a balance between people's rights and the rights of the community, particularly for non-offenders, is very important. If there are to be some implications for offenders, then the Act should allow for them to have some course to treatment through intervention but they need to have a choice.

(The witness withdrew)

(Short adjournment)

TERRY ROSS CARNEY, Professor of Law and Director of Research, Faculty of Law, University of Sydney, 173-175 Phillip Street, Sydney, affirmed and examined:

CHAIR: You have received a number of questions and you have talked to Merrin about their appropriateness.

Professor CARNEY: Indeed.

CHAIR: Do you wish to make an opening statement or start off by giving us a brief overview of your expertise and activities over the years?

Professor CARNEY: I am pretty much happy to start with questions. My contribution is based on my doctoral thesis and subsequent book, and also my status as President-elect of the International Academy of Law and Mental Health.

CHAIR: Do you wish to outline to the Committee in more detail your activities over the years that relate to compulsory treatment, mental health and so on, or should we move now to questions?

Professor CARNEY: I am happy to go straight to questions.

CHAIR: When did you do your thesis and your book, which dealt with the Inebriates Act?

Professor CARNEY: The thesis was 1980 and I turned it into a book, after doing a few other things, in 1987.

CHAIR: Have you revisited the specific issues in any academic way since then?

Professor CARNEY: Yes. I gave evidence to the injecting room inquiry and served for four years on the NCEHP/ACC National heroin trial. I was a consultant to the national group that produced the report on cannabis and cannabis policy. I have been involved in that sort of standard consultancy work over the years.

CHAIR: We are interested in your view on the important ethical issues. All witnesses before the Committee have been asked this set of questions, but we are particularly interested in your view from the legal perspective about the meaning of competence in the context of drug or alcohol dependence, when it is legitimate for the State to intervene and remove someone's rights, the relevant principles and the other matters in question 2?

Professor CARNEY: In relation to the question, there are three points I would make in response:

Firstly, and the most important ethical principle, in this context, is autonomy. It is the most important principle because of a lack of a sound philosophical basis for its competitor, paternalism the countervailing consideration to carry weight. Paternalism fails to carry substantial weight because the justification for beneficence, as the medical profession would call it, or paternalism as lawyers and philosophers would describe it, is that there is something that works that can be done by the State in order to advance the health welfare of the person who is the subject of State intervention. A related complicating philosophical point here—and you touched on competence—is that except in situations of acute intoxication, the person retains capacity to consent or not to consent throughout most of their life as an alcoholic or drug dependent person, and that is true both legally and philosophically. That is the first point.

The second point is not strictly a philosophical one but I note that the Committee has not yet received evidence in relation to the international treaties and instruments that set down standards for mental health legislation.

CHAIR: No, we have not.

Professor CARNEY: Those statements are certainly broad enough to encompass the work of this inquiry and the first stage of the national and State and Territory strategy adopted, as a prime Mental Health objective, the bringing up to international standards all mental health legislation throughout the country. There was work done to develop a "rights instrument", which has now achieved international recognition and all States, including New South Wales, amended their legislation to bring it into conformity with those standards, including standards about greater respect for the capacity or not of an individual to consent or not to intervention. I can provide the references to Helen Watchir's work with the Commonwealth Attorney-General's Department and the several quite extensive documents that have been produced, both the articulation of the standards and then the State by State measurement of how each Mental Health Act did or did not stand up against that test.

The Hon. GREG PEARCE: Are these treaties?

Professor CARNEY: They are international—

The Hon. GREG PEARCE: Health standards, or what?

Professor CARNEY: They are the standard short of a UN treaty. They are like the precursor to the Convention on the Rights of the Child the Declaration of the Rights of the Child.

The Hon. GREG PEARCE: Are they UNESCO?

Professor CARNEY: They are declarations of the United Nations and all States and Territories determined, as indeed most countries in the world have agreed, that they should conform to those standards because the genesis was the kinds of human rights abuses that were found in the former Soviet Union and some other countries. As a matter of good international citizenship, Australia, with the Australian Federation, committed itself to rapidly bringing its legislation into line.

CHAIR: I assume the guardianship legislation in New South Wales would also conform with those standards?

Professor CARNEY: It does, and did not require amendment because one of the key principles in the United Nations declaration on this subject is the least restrictive alternative principle, and other objectives of that kind.

The third answer to your question two, maybe the one that is the sharpest, is the John Stuart Mill utilitarian liberal position which informed debate when all of these pieces of legislation were first enacted—and New South Wales may have the oldest Act but it was one of the last States to introduce it, and it looks like being the last in this country to repeal it—one sees from the parliamentary debates there was very vigorous engagement with John Stuart Mill's proposition that the only warrant for State intervention in the lives of citizens is harm to others or harm to self. The difficulty in the alcohol and addiction area is captured in what I want to say on this third point. In the absence of a showing of a sufficient harm to others—that is the criminal area where you have posed a question later— then the only warrant for involuntary intervention grounded in harm to self rests on showing real and substantial harm. Such harm is, however, a necessary, but not sufficient pre-condition.

The second of the necessary conditions is a lack of capacity on the part of individuals to consent or not to treatment to alleviate those harms. Unlike New South Wales, in Victoria that is part of the mental health legislation. That is a criterion in Victoria for admission, and the United Nations principles emphasise that it should be such a criterion. The third required element is benefit. There must be some benefit from the treatment intervention. That has recently been endorsed by the Victorian Law Reform Commission in considering another very difficult group of people: intellectually disabled people whose behaviour poses a risk to the community. In several places in its report of last year, particularly at page 45, the Commission spelt that out as a principle: that intervention will only be warranted if a treatment plan can demonstrate that the services to be marshalled or other interventions will confer a real and significant benefit on the individual concerned. That likewise applies in this context.

