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REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO THE *INEBRIATES ACT 1912*

At Sydney on Wednesday, 18 February 2004

The Committee met at 9.30 a.m.

PRESENT

The Hon. Robyn Parker (Acting Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Catherine Cusack
The Hon. Kayee Griffin
The Hon. Ian West

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IAN WILLIAM WEBSTER, Medical Practitioner, affirmed and examined:

ACTING CHAIR: Do you wish to make a brief opening statement prior to the questioning?

Prof. WEBSTER: Not really, no.

ACTING CHAIR: After the formal questions, it is possible to present any in camera evidence that you need to and you could make a statement along those lines. If at any stage you consider during your evidence that evidence or documents you may wish to present should be heard or seen in private by the Committee, the Committee will consider your request. However, the Committee or the Legislative Council itself may publish evidence if they decide it is in the public interest to do so.

Could you just tell the Committee about your experience in the drug and alcohol field? I know that is expansive. We have a brief synopsis of it, but specifically in relation to the Inebriates Act?

Prof. WEBSTER: I expect that most doctors who work in public hospitals and in community settings meet this problem from time to time and some of us very often. I have been a professor of community medicine and public health for many years now and that has been a discipline which has been concerned about areas of health which have not been normally picked up by the traditional health services. The drugs and alcohol problem has always been a major gap in health care provision and indeed the way medical schools and medicine itself functions, and so I have been interested in that area most of my life and the places I have worked in have concentrations of those problems. I tend to practice medicine in industrial communities, and drinking and drug problems and smoking problems are very prevalent in those environments. Because there has been a lack of interest in medicine in this field it became a special interest of mine and some of my colleagues and we tried over the years to interest medicine in drug and alcohol problems. So I have been involved in special discussions in those fields with people who are concerned with these issues.

In terms of my direct role, I was initially a doctor in lung disease, and lung disease of course is associated with smoking predominantly, and then more than a decade ago I became the Director of Drug and Alcohol Services in Southwest Sydney and had to run major drug and alcohol services. Since about 1976 I have run a free clinic with nurses at Matthew Talbot for homeless people and in that environment I have seen literally thousands of people with both mental health problems and drug and alcohol problems. I probably have the personal files of several thousand there and so I have had very direct experience of people who become very disadvantaged and homeless as a result of this.

Because of my general interest I have been interested in mental health and for many years I was President of the Mental Health Association. I am currently the Chair of the National Advisory Council on Suicide Prevention. That is not something I have necessarily chosen. People have invited me to do those things because they saw me as a doctor from medicine with a wider interest in social issues. I have had a long practical experience with both the preventative and the end stages of this problem.

ACTING CHAIR: As I explained before, we are looking at compulsory rehabilitation and looking at procedures. What do you see as the ethical issues in relation to compulsive treatment for people with severe drug or alcohol dependence and is there a point at which people with substance dependence no longer have a capacity to make their own decisions?

Prof. WEBSTER: I think there are two frameworks you are addressing there. You initially spoke about offenders, and your question did not actually relate to offenders but to people in general and I would like to deal with those people first.

I think the first problem is the conception that people have of what treatment or intervention is,

and I will deal with that in a minute, but what effect does the use of alcohol or other drugs have on a person? It affects people at numbers of different levels. First of all, the person may have the problem of addiction, which is something to do with the way the brain works and functions. The person then may have the medical effects of drug use, such as the effect of alcohol on the liver or the brain or the effect of another substance on the body organ system. Then the person may be impaired by that; maybe they cannot think clearly; maybe they cannot walk adequately, so it may affect their function and what we call disable them, producing instability. The next step may well be the way it alters their social relationships and their status in life and they become socially disadvantaged, and of course most of them are disadvantaged, those who are homeless, and so you have got this cascading effect of the use of substances. If you use the word "treatment" in its broadest sense, treatment could be anything. Although we do often think of treatment as being either a doctor operating on you or prescribing a pill for you, the word "treatment" in this field is used very broadly as interventions at each of those levels, and so the ethical issues become different because it depends then on, firstly, whether the capacity of the person to make a decision is there and, secondly, on whether what you propose to do will work.

Now, that is when the problems start to arise. Clearly, a person who is only in the early stages can make sensible and clear decisions about themselves and it would not require much effort to get them to change their direction, but a person who is heavily dependent and has brain impairment and has become homeless and had a very well established pattern of living which they have adapted to and has become their life, you virtually can never turn the clock back, and so you have to deal with the predicament they are in, and that predicament is basically about basic needs, living, surviving, nutrition, housing, security, and so the ethical questions are different. At the top end of that, if you are to make a decision about a person's addiction, that will not work if the person is not prepared to make that decision, because dependence and addiction is not a simple biological trigger. It is not something you can turn off and on. It is something which has become built into that person's biology, their brain functions, and it has become built into their life, and for that person to change has to change their life, and changing lives takes time and is difficult and involves the person.

There are things which can cause people to change their lives. For example, heavy drinkers if they get married or change their work situation may change their pattern of drinking and that has been shown in studies in other countries. A doctor who has been excluded from practice who has been drinking or using drugs can often change their behaviour if there is a threat of loss of their standing. So coercion can work in certain circumstances, but that requires the person to have a set of other skills and other capacities for making change, but at the end the person is very damaged and his life has become absolutely dominated by it, they cannot change. The number of occasions on which I have seen a homeless person of longstanding become a non-homeless person you can count on the fingers of one or two hands. The most we can do at that level is be decent and reasonable to people and offer them housing and some different lifestyle. The idea that you can turn the clock back and get people into a situation where they can work, for many of these very advanced people is a fantasy, as I said before.

Clearly, there are other stages along this pathway. For example, a lot of interest has been shown in early intervention of people who become homeless. In fact, in England they have a statement in the area of crisis care which they call the "three week rule", and I know that this is sort of encapsulating an idea in a brief way, but what it is really saying is if you have not intervened or been able to do something with a person in the first three weeks of becoming homeless or that rather desperate stage, you will not achieve anything at all. So it is that early intervention.

The ethical issues, therefore, are at many different levels. I often teach medical students about ethical medical decision-making and often we use the sort of people we are discussing as examples and, clearly, there are medical rules. There is a right thing to do for pneumonia, there is a right thing to do for heart attack, there is a right thing to do for even addiction as we think, but when you have got a person whose life has become so dominated by disadvantage and difficulties, what they will decide is good for them is quite different from what you will decide is good for them. If they are at the same time mentally ill and very disabled, the quality of the life that they are looking for will be quite different from the quality

of life that you and I will look for, and if in that environment you decide that there is a course of action that you should follow but you have not got the resources to do it, you cannot do it, or if you cannot get access to those resources you cannot do it.

To give perhaps a hypothetical example of that, if you have got a mentally ill person who is poor and has got a massive hernia, it is almost impossible to get that treated, because the hospitals find it very difficult, unless it is a crisis, to admit that person for an elective operation. That is an extreme case, but it is all those qualities around that person which cause people to react differently to them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you were talking about what one might loosely call having fixed support for inebriates, you talked about the degree of impairment that they had. Presumably this is both psychological and physical?

Prof. WEBSTER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the sense they might have some dementia or they do not have the ability to learn?

Prof. WEBSTER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there some inebriates who do not have significant dementia or lack of ability to learn, who if you put them in a situation where they had a real possible career path, from the day you intervened you could retrain them, assuming they could learn? I suppose I am talking about a population who perhaps came off the rails for some emotional reason when they were young and then never really got their life together, so they have the possibility in talent terms of getting out. Obviously, if they are a doctor they have got something to fight for and a background that would enable them to rebuild their life, assuming at the time you intervene you do not just put them in gaol, if you like, for three months as an inebriate but during the time at which you intervened, with more or less a degree of compulsion, that you had some real life plan that you could put in place?

Prof. WEBSTER: That is the hardest question of all that you have just asked me because in many circumstances, of course, the situations I have been describing are very mixed, but I think in the case you describe there would be a group who could be rehabilitated to a pretty worthwhile life, but it is very difficult to test because it is hard to find and discover those people. They are not that evident.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you were, for example, doing an admission to somewhere like Matthew Talbot, presumably you would get some idea of the degree of impairment that they had and you would know their degree of intelligence.

Prof. WEBSTER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The personality in a sense might be harder to assess in the short-term.

Prof. WEBSTER: All of those are important and I think it is possible that there may be some, but the problem is that that is an area where not much research has been done. Perhaps if I just take an example. In methadone programs there has been very little research on the brain impairment of people on methadone programs but when it has been done it has been shown that quite a lot of them have actually brain impairment as a result of previous overdoses. It is not an area that people have explored a great deal.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously in some cases where they have

been drinking metho or whatever and their brain is fried and they have never really had a job to model that they could go back to and in that case, as you say, the best you would get would be them being fed in an almost - like catatonic mental patients from years ago, warehouses of them permanently there. That would be what one would do if one could afford to presumably, but there must be some who get to that point, some who could work their way out of that.

Prof. WEBSTER: Of course, and I probably should say that there are degrees of gains that can be made because there are different dimensions that may be affected in this situation.

I have got a friend who wrote one of the first theses ever written in Melbourne on homeless people. He studied a thousand homeless men, and during the course of his thesis he sent me this chapter in which he describes the extraordinary event of the death of his wife, which is very unusual in a thesis, but it actually described the response of a homeless man who had been working as a janitor around the place he was living at, and this heavily dependent inebriated alcohol dependent person in the environment of that person's home developed a supportive relationship with the family. That particular man became profoundly affected by the death of my colleague's wife and became a citizen who could make a contribution, but nothing like the contribution that he had made previously. I cannot recall what he was. So that yes, you can regain some function and you can, of course, return to some form of worthwhile living, and I certainly would not entertain the idea that people be locked away forever because they will not improve in some way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Support would seem to be the other option.

Prof. WEBSTER: Yes.

The Hon. IAN WEST: Following on from that question, what do you see of the ethical issues in relation to the compulsory treatment of people with drug and alcohol problems?

Prof. WEBSTER: It goes back partly to the line of thinking that I started off with. If it is treatment to deal with survival of the person, I have no ethical problems with treatment being against the person's will. If it is treatment to force a person to change their way of behaviour and use of substances, that is when the difficulty arises. The evidence is from lots of studies that you really have to have the person engaged in the decision they make. As I mentioned before, people have to change their lives. If you go to Malaysia or Indonesia or Thailand you will see different examples of people in prison who are there because of drug use, with intensive rehabilitation programs, often with a religious basis, and the recidivism rates there are massive. They do not achieve much at all. So that approach is not particularly effective and, of course, prisons in a way have been what we have tried to do here in Australia.

There are other programs in the prison environment where people have tried to introduce a decent drug and alcohol program, and Professor Wayne Hall, who I think may be giving evidence to you at some point, has done an international comparison of these studies. He has shown that many of these programs in the United States really have not worked at all, and the more they are based within a prison environment, the less well they work, but he has shown that there are some gains in some programs where there are stages of progression, from some intervention within the prison, from then some graded support of a person when they leave prison and a significant community program. As I understand it from his review of that literature, they have been the only programs which have been effective in prison or corrective services based coerced treatment. You will find he will say something else, that it has to be, from his point of view, if it is to work, what is called a constrained choice. In other words, the person has got an opportunity to make a choice of some kind.

When the Drug Court program was introduced in New South Wales I was, like many doctors, very apprehensive about whether it should intervene, but I accept that the community had debated it, that

the broad public interest had been considered and that the Parliament in the end had said it was worth trying and that in that process lots of particular perspectives had been, I hope, reconciled in a proper democratic way. So in one sense one accepts that that is a process which the State has gone through, a reasonable process. I actually look after people in the Drug Court program and I have found that the people who were in that program, the ones I met, were very optimistic, far more optimistic than many of the people I have met in other treatment programs. They were going through a very staged program and they were quite proud of their achievements. When they went to the court, the court would praise them if they had done well, and of course sanction them if they had failed.

The key to that program to me was that the person still had a choice. They chose to go into that scheme rather than being directed to go, rather than going to prison. That was the option given to them. So they were able to exercise some responsibility. Another reason why that program seemed to be effective was it had far more resources available to it than any other program you will ever find.

The Hon. IAN WEST: Is there a point where the word "choice" becomes irrelevant in all circumstances? In other words, is there a point where a person's substance abuse or underlying medical state is such that they are not in a position to make free choice?

Prof. WEBSTER: Yes.

The Hon. IAN WEST: There is?

Prof. WEBSTER: Yes.

The Hon. IAN WEST: Do you have any idea what that is?

Prof. WEBSTER: In the extreme cases that I described to you earlier, where the person has damage and has a lifestyle which has been damaging, almost no decisions they make, apart from some very basic decisions about eating and drinking water, are free will choices. They are totally out of their minds. I wrote a little story in one of my submissions to you. That man eventually was living under the Inebriates Act many years ago. He believed constantly that he was in the Vietnam War and he was still fighting the Vietnam War. His brain and mental state had been so damaged that he knew virtually nothing about his life or the choices he could make living on the streets. He could make some choices, which were that he needed to have a drink or he needed to have some food if he was hungry. Of course, in a mentally ill person when they are deluded and they have totally inappropriate ideas and perceptions about what is happening around them, and even about their thinking in response to it, they cannot make proper choices about significant decisions. That sort of phenomenon can happen to some people with alcohol problems, particularly when they become quite psychotic with alcohol disorders, and be similar to a person with a florid mental illness.

The Hon. CATHERINE CUSACK: Severe addiction to alcohol will almost inevitably lead to some mental illnesses, is that the case?

Prof. WEBSTER: Yes.

The Hon. CATHERINE CUSACK: In terms of the ethics of what choices we can make on behalf of these people you say you have no problems with the issue of survival. I assume you mean physical survival. I am interested in the emotional and I am wondering what the definition of "survival" actually means.

Prof. WEBSTER: I think that is a very important question. I sometimes use the word "welfare" rather than "survival"; the person is being concerned about the welfare. The World Health Organisation has had a set of definitions about impairment, about disability and about handicap and in

its definitions of handicap it has about five different attributes and they call these "survival characteristics". One is mobility, ability to move around; one is being able to have social engagements, another is to survive economically; and one which is not on the list but goes back to fundamental biological things, the ability to get food and water and sustain your body systems. Although this is probably not one of their categories it is about having meaningful social relationships. I would actually include that too in my terminology of "survival", that a person has a reasonable existence which involves at least some worthwhile relationships.

The Hon. CATHERINE CUSACK: I guess as a committee one of the problems with this Act is how do you decide, in a measurable way that doctors and policy makers can all understand, the point at which compulsory intervention is appropriate?