CHAIR: The Committee will soon be visiting Victoria and we will get a lot more information than we currently have about the work that has been going on there. That last point you

made about benefit, would that sum up your answer to our question in the second dot point about the responsibilities the State has in return?

Professor CARNEY: Yes, very definitely. Modern legislation—and I remain to be convinced that there is a case for doing other than repeal this Act—must, as an absolutely fundamental requirement, have quite strong provisions, not just lip service provisions, about treatment plans and the accountability of the State to honour those obligations. In the State of Victoria the Disability Services Act set up a separate panel or tribunal to adjudicate cases—where what the State said it would do when it intervened in a person's life is not honoured. It allows the State to be held to account, to honour its planning instrument. That is the kind of real application of the benefit principle that is required if there is to be intervention, in my view.

CHAIR: I guess that would cover the real provision of treatment? It would also cover evidence about efficacy of treatment?

Professor CARNEY: Yes. The difficulty about efficacy of treatment is that the international research literature has been speaking with one voice about this for about 30 or 40 years. That voice is that there is no efficacious compulsory treatment for addiction. Wayne Hall's piece in the 1997 *International Journal of Criminology*, the evidence in the New Zealand consultation paper on the review of their Act and the Kirketon Road submission to this Committee all provide neatly accessible reviews of the current state of literature.

The Hon. GREG PEARCE: I take it from what you are saying that you would be highly critical of the way the Inebriates Act has been operating in the past decade at least, where those who have been subject to orders have either been placed in a mental institution and left in a ward with people with mental illness or have been placed in a secure aged facility of some description and really have not had any treatment at all? The complaint of those people has been that they have come back to sobriety and found themselves in this dreadful place where they had no treatment and no assistance.

Professor CARNEY: Yes, indeed. One may have views about the adequacy or not of the current mental health legislative regime, but by and large New South Wales is at the forefront in most areas of having contemporary legislation which meets the international standards and which provides therefore a greater degree of accountability to the person dealt with under the Mental Health Act. Certainly, that is anything but the case with the 1912 Inebriates Act. It is almost impossible to find any serious protection on paper or in practice wherever you look in that legislation. Yes, it invited that sort of warehousing and neglect of the small number of people who are admitted under it.

CHAIR: I am not sure whether you should say more about the meaning of competence in the context of drug or alcohol dependence. If you have more prepared to say about that it is an area we need to touch on.

Professor CARNEY: Yes, I do. It may assist the Committee if the notes that I am working from are in front of you.

Motion by the Hon. Greg Pearce agreed to:

That Professor Carney's document be tabled.

Professor CARNEY: This will certainly speed, I guess, my engagement with this issue. I have already hinted at the first answer to the competence issue. That is, that except when acutely intoxicated, even a chronic alcoholic is competent in law. One of the consequences of that is that something like the Intoxicated Persons Act-if there is to be any vehicle that is considered for dealing with the acute case-would be a more appropriate legislative model than are the longer-term intervention legislative measures. You will see I go on to say that there is no warrant for non-consensual intervention except during the period of acute intoxication and for the purpose of preserving health and safety and of detoxification to return that person's capacity to decide. I have cited two recent papers that I know the Committee has by the late Professor Pierre Beumont, Professor of Psychiatry here at Sydney, which we wrote in relation to another vexed issue—anorexia nervosa—in which the evidence suggests a lack of capacity is much stronger than alcoholism. We take the same position.

CHAIR: What about the evidence we have heard, mixed as it is, about alcohol-related brain damage and arguments about a loss of competence occurring in those cases?

Professor CARNEY: Yes, I have read that evidence, or much of it, on the public record. I do not find it persuasive or convincing. I do not find there is good science behind the proposition. I do not find any reference even to the popular American instruments developed by my colleague Paul Applebaum and others, which are measures, (or instruments), to establish a person's degree of competence or not. In the United States of America and many other parts of the world that is the way in which guardianship tribunals operate to parallel the decision that Nick O'Neil and his Guardianship tribunal make more subjectively. In the absence of measures that show that there is an instrument measuring a level of incompetence that would warrant the intervention of the Guardianship Board, like Nick O'Neil I do not believe that the group that you are discussing reaches anything like that level of incompetence. I would have to say really all you have is evidence of understandable, clinical angst about the agony of watching people accelerate their date of death, or degree of morbidity. That occurs in lots of spheres in life. Philosophically and legally you have to have reason to single out this particular complex causal chain.

The Hon. IAN WEST: Are you saying that the brain never gets to the point of being unable to make a rational decision?

Professor CARNEY: No, it is not that it does not reach that stage, but alcohol generally does not take it to the point where the sober person no longer has the ability to assess. The Applebaum instruments look at whether the person is able to understand the information that is provided to them, to process that information and to reach a logical, but not necessarily rational, conclusion about what you do in response to that information. It is not that there are not some severely brain-damaged individuals who also drink, who might meet that test. There is the odd one; but other legislation such as that of the Victorian Law Reform Commission in respect of people with brain disabilities is your warrant for intervention in such cases; and then only if they pose significant harm to others. That is a very different logic of debate from the one that this Committee has been considering; it is the harm to self which is relied upon in conjunction with some suggested incapacity.

The Hon. IAN WEST: What is the difference between rational and logical?

Professor CARNEY: Whether one goes skydiving or not. We do all kinds of things in our lives. In the disability arena that is called the dignity of risk, it is the respect that we give to each other as members of society for the good and bad, the wise and unwise, choices that we make in our lives.

The Hon. IAN WEST: Are you saying that it would be rational for me to jump out of a plane wearing a parachute that has a hole in it?

Professor CARNEY: No, but to take your metaphor, yes. Although a parachutist would say that the hole is the important way of ensuring that it remains stable.

The Hon. IAN WEST: Assume that the hole is big enough to make a parachute work. Would it be irrational for me to do that?

Professor CARNEY: It is even more rational to do that than what that man did with his Superman wings who hit a bridge because he miscalculated. But it was entirely his right to make a decision about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that the civil libertarian view about competence to make decisions? If someone goes skydiving and assumes that they are such a good parachutist that they can land on a bridge, they are taking a risk, but they calculate that risk. You said that self-destruction is a relatively common behaviour, so why single that out?

Professor CARNEY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I guess because alcohol is the cause of self-destructive behaviour and is more evident and more overt than other personality traits. It may be self-destructive and may work over a period of years in less obvious ways. In a sense that is the

cutting edge that puts dilemma in one's face. The fact that the other more complex self-destructive behaviours are not acted on is irrelevant. The question really is, if someone really is self-destructive because of alcohol that is visible, should you intervene?

Professor CARNEY: That is part of the question. The first part of their difficulty is, as I mentioned, that coercive intervention is no more likely to fix it than non-intervention and leaving it to the vagaries of whether people choose to volunteer for treatment. The second part of the difficulty is that in respect of lots of dangerous behaviour we know that those behaviours dramatically increase death and morbidity. Tobacco smoking has a much higher level of debt and morbidity than does alcoholism, which has the second highest rate. There was some discussion in the previous evidence about the incidence of health consequences for people who drink too much. For about 40 years, ever since the work of Ledderman, we know that the level of per capita consumption of absolute alcohol or any other drug is directly correlated with the incidence throughout the community of morbidity or death stemming from those conditions. If one is really concerned about doing something to reduce the suffering of chronic alcoholics, one should support moves to increase the unit cost of the drug of choice. In this case that is alcohol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some of us have no problem with that concept, but you are relying on two things. One, the civil libertarian aspect that a person affected by alcohol has as much capacity to make a decision as has the Hon. Ian West to decide which parachute he takes?

Professor CARNEY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a fairly suspect proposition. The fact that treatment does not work is a separate argument. Obviously if the treatment does not work, and people have given evidence to say that, it has as good a success rate as many other treatments that are currently used, because the assumption is that all treatments are successful. Of course that is grossly wrong.

Professor CARNEY: We are talking about treatments which are imposed on people as distinct from those that people choose in their wisdom or otherwise as being snake oil or good medicine. That is the first point. The second point is that I stand by what I said in relation to competence. It is not a civil liberty position, it is grounded in evidence about what competence is and how the new measures determine if it is present or absent. The Committee has not been presented with any evidence to contradict what I have said about competence being retained. The third point is that it might be useful to consult the judgement of the Court of Criminal Appeal in Henry's case, in about 1997, where Chief Justice Spigelman and his colleagues considered whether addiction took away a person's capacity to choose. The full court concluded that volitional capacity and competence were retained for criminal purposes. My position is not a minority or grounded one.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I find it hard to believe that a chronic alcoholic has good, cognitive functioning in determining whether drinking is a good idea.

Professor CARNEY: I cannot help you with the difficulty you are having in understanding this. It might be helpful to reflect on centrally important values and behaviours in your own life and your colleagues' lives. I for one might be thought by my behaviour of going jogging most mornings, rain hail or shine, to have a similar difficulty in comprehending the rationality or not of what I do. But nobody would suggest that I lack the competence to make that decision each morning

The Hon. GREG PEARCE: Without putting words in your mouth, much of the evidence before the Committee about dealing with people who are subject to inebriate orders is that first they have to be sobered up and assessed. Once they are sober, they have an ability to consent?

Professor CARNEY: Yes.

The Hon. GREG PEARCE: Unless they are mentally ill, which is a separate issue.

Professor CARNEY: Sure.

The Hon. GREG PEARCE: Or they have a disability, which is brain damage?

Professor CARNEY: A severe brain injury.

The Hon. GREG PEARCE: So we are going around in a bit of a circle. Coming to the end of your argument, there is no reason to lock up someone simply because he or she gets drunk quite often and if, when the person is sober, they can consent and make a decision about what they are doing?

Professor CARNEY: Exactly. The research evidence shows that a policy founded on the values and assumptions I have expounded, achieves exactly the same proportion of beneficial results for people, the client group, that is the focus of the work of this Committee.

The Hon. GREG PEARCE: The Committee has not really seen much evidence, if any, to contradict that. The experience of those few who have been locked up is that mostly it does not make any difference whatsoever.

Professor CARNEY: Indeed.

The Hon. GREG PEARCE: Except for the period that they are locked up.

CHAIR: It would be true to say that the staff in the remaining gazetted institutions would say that in some cases the person is still alive six months later and, in their opinion, would not have been still alive. It is a bit incidental, I guess, that the person has been locked up to save a life. They are admitting that the treatment is neither non-existent or fairly irrelevant?

Professor CARNEY: Yes.

CHAIR: But the physical improvement is a major issue. Obviously, you would have read the transcript of evidence, some people have said that they are content to use the saving of a life as a justification for compulsory treatment.

Professor CARNEY: In my answers I have not yet touched on what I am about to say, but one helpful way of thinking about this is to look at the literature on the incidence of the condition that defines your client group. Again, international literature on alcoholism has had the consensus that between 3 and 5 per cent of the population at any one time meets that definition. You can do projections against the population and compare that with the numbers who currently are dealt with by the Inebriate's Act, or would be dealt with by modern replacement legislation. It would cause you to ask yourself what is it about this 1, or 0.5, or 0.25, or smaller per cent of the total proportion of alcoholics that leads them to present or be candidates dealt with under this legislation.