Prof. WEBSTER: You cannot. You cannot trust doctors to do it, you probably cannot trust any group to do it. Ultimately it has to be a reconciliation of a number of views. There ought to be a process where thoughtful citizens are involved, people with some special knowledge of the area, such as doctors, welfare workers, people with mental health perspectives and I think that is ultimately the way we decide all our complicated issues in society. We decide whether people are guilty, and in some countries they decide whether a person's life will be taken away. We could draw on special skills but we also need to accept the fact that there are levels of wisdom and appreciation that we all generally share about what is worthwhile in life, our values and so on.

The Hon. CATHERINE CUSACK: What you have said can be quite different to what the person wants for themselves?

Prof. WEBSTER: At the time.

The Hon. CATHERINE CUSACK: Are you suggesting a case by case decision as opposed to a general policy?

Prof. WEBSTER: Yes.

ACTING CHAIR: For us we need to have a look at perhaps the legislative framework that will enable that to happen, if that is the way we proceed. Are you suggesting a formalised tribunal or an informal group of people, team of people?

Prof. WEBSTER: I think it ought to be formalised and I propose something along the medical tribunal lines or the guardianship board. But I should say that we should not do any of this if we have not got a way of helping these people. There is no point in making a decision like this if we have not got places or environments where people can be cared for. I think that is probably fundamental: Is society prepared to provide the support? It ought to, but is it able to or prepared to provide an environment where people who are so vulnerable or harmed can get some support?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that saying in a blunt way that there is no point talking about compulsory treatment which might benefit a few if you have got no significant treatment for many?

Prof. WEBSTER: Yes.

ACTING CHAIR: You mentioned earlier the need to have adequate resources and services to back that up and particularly you were talking about in rural and regional areas. What do you see then as the right sort of service system to support these initiatives?

Prof. WEBSTER: We had a bit of a discussion around the idea of treatment earlier on. I do

not think this is a health problem and I would not like to cast it as a problem for any particular domain of Government but it is essentially about place. Wwhat is an environment where people can be which is reasonable, secure, safe and in which some of the basic requirements of a person's life can be met? So it is a living environment and one can argue about what the framework of that living environment would be.

Over the years I have said that one of the main aims of working as a doctor at Matthew Talbot, one of the main aims of that service, is to get people to at least the next stage or a decent level of accommodation. That did not mean it was going to solve their problems for accommodation but it meant a level of accommodation where the person would have some privacy, would have some opportunity to have personal space and be able to be secure from being hassled by other people and have access to food and some of the amenities of life.

I have some photographs which were taken 30 years ago. It is not like this now, but in some situations it is not far from this. The pictures I have are of some of these inner city hostels with beds piled one on top of the other, close together cheek by jowl. This does not exist now, but this is 30 years ago I am describing. It is sort of a caricature of what can still happen. The only space that people had was a wire basket at the end of the bed so that everything you had, your most personal possessions, were public. I mean it was in a wire basket and almost everything else you did was public. Going to the toilet was pretty public in some of these places.

It is one of the problems. We have problems with drinking on the street. The only place you can drink is in public and be visible. I do not have a recipe for what I think that place should be or the shape of it. I do not know whether it is public housing. There are lots of arguments about whether particular policies of public housing should work. I do not know whether it is through Government agencies. I do not know whether it is through innovative ways of the private sector providing these things. Incidentally, my impression is that housing in this State is trying to respond innovatively to some of these complex things, and in fact I understand about 80 per cent of the people who are demanding emergency housing these days are people with combined mental health and substance abuse problems. We have an environment where there is a huge demand for place and space and support and we are not able to do it or not doing it very well.

The Hon. IAN WEST: Can I clarify that? Did I hear you to say 80 per cent?

Prof. WEBSTER: I used the figure 80 per cent.

The Hon. CATHERINE CUSACK: That would be people achieving mental health places?

Prof. WEBSTER: I should qualify that by saying I understand it is 80 per cent. It is certainly very very high.

ACTING CHAIR: We have talked a lot today about the extreme end of homeless people. What about the situation of someone who is living perhaps in the suburbs or in a regional area, still living in a family situation? We have been presented, through the alcohol summit, with cases such as that. Do you think compulsory treatment is appropriate for that person?

Prof. WEBSTER: It depends what "compulsory" means. I think there should be powers which could direct that person to be assessed and contained for a period in an environment where an assessment could be made and initial treatment started so that person could better make judgments about their life circumstances and their future. So I would argue that there are circumstances where being held for a period of time would be reasonable. In fact, the Mental Health Act allows that to happen. The Mental Health Act allows for people who are drug and alcohol affected with the syndromes or characteristics related to a mental disorder to be held for three days. That is used very

rarely for this purpose and it is an area which could be explored with greater thoughtfulness, I think.

The Hon. CATHERINE CUSACK: The mental health framework and the laws and committees in place now, would they be appropriate for dealing with people currently under the Inebriates Act? Do we need to create a new system?

Prof. WEBSTER: I think that legislation could be made to work but you probably need to alter the base with it because it specifically excludes people with drug or alcohol problems, but allows for a person temporarily disordered to be assessed and held for three days and that could well be a drug using person and quite often is an amphetamine using person and, I would argue too, infrequently an alcohol using person, but the caveat to that would be that the mental health system's capacities and service arrangements would have to be rethought.

The Hon. IAN WEST: Can I clarify, is that the reason why you made the comment earlier that it is not a health problem?

Prof. WEBSTER: In my submission you will see that the health system is progressively focusing down on shorter and shorter term interventions, both in the drug and alcohol field, but everywhere. So there are shorter stays in the hospital and the idea of long stay is either not being funded or in some circumstances is being seen as the proper province of more welfare based organisations. For example, there is a big debate whether nursing homes are health institutions or social care places. In England they are social care places.

ACTING CHAIR: You have talked about under the Mental Health Act three days being a time. I assume that three days would not be an appropriate period of time for someone under an inebriates order. What sort of time frame would you think would be appropriate?

Prof. WEBSTER: I would be reluctant to make it a major issue but I think that with proper checks and balances and the sorts of tribunals oversighting it that we have talked about, I think it would be reasonable to do it for a week.

The Hon. CATHERINE CUSACK: For the crisis care?

Prof. WEBSTER: Yes.

ACTING CHAIR: And if they refuse to go?

Prof. WEBSTER: I think the same provisions that apply to the Mental Health Act, people could be taken to these places.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You think the output at the end of that week justifies the compulsory treatment?

Prof. WEBSTER: Compulsory treatment of a person who has been assessed as being severely affected who would have shown a long history of problems with inebriation and have demonstrated failures of past interventions. The sort of framework that is being used in the current legislation will come before the Parliament about enforced treatment in the prison system where they talk about recidivist offenders. This person is not necessarily an offender but a person who must demonstrate failure of previous attempts over a substantial period of time to have responded.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is not this person who has failed so many times before the "unfixable" one? Why are they not the "unfixable" one? You did not use the word "unfixable"; that is my word. I did not explore whether the problem was mainly psychological or

physical in the sense that presumably if they are physically damaged they cannot learn and if they are demented they cannot learn. Are you stopping the danger to society in these people? Are you stopping the suicide risk or are you giving a long term outcome?

Prof. WEBSTER: Both. What I think is biologically and socially damaged? It is a person who has a degree of severe dependence that is demonstrated over a long period of time and it has been demonstrated that it has not been able to be broken. What we are proposing in this discussion is that they be given a week of compulsory treatment, that is being brought into a place where they would be detoxified and where an assessment could be made of them and a discussion with them and their family, and whoever it might be, about the potential for further intervention.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that different from what I am suggesting, what I mentioned before of the assessment of someone coming into Matthew Talbot where you said, "Has this person got the potential for more extensive intervention"?

Prof. WEBSTER: It has a period of time and it has the capacity to bring to bear a lot of information and skills. You would have other people looking at the person; you probably do blood tests; you would have relatives involved.

ACTING CHAIR: What follow-up after that week would you see as being appropriate? I assume you would see a need for a follow-up from that. What if the person said, "Thanks, I have done my week. I am going back to my life"?

Prof. WEBSTER: That too is a critical question. One of the major failures of all our systems which deal with addiction, prison, mental illness is the failure to follow people up. I use the words "the chain of care". We do not connect or link the person, strongly, adequately or with strength, to the next stage. Follow-up would be important and I suppose the way I am moving in my discussion now, I would require the person to present for follow-up assessment at an appropriate time in a short period of time.

ACTING CHAIR: What sanctions do you think ought to be applied if they decided not to?

Prof. WEBSTER: I don't know.

The Hon. KAYEE GRIFFIN: Professor Webster, in terms of your suggesting a week, if you used similar legislation to the Mental Health Act at the moment, in terms of detoxification is there a set period for a person to be detoxified and does every one fit into that sort of set timeframe?

Prof. WEBSTER: Not really. The word "detoxification" is one of those myth words. People sort of believe that you are removing the poisons from a person's body and it is everything. It is not. Detoxification is the first stages of withdrawal from the use of a substance and in the case of alcohol it is usually over in one week, where the person is quite ill and sick and often requires intensive support. For opiates like heroin it usually occurs within the first few days, but you are right, there are other substances where that process of withdrawal would take weeks, like the benzodiazepine drugs and some of the longer opiates like methadone, but in general, if you were to look at most acute services which we have established for detoxification, it is usually anticipated that people will be in for a week.

The Hon. KAYEE GRIFFIN: If this did occur and a person was, say, held for a week, and then during that period of time, there were supposedly, or hopefully, appropriate measures put in place to take them on the next part of the journey away from their addiction, if the period could only be a week, then what sort of guarantee, I suppose, would there be, if there was no compulsion after that week, that the person would continue along the suggested lines of treatment or counselling or whatever it might be? Do you think that there would need to be perhaps more compulsion after that week to try

and keep the person on the path?

Prof. WEBSTER: Well, it could be. In our discussion a moment ago we proposed there should be compulsory follow ups of the person and that might be sufficient trigger for the person to change.

If you think about the problem of being dependent, there are two intersecting issues. One is what we might call motivation and the other is the degree of dependence that a person has. Now, clearly some people are going to be highly motivated. A doctor who is going to lose his licence for having a dependence is going to be highly motivated and almost every effort will be put into change, and if he is not very dependent he will change easily. If the person is very dependent it will take a lot of effort. These things are an intersection between a lot of different judgments. The reason we use methadone is because we are replacing some of the characteristics of dependence in a person who is not highly motivated and we are trying to, over a period of time, effect that person's motivation and engagement. The reason we use nicotine replacement is to replace the degree of dependence of a tobacco smoker, hoping their motivation will change. My colleague over there, Arthur, has been very effective with his public advertising campaigns. In some people who are not heavily dependent on cigarettes that would be sufficient to change them.

None of these things are absolute and we are not going to succeed every time. The success rate in treating alcohol dependence is of the order of 60 per cent. Incidentally, that is as good as the treatment of most medical conditions, so we should not look down on that. The relapse rate of asthma or the relapse rate of diabetes, the relapse rate for hypertension treatment is very high, so we have always got to have a process. It goes back to the Chair's proposition about follow-up. None of these things can work as a one hit measure. No one detoxification fixes anybody. Perhaps occasionally it does. It requires that ongoing acceptance and input, if a person has been dependent, to cause them to change. For many of these people it is a lifetime struggle to remain non-drug using or out of trouble if they do continue some drug use.

ACTING CHAIR: We know we can talk forever on these issues and it is so complex. I wanted to get your view specifically on proposals recently to establish a wet centre for street people in the inner city. What is your view on that?

Prof. WEBSTER: I spoke at that meeting that was held and supported the idea on the basis - how my discussion earlier on went, where I was talking about the fact that some people are street living people who have no private space and they need to be given space and there are people amongst them who are mentally ill who have no space but they ought to be able to have a drink somewhere. That is sort of my argument about that.

I must say the police have another argument. I think they were not supportive at that meeting of the idea of wet centres. Their argument went that there are provisions in legislation in the Intoxicated Persons Act, in the provision of proclaimed places and in the ability to take people for detoxification which allow that problem of public drinking and that seems to concern local communities. However, the caveat to that, one of the caveats about this thinking, is that the proclaimed places are inaccessible, there are very few of them. The inner city agencies seem to be closing them down for reasons which are perplexing.

Access to detoxification is relatively poor and there is this idea, which I suppose we are toying with in the whole of this discussion that the only worthwhile thing to do for a person who is drunk and habitually drunk is to reform them back to normal, when the argument, certainly from my perspective, and certainly most medical perspectives I would say, is that the first thing to do is to make a person safe, in other words secure, and stop them dying. If that is the objective, helping people and supporting people so they do not die while they are drunk is an important game.

Professor Tony Vincent when he was the head of the Bureau of Crime Statistics many years ago wrote a publication which was called *Drunks in Gaol*, which described drunks in gaol in New South Wales and reported a number of deaths that were taking place in the gaols then. That in my thinking, and I think it is probably true, led to the abolition of the Summary Offences Act many years ago because people were inappropriately being put in gaols where they could not be supervised. If you go to Darwin, Alice Springs or Adelaide you will find that there are sobering up places, which are places to which often Aboriginal or other people are taken. They are safe places. They are terrific; they get a bath; no judgmental action is taken about them. They survive and in a way that becomes part of a new connection. In Alice Springs they have the night patrol manned by Aboriginal people picking up the drunken people and bringing them back to the sobering up shelter so they survive, get fed and some of them change their patterns. In Aboriginal communities they probably change their patterns rather than our communities change their lives.

The Hon. CATHERINE CUSACK: You are a supporter of proclaimed places?

Prof. WEBSTER: Absolutely.

The Hon. CATHERINE CUSACK: Did you see any problems with the way they were operated?

Prof. WEBSTER: I must say I have not kept up. The legislation has been changed in recent times and, without having studied it, I am concerned that something has happened which has decreased the access to those places for the sorts of people we are talking about.

The Hon. CATHERINE CUSACK: The power to detain has been taken away.

Prof. WEBSTER: Under those circumstances I think that has not been a good decision. I visited proclaimed places for years and years and years. I have gone in as a doctor and examined patients and arranged treatment for them at one of the ones I used to visit. That is closed now.

The Hon. IAN WEST: When we come to grips with the method of assessing someone's inability to make choice and come to grips with the legislative requirements, how we integrate it with the mental health system, et cetera, and we come to grips with the issue of how long we detain the person, say it is a week, what happens after that in that follow-up period? You mentioned very clearly in your submission the issue of the necessity of highlighting those basic needs of health care, nutrition, shelter. One thing that I was trying to come to grips with that seemed to be missing from that is in that motivational side of things there seems to be missing the issue of some sort of mentoring, some sort of involvement by other than yourself, other than the person affected which seems to be just as important, one of the most important factors.