Usually it is the kind of utter chaos in their life. Such chaos, or "complex need" is the subject of the Victorian Human Services Complex Needs Bill. It is the lack of services. Over the past 10 or 20 years, as the nature of government has changed, one of the consequences has been that you get service siloing. The former services that dealt with complex needs, multiproblem clients, have disappeared or have been markedly reduced. When looking at the characteristics of the customers of this legislation, we tend to find that they have never married and, in the main, they have very limited education. Looking across the range of socioeconomic indicators or personal life factors, we find need almost wherever we look. Any intervention will help these people. Offering them a housing commission flat might well have achieved the same lifesaving outcome.

The Hon. IAN WEST: I was trying to come to grips not with the concept of harm to others but the harm they cause to themselves and the extent to which society should stand back and allow that to occur. Your tolerance is obviously much greater than mine. Is there a point in a person's development at which he or she needs some assistance from fellow human beings?

Professor CARNEY: Of course there is. The question one needs to ask is whether those often quite heavy-handed but non-legislative informal measures of suasion are not already enough to achieve the desired result? Or could not, through better resourcing of the service or other means, be made more suitable to achieve the purpose? My answer is that they can. Most people who decide to

enter treatment voluntarily do so because of pressure from family, current or former employers or other such events. The research evidence is very clear. Let us make this absolutely crystal clear: Using the law to compel a person to enter treatment does not work. That is the bluntest way I can put it. That view is based on international studies that apply the proper evidence-based analysis—good science—for which I am pleased to say this State has become a leader in the Federation. Social policies are based in good scientific evidence, whether those policies be proposed by professors of law or eminent clinicians. There are many myths and genuine, well-held, good-intentioned beliefs in the research world that do not pass when put to the scientific test—as compulsory treatment has been put to the test by the World Health Organisation and other studies I have mentioned.

The Hon. IAN WEST: That is taking it one step further. I am referring to the question of whether treatment works. The definition of working is another subject. Are you saying that if my 10-year-old daughter makes a logical decision to associate with people who are going to harm her then I should not interfere? That is a logical decision made by her and I should not interfere.

Professor CARNEY: No, I am certainly not saying that. As the author of Victoria's child welfare laws, I would not say that. A well-established body of good, scientific evidence indicates that up to about age 14 a person lacks the capacity to make wise choices. We are talking here about adults, not young people.

The Hon. IAN WEST: Are you saying that the involvement of a mind-altering substance does not affect my ability to make a logical decision?

Professor CARNEY: It will while you are intoxicated. My position is that while you are intoxicated the State is entitled to hold you for your protection. However, you will not stay intoxicated for more than a few days at most.

The Hon. IAN WEST: After that period of intoxication can society make an assessment of whether I should be given some assistance?

Professor CARNEY: We can make an assessment in a day or two and offer the person a choice at exit from the compulsory period of detention. However, we must respect that individual's choice. I am afraid that, as I said, the evidence indicates that compelling them to stay and to accept that "advice" does not work any better than doing what I recommend, which is to let the person make his or her own decision.

CHAIR: The representatives from Kirketon Road raised a case study yesterday. You mentioned that you had read their submission. They went into a lot more detail about the first of the case studies involving a young woman referred to as LT. She was addicted to cocaine. The focus of the story was the roughly 12 hours before the effects of the drug wore off. She had 20 or more presentations to Kirketon Road and other places. When the drug had worn off, she said she wanted to change and to get her chaotic life back together. However, she would have more cocaine and she would go through the 12 hours of intoxication again. It went on and on. She eventually went to St Vincent's Hospital because she needed treatment for a serious arm infection. She was briefly scheduled under the Mental Health Act, but 12 hours later she was tested and did not fit any of the criterion and was released. That case raised all these issues. She would have been one of the few people they have had who would have been a candidate for the Inebriates Act.

Professor CARNEY: There is no doubt that the Act as it stands or as it might be revised would be a way of dealing with such a person. My third dot point in response to question three draws attention to the fact that there are only two other models of jurisdictions that have kept legislation like this. Victoria is one—although it has modernised its legislation in 1968 and is now reviewing it with a view to repeal—and New Zealand is the other. The New Zealand Act has a strange provision—it sounds contradictory—whereby a person can, when competent, volunteer to be detained. It is the most popular provision in the New Zealand Act, which I think caters for about 200 people a year. However, New Zealand may well repeal that Act despite this provision. My reading of the way it is heading suggests that the Act will be repealed.

CHAIR: Having volunteered, a decision is made about the period of compulsory containment.

Professor CARNEY: That is correct.

CHAIR: One does not then have a choice to withdraw consent.

Professor CARNEY: That is correct. The second dot point in response to question three deals with that. This State provides for a personal guardianship arrangement or an enduring power of attorney that a person currently already can make. In British Columbia they are called representation agreements. When a person has the capacity, he or she can execute a document that usually empowers a group of friends or family members to override his or her objections to doing what has been set down in the instrument. It allows a person to tailor-make the length and form of any intervention that is to occur should he or she relapse. It has been used extensively in relation to schizophrenia—another chronic relapsing condition. The Australian Human Rights and Equal Opportunity Commission calls them living wills. The names do not matter. They clearly have a capacity to deal with some portion of the group in which the committee is interested in a way that I would say is compatible with the philosophic and principled position that I have outlined.

The Hon. GREG PEARCE: Is not the problem with that and the New Zealand experience that someone who has sobered up and consents to being locked away may not then be able to get out when he or she wants to leave? They will not benefit and when they get out they will go back to what they were doing. It does not follow logically. The problem with LT was not so much whether she was locked up, but that she was turned away by hospitals, doctors and so on. No-one was prepared to look after her.

CHAIR: That was true in respect of her physical condition—the infected arm. As they said, when she was scheduled under the Mental Health Act she was automatically released because when she was assessed the following day it was correctly determined that she did not have a mental illness. She was turned away, but because no-one had a right to keep her.

Professor CARNEY: That is a very important issue. Most clinicians, when asked in their cups, would confess that they find this client group one of the most difficult to deal with. For the last century or so, they have found any excuse not to admit them in the first place or, having admitted them, to discharge them at the earliest opportunity. It is correct that a representation agreement or a Ulysses agreement would need to be adapted. It would need to be document that the person executed in consultation with not only their family, who would be the honest brokers and wield the power, but also with service providers. Quite commonly a person who presents is told that he or she is a no-win case and that there are other more pressing priorities, and a reason is found not to assist them. So service access must be tackled too.

CHAIR: One of the people under an inebriates order we spoke to at Bloomfield had asked to be placed under an order through a police officer he knew. He gave the committee a graphic description of the inadequacy of the treatment. Nevertheless, he had put on weight and was much healthier. His was a case of someone who had sought an order and had not changed his mind. Even though he was not impressed with what was happening at Bloomfield, he did not say he wanted to leave. The committee has heard evidence about others under inebriates orders in New South Wales having sought them, with varying degrees of coercion from families and others. That is another question.

Professor CARNEY: That is why these mechanisms that lie in the terrain of guardianship have the greatest potential for putting this State, if it is going to introduce legislative initiatives, back at the forefront of the international community in terms of creating effective machinery. If the question is how we construct it, we could include elements of the Victorian Complex-Needs Bill and some elements of the Ulysses agreement. You would also want some nexus with service providers. In grappling with this for the disability group, the Victoria Law Reform Commission came up with some ideas that might be productively adapted.

The Hon. ROBYN PARKER: I am interested in the point at which you say it is appropriate for people to choose further treatment after a detoxification period. The Committee has been presented with evidence that the point at which people are able to make that choice is not always immediately after detoxification. We have heard that some in the MERIT program, the Drug Court or other

processes there is a point along which they realise that they are getting better. They may have slipped up a couple of times but eventually, even some people in gaol even though that might not have been the original point, with time have made that decision. If the committee makes the point of decision-making immediately after detoxification that we will miss some opportunities?

Professor CARNEY: Your point about the sort of rocky episodic road that these customers travel is right. You do need some follow-up post detoxification but I guess I would not see it principally or even at all as a legislative follow-up. I return to the point I was making about the decline in services for people with complex needs and turn to the establishment of a case manager who would be accessible enough to the individual in the region in which they lived in the State to be in a position to recontact that person post-detoxification, at a couple of critically chosen timeline points following their discharge, to reoffer or to offer packages of services that, if they elected to take them, we know are likely to help.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think we would get more bang for our buck if you had better co-ordinated services than if we had compulsory services in terms of resource allocation?

Professor CARNEY: Yes, I do. It needs to be set against the really appalling record of this State in terms of its level of investment in mental health services. We have the lowest per dollar expenditure on mental health services through the whole Federation. We expend about one-third. Australia spends less than does Britain, Canada or other countries. The scarcity of the dollar—and bang for the buck, as you put it—must be a crucial issue in constructing any recommendation. It means that anything you do should be tacked onto and supplement existing service systems or legislative structures. It is a nonsense organisationally to retain a free-standing piece of legislation like the Inebriates Act to deal with maybe 200 customers a year when there is other machinery. We have a Guardianship Board that deals with about 2,500 people a year and is therefore better staffed, better resourced and is able to deal with the geographic dispersal of our population.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not have any problems with your comments on mental health, of course, but I have to take a devil's advocate position and say that you have made this assertion that you would get more bang for your buck. Do you have any evidence?

Professor CARNEY: The evidence res ipsa loquitur. Does it not speak for itself? Three people are currently being dealt with under the Act. If you look at the New Zealand or Victorian Acts and ask questions about the composition of the population "served" it is pretty much a lottery in terms of the coming together of persons being placed under the Act because it was possible to find a service that was close enough and will enough to accept the person. The lack of any equity or rationality about the policy, as I say, speaks for itself.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are quite happy to accept that many people self-destruct. Can you not accept that many people live in lotteries? You want the arbitrariness in one case but you will not tolerate it in another.

Professor CARNEY: I think you need to be in a lottery you have a chance to win.

CHAIR: In view of the time, will you address questions after number two?

Professor CARNEY: I have said all I want to say about question three. The most important thing is that we are in a very small minority within the Western World in having and contemplating the modernisation of this kind of civil committal legislative model which was born in Scotland in the 1850s. The Scots did not enact it. The Victorians thought they had, and the Victorian Parliament was the first in the country in late 1857 and 1872 to introduce legislation that, 30 years later, New South Wales got around to copying. That is how ancient the model is. We need better service system approaches and, if needed, legislative models that are more modern.

The Hon. GREG PEARCE: In New Zealand the basis of it is still consent?

Professor CARNEY: It is in the New Zealand Act. It is a strange provision that a person can be presented to the door of the facility and in place of the committal mechanism being invoked against

them—this also used to be a routine component of all Mental Health Acts—you had that ability to agree to a period of compulsory detention.