Is there a way that in the compulsory treatment we can have in that follow-up, as part of the assessment, the follow-up effectively having some method, assuming the resources are available, where the person is mentored in a compulsory way that they end up with the relative you have when you have not got a relative?

Prof. WEBSTER: That is a very important idea. The difficulties are that when we are trying to construct through legislation appropriate response we have to define things. In an ideal world these sorts of problems would not have to be managed in institutions that we describe, they would be managed in their local communities and in an ideal world we would have general practitioners and primary health care people who were widely interested in managing problems like this. Increasingly general practitioners are getting involved in this and it would not be seen so much as a big brother coming in to control it and direct what was happening, the relationships would be worthwhile. I think

one of the problems we are facing is that we create institutions to respond to problems which ought to be handled in a different way in community environments and of course cities muck that up. I do not know what the answer to your question is. I do not know who. I was thinking of a general practitioner, but you are not going to be able to railroad a general practioner into a role like that.

The Hon. IAN WEST: No, I was thinking more of examples that no doubt all of us have been through with aged relatives, where with all the best motivation in the world their ability to maintain nutrition, cleanliness and appropriate shelter is determined not by their complete inability to make choices but their hazy understanding of the choices they are making, and a relative who comes along usually assists them in making better choices. So in just saying yes, an individual can be motivated to make the direct choices on nutrition, health, food, clothes and shelter, falls short of the mark in the sense that we do not always make the right choices without assistance from peers and fellow human beings.

Prof. WEBSTER: Yes, I think you are right, and of course with elderly people, when power of attorney and so on is handed over to relatives, you can make decisions on behalf of the person. Many years ago there was a review of the problems of the handicapped in England by Judge Morelock and the idea that grew up in that area of disability was the idea of having what is called a nominated person. Someone could be nominated as the person who would be that person's advocate, because that person could help represent that person's interests in another place or see that they got those things. I suppose that something along those lines of attempting to define a person in the way you are thinking, Mr West, who could have a special designation - I rather like the words "nominated person". Obviously it would be an onerous job but at least there ought to be some aspects of it which they can help out on.

The Hon. IAN WEST: I say what I just said in light of the tortured path of admission in the case that you referred to in the submission, and in reading that case that you referred to at Matthew Talbot, it struck home to me very clearly the complete lack of human contact that that person had.

Prof. WEBSTER: Well, it was one nurse who became the nominated person. For three months at least she explored all those options that I described and she went with the person to the court. The disappointing thing about that story, which I did not put in the submission, was that we were hoping, or I was expecting, that the person would have been sent by the magistrate to care and that the person would not have to sign the form. In other words, I thought this was going to really test whether there could be direct or compulsory treatment, but in the end the magistrate required the person to agree to go. So it was a form of constrained choice, rather than directed. When I say I am disappointed, I was very pleased for him, but we were trying to make a system work at that time and in the end he did not really test it.

ACTING CHAIR: I would like to ask a follow-up question on that specifically. I know Catherine has a clarification question too. What role do you see the judiciary having in this process, because we have heard from Justice Price his views about the role of the judiciary and I was just wondering where you see that fitting into the parliamentary legislative framework?

Prof. WEBSTER: The Mental Health Act has magistrates involved in it and I think that is an important protection. Is that what you were referring to?

ACTING CHAIR: Yes. At what point in the process do you see their involvement?

Prof. WEBSTER: In the Mental Health Act magistrates are called upon to review at a certain point whether the person has appropriately been admitted. They are called upon at certain times to decide whether the person should be held for longer, and maybe that sort of provision could prevail in this area we are discussing. We have an oversighting tribunal, the Mental Health Review Tribunal, which reviews these situations overall, which has got, again, a degree of representation. I cannot remember the format or the makeup of it, but I think the Mental Health Review Tribunal has enormous potential and has done some very good work, although, again, I was disappointed with Matthew's progression. He was a young

man I would have have liked to have dealt with who was in prison with a mental illness. In other words, there are some gaps in the process. So I could see it as rather similar to that which applies to the Mental Health Act.

The Hon. CATHERINE CUSACK: The concept of compulsory detention under the Intoxicated Persons Act, you would support that?

Prof. WEBSTER: Absolutely.

The Hon. CATHERINE CUSACK: Do you believe there is any role for institutional care in relation to inebriated people?

Prof. WEBSTER: No.

The Hon. CATHERINE CUSACK: The other question which I am having a lot of trouble with I have discussed with Brian Tierney who chairs the Mental Health Review Tribunal. The discussion was along the lines that people who have got mental illness, people who are targeted as being inebriates, many are drug addicted, many are people with a multiplicity of problems, and how futile it is going to be setting up a structure for this problem, a structure for that problem, and actually, with exceptions, we are talking about the same people and the first problem they had has become quite irrelevant to finding the solution to the whole issue and creating obstructions is creating a revolving door for people who are not able to get their act together anyway to shop around. If you want to set up a separate structure, is it not possible that we can look at these people as people with a lot of problems rather than one problem?

Prof. WEBSTER: I agree with that. As I mentioned, I was the chair of the Suicide Prevention Council, and if you look at the risks of suicide in young people and look at the risk factors and protective factors, they are exactly the same as the risk factors for substance abuse and indeed in the development of mental illness. If you look at the people on methadone programs and look at the level of mental disorder amongst them, it is very high. In the prison population there are massive rates of co-morbidity there.

Tomorrow I am launching a major program - I chair a foundation with around $2 million - around the issue of co-morbidity to general practice, for the Australian Division of General Practice, and essentially the whole discussion for those two days is going to be about the intersecting problems, which in a sense are problems which we have created with the institutions we have created. Some of the reason that we have got separation is because the mental health system became too coercive and peoples' lives were so quickly taken away, that the advocates of rights and the legal systems and the public generally said: We want to constrain this so that whenever decisions are taken about people it is only taken about a very small group of people; we want to exclude people with alcohol problems because there is nothing that we offer to them in this environment that they are going to do; and in a way we now need to say we really need systems which manage complexity better.

In the 19th Century there were these parishes in England, the poor people - and I am certainly not wanting to return at all to any of this stuff - but people could present to the parish who were homeless, who were poor, who were mentally ill and broadly these places were called reception centres. In a way the parish saw itself as having some responsibility to try and develop a response. Out of that grew poor houses, unfortunately, but also asylums, and in England there were huge institutions for homeless people. If you read George Orwell's book *Down and Out in Paris and London*, you will see that he studied at the Camden or Camberwell reception centre, which was a massive place for hundreds of people. That was a relic of reception centres that arose out of a charity and parish idea. So they were at least then recognising there were some people who had lots of difficulties in surviving and they were trying to develop some sort of response, and at least develop a response to homeless people, which we have not developed in Australia. We have rejected in Australia a church charity based response, which has changed in the last 20 or 30 years.

I do not know what the solution in the end is but a lot of the problem we are talking about, the drugs problem in general, is complexity - how we deal with the origins of these complex things. Our Government is responding across the board because different departments are set up to respond in different ways. But it is at this difficult end, the massive problems that people have who are old and disabled are very often not dissimilar to the person who is a long-term alcohol dependent on the street, except he is much younger, he or she is 40, whereas the other person is about 70, and often the person has severe mental illness has become socially marginalised. All these problems lead to what is called social drift. People move down the scale. They do not end up in the suburb I live in, but they end up in the disintegrated parts of the city, and we need systems which in fact think about it differently, which think about place, think about engaging with a wider range of needs to address, not trying to divide the problem up into little parcels.

In fact, the way we have built our health system and other systems we actually make the problems worse. I use the words "compounding need". As soon as a person has got one other problem, you double the likelihood that they will not get fit or healthy. They have got a fist full of problems, most of these people. The likelihood that they will not get any help at all is very high indeed. I used the case of a hernia in a mentally ill person. There are two problems to handle and people do not know how to put it together.

When I was responding to Mr West, I started talking about general practice and primary care. In the health system we actually need much better response at that level than we do in the specialist response. We have got a very good specialist system, it is doing pretty well, but what we are not doing is at that generic, all person bit, managing things at all well.

The Hon. IAN WEST: Of course, the dilemma is that resources are to attracted to bricks and mortar.

Prof. WEBSTER: Of course.

The Hon. IAN WEST: And when we talk about devolving out of institutions into homes, we have this great dilemma where resources become dissipated and you cannot keep a handle on it and politically then obviously, as you were then saying, the resources tend not to be properly allocated and that is the dilemma we have to come to grips with politically. I understand what you are saying, the other side of the picture.

Prof. WEBSTER: Yes.

ACTING CHAIR: The Committee would like to know what your views are on the effectiveness of compulsive treatment for offenders, specifically what your views are on the Drug Court and the proposed drug gaol.

Prof. WEBSTER: The Drug Court idea, like many people I was apprehensive about it, but having experienced seeing people in it and how they had responded to it and the opportunities that were given to them in the associated programs with it and the way it has been run, I feel quite positively about it, and I was rather surprised at the results, although they were positive, in the analysis, they were not more positive than they had been. So in terms of research and analysing the outcomes of Drug Courts, I think that is still an open question. My personal experience of them in southwest Sydney, where I have worked both with the individuals in it, but also with the staff who are running it, and the effort they put into organising housing, organising attendance at TAFE, it is positive. So I would finish at that point.

In relation to the treatment of prisoners, recidivist drug offenders, again I had reservations, and I pointed earlier to Wayne Hall's research about what has happened in the United States where these

programs when run inside the prison institutions had been ineffective, but where they are staged programs, as is proposed in New South Wales, with a period of incarceration, a period of transition between incarceration and the community over a period in the community where they would be followed up, I think is a reasonable proposal. It is proposed that it be put forward to the Parliament as a trial, and I think that is reasonable, because it means that people with scientific interest but also parliamentarians and the public generally can make a judgment about it.

I am actually on the committee for it and, of course, have raised lots of questions about the access of families. If it is to be a totally contained place, is that not counter to some of the things we are trying to achieve of contact with families and the like. I hope that some of those things are being addressed, but just like the discussion here about lots of issues, I have certainly raised a lot of those issues and I have criticised the documents that I have seen, and so far what is likely to come forward to the Parliament is I think a pretty good attempt to develop a program as a trial. One of the concerns is that the numbers involved may not be sufficient to tell us the answer to the particular problems.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that a cost constraint? This is not your question, is it?

Prof. WEBSTER: No, I thought it was a given by some political promise, that someone said we were going to have a - I don't know why the number has been chosen.

The Hon. CATHERINE CUSACK: If you are trying to decide where to draw the line or how the line should be drawn in relation to people's rights, do you think the research is strong enough for us to make those decisions?

Prof. WEBSTER: I think the protection - well, I think you should be very conservative, because I think we often get it wrong. The history of the Inebriates Act in England, in places it was used unreasonably against women in the early days, there is evidence it was used unreasonably against Aboriginal people, so there are lots of social perceptions and judgments which are made in this, and I think the protection to have is to try as best we can in the community, in a democracy, to have sufficient people oversighting what happens and enough perspectives bringing to bear on it, that means transparency that we can make judgments and criticisms about it. In the end, I think we have got to put trust in the group of people who would assess and talk with and understand the predicament of the person. After all, as I mentioned before, we allow citizens to make judgments about other complex cases.

ACTING CHAIR: Just in closing, what do you hope will come out of this inquiry?

Prof. WEBSTER: Essentially what I have said in responding to Catherine, a humane response which has the interests of the broad welfare of the person - I am using the word "welfare" very broadly - and in which the judgment is made from a range of perspectives, in which a genuine attempt is made to reconcile the problem of the person with the perspectives that some others we put trust in bring to bear on the problem, and if decisions are to be made along those lines, that we do have the capacity to respond. As I said before, I do not think we should do anything unless we felt some way forward of finding a place, places for people to be, therefore bringing these people into place in Australia.

ACTING CHAIR: Is there anything you would like to add at all?

Prof. WEBSTER: No. I apologise for the fact that it is difficult to find measurements, but this is an intersecting area of what a person is, with a whole set of other areas which we can measure about medicine and mental capacity, but even the idea of dependence is not an absolute. There are degrees of dependence. Some people can be heavily dependent and some people not. You also make judgments about that. In the end you have got to trust a process and have appropriate accountability for that process, that people try and make the best judgment they can in the interests of that person and the people around

him.

(The witness withdrew)

(Short adjournment)

JOHN ROBERT SCANTLETON, Area Manager, Northern Rivers Area Health Service, Magistrates Early Referral Into Treatment Program, Level 2, 29 Molesworth Street, Lismore, NSW, affirmed and examined;

ACTING CHAIR: In what official capacity are you appearing before the Committee, as a private individual or a representative of an organisation or business?

Mr SCANTLETON: As a representative of the Northern Rivers Area Health Service and in particular the MERIT program.

ACTING CHAIR: I know you have a Power Point program. Do you wish to make a brief opening statement?

Mr SCANTLETON: No, I think it is all contained in the Power Point presentation and subsequent questions.

ACTING CHAIR: At the end of formal questions it is customary for me to let you know if there is anything in camera that you would like to present. I am letting you know that now. If at any stage during your evidence you think there are certain documents that you wish to present that you think should be heard in private you may do so. Of course, the Committee or the Legislative Council may subsequently publish the evidence if they decide it is in the public interest to do so.

Mr SCANTLETON: The MERIT program emanated from the 1999 New South Wales Drug Summit. I believe some of this is probably history to the Committee, having read some papers on it, but I will quickly run through the background of MERIT. It is funded through the National Illicit Drug Strategy. It generally falls under the umbrella of the Drug Court which can be pre-plea, post plea or pre-sentence. It was trialled in the northern rivers and now is rolled out State-wide. In November 2001 we were fortunate in being awarded the Premier's public sector award in the service delivery section.

The successful MERIT program is very much dependent on a partnership approach between health, courts and police and in regional centres also with the community as well. There was a very significant emphasis on community protection issues and all the employees are Health employed as opposed to some of the other Drug Court type programs. They are required to be fairly multi-skilled because they have a variety of functions to do in the health arena and legal arena.

The intervention approach: Health traditionally is a harm minimisation approach and MERIT was based on a harm minimisation in a health based program. More and more as the program goes on - it has been running for three and a half years in the northern rivers area - both clients and the case workers who supervise them are moving towards an abstinence approach, and whilst it is not something we have been recording details of right from the inception of the program, currently about 32 per cent of the clients who are completing the program are attaining abstinence from all illicit drugs, which is quite significant given the background of these people, which I will explain more of later in the presentation.

The Hon. CATHERINE CUSACK: That 155 is the completed clients, is it, or the 32 per cent?

Mr SCANTLETON: 32 per cent of 155, not that there is only 155 who have completed the program. It is information we were not recording in the initial stages of the program in terms of we were not doing it well enough to record results of urine analysis at the completion of the program. At a certain point we started to look more seriously at the level of abstinence which was being achieved by clients.

The coercion factor is something which obviously has been talked about a lot before this Committee, and it is something which comes into play very much with the MERIT program. Whilst MERIT is very much a voluntary program the law enforcement aspect of the program does encourage people to enter treatment who might not otherwise have contemplated doing so. The threat of breach action, and particularly the involvement of the criminal justice system, can be very useful in helping people to keep them in treatment when they might otherwise want to drop out. It is an interesting concept of coercion when it is a voluntary program. It certainly does not present any problems for me from an ethical point of view but it is something which has enabled us to have far more significant outcomes.

Client assessments: We undertake very significant client assessments with the people who come into the program. There is very detailed psychosocial information, their criminogenic backgrounds, all sorts of information about family issues and whatever. In addition to that, as the program has been rolled out State-wide, there has been a development of various tools to measure where these people are at at the time of coming into the program and where they are at when leaving the program. The short form 36, the Kessler 10 looks at mental health issues and the severity of dependence scale which is self-explanatory. All of those tools State-wide now are administered both at the beginning and at the end and we are now just starting to pull the figures out and looking at the comparison and at this stage, it is early days, but it is looking very favourable. In addition to that, from the beginning of it we have also undertaken with all clients a "Readiness to Change" questionnaire which looks at people's motivation at the time of coming into the program. A lot of people who come into MERIT are in the pre-contemplation stages and not a lot in reaction stage and those in the pre-contemplation stage, there is a lot of work that case managers need to do to get them on track with their issues.

An audit or drink check is another thing we do administer with everyone. This obviously has relevance to this Committee. It looks at the alcohol use. Of the 570 accepted clients in the northern rivers program since the program's inception, 27 per cent of those have had alcohol as a secondary drug. Of those not accepted, 167, or 20 per cent had alcohol as a primary drug and 42 per cent had alcohol as a secondary drug. There is obviously a lot of issues to look at why they were not accepted into the program. Alcohol has presented as a fairly significant issue with a lot of these people, particularly with Aboriginal people, for example.

Case managers and the clients who enter the program are expected to adhere to minimum standards of program behaviour to continue their involvement in the program. It is a very intensive program. There is very regular contact with the case workers, particularly in the initial stages. There is a structured and timeframed treatment program. This is one of the key elements to the program's success. Drug addicted people are not used to having long term involvement with drug and alcohol workers. They tend to access them in a crisis situation and when things are going okay they will not bother with that part of their life and they will come back when life is in crisis. In MERIT it is right from the word go they sign an undertaking which details what their obligations are in terms of involvement in the program, urine analysis, all sorts of issues. By and large they stick with it and stick with it very well.

Supervised urine analysis is another key element to the program where we can keep them honest. We can check up what they are doing with their drug use. It is not used for legal purposes, it is only there for therapeutic purposes, so we are not providing reports to the court to say Joe Bloggs does have dirty urine at this point in time. What we will do in court reports is report where someone is able to demonstrate abstinence. As previously indicated, standardised instruments are used to identify social issues, family problems, whatever. Home visits are undertaken fairly regularly. Clients are unaware of these client visits unless there are safety issues that case managers need to be aware of. We have a lot of contact with significant others.

ACTING CHAIR: Can I ask for clarification on home visits? When you said they are not aware of home visits, you mean you will turn up unannounced?

Mr SCANTLETON: Yes.

ACTING CHAIR: You are there without them knowing?

Mr SCANTLETON: When they come into the program it is expected that they are going to be checked out at home and they are not going to know about it until it happens generally. There is a lot of emphasis on people changing a lot of their lifestyle issues, including accommodation, who they are living with and who they are associating with and this is one way of verifying those activities.

The typical MERIT participant: They generally come from a highly criminogenic background; 65 per cent have previously been in gaol, 93 per cent have had prior convictions. MERIT was initially proposed to look at people who were in the early stages of their drug using career, and whilst we have taken a lot of those people on board it has also taken a lot of people with significant criminogenic backgrounds who are in the early stages of their particular process through the court with particular crimes. So it has taken both groups of people.

Interestingly enough we probably have more success with the longer term criminal who has been in and out of the court system and gaol system. Many of these people are well known to the police and some of them are strategic police targets. The police may be giving them a hard time during their involvement with the program. They are likely to be committing further offences. The police are not necessarily keen to have them on the program and on the streets and this is one area of conflict we might have with the police. The majority of the program, 54 per cent, have presented with heroin as their primary drug. Certainly, in our area there has been an increase in use of amphetamines as the primary drug, which has resulted in different types of behaviours that the case managers have to deal with. I guess with an increasing number of amphetamine users we have an increasing number of people with apprehended violence orders; that is 13 per cent throughout the program. Eight per cent have breached an apprehended domestic violence order. That is an issue we have to deal with and I suspect dealing with alcohol issues predominantly that would be a far more significant percentage.

Many of these people, if MERIT was not around, would probably get by but there would not be anything other than perhaps police reporting conditions, or something like that, which is unlikely to help them interfere with their problematic lifestyle. MERIT picks them up at this point in time and ideally we would like to get them all referred to the program at the point of arrest which is a month prior to their court appearance, and when that happens we are able to have a far more significant impact on their behaviour during that bail period.

The Hon. CATHERINE CUSACK: Before you move on from the profile, can you give us something about the age, gender and racial background?

Mr SCANTLETON: It is not included but I can provide that for you. Do you want me to move on to that now?

The Hon. CATHERINE CUSACK: As part of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At the end is fine. Are you happy with that?

The Hon. CATHERINE CUSACK: I see it as part of the profile.

ACTING CHAIR: Perhaps if you do that at the end?

Mr SCANTLETON: I will quickly run through it. From a community accountability point of view, with the criminal justice system we have a process where people who are committing or believed to be committing further offences and are not complying with the program can be breached from the program and brought before the court. For those not referred through the Police Service those reports are referred directly to the court.

Looking at program outcomes: In April 2002 we undertook to prepare a conference paper for the Australasian Drug Strategy Conference and the police helped us with that and participated in that paper and undertook to do COPS checks on 96 graduates. The average time between the COPS check and the program entry was 13 months. Considering it is a 12 week program that is a fairly good timeframe for the type of people we are talking about. Of those people 60 per cent had no legal action against them during the time of that 13 months and 40.6 per cent had not come under any police notice whatsoever including intelligence reports. So, if they were seen by police or not seen by police to be down town with someone else who is a known drug user, criminal, whatever, is the type of information which is generally included in intelligence reports. At that point in time we were very happy with those outcomes.

Perhaps before I get onto the formal evaluation would you like me to go through some of the specifics about the genders?

The Hon. CATHERINE CUSACK: If you could quickly.

Mr SCANTLETON: The gender break-up is 25 per cent female and 75 per cent male. That is consistent. Average age of the participant is 29. We are only, by and large, dealing with adults. There has been some flexibility there but strictly speaking we are only dealing with adults, and Aboriginal participation has been about 17 per cent throughout the program.

The Lismore MERIT program was formally evaluated. I am informed that that report was tabled in Parliament yesterday and should be available for the Committee to access and so I think I am free to talk about the contents of it. In summary, it indicated there were significant improvements in drug use, health and social functioning. Where heroin was a drug of choice there was a significant reduction in the heroin use. The participants reported substantial improvements in life skills, family relationships and self-esteem. Re-offending was reduced amongst completers and the evaluation covered five main areas which I will quickly run through: Recidivism, non-completers were twice as likely to re-offend than completers. One of the things we have done is also looked at people who have completed the program and not completed the program and a lot of those non-completers have gone on and undertaken treatment under their own steam. MERIT has started something happening with them and they have followed through with it without the benefit of MERIT. The evaluation concluded that the program does reduce recidivism following the program completion and that is supported by the COPS check.

The Hon. IAN WEST: In the evaluation is there any input from the participants, any documentation from the actual people themselves?

Mr SCANTLETON: The report itself is about 150 pages in length and there are a lot of comments from program participants, stakeholders, legal practitioners, police and the like.

The Hon. IAN WEST: I am thinking of the participants themselves, what they feel.

Mr SCANTLETON: There is quite a lot of reported information from the participants.

The Hon. IAN WEST: Is there comment from them?

Mr SCANTLETON: Yes.

ACTING CHAIR: We are going to get a copy of that report now that it has been tabled in Parliament for Committee members today so we can refer to that.

Mr SCANTLETON: I do have a copy in my briefcase if the Committee would like it. I think I am at liberty to release it.

ACTING CHAIR: That would be excellent.

Mr SCANTLETON: From a health and social functioning point of view there were significant declines in reported drug use. Respondents reported spending less time with other illicit drug users, that is a key lifestyle change for a lot of these people. There are significant improvements in health and social functioning, notable with psychological and physical health and that is to be expected. One of the things we did do in the program, males particularly took it up, is we assisted them to go to gym programs as part of a lifestyle change, a lot of people took that up.

From a participant's perspective the program will only work for those willing to make the effort. I think that speaks for itself. The very interesting one from the participants is they saw a need for increased rigour of urine analysis testing. Urine analysis testing is not the most desirable thing anyone has to do; most felt very uncomfortable about it. When I followed up with people months later they said, "One of the best things about the program is it kept me honest and there was no nonsense about what I could tell you. You knew what I was up to, you knew who I was associating with and you knew where I was living and at the end of the day you knew what I was putting into my body".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you get good voluntary compliance with that? I have found supervising that with paroled people was the closest I have felt to getting a bunch of fives as a doctor.

Mr SCANTLETON: It is a requirement of the program. There is a minimum standard that they must do a urine analysis in the first two weeks and last two weeks. The majority of them do a lot in between that. Unless there is a good reason everyone would do urines in between that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who does that?

Mr SCANTLETON: That is a private pathology company and we get a written report and it is to a legal standard. Those people who will not comply with it, one way or the other, they will be removed from the program. It is seen as a mandatory part of the program.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that the only monitoring that goes on?

Mr SCANTLETON: Other than home visits and contact with family, significant others, that is the only independent monitoring that we can undertake.

ACTING CHAIR: Could you just clarify something on the urine test measurements? You mentioned before that the results of that would not be used in court if they were positive, yet with negative results it could be good for the clients to present them in court. Would the court then assume that if there were no test results available, that was because they were not up to standard?

Mr SCANTLETON: When writing a final report on one of these people there are generally lots of other issues which will support where that person is at in terms of lifestyle issues and whatever, and

with people who were not able to achieve abstinence from drugs, generally speaking in the report there would be clear indications of other problematic issues, but generally speaking you are right. Where the report indicated nothing about urine analysis, certainly it would state in the report that the person complied with the urine analysis requirement, but if the urine analysis was positive there would be nothing in the treatment section of the report to indicate that they were positive.

ACTING CHAIR: So one failed test then would knock them out of presenting a view to the court that they had succeeded in--

Mr SCANTLETON: No, the majority of them would be positive urines at the beginning of the program. We would expect that. If they can work towards a series of clean urines at the end of the program, then that would demonstrate abstinence and we would include that in the report.

ACTING CHAIR: At what period do you then take those results into account?

Mr SCANTLETON: A lot depends on the drug use. For example, cannabis might stay in the system for a month. So someone who can come up clean to cannabis by the end of the program is going to be doing fairly well. Some of the cannabis users are very significant cannabis users and getting clean urine might be longer than a month. It depends on their body makeup. Heroin, amphetamines and some of the other drugs only stay in the system for a shorter period of time, so with those people we would be expecting a series of urines to be able to be clean before we would be able to say in the report the person had demonstrated abstinence.

The participants are quite critical of the program in that when it ends it ends and they effectively have no more program support. Quite clearly there is a need for post-program, after care type support program. When we do a final report, on just about everyone we will include a relapse prevention plan which refers them to community based services. Some people will take that up on a voluntary basis, some people will not. In some cases where there is a high risk of a person re-offending we might write in the report that at some future time this person might benefit from more formal support with a counseling role, and if the person is convicted the court might put them on a supervised bond as a result of those comments, but generally speaking it is quite well acknowledged in a lot of information that an after care program would be desirable.

Respondents reported an extremely high satisfaction rate with case managers and saw their role as vital to the participants. From the stakeholders' point of view, the earliest possible time people are referred into the program the better. The police expressed great satisfaction with partnership co-operation. Other treating agencies were less satisfied with the level of co-operation from the MERIT team.

The program needs to be more closely aligned to Aboriginal agencies and communities. In the Northern Rivers area we have got five designated Aboriginal communities. Some of those are fairly remote and allowing these people to access the program is problematic. 17 per cent of indigenous people come into the program. It is still quite remarkable but there is a lot more work to be done in that area. All services except alcohol and drug services reported a reduction in workload associated with MERIT. The need for more formal inter-agency arrangements with police and some of the other departments was seen as a desirable need.

From an economic point of view, the report indicated a saving range between $2.41 to $5.54 for every dollar spent or $16,600 per completer. This estimate is considered conservative given the short time of the evaluation and that it is limited to completers, and there is no assessment of likely accumulation of savings with recidivism, victims of crime and the like. So potentially it is quite a significant saving.

From a legal perspective, legislation to underpin MERIT is not required. MERIT works under

the bail system. The amendment to the bail act, section 36 which allowed treatment to be undertaken for 12 months, is seen to be quite adequate. There is some talk about providing legislation but I really do not think it is necessary. MERIT fits in very well with the shift from the adversarial criminal justice system to therapeutic jurisprudence, allowing the court to address the causes of crime. That will come up in my questions later on.

The partnership between the legal and health professionals was seen to be an extremely positive aspect of MERIT and some changes to eligibility criteria if possible. A lot of people would like to see MERIT for juveniles. The eligibility criteria limits MERIT to those people without serious violent offences, sex offences, obviously they have to be adult. So a lot of those issues are about the indictable offences. It is limited currently to non-indictable matters and a lot of people who certainly fit the criteria for needing treatment end up in the District Court and therefore they are not able to come onto the program.

Critical success factors, and this is the final slide of the presentation: Program intensity, structure and flexibility was identified by clients as a key factor to its successful completion. As I indicated before, the intensive structure and quite often the intrusive nature of the program is pretty hard on clients, but at the end of the day they respond very well to it. The more structure there is, the better they respond to it. Positive level of relationship between the senior staff and the critical players; professionalism of the MERIT staff reported by both agencies and clients; and adequate resourcing. Whichever program you are in you always have that complained about.