CHAIR: I note all of your reservations about a compulsory system. You then talked about the Victorian model and the New South Wales Mental Health Act model. You said earlier that if we were to go down this path you think it would be ridiculous for us to have a stand alone Act. You think this group of people should be incorporated either into the Guardianship Act or the Mental Health Act.

Professor CARNEY: Indeed.

CHAIR: Do you want to say anything about the model, criteria and safeguards?

Professor CARNEY: Not really. Understandably uppermost in the mind of this committee is to ensure that any legislative model should have good protective mechanisms within it that strike the appropriate balances. In my tabled notes I have drawn attention to the two really extensive government commissioned empirical inquiries in Britain into the workings of its Mental Health Act. It shows that in practice what the courts and Parliament say cuts virtually no ice at all in regulating the behaviour of clinicians. This is true even the tribunals that are set up to be the gatekeepers to apply the policies that the Parliament has stipulated. I have given references to the two books and several other journal articles that make that point. There is massive evidence from the United States of America to the same effect. It does not mean formal protections should not be written into legislation, of course, you should but you should not assume that having been put in legislation that they will work the way you thought they would.

I made the point about "consent" being one of the criteria. Consent means the inability to consent to treatment. In practice that operates by clinicians admissions discussing whether a person has insight into their condition. I think the question of the Hon. Ian West earlier was in that vein. That is what at the operational level a criterion like that translates into.

I like the two-stage process of the NSW Mental Health Act. If there is to be civil committal there must be an immediate judicial mind brought to bear on it and here in this State it is the magistrate, followed by a multidisciplinary tribunal. Given the bang for buck point, if you wanted that model the sensible thing would be to add chronic alcoholism and addiction to the mandate of the Mental Health Act and perhaps to modify the powers under the Mental Health Act that could be brought to bear on such patients. For example, I suggest that inpatient care should *not* be an option and that of the two forms of community treatment order, only the least intrusive of those, the 'service-managerial one, would be the kind of mechanism that you would include.

CHAIR: A lot of the arguments from witnesses about whether to repeal the Inebriates Act and replace it with a new Act—perhaps following the Mental Health Act model—or to incorporate this group of people under the Mental Health Act have been to do with training and the kinds of treatment and everything else offered in drug and alcohol services is very different from the kind of care and treatment offered in mental health. In relation to your insistence that this group should be dealt with under the Mental Health Act or the Guardianship Act, do you have a comment on the role of drug and alcohol services versus mental health services?

Professor CARNEY: I probably have not been very clear. I guess this is my worse case option that I am discussing. If you decide on having some degree of civil committal then do it in the way I have just been discussing. But, no, my preference is to repeal the Act without any replacement at all. I would prefer to see attention given to case management and other mechanisms within the service system. And if it is thought that you need, contrary to my ideal position, some involvement of the law then, as I say, the enduring power of attorney type, personal guardianship mechanism which has been an add-on to the Guardianship Act and original model that I developed in Victoria, is the one that would repay attention.

CHAIR: You commented on the level of expenditure on the mental health system in New South Wales but you are not personally entering into the more clinical arguments about who should provide what services, with what training in what facilities?

Professor CARNEY: No.

CHAIR: But you are stressing community treatment orders rather than inpatient which addresses some of that issue which has concerned the medical people who have spoken to us.

Professor CARNEY: It needs to be in the hands of people with the greatest expertise in providing those kinds of services. The alcohol section is undoubtedly better equipped than the mental health sector generally, yes.

CHAIR: Those questions of assisting people are the same whether it is compulsory?

Professor CARNEY: That is right.

The Hon. ROBYN PARKER: In terms of intervention of the judiciary, you place that role at the beginning of the process. A lot of evidence presented to this committee has suggested that that is not an appropriate place for the judiciary. Would you expand your views?

Professor CARNEY: First, it is a fundamental requirement under a United Nations principle that any deprivation of liberty is to be adjudicated by a judicial branch of government. Second, I have read some of the evidence suggesting differently, but I have not found it convincing. I asked myself "What is the argument as to why it is not appropriate" and I could not find it, other than people saying that in their clinical experience they do not think it is a good idea.

The Hon. ROBYN PARKER: The Chief Justice thought it was not. But I do not want to verbal him.

Professor CARNEY: Nor do I. I did not see any reasoned convincing argument in any of the evidence that I read.

The Hon. GREG PEARCE: So your very strong considered opinion is that alcoholism or drug addiction of itself should not be a ground for incarceration?

Professor CARNEY: That is right.

The Hon. GREG PEARCE: To the extent that there is an issue of self harm there may be a provision under the intoxication Act or whatever to lock someone up while they are intoxicated or affected by drugs but that is the end of it.

Professor CARNEY: That is right. The question of the duration of that period when incapacity is clearly lost differs. I referred to chapter 9 of my book where the various Intoxication Acts were reviewed. Some of them have longer periods of time than is stipulated in the New South Wales Act. It may be that if that was to be the vehicle, or one of the vehicles, for any recommendation that the Committee might make, then one of the things you might do is reconsider the duration of the detention.

The Hon. GREG PEARCE: So the grounds for incarceration should be limited to criminal offences being dealt with under the criminal law and mental illness or disability dealt with under the current systems.

Professor CARNEY: Indeed, or that temporary period of loss of capacity.

CHAIR: We have had quite a bit of medical comment about the length of that period. For instance, three to five days is suggested for detoxication from alcohol. Would you be comfortable with that sort of period?

Professor CARNEY: I guess that is the consensus when you look at the conclusions that parliaments around the world have drawn when addressing that kind of question. Yes, it is also compatible with the clinical experience, as I have read it, about the absolute *maximum* amount of time that you might need.