That is the completion of the Power Point presentation.

ACTING CHAIR: Before we move on to some questions, and I know a number of us have questions arising from that presentation, would you please formally table that report?

Mr SCANTLETON: Yes.

ACTING CHAIR: We have, as you know, some questions we would like to ask you but perhaps if the members of the Committee have questions arising from the Power Point presentation you would like to ask those now.

The Hon. KAYEE GRIFFIN: In relation to the client assessment, you talk about there having been 576 accepted clients who had alcohol as a secondary dependence, and there were 167 not accepted. Could you elaborate on the reasons for the non-acceptance?

Mr SCANTLETON: The eligibility criteria is limited to adults with a demonstrable drug problem that do not have outstanding serious violence, sex offences or indictable matters. They are fairly clear guidelines. Those guidelines have been relaxed to some degree to allow some people with particular needs to enter the program. There are some cases where the court makes specific directions about the eligibility criteria, this person really fits or needs the likes of the MERIT program, and obviously we would follow suit with that recommendation.

Certainly, alcohol is a primary drug. It was an exclusion criteria, and that is a particular issue which probably prevented a lot of Aboriginal people coming in, although particularly with Koori people we were very flexible as far as that criteria went. Significant violence is another issue and sex offences also. Violent offenders do present with fairly unique problems and to run them in a program which has a lot of group structure and a lot of involvement with other clients, with some of those people it presented problems. We would not exclude people who generally speaking had prior convictions for violence. So there were people who came into the program who might have had previous convictions for armed robbery, could have gone to gaol and been heroin users most of their life. The potential is there for very significant violence but their current matters were quite minor, so they were considered to be eligible.

Probably the biggest one is motivation. If someone is not motivated to deal with their problem, if the only reason they want to come on the program is to get a good court outcome, then I am sorry, you are not suitable for the program. You need to acknowledge the fact that you have got a drug problem; you need to want to do something about it. Having said that, a lot of people came into the program as pre-contemplators, after fairly detailed assessments. Perhaps we might adjourn the assessment for a week or so and allow the people to demonstrate their ability to show a level of motivation and insight into their drug problem. If they could not do that in a timeframe of two weeks, we would probably suggest to the court they are not suitable for the program.

The Hon. KAYEE GRIFFIN: The other issue you were talking about was that the program is limited to adults. What happens with younger people in relation to other avenues available to them that are around at the moment? Is there a proposal to perhaps move young people to a similar system?

Mr SCANTLETON: Juveniles present with a fairly unique problem. There were a couple of occasions when we have broken the rules and let juveniles in. One particular case was a young fellow who was 17 years of age when he committed the offence. It was an assault and robbery, so it was a very serious offence. He had no prior convictions and he had been caught up with a very significant amphetamine addiction. The magistrate agreed to adjourn the matter for a period of MERIT before committing it up to the District Court. That was a very simple solution. This young fellow went through the program quite well and the reports that went to the District Court certainly helped him out because they were able to report on the outcomes he achieved during that time.

With juveniles probably one of the most challenging things is their level of maturity. If you were to run a MERIT style program for juveniles I think it would be very challenging for young people who have not got to the point where they realise they have got a drug problem. They are still in party mode; they have not reached that stage where they say, "Hell, my life has fallen apart". Until people get to that stage you are not going to get that level of insight and consequently you are not going to get the level of motivation to want to do something about it. I think it will eventually come, but when it comes I think it will be very challenging for the people who do it. A lot of the juveniles I have dealt with over the years are pretty fearless and rarely have insight into what some of their issues are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage of people who go to court go to MERIT and what percentage are taken out of the system?

Mr SCANTLETON: It seems like a very small percentage, five per cent. It is something I have never looked at actually.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps the Bureau of Crime Statistics might know that, would they?

Mr SCANTLETON: Yes, possibly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage complete?

Mr SCANTLETON: Perhaps what I can also table is a report in relation to the monthly statistics of our MERIT program, and this shows - these were as at 31 January - number referred into the program was 788, ineligible 220. This is the program from 3 July 2000 when we started. Accepted 566; number of ineligible, unsuitable, declined to appear was 220.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is entries. What about completed?

Mr SCANTLETON: The number who completed the program was 266 and at the time this

report was done. There were 40 remaining in the program.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is about half of those who start?

Mr SCANTLETON: A little bit over fifty per cent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So your statistic of money saved was of those who complete?

Mr SCANTLETON: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If only half of them complete, you would have dead money or what might be dead money, so you would actually put the statistics down badly in terms of the overall success?

Mr SCANTLETON: If you looked at all the people who came to the program?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. You said that your saving was between $2.50 and $5 per completer for every dollar spent, but if a large percentage do not complete, then that money is dead money in the sense you have not got a lot from it. You might get a better result if you had not tried I suppose, but if that were to be independently evaluated that would be the case, would it not?

Mr SCANTLETON: Yes, you probably need to read the report in that area to look at it. It is a fairly complex issue and certainly what they were wanting to do in the evaluation was to set up a control group, which was something that was not possible for a number of reasons. That would have given probably a better indication as to exactly what the dollar savings were. Of those who did not complete, they go back to the court system and are dealt with as if MERIT never existed. Whether their drug issues and the outcomes of the drug issues are going to be any different as to when they did have a briefing eventually with the MERIT program is something which would be the subject of another evaluation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that some of the other agencies were unhappy. You said the police and the courts were happy but some of the other agencies were not happy. Is that because you are seen as creaming the resources that they otherwise might have or is it because of liaison difficulties?

Mr SCANTLETON: No, I do not think it is creaming resources. I think traditional health based drug and alcohol programs, with Health whatever, tend not to be as well resourced as we are and tend not to be able to provide the level of intensity with the program that we are able to do. We keep our case loads down and we expect our clients and case managers to do all the work with each other. So it is a very intensive program. Because of that intensity I suppose, we are not referring people until they complete the program through to other agencies, and certainly from a management point of view it is something I need to look at in terms of why these people were less satisfied with the case management.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What you are saying is you are much better resourced than they are and they might be a little jealous, might they not?

Mr SCANTLETON: No, I do not think they are jealous. Maybe the resources issue is not the one to talk about. But the expectation is that we do very intensive and structured work with our clients, whereas most of the drug and alcohol community based programs are very much on a voluntary basis, the client comes in very much on a voluntary basis, there is not a lot of structure necessarily in it. If a client does not want to turn up for counselling, then there might be a phone call, but there is no real compulsion to insist that the person does come in.

ACTING CHAIR: You mentioned post-program, after care support and that was identified as a need. What form of after care support program would you like to see in an ideal world?

Mr SCANTLETON: One of the MERIT sites, the second year it commenced, down in the Illawarra, did actually start an after care program, and what that comprised of I am not sure, but certainly that reached the people. A lot of people found that to be very rewarding, to be able to talk through their issues, to look at how to change lifestyle issues, how to deal with management, how to deal with a lot of associated issues with drug using behaviour, just receiving directions from people in terms of family relationships and how to deal with those sort of issues, where to be referred to in terms of other problems which might develop, because some of these people do not look for answers. Most of these people focus very much on the negative in their life. They get beaten around by the system from time to time. They do not look at positives, they do not look at what is good in them, and that is where MERIT really does focus on what is good about them, and consequently during case management, counselling, whatever, we focus on solving the problems and dealing with their positive aspects. It is something that they respond to quite well. Again, an after care program, to do it properly would probably require significant funding, and funding is always an ongoing issue. Just to keep our current program running as it is, there are going to be funding issues in the future.

The Hon. IAN WEST: The participants seem to be saying that the motivation comes from those very nebulous words, words that mean a lot of different things to different people, "structured", "flexible", "relationship with the case worker", "intensive". We need to get some definition as to what those words mean. Are the definitions of those words in the document that you have submitted here?

Mr SCANTLETON: It is certainly in the evaluation report.

ACTING CHAIR: Could I ask perhaps that you formally table that as well? That might help. Is that possible?

Mr SCANTLETON: Yes.

The Hon. IAN WEST: And then maybe you could give us some very brief thoughts as to what those words mean.

Mr SCANTLETON: In terms of?

The Hon. **IAN WEST**: What does "structure" mean, what does "flexible" mean, what does "the relationship with case worker" mean?

Mr SCANTLETON: I guess it comes down to these type of people need to be told what to do to change their lives. They need a lot of clear direction in terms of if you want to go down this track this is what you have to do and I am going to stand there next to you and make sure you do it. It is challenging I think from a legal perspective when you are talking about coercion in a voluntary program, and a lot of participants have had some difficulty with that concept. It is something which I will talk about later on in terms of future proposals for alcohol treatment. I think coercing certainly has a place. Certainly these people need insight and they need to acknowledge that they have an issue, but in order to achieve those outcomes they need a lot of assistance to identify where they are going to go and how they are going to achieve those outcomes I suppose.

The Hon. IAN WEST: Is it possible to present us with a case study, a success story? Can you take that on notice?

Mr SCANTLETON: Certainly I can.

ACTING CHAIR: Does that form part of the evaluation?

Mr SCANTLETON: The two people I am talking about who are in the evaluation are obviously disidentified.

ACTING CHAIR: If they are in the evaluation, we can read that.

Mr SCANTLETON: Perhaps just very quickly, there is one chap who came into the program that explains a few issues. He came into the program on a malicious damage charge, which would only have resulted in him getting a fine anyway, so in terms of his desire to receive greater court outcomes he was only going to get a fine, so he was directed to take a three or four month fairly intensive program with a lot of restrictions and the like. The fact is that he was a daily heroin user and he was committing other offences to support his heroin addiction. He was supplying drugs every day. He ended up on the program for about five months, did a residential program eventually, and there were a lot of times when he was almost thrown out of the program in the beginning, but at the end of the day he found his way into the residential program, and he is one of two people I keep fairly regular contact with in terms of where they are going. They both remain on the North Coast and they have both done exceptionally well, and I guess they support each other too in the process.

The Hon. CATHERINE CUSACK: What is the total funding for the program?

Mr SCANTLETON: In the Northern Rivers it is $980,000.

The Hon. CATHERINE CUSACK: That is 980,000 per year?

Mr SCANTLETON: Per year.

The Hon. CATHERINE CUSACK: And what is the source of that funding?

Mr SCANTLETON: The source is the National Illicit Drug Strategy which comes through State Health. I probably need to qualify that, because within that budget we also employ a position which is a research and quality officer, which now has largely a State-wide role, and we also employ a data base manager, which, whilst separately funded, there is not adequate funding for his position, so that is also supplemented out of our core funding.

The Hon. CATHERINE CUSACK: Are those positions in Lismore?

Mr SCANTLETON: In Lismore, yes.

ACTING CHAIR: At a State level it is being driven out of MERIT in Lismore?

Mr SCANTLETON: Yes. It probably should not happen that way, but because we were the trial site, we have responsibility for the development of the data base, operation manual and a lot of other initiatives which have assisted the State-wide roll out. The program is led through the Attorney General's agency the Crime Prevention Division and also the Centre for Drug and Alcohol with the New South Wales Health Department.

The Hon. CATHERINE CUSACK: Basically that funding was made available free and clear of anything else the area health service has to do. The area health service did not need to contribute financially to MERIT in Lismore?

Mr SCANTLETON: Yes, they contribute. We do not contribute presently with

pharmacotherapy. If we send clients off for pharmacotherapy, we do not contribute to that. We no longer contribute to the detox beds. So anyone we put into detox through the Riverlands Detox, Drug and Alcohol Centre in Lismore, we do not formally contribute to that. The area health service is also making a contribution.

The Hon. CATHERINE CUSACK: They picked that up after the pilot period. Of the $980,000 how much of that is for the State-wide functions you perform? Can you split that up into how much is going into the direct operation of the program?

Mr SCANTLETON: I would say probably $180-190,000.

The Hon. CATHERINE CUSACK: Have you visited MERIT programs that have opened up in the other States?

Mr SCANTLETON: I visited some of them, not all of them. I have more so been involved in staff selection and those sort of things when the programs were initially being commenced. As far as operational programs, no, I have not had much of an opportunity.

The Hon. CATHERINE CUSACK: We had negative feedback about the MERIT program operating in the inner city of Sydney. I actually asked the police in Lismore about that because, as you say, feedback is very positive about MERIT. Their comment was it is MERIT in name in other parts of the State because they have not received the resourcing that Lismore has received because it was a pilot.

Mr SCANTLETON: This was covered in one of the questions later on but I think one of the most important aspects of a successful MERIT program was the employment of the right people. We were very particular about selecting staff from a wide range of areas. My background is in relation to Probation and Parole Service. We employed psychologists, nurses, people from drug and alcohol, there was a wide range and the skills they brought in complemented each other. Where as other MERIT sites have employed people primarily from the drug and alcohol or welfare background. From my observations those sites have far less emphasis on community protection, far less emphasis or far less dealings with the police and far less direct dealings with the courts. It is a fairly general statement but it is certainly something which is a fairly clear observation. When you are talking about a program which has accountabilities to the criminal justice system, if you are not playing ball with the police, if you are not appearing in court regularly, if you are not well known to the magistrate, the magistrate does not know what MERIT is about and what your case managers are doing, then perhaps that would contribute to that criticism.

The Hon. CATHERINE CUSACK: Just the move away from harm minimisation is a pretty significant invasion in your model, would you say, and that would be something that the welfare community would find hard.

Mr SCANTLETON: Although your drug and alcohol people would not have a problem with the abstinence approach, they would probably have problems with the coercion side of the program, and we are saying you do this or you are not going to stay in the program, these are the standards, you comply with them or you are going to have to be removed from the program.

ACTING CHAIR: Just in relation to proposals for having a program of MERIT for alcohol related offences, you have talked briefly about potential problems associated with that, have you got any expansion that you might want to make on the potential problems associated with that?

Mr SCANTLETON: Certainly it is going to be far more complex. One of the beauties of the current MERIT program is that we are specialising in illicit drug users, and that is behaviour that people are coming in with. With alcohol the biggest problem is: Why do I need to stop drinking? I really do

not drink excessively, except when I get caught; something happens, the police catch me, I belt my wife. With that comes quite aggressive behaviours, domestic violence, a lot of anger management type stuff and you would have to design programs around managing that sort of behaviour, whereas all of our case managers undertake all of the treatment including all the group type programs.

When we proposed a MERIT alcohol trial in the Northern Rivers we looked at the various infrastructure which were around and one of those was a program which specialises in dealing with males with anger management problems. I would be hoping that any alcohol based program is able to utilise resources like that which is very focused and specialised in that area. It would be very very challenging. I think that is probably one of the biggest issues. Again you are looking at a person's motivation to want to stop drinking. Do you look at a harm minimisation approach or an abstinence approach? With my experience in probation and parole, I would think in the majority of cases an abstinence approach would be far more effective: I only do it every Friday night and every second Friday night I end up on a charge. That rationale is used by repeat offenders.

ACTING CHAIR: You would be aware of the pilot in the central west for alcohol. Do you have any comments to make specifically on that?

Mr SCANTLETON: I think it is unfortunate circumstances. The Committee might be aware that the MERIT funding was held up late last year and early this year and as a consequence of that a lot of the experienced staff in the mid west have actually left the program. So their skills base is probably not desirable to run a challenging program like that. I visited the mid west area and, whilst they have an NGO out there that provides a detox facility and rehab, I think the area generally is a bit light on in terms of some of the other infrastructure to support the likes of an alcohol program like that. So I think one way or the other it is going to be quite challenging.

They have also been requested to start the program in two courts, Orange and Bathurst, and both of those are fairly busy courts and there will be a lot of people referred to the program. I think it is going to be very challenging. It will be challenging in any area but I think it will be more challenging in that area because of unfortunate circumstances and the lack of infrastructure.

ACTING CHAIR: Moving on to offenders, there have been initiatives for offenders with drug related problems, the Drug Court and the youth Drug Court, what initiatives do you see could be introduced for offenders in relation to alcohol?

Mr SCANTLETON: Is this the formal questions?

ACTING CHAIR: Well, it is loosely based around question five, I think. Have you got some prepared answers?

Mr SCANTLETON: Yes, I have some prepared answers.

ACTING CHAIR: If you would like to table those?

Mr SCANTLETON: Yes, I can do that, and perhaps the comment I can make is that I am aware that the Committee was interested in speaking with Jeff Linden, the senior magistrate of the Northern Rivers area, and I sent these answers to him and he has endorsed them, if that has any significance. I will table them.

The Hon. CATHERINE CUSACK: He is a contributor to the success of MERIT, as I understand it.

Mr SCANTLETON: Magistrate Linden, very much so. He was not someone convinced

about the program when it started. He was not supportive of it at all but he soon came around to what the potential of it was. He and I had known each other for some time through my involvement with probation and parole. Together we looked at various issues. The model, when I came in, really had not been developed. One of the proposals, for example, was to prepare a comprehensive report on the person when they first appeared in court. His view was, "Why do we do that? I don't want that information at the beginning. I want that at the end to see what they have done". That is what we have done. There are a lot of issues where Magistrate Linden has been very much a participant in the development of it.

ACTING CHAIR: Now that you have formally tabled those comments, have you got anything to add in terms of this inquiry? Is there something you would like to make further comment on and what do you think we should be trying to achieve out of this inquiry?

Mr SCANTLETON: Perhaps I will loosely expand on some of those questions. There were some issues that are not actually clearly included in those answers. I guess one of the significant ones, my background is 20 plus years with the Probation and Parole Service working primarily in community settings. I have been in the Lismore area for 15 years and I have dealt with a lot of the same sort of people where they have been mandated by the courts to undertake treatment by way of bonds or parole or whatever, "I am going to release you on a bond, these are the conditions. You must do it. If you do not do it X, Y, Z is going to happen." Invariably they do not do it. Drug offenders are notorious for denial of their problem. They do not do it unless there is good reason.

The people supervising them might send them off to a drug and alcohol counsellor and they see the counsellor and say, "I don't have a problem. I am here because the probation officer or court have told them to be here." The counsellor will give them some education, brief intervention, and tell them to come back when they do have a problem, which is inevitably when they are in crisis and it is too late. The people are unsupervised on probation and parole and subsequently they have come into this program, particularly with heroin addictions, and they have responded well to the structure. "If you do not want to be here, there is the door. See you later. There is no penalty. Your matters will go back to court. You are not going to be penalised for leaving the program." When people are not able to comply we give them that option and they turn and say, "I don't want to leave the program. I want to stay in and I will comply." Some of these people who may have 20 pages of police antecedents of invariably serious charges have responded exceptionally well and some three years later have not re-offended and have established very stable lifestyles. There are very significant outcomes when it comes from a pre-plea model. I think that is one of the most important elements of the program.

The other thing I will raise is something which I think I have covered to some degree in question seven and question five, and it perhaps follows on a bit from your discussion with Professor Webster. I can see, I guess in terms of structured treatment, whether it be for offenders or non-offenders, I think the results of the MERIT program have demonstrated that the court's involvement, or to a lesser degree tribunal involvement, can assist these people to be coerced into continuing with treatment. I think there is value in people who have these problems being answerable to some sort of a judicial body who is going to continue to give them encouragement to continue to do what they are doing. We have had people who have come off the street and said, "I want to get on the MERIT program. It has the intensity, it has everything I want." We say, "Have you got any criminal offences?" The answer is, "No, I have not got any criminal offences." And we say, "Sorry, you cannot come on to the program." It has almost come to the point that people want to commit a criminal offence to get onto the program.

Due to the structure of the program it is a program that has a good name on the street with the offenders. Whether that would be the same for alcohol users I am not sure, because, as previously indicated, the complexities of alcohol use are very significant, and particularly with the legalities of it. I think it is something worth looking at. I think some sort of judicial oversight is necessary to encourage

these people to stay in the program, something similar to the Mental Health Tribunal is worth looking at.

The Hon. CATHERINE CUSACK: Still on that therapeutic jurisprudence, can you recommend any reading for us on that issue that might be useful in relation to the success of rehabilitation programs in a custodial setting?

Mr SCANTLETON: Not offhand.

The Hon. CATHERINE CUSACK: As a question on notice, perhaps, is there research?

Mr SCANTLETON: There is not a lot of information that is available on therapeutic jurisprudence in a pre-plea type situation. It is talked about a lot with American Drug Courts, and the majority of those which have been reported on are generally post-plea or even post-sentence. People are put on bonds conditioned to go to a Drug Court. Unfortunately, there is not a lot in relation to a pre-plea and voluntary type situation. Probably the answer is no to that. There is quite a bit of information about therapeutic jurisprudence, generally speaking, particularly as far as Drug Courts go in America.

ACTING CHAIR: I need to formally get one of the Committee to accept all of your documents that you have tabled.

The Hon. KAYEE GRIFFIN: Yes.

(The witness withdrew)

(Luncheon adjournment)

DR DONALD JAMES WEATHERBURN, Criminologist, Director, Bureau of Crime Statistics and Research, Level 8, St James Centre, 111 Elizabeth Street, Sydney, affirmed and examined;

ACTING CHAIR: Do you wish to make a brief opening statement?

Dr WEATHERBURN: I understand the Committee would like me to give a presentation on the Drug Court evaluation.

ACTING CHAIR: Would you like to table that report as well?

Dr WEATHERBURN: Yes.

ACTING CHAIR: It is useful for us if it is tabled and we have something to go on and ask further questions.

Dr WEATHERBURN: Okay.

ACTING CHAIR: The other thing I should say is if there is anything that you would like to present later in camera, if that is appropriate, and if there is any evidence or documents you want to present in private, please let us know, but the Committee or the Legislative Council itself may subsequently publish the evidence if we decide it is in the public interest to do so.

Dr WEATHERBURN: I should say that although you have asked me to give an overview of the evaluation of the Drug Court, I do not want to spend too much time on the details because it occurs to me that the details are not wholly relevant to your inquiry. I am going to give you an overview at about 30,000 feet and if you are missing the fine detail I can fill in the blanks later. I think it is important to get to the questions you have asked me.

The essentials of the Drug Court program, as most of you I imagine know, is basically an arrangement whereby treatment is fully integrated with the criminal justice system. It is a team based approach to managing offenders dealt with under the system. Individuals who are placed on the Drug Court program are given individualised case management plans. There is a requirement for regular and frequent report backs to the court, to the Drug Court team. There are explicit rewards for progress and explicit sanctions for non-compliance with program conditions. There are three phases. Phase one is initiation and stabilisation which in theory is meant to last three to four months, but in practice often lasts longer, phase two is designated consolidation and early re-integration which is meant to last six to eight months and phase three is re-integration which is meant to take a minimum of 12 months, but in practice again often takes a lot longer.

Our evaluation had three components to it. The first part, and the main part, was to look at the cost effectiveness of the Drug Court in reducing recidivism compared with conventional sanctions, which for the most part means prison. We chose that as the centrepiece because the legislation itself makes it very clear that the primary object of the Drug Court program is to reduce drug related crime. We could have given emphasis to the health side of things had the legislation had a somewhat different focus. We did have a look at the effectiveness the Act in improving the health and social functioning of people placed on the Drug Court program. The third component was a process evaluation to try and identify problems in the administration of the Drug Court program. It is, of course, essential if you come up with unhappy findings or adverse findings to know whether it was implementation of the program or whether the program was properly implemented and having effects that were not expected. Let us go through each of these evaluations.

The cost effectiveness strategy: We persuaded the court to randomly allocate those deemed

eligible for the Drug Court program to treatment and control groups. We were able to do this in an ethical way because there is an over supply of eligible people for places, so whenever there are two or three places available and four or five people applying, the court would randomly allocate them. We would run a random number generator in our pocket calculators and tell the court which case file was the one to be allocated to the Drug Court program.

We then followed up both groups over more than a year to see which group offended more, taking into account any time spent in custody. We compared the effectiveness with the cost of the Drug Court and conventional sanctions. We had two measures of improvement in reducing crime. One was the length of time to first offence and the other one was offending frequency as measured by the number of offences for which a person is arrested and brought to court. "Time" in this case is time where you could offend, that is time not in gaol.

ACTING CHAIR: Could you just go back to that one point?

Dr WEATHERBURN: Time to the first offence excluded any time they spent locked up where they could not offend. The results at a glance, people who went to the Drug Court program generally took longer to their first offence, if they had a first offence, than people who received conventional sanctions. Treated subjects, that is to say people in the Drug Court program, generally appeared less often than did people given conventional sanctions. The Drug Court turned out to be slightly cheaper than conventional sanctions, although I should say right at this point it had the potential to be substantially cheaper than conventional sanctions. The reason for that I will explain later on.

Just to illustrate the differences, I will not give you too many of these graphs, but you can see here number of days from entry on to the Drug Court program and in each of these two groups you have the proportion in the control group who still have not committed an offence and the proportion in the treatment group. The salient point here is that at any given point in time there is a larger proportion of Drug Court participants who still have not offended than there is in the control group. Of course, as time passes both groups, fewer and fewer of them have managed to survive without an offence up to the follow-up period 500 days later, where you still have 40 per cent that did not re-offend. Again, the differences persist in favour of the Drug Court. This was for a drug offence. You saw much the same pattern for a range of other offences such as shop stealing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did it go down at the end?

Dr WEATHERBURN: Ran out of subjects. When you get to this point here there is no-one left, that is the end of our follow-up period and there are no further measurements. You are getting down to two and three people at this point. It is not as if, if you continued, that they would fall off. If you had sufficient subjects the dips would disappear and they would continue to go down nice and gracefully. It is not as if they all decided at the 515 day mark to re-offend.

Looking at the average number of drug offences per year, this is illustrative of the results. I have not bothered you with all the statistical details, but the basic point here is that Drug Court participants had an average offence rate per year which was considerably lower than non-Drug Court participants. Worth noting though that these rates are very low, less than an average of one offence per year. That is not the true rate of offending, that is the measured rate of offending in terms of court appearances.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the ones that are caught in other words?

Dr WEATHERBURN: We are working on the assumption that they are no more or less likely to be caught if they offend on the Drug Court program than if they go to the conventional sanctions. It

would be nice if we could have a precise measure of their true rate of offending, but of course it is pointless going to people on the program and asking them whether they have offended. In this instance we have to rely on the officially recorded rates of offending with all their faults.

The Hon. CATHERINE CUSACK: The control subjects would have been eligible but there was not space?

Dr WEATHERBURN: That is right, they are eligible. They are identical in all relevant respects to people going onto the program. They have gone through the entire selection process; they have been deemed to be people whose offending is drug related; they have been deemed to be eligible for the Drug Court program; they have shown a willingness to plead guilty to get on to the program; as much as we can make it so they are identical in all relevant respects to people on the Drug Court program; or, to put the matter as statisticians like to, there are no selection biases in the process.

ACTING CHAIR: Can I ask a question about that control group? If that control group are those that have been eligible for the program do you then keep them out of the program, so therefore their number does not come up in your random selection of people for that period because they are in the control group?

Dr WEATHERBURN: I am not sure I understand your question. If they were allocated to the control group and subsequently came before the courts again and got into the Drug Court program, is that what you mean?

ACTING CHAIR: You said you randomly select people when a place crops up, what I am asking is if they are in that recognised control group and their number comes up or does their number come up?

Dr WEATHERBURN: Once they have been allocated to the control group, once they have been sent back to an ordinary court to be sentenced in the usual way, they are no longer in our treatment group, even if they subsequently get allocated to the Drug Court program. You can have several bites of the cherry. They might subsequently, after re-offending again, have tried to get into the Drug Court and got in. We weeded them out. You cannot be in both places. In practice there are very few people who having been rejected initially for the Drug Court who got in subsequently. That may have changed since our evaluation.

The comparison I showed you was with people in the control group and people with the treatment group, even if they failed on the program. That treatment group includes people who stayed with the program for the entire year but also includes people who re-offended within a week and got thrown off the program. It is a conservative picture of the success of the strategy. In medical research you work on the principle of intention to treat. In testing a new drug you do not throw out the people who fail to take the drug. It is worth having a look at the differences between people who completed the program and the people who got thrown off the program. You can see the differences are quite substantial. Those differences remain in favour of the treatment group even after you control - you have to control now - the differences between the groups in age and gender and prior record and so on. Those who got through the program performed quite well compared to the control group and even better compared with those who got placed on the program and failed. That persists even after you control for differences in prior record and so on. Likewise, even better results if you count up the number of times they appear in court. The non-terminated group had an average of one court appearance per year after entry on to the program, the terminated group had an average of six and the control group had an average of four.

This horrifying table is the cost effectiveness result. I did not want to show you this but there is no way of avoiding it. What you need to know in evaluating cost effectiveness is the trade-off

between how well they do and how much it costs. How well they do has two measures, the numbers of days to the first offence and the mean number of drug related offences they commit per day of free time. That shockingly small number is because you are dividing one court appearance per year by 365 and getting a small number. To get the cost effectiveness we organise out the cost per day of being on the program and divide that into either of these outcome measures, likewise for the control group. It is costing $144 per day to be in the Drug Court, $152 per day to be in gaol and we are taking 537 days to get to the first offence on average in the treatment group.