CHAIR: Presumably if new legislation were to be introduced or existing legislation amended it would need to lay down a maximum time.

Professor CARNEY: Yes.

CHAIR: If it were going down the path that you have suggested—dealing only with compulsion for the period of detoxification—a legislative requirement for a maximum time would be needed or else a reference to a tribunal or somebody else to make that decision.

Professor CARNEY: Commonly you set a maximum and the law empowers the clinician to discharge before that period has elapsed if they are satisfied that the person has recovered sufficiently to warrant that.

CHAIR: Is there any legislation that presently enables that for the inebriates group with which we are concerned?

Professor CARNEY: The nearest is the Intoxication Act but I have not directly looked at its current provisions. I know that most of the proclaimed places under that Act were de-proclaimed and I am not sure how much of a dead letter it has become.

CHAIR: I do not think you can detain under that Act. Probably the only Act would be the Mental Health Act, such as in the case study given by the Kirketon Road Centre people. The Mental Health Act is used briefly for some people.

Professor CARNEY: The Intoxicated Persons Act provided for the retention of a person either in police cells or another designated place for 36 hours. I have to check, but it was for a stipulated period.

CHAIR: It was certainly not for as long as the medical consensus suggests is necessary for detoxification.

Professor CARNEY: No. My recollection is that the Northern Territory legislation has the longest period. The details are in that Chapter of mine.

CHAIR: We had some evidence that suggested that the Northern Territory model was worth looking at. I think you have already answered question No. 6 in part in your comments on alcohol-related brain damage. You referred to the submission from the president of the Guardianship Tribunal and your broad agreement with it.

Professor CARNEY: I think I have covered all of those points already. The only ones that I have not covered relate to question No. 5. It summarises research on community treatment orders. The Ring and Brophy study is an Australian Victorian study of whether community treatment orders do prioritise—as is claimed to be their main benefit—access to services and help to facilitate the harnessing of services. The study came to a negative conclusion on the Victorian evidence. My colleague from the United States Virginia Hiday and the Preston study, which is a Western Australian study of community treatment orders, asked that evidence-based question: Do they work? If they do make a contribution, then it is a small one—this is in the mental health context—and you would have to weigh up whether that contribution was large enough and whether it would be replicated in relation to this kind of group.

CHAIR: You stressed earlier the importance of case managers. Is that in your view essentially the alternative and a much better way of making a community treatment order type of program work?

Professor CARNEY: Indeed. It is an essential element of community treatment order legislation. Apart from allowing the person to remain in the community, subject to obligations to take medication and sometimes quite extensive controls on their life—including where they live and such matters—it is the individual case manager who develops a relationship with the person under the order. That is the be-all and end-all of whether the order makes a contribution. That then raises the question: Do you necessarily need to have a legislative framework to enable that to happen?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are effectively suggesting that the inefficiencies in community treatment orders and co-ordination are the major problem and that legislative solutions are almost irrelevant because they are not the source of the problem.

Professor CARNEY: Yes. The case managers may be much more effective, although the international literature finds a similar degree of scepticism about the contribution of CTOs. It is tricky because in the United States community treatment orders are quite rare and Canada and Britain do not have them at all. They are only used overseas as an alternative for somebody who would have been institutionalised, and in some overseas jurisdictions, people who have already been institutionalised for lengthy periods. They deal with very low volumes of very chronic people overseas whereas in Australia there are several thousand such people on community treatment orders at any one time. It is a much more *preventive* measure. Certainly the international literature argues that it is not a real test of whether they work. Why is it not a real test? It is because the services are not out there to be marshalled. Why not? It is because States are underinvesting in those kinds of service networks. So understandably case managers, who might be very effective if only the resources were there to be harnessed, fail because the resources are not there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the central problem the fact that we cannot de-institutionalise our service delivery and this is merely another expression of that problem?

Professor CARNEY: It is not that we cannot de-institutionalise, it is that when we have de-institutionalised we have made it an excuse to please Treasury by diverting the savings to other public expenditures or to tax cuts.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, they have not been delivered at all. The de-institutionalisation process has not seen a transfer of resources to the delivery of services in a community-based manner. It has been simply a way of cutting services altogether and assuming that the community will magically fix it.

Professor CARNEY: That is right. It has left the responsibility with civil society. It has largely abnegated the Government's responsibility to provide assistance to a vulnerable population. That was never the intention of de-institutionalisation. The intention was to allow people to operate in the community and for governments to continue to invest the same number of dollars that used to be invested in institutional care in the more effective community-based care. I am speaking internationally; I am not having a go at New South Wales.

CHAIR: Returning to the point you made about case managers, community treatment orders and checking the material that you have prepared, in the points at the end of your comments in answer to question No. 6 you stress that the good aspects of the Guardianship Act include the interposition of a third-party between patient and therapist, which is quite different from the Mental Health Act model. You also make other points about that. I am anxious that you have a chance to put on the record your points in relation to the Guardianship Act.

Professor CARNEY: The Guardianship Act operates to a very different logic. As I said in that question and in an earlier one, it works to an empowering restoration of social functioning logic, and that is important. Yes, in work we have done in mental health and in anorexia, consumers and their families appreciate having an intermediary between the complex needs of the person and treating staff. That also is quite important.

CHAIR: The other areas where it seems we have not had much chance to get your comments on the record are the MERIT Program, the Drug Court and other recent initiatives associated with offenders as distinct from the non-offenders about whom we have been talking until now.