The bottom line is that in terms of the first outcome, mean number of days to the first offence, the two options are level pegging in terms of cost effectiveness. It is about as cost effective, in terms of first time to first offence, to put someone in gaol as it is to leave them free and put them in the community. In terms of the rate of offending, it is more cost effective to have them on the Drug Court program.

The Hon. IAN WEST: It is clear but I do not understand the "Shoplifting" heading.

Dr WEATHERBURN: I chose a single offence. I am trying not to give you too much detail.

The Hon. IAN WEST: The detail we will worry about later. I find that a strange comparison.

Dr WEATHERBURN: Shoplifting was one of the offences for which there were quite notable differences in rates of appearance, so too for drug offences, but in order not to bog you down in detail I am just using some illustrations. The full report contains all of the offences, break and enter and so on. I am sorry if it looks odd, the choices.

The Hon. IAN WEST: I don't mean that in a criticising way.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a typical one and best one?

Dr WEATHERBURN: Shoplifting is actually a very common offence for them, remembering you cannot get onto the Drug Court program for a robbery. So more interesting offences like that were technically excluded from the Drug Court program. To evaluate the effect on health and social functioning we followed a large group of participants through the drug program. We interviewed them at base line and at four, eight and twelve months, and conducted standard tests at each interview of health and social functioning.

The results at a glance: The health of Drug Court participants who stayed on the program definitely improved. Their social functioning improved. That is to say they had more stable relationships, more chance of being in a job, more stable addresses, and their income from illegal sources dropped sharply, although I should add that assessment is based on self-report. It was to some extent backed up by the results of urine tests that were conducted.

There are standard measures of health, the technical details of which probably are not of great interest here but I am happy to answer questions on them. These dimensions here, physical functioning role, physical bodily pain, general health, vitality, are all measures of health. They are the results of questionnaires administered to these people. The significant point is that when you compare people over 12 months, for all of them except this first one, physical functioning, they performed better after 12 months than they did at the start. There are big improvements in health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there controls for that?

Dr WEATHERBURN: What you are doing, in a sense, is taking each person as their own

control.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have not done the changes in health in the control groups?

Dr WEATHERBURN: No. That would have been wonderful to get in to see whether the health of people in gaol improves. I would not be surprised if it did, but there were logistical difficulties in getting in and doing this sort of thing. It would have been nice to do it. It is a good point.

Improvements in social functioning: Again this is a standard measure. This taps into things like stability of employment, relationships and so on. Lower scores here mean better performance, better performance in social functioning, and when you apply this standard measure, as we did at the base line, four months, eight months and twelve months, there were progressive improvements in social functioning as well. We had asked them at base line how much money they earned legally and how much they were spending, and, as you can see, at base line they were spending a lot more money than they were legally earning. Subsequent to that, mercifully their legal income and spending were pretty much in line. You would otherwise be concerned whether this could be believed, since it is based on self-report. The urine test results tended to back this up. In other words, they were testing positive far less often.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did not attempt to get some cost of the illegal income, did you?

Dr WEATHERBURN: We did not do a cost benefit analysis. In other words, what we did was measure the effectiveness of the two options and look at the cost of running those two options. We did not attempt to quantify the benefits in monetary terms of going in to a Drug Court program. It is hard to quantify some things such as improvements in public safety in dollar terms.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they steal $1,000 worth of goods and fence them for $100, the insurance cost would be $2,000 per $100 of income.

Dr WEATHERBURN: If your point is that there were substantial monetary savings from reducing the amount of crime they committed, the answer is absolutely, and criminal justice savings, but our evaluation was conservative in the sense we paid no heed to those monetary savings.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you had an index of cost of stolen goods versus harm to society of fixing that cost, you could plug that index into all these formulae of each cost evaluation, could you not?

Dr WEATHERBURN: If you could and if you are an economist.

The Hon. CATHERINE CUSACK: To get the $1,000 of income they have stolen $20,000 of goods.

Dr WEATHERBURN: As I say, there is a lot to get through so I don't want to delay you. We did a process evaluation. In some ways this would be more interesting to you. We interviewed central players in the day to day operation of the Drug Court to identify problems in the operation and tried to document these problems and how they might have been addressed.

The first thing we found, and this is of much greater relevance to the Inebriates Act Inquiry, we found at the beginning considerable tension between the court and treatment providers. There were some very fractious times. They had different perspectives on what was appropriate, for example urine

testing. Treatment providers were less than happy about regular urine testing, having moved away from that themselves some years earlier. The court, however, saw urine testing as an important test of conformity with program requirements, a test of the integrity of the program. There were considerable arguments about the criteria for program termination. Under the Act a person could stay on the Drug Court program unless "there was no useful purpose to be served by taking them off the program", and one unfortunate feature of that inquiry is it invites the court to consider only whether there is any useful purpose from the vantage point of that individual, rather than whether there is any useful purpose from the vantage point of society at large.

One effect of that is people who were frequently breaching conditions of the Act, and over an extended period of time, were not thrown off because they were showing some sign of progress. It could be argued that the opportunity costs of keeping some individuals who are not performing well on the program were too big to bear, they were denying a place to someone else who might have performed better. But those two arguments, "Should we put this person off the program and let some one else in or should we persist with this person because they are showing signs of improvement", were quite a highly contested issue early on in the program, not so much later on as I understand it.

There were problems with sanctions. One of the reasons why the cost of the program was approximate to the cost of imprisonment was the court in the early days was using imprisonment to punish people for breaching the program, so much so that there was not a huge difference in the amount of time that people on the program were spending in gaol compared with people who had been sentenced in a normal way. That is no longer true. There were some problems with graduation criteria. The requirement for graduation was that they be drug free for six months. The Drug Court found early on that substantial progress could be made with people who had not given up using drugs. For example, people who had stopped using heroin but who were managing their way off it by using more cannabis would in most people's views be regarded as progressing, but under the Act you had to be drug free. That was problematic. Urine testing was not run well at the beginning. That improved later.

Aboriginal offenders were less represented in the program than one might hope because so many of them are picked up for violent offences and the condition of the Act was that you could not get into the program if you committed a violent offence. The court itself had considerable discussion over what constituted a violent offence, but I will not go into that. The Act also excluded people, from memory, who had mental health problems but a lot of people turning up for the Drug Court program had co-occurring mental health problems and that was a difficulty. After care was a difficulty, that is to say, once you left the program, that was it, there was no further support available.

Our conclusions: The Drug Court program is effective. It could be made more effective. It could be made more cost effective and has since been made more cost effective because under the current arrangements you can bank these custodial sanctions. That is to say, if you breach the Act, a custodial penalty might be imposed but you can work that penalty down by remaining in compliance with the program rather than being sent to gaol every time you breach. So, having made a mistake you can earn your way back out of gaol, as it were.

That is really it. Sorry it is skeletal in presentation but I did not think you would want to know the details of the evaluation.

The Hon. CATHERINE CUSACK: About the cost per day, the people involved in the program were involved for many many days, whereas for the crime of shoplifting you probably would not go to gaol for that offence itself. Did that factor in?

Dr WEATHERBURN: That is a good point. The way it should have been done is to actually cost an episode of the Drug Court program: How much does it cost on average to send someone off to a Drug Court program? How much does it cost on average to send someone to gaol? The unexpected

problem that prevented us answering those questions was by the time the evaluation was due we had too few graduates. There were too few people who had actually come out of the program for us to reliably or accurately estimate the average cost of sending someone to the Drug Court, so we were forced to do it on a per day basis. It is a good point.

The Hon. CATHERINE CUSACK: Because in reality the drug program for the shoplifter would have meant that they may not have spent gaol time at all, so it is on a pure episode basis. I am only saying that it possibly does represent savings in that sense.

Dr WEATHERBURN: Yes, it possibly does. I take your point but it is worth remembering that we might have picked them up in the re-offending part of the evaluation for shoplifting but it is doubtful whether that was what got them onto the Drug Court program. In order to get onto the program you have to be facing a serious prospect of imprisonment, more likely go to gaol than not. There would not be too many people who were picked up for a shoplifting offence that would be in that situation. It is doubtful therefore whether those who were placed on the Drug Court program were receiving the sorts of sentences that shoplifters normally get.

ACTING CHAIR: Can I just clarify the type of offences that the clients in the Drug Court have committed. They are not people who have committed a violent offence, they are people who might have robbed a shop to get some money to buy drugs or break and enter is not likely because it is violent?

Dr WEATHERBURN: No, break and enter is very likely.

ACTING CHAIR: Is it that armed robbery or something like that would exclude them but something like break and enter would not be as violent, even if they had threatened a shop owner or something like that?

Dr WEATHERBURN: Well, that would not be break and enter.

ACTING CHAIR: So if they had threatened someone in that situation?

Dr WEATHERBURN: If you threaten violence or inflict violence in the course of a robbery, the access that applies is you are not allowed onto the program if you have committed a violent offence. Now, it has to be said that technically that would exclude robbery and assault, but if the court formed the view later on in its proceedings - actually Bruce Slater may be able to help you more here - but my understanding is that if the court formed the view that even if it was a robbery but no violence was actually inflicted on the person, you might get into the program. So I am not sure the court took quite the technical approach that one might have towards the requirement to exclude violent offences.

As to who turned up on the Drug Court program, mostly people who had long criminal records for break enter and steal, motor vehicle theft, fraud, those sorts of offences were characteristic, people who were going to go to gaol because of their long criminal record but for whom their present offence, the offence that had brought them before the Drug Court, did not explicitly involve violence.

ACTING CHAIR: In your view is there one particular type of offender that would be more frequent than another in the Drug Court process?

Dr WEATHERBURN: We are just in the middle of answering that very question. We have done a major study which we are analysing now to try to identify the characteristics of those who succeed and those who do not. I have not seen the results of that analysis, so I cannot inform you here. All I can say is that in our preliminary analysis the people who did better were those with the longer sentences, but in terms of characteristics of individuals I cannot answer that question yet.

ACTING CHAIR: When do you think you will have those results?

Dr WEATHERBURN: I asked our research manager that very question this morning. In terms of being able to make them public, I suspect about three months from now.

The Hon. CATHERINE CUSACK: Are there any gender differences?

Dr WEATHERBURN: In terms of performance on the program, we did not look closely at the gender differences. There just were not sufficient subjects to make an adequate analysis of them. There were gender differences in people on the program. There were disproportionately more women than men on the program. We had a control for that.

ACTING CHAIR: I am just going to ask you some of our formal questions. Have you got any general comments on therapeutic jurisprudence as a model for dealing with offenders? For example, what do you believe are the ethical issues, as well as the strengths and limitations of coercive treatment?

Dr WEATHERBURN: Arie Freiberg is probably much better placed to answer this question than me, but I think a general principle at stake here is that whatever you do in the name of reducing re-offending, whatever treatment program you might offer ought not be more onerous than the punishment that might be appropriate to the offence that occasioned the treatment. Through the 1970s there was great concern that in the name of treating offenders we often subjected them to deprivations of liberty and intrusions on their freedom that were well out of proportion to the offence that started the problem. I think any kind of introduction of therapy or treatment within the criminal justice system has to be in the context that we are providing a punishment by any other name to an offender and it must be proportional to the offence.

The second point to make on this score is that, although we know that some forms of coerced treatment work when they are well resourced, we know very little about who they work best with and in what circumstances. Most Drug Court evaluations, for example, do not get beyond the question of whether people placed on the program are less likely to re-offend than people placed on conventional sanctions. We have not got to the point yet of identifying the key features of a Drug Court program that make it effective or the key characteristics of individuals who are most likely to succeed. I do not think we know the answer to that question yet.

I cannot resist saying that there is a very nice review of the ethical issues associated with coerced treatment in Arie Freiberg's statement from the Law Journal, but he will probably relate on that issue later. There is also a good review of coerced treatment and the conditions in which it might be effective by Wayne Hall. Are you aware of that one?

ACTING CHAIR: Yes.

Dr WEATHERBURN: That is all I have to say on that issue.

ACTING CHAIR: We are charged with looking at ways in which we can address alcohol and those dependent on alcohol. Do you see that there is an opportunity here for targeting offenders with illicit drug dependence mirroring that program for alcohol offenders?

Dr WEATHERBURN: I do not see any reason in principle at all to exclude people whose crime is alcohol related, particularly if it is the result of alcohol dependence, from a Drug Court type program. Again, I am not an expert in this area but I have just seen an article recently in the Medical Journal of Australia on the drugs Campersote and Naltrexone which are being used to try and manage people who have an alcohol addiction. In that sense it is somewhat analogous to putting people on methadone in order to deal with their illicit drug problems.

There are some specific issues that come up in the context of trying to deal with alcohol related crime by a Drug Court process. One of them is that there are vast numbers of people involved. A Drug Court which is at the moment barely adequate to meet the existing demands it faces would have to be dramatically expanded if you were going to try and include people with alcohol related problems in that program.

The second one, of course, is that it is easy to find people who are heroin addicted and who have committed non-violent property crimes; it is somewhat harder to find people who are addicted to alcohol who have not committed a violent offence. Well, if not politically fraught, at least there are bigger public safety issues associated with taking someone who has committed a violent offence and who might be otherwise suitable for gaol and placing them in a treatment program in the community. So there is that difficulty, but, as I say, in principle I cannot see any reason why you could not include people whose crime is alcohol related on a Drug Court type program or on a MERIT program for example.

ACTING CHAIR: Do you think coercive treatment should be used as a strategy to address domestic violence? We have had evidence from the Chief Magistrate Judge Price who recommended that the Local Court's power to make apprehended violence orders be extended so that the court could order, in appropriate cases, that offenders undertake treatment programs. You are saying that violence has significant problems. What do you think about this recommendation?

Dr WEATHERBURN: The research on the effectiveness of offender programs for domestic violence is nowhere near as clear cut as the research on the effectiveness, for example, of methadone reducing illicit drug consumption and drug related property crime. Many of the studies are faulty; they make no control for selection bias; typically they compare the performance of people who have gone through these programs with people who have dropped out of them, and, unsurprisingly, the people who completed the programs are less likely to re-offend against their spouse or family than people who failed, but to me that tells me nothing about whether it was the program that was effective or whether the people who wanted to change anyway stayed with the program.

There is a little bit of evidence supporting these programs. There was an article that has just come out in the Journal of Quantitative Criminology I can refer you to which made a very serious effort to control for these selection biases and produce some sort of evidence that these programs are effective in reducing domestic violence. There is some empirical justification for the Chief Magistrate's proposal to include them. I would say though that in my view the general problem of domestic violence is probably better managed, or most of the resources ought to go to managing problems such as the availability of alcohol, particularly in our regional communities. There is good evidence that self-imposed restrictions on alcohol consumption can make a big difference to general levels of violence in those communities and that looks to me to be a more promising line of attack on alcohol related violence, but I acknowledge that you could go both ways.

ACTING CHAIR: The Carr Government recently announced that a drug gaol is planned for New South Wales. Do you have a view in terms of the advantages and disadvantages of a drug gaol?

Dr WEATHERBURN: No, I do not. We are charged with responsibility for evaluating the drug gaol and it would be wrong for me to form a view at this early stage about its likely effectiveness. It is also fair to say that the details of the drug gaol program are yet to be fully worked out. So I would not want to speculate about its potential value.

The Hon. IAN WEST: You have indicated that there were some graduates, however thin on the ground. Can you let us know how many graduates there are and would you see any value in us having a chat with those graduates?

Dr WEATHERBURN: As to the first part of your question, I cannot tell you immediately how many graduates there are, although obviously there have been far more than there were when we completed our evaluation. I think the Drug Court itself has just published or is about to publish a report which would include information on the number of graduates. It is stirring stuff talking to people, listening to people talk about their success in the Drug Court program. It certainly humanised it for me and I would have thought it would be interesting for this Committee to interview some of these people. That is an arrangement you would have to set up with the Drug Court. But it certainly puts flesh on the bones of policy when you see someone who has actually tried to change their life and has succeeded, and for that reason, if no other, it is working.

ACTING CHAIR: Are you aware of our visit to the Drug Court?

Dr WEATHERBURN: No, I was not.

ACTING CHAIR: We are to do that tomorrow.

Dr WEATHERBURN: Great.

ACTING CHAIR: Have you got any general comments that you would like to make, in particular in terms of what you would like this inquiry to achieve?

Dr WEATHERBURN: I do not have any general comments to make. I must confess that up until fairly recently I was pretty ignorant of the Inebriates Act. I did not know it existed. I was more familiar with the Intoxicated Persons Act. I was surprised to see it. I was surprised even more to see the terms and conditions or the divisions of the Act when it was brought into play in the 1890s, but I have no general comment to make other than that which I have given you so far.

ACTING CHAIR: What do you hope we are going to achieve with our inquiry?

Dr WEATHERBURN: A better way of dealing with people who repeatedly appear before the courts because they have got a serious, unmanaged alcohol related problem. That would be a great step forward. There are very many people who cycle through the courts over and over again. They are too persistent not to give a gaol sentence to, at least from the court's perspective. They generally often get short sentences in the absence of adequate ways of dealing with these people who are a significant problem. If, of course, you can reduce alcohol related violence in Aboriginal communities, that would be fantastic, but, as I say, I think that is more a supply side issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean the supply of alcohol?

Dr WEATHERBURN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you mean cut out the whole supply?

Dr WEATHERBURN: No, I do not want to see the unilateral cutting of supplies of alcohol. What I am supportive of is the efforts on the part of Aboriginal people who are trying to restrict availability, someone such as Noel Pearson, and it has occurred in central Australia where Aboriginal people have managed to keep alcohol out of their communities. There have been substantial reductions in crime in those communities. Treatment is good, but the difficulty with treatment is that you are often providing it long after the damage is done, and I would not discount the value of treatment programs for people whose crime is alcohol related, but if I had a million dollars to spend, most of the money would go in trying to control the availability and supply of alcohol and a lesser amount to treatment programs.

ACTING CHAIR: Our role is one of defining where we head with the Inebriates Act, to come

up with a legislative framework obviously suggesting how it might best be dealt with. I just wonder if you have a view on the best way to proceed with that, particularly in terms of the sort of framework we should follow? Some people have talked about the Mental Health Act as being a good model. Nearly every person who has presented has talked about resources. I am just wondering if you had formed any view in your thoughts about just what is a good model for us to proceed on?

Dr WEATHERBURN: I have not given any thought to the appropriate sort of framework for dealing with these issues. All I would say is that when Professor Freiberg and I were discussing this issue a couple of hours before coming here he showed me a very interesting piece of Victorian legislation, but I promised I would not dominate on that and I would leave it to him to describe to you. So he has an interesting framework to talk about but it is best that he tells it.

The Hon. CATHERINE CUSACK: Are you aware of any research which compares coercive treatment programs pre-sentencing to coercive treatment programs post-sentencing?

Dr WEATHERBURN: I have seen no comparisons of that kind at all.

The Hon. CATHERINE CUSACK: When the new drug gaol is set up, I guess that will give an opportunity to look at that. I suppose it will be functioning very differently to the Drug Court.

Dr WEATHERBURN: The big difficulty with these comparisons is that it is easy to make broad comparisons but hard to interpret the results. The profile of people who will get into a drug treatment gaol is going to be very different to those who might be suitable for, say, a bail based scheme or a pre-conviction scheme. You need to control for those differences if you are going to make valid judgments about whether the program is what accounts for the difference in recidivism. People, for example, who are suitable for a pre-conviction scheme will generally have shorter criminal records and have committed less serious offences and perhaps have better community ties than someone who is deemed to have to go to gaol and might be suitable for a drug gaol.

The Hon. CATHERINE CUSACK: And it could be that it was early intervention.

Dr WEATHERBURN: It could be. This is the big difficulty with evaluation in this area. There are pre-existing differences that you need to control for, tedious as it may be, before you can draw conclusions about the program's effectiveness.

The Hon. CATHERINE CUSACK: Is there evidence of coercive treatment actually working?

Dr WEATHERBURN: Well, the Drug Court. The evidence generally is strongly in favour of Drug Court programs. There are some negative findings but they are outweighed by positive findings in well-conducted studies. If you read Wayne Hall's review in the Australian New Zealand Journal of Criminology where he goes through a sea of coercive treatment programs, I think he draws the conclusion that if they are adequately resourced - and that is a key point - if they are adequately resourced they are effective. The mere fact that they involve some degree of coercion does not necessarily make them ineffective.

ACTING CHAIR: Do you see an expansion of the Drug Court as being workable in other courts around New South Wales? Will that work?

Dr WEATHERBURN: I am a bit of a fan of the Drug Court, partly because much of the work on the diversion tends to be directed towards people whose risk of re-offending is much lower. We do not have a lot of programs for people who have shown themselves to be seemingly intractable offenders. We do not have a lot of programs for people who are being released from gaol or a lot of programs for people who are otherwise likely to go to gaol. The Drug Court is the outstanding example, and yet there is an

oversupply of people who would be suitable for that program and who cannot get on, but it is not for me to say whether the Government should extend it and, if so, how far. I just think it is a demonstrably effective, if not spectacularly effective, program and I see no reason why it should not be extended.

The Hon. IAN WEST: Is there any international evidence in regard to coercive treatments as opposed to imprisonment?

Dr WEATHERBURN: In the introduction to our report, which I make available to you, on cost effectiveness there is a full review of international literature on Drug Court per region, and as I say, although it is getting a little older now, Wayne Hall's review looks more broadly at coerced treatment. Between the two of them, and whatever Arie has to say, I think you should be able to cover the field.

The Hon. IAN WEST: In those are there any, for lack of a better term, exit polls of graduates?

Dr WEATHERBURN: Sure. We conducted an exit poll. I think it is an entirely apt description. We conducted an exit poll of people on the Drug Court program. They were generally very supportive of it. They had their preferences. They were much happier with the treatment staff than they were with the court staff, but since it was the court staff who were dishing out the punishment that is not surprising, but they were generally very supportive of it and very supportive of those who participated in the Drug Court team, and that includes people who had not yet graduated as well as those people who had. So there is certainly a buyer acceptance of the program.

The Hon. IAN WEST: Have we got information on that buyer acceptance?

Dr WEATHERBURN: Yes, it is in our report, which I make available.

ACTING CHAIR: You mentioned in your report a lack of after care and follow-up in your Drug Court evaluation. Do you have a view as to what would be an adequately resourced after care program?

Dr WEATHERBURN: No, I do not have definite views on that. I think it is desirable not simply, once a person has shown they are capable of doing without drugs or substantially reducing their drug consumption and certainly eliminating crime, to just wave goodbye at the door of the court as if there were no further risks at hand. I have not thought about how you might close that gap without keeping them on a program forever. I would need to give some thought to that before commenting.

The Hon. CATHERINE CUSACK: With domestic violence, I know there are a lot of offences in indigenous communities, for which there is a very low conviction rate I believe.

Dr WEATHERBURN: Yes, I wouldn't have thought that, but do you have a reason for thinking that?

The Hon. CATHERINE CUSACK: Yes, that a lot of charges are laid and then witnesses withdraw before it comes to court.

Dr WEATHERBURN: There are.

The Hon. CATHERINE CUSACK: The charges are later withdrawn or the matter does not proceed in court. I have heard in the Bourke area there is a 68 per cent rate of convictions for domestic violence amongst those communities, traditionally pleading not guilty, which would disqualify them from any of those pre-sentencing programs or pre-bail related programs anyway. I just wondered would you agree that alcohol is a contributing factor to domestic violence in these areas?

Dr WEATHERBURN: Certainly it is a contributing factor. It is not the only factor. There was a futile debate some years ago about whether it was just a patriarchal society or alcohol that was causing the problem, and it was clearly both, but the fact that there is such a strong correlation, and you will see this in previous research we have done, between the amount of alcohol sold in the postcode and the level of violence in the postcode, should leave no-one in any doubt about the contribution of alcohol to violence generally, not just domestic violence, but I would not have thought if we were to eliminate alcohol or percentages of alcohol consumption that the problem of domestic violence would disappear.

I just think that with these things you do not have the luxury of picking and choosing options for control, you have to take your leverage where you find it. So, yes, you want young boys to go to school brought up to understand that it is not a legitimate way of solving disputes to inflict violence on their female friends or partners, but you also want to ensure that people are not placed in circumstances where they lose control of themselves or where they drink in circumstances that provoke violence, as so often happens in pubs and clubs around Sydney and elsewhere.

The Hon. CATHERINE CUSACK: The type of person we are thinking of at the moment is someone whose charges did not proceed, so therefore they are a non-offender, but they have got certain problems, either aggressive, self-harm or an alcohol dependency, which causes harm to their family. Is there any role for coercion in those circumstances?

Dr WEATHERBURN: Of course you have apprehended violence orders which do not necessarily involve any charge of assault proceeding. So there is a remedy there, and they hold a great degree of coercion, that is to say the offender, if they do not comply with the conditions of a domestic violence order, is liable for prosecution. We did an evaluation of those orders and found them to be very effective. Whether there is an additional power which should be given to courts to order these offenders into treatment raises all sorts of other issues, not the least of which is the legitimacy of ordering someone into treatment before they have been convicted of any offence, but, as I say, there are other issues there, such as whether treatment is an effective way of dealing with the problem.

I really would not want to make hard and fast judgments, just because I do not have the expertise on what power should be given to magistrates to manage this sort of problem. I am happy to concede that alcohol is a contributing factor though to domestic violence and we need to find some way of limiting alcohol consumption. I think a case can be made for the proposition that it ought to be possible to coerce people who commit violent offences by reason of alcohol into some form of treatment.

The Hon. CATHERINE CUSACK: What about allowing for a greater prohibition on alcohol as their treatment? What these families want is the violence to stop.

Dr WEATHERBURN: Exactly.

The Hon. CATHERINE CUSACK: They are not looking for punishment.

Dr WEATHERBURN: No. I think it would be a very interesting thing to try and evaluate, to try to put into effect and then to evaluate to see what effect it had. There are obviously risks associated with that, but there are risks in not doing anything either. So I guess the point is at the moment the choice is a non-custodial order with very little option for treatment and a custodial order which may not be the outcome which the victims themselves want.

(The witness withdrew)

PROFESSOR ARIE FREIBERG, Dean, Faculty of Law, Monash University, Clayton, Victoria, affirmed and examined:

ACTING CHAIR: Professor in what official capacity are you appearing before the committee?

Prof. FREIBERG: As a private individual.

ACTING CHAIR: Do you wish to make an opening statement?

Prof. FREIBERG: You have asked me in the preliminary notes to make some introductory comments on therapeutic jurisprudence and the model for offenders. Would you like me to make comments in that regard first, which would perhaps set the scene for why you have invited me up here?

The field of therapeutic jurisprudence is of relatively recent origin. It is only since the late 1980s when David Wexler and Bruce Winnick started writing in the area using the term "therapeutic jurisprudence" covering an area of mental health law, but following that expanding to criminal law, family law, juvenile law, health law, preventive law, tort law, commercial law and so on. It is not a particular doctrine which you can say has a core which you can identify as being therapeutic jurisprudence. It is more a school of social inquiry. It is an approach to an understanding of law in the legal system rather than a doctrine that might be some economic approach or Marxism where you can say this is what it stands for. It is a way of looking at things.

Perhaps the best way to describe it is:

> A method or an approach which seeks to assess the therapeutic and counter therapeutic consequences of law and how it is applied and to effect legal change designed to increase the former, that is therapeutic consequences, and to decrease the later. It is a mental health approach to law that uses the tools of behavioural sciences to assess the law's therapeutic impact and, where consistent with other important values, to reshape the law and legal processes in ways that can improve the psychological functioning and social well-being of those affected.

That is Bruce Winnick. There are a number of aspects of therapeutic jurisprudence. It plays out in a number of areas. The Drug Court is one example. Juvenile drug courts, sentencing circles, teen courts, domestic violence courts, mental health courts, re-entry courts and what might be called problem solving courts generally are other examples. Because there are a number of approaches, you find that different people emphasise different aspects of it. In my own work I have used five primary dimensions which have grown out of work from the Drug Courts when I was involved in the establishment of the Drug Court in Victoria after looking at the examples here in New South Wales.

Those primary elements which are court focused, (and not all therapeutic jurisprudence is court focused), are the elements of judicial supervision, the availability of treatment and service provisions, team work, a system of rewards and sanctions - by team work I mean a multi-disciplinary approach from different disciplines – and, finally, stressing the importance of procedural justice in processes and what another author has called "narrative competence". That is, the ability of people to understand the significance and meaning of stories through cognitive, symbolic and affective means. That is the importance of telling your story. The importance of being understood and listened to is as important as the outcome. I think that will become significant when we come to a discussion of coercion versus non-coercion. I think that is an inappropriate distinction or dichotomy other than where we are looking in a legal context in terms of getting people to buy in to what is an appropriate life change or outcome for them and how the law can bring about changes and I think the concentration on coercion