Professor CARNEY: So far as offenders are concerned, the argument shifts fairly dramatically. I support any measure that offers any kind of treatment option *within* the duration of the deprivation of liberty that would otherwise have been imposed on the basis of the gravity of the offence that has triggered the person's presence within a correctional facility or under any correctional order. I have given the references to the superior case law in this country and overseas. That indicates that as a matter of common law principle it has always been the case that it is wrong to extend

treatment beyond that period that would otherwise have been provided had the person been treated as an offender and sentenced in the ordinary way.

The second dot point is an important one for legislatures. New South Wales has a reputation, which is well deserved, for avoiding the pitfall of falling for the latest fad. There is a tendency when a social problem arises to assume that the latest ism, acronym, program or piece of legislation is the panacea. That was said about probation in the 1930s and it has been said about virtually every new idea ever since. As a criminologist, the criminological evidence has rarely supported the merit of those new initiatives. The Drug Court has been properly scientifically investigated and it confers—as I am sure this Committee is aware—a small benefit. There is a small positive side on the ledger from that program. The MERIT Program has not been as rigorously scientifically evaluated but the evidence in respect of it suggests to me that it, too, is making a small positive contribution. The exposure draft for the new addiction and corrections centre is probably acceptable so far as it stays within the existing duration of the criminal justice orders, on my initial opening remarks on that point. It would be unwarranted if it spilled beyond that duration.

CHAIR: The trial is about to start on Magistrates Early Referral Into Treatment [MERIT] program for alcohol as well. That will start perhaps later this year.

Professor CARNEY: Given the lack of amenability of alcohol too, one has to have very low expectations in these areas. That is borne out by the work of the drug court, that the overwhelming majority of customers in that well-resourced program do not complete the first stage, much less the second and third stages. But, for the investment, it does achieve a small improvement for those who do manage to stay the distance. I think that justifies that particular initiative, although a bean counter looking at the total number of drug offenders and the small number of successful graduates of the drug court has a process of reasoning to go through even so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is not the only measure. If the consumption per day is lessened for a period, presumably that would result in a lot less crimes because, as you said, the total harm is very much proportional to the total use.

Professor CARNEY: Yes. It is often said that the only attraction of incarceration is that it takes somebody off the streets for a certain period of time. It is that kind of argument.

The Hon. ROBYN PARKER: I have got lots of other questions because I have found your evidence to be very useful, but for now I am just interested in this: you started to talk about the value of the drug court and MERIT programs. What is your view of the drug gaol?

Professor CARNEY: That is what I was just saying—

The Hon. ROBYN PARKER: Were you talking about the drug gaol when you commented about taking people off the streets and there was no other merit in it?

Professor CARNEY: The merit that I opened with, that is that the exposure draft of the, whatever it is called, the Corrections Centre (Addictions) Bill, is designed to provide a legislative framework around the existing experimentation with a drug gaol. Yes, there is certainly merit in offering services to people who suffer from an addiction and are going to be detained because of an offence that they have committed. There are clearly strong humanitarian, medical, ethical and many other arguments to be made in favour of basically offering rehabilitation opportunities within a person's period of incarceration. The only reservation one finds in the literature is that people should not have their hand forced any more than we allow a person to be forced to enter a clinical trial just because they happen to be a prisoner. Similarly, you have to be a bit careful about treatment.

The Hon. ROBYN PARKER: So it should be their choice to go into a drug gaol program?

Professor CARNEY: Yes, you may have some strongly persuasive inducements but you need to be wary of totally removing opportunities for dialogue and choice. I did not comment in relation to the Mental Health Act. I observe that Australia's position in relation to detention and treatment, rolling them together, is different from most of the rest of the Western world. Mental health Acts in other countries generally have two quite separate decisions: one, the decision to detain—and,

having been detained, even mentally ill people are presumed to retain the capacity to decide whether to be treated or not—and there is a separate, second process for those who refuse treatment, and their capacity or otherwise to consent (or verbally refuse consent) is able to be adjudicated.

CHAIR: Our last question. I think we are fairly clear on what you are going to tell us you want to come out of this inquiry but let us put it on record.

Professor CARNEY: The repeal and non-replacement of the Civil Committal Inebriates Act-type measure; investment in the multi-problem complex chronic case, and as I have elaborated—the case manager type ideas, the human services complex needs legislation out of Victoria, the work of the Victorian Law Reform Commission in relation to people with intellectual disabilities—and toying with ways in which if a legislative framework is needed one could play around with either community treatment orders or, preferably I think, some modification of personal guardianship Ulysses agreement-type advanced directive-type living will-type answers to the question. The blank dot point is that I do support having a power to detain a person for the number of days or hours that their intoxication persists and removes or sufficiently diminishes—one needs to be realistic about this, it is not exactly at the point where you sober up that you might say the detention ends, but a short period of detention where a person's capacity to decide to access treatment or not is impaired—I do support having some provision which allows that to be done.

I guess the main fourth plea is that whatever is done in relation to social policy, I would urge the Committee to ensure that it has the maximum impact, the maximum bang for the buck—which I think was Arthur's question to me earlier—so that a degree of social equity and geographic equity is achieved. It is critically important that we appreciate that the addictions, no matter how troubling for individuals, are only one of many troubling problems in the mental health and related area. Just as we would not think that we have a special service for phobias or a special service for schizophrenia, or other such special Acts and services-any further fragmentation and dwindling of public investment in overall service systems that that will entail is much to be resisted.

CHAIR: Thank you very much for your very firmly expressed views—quite different in several areas from other evidence we have had, and to that extent much more useful too. Thank you also for your list of references and your help with what is happening in other jurisdictions.

(The witness withdrew)

(The Committee adjourned at 12.40 p.m.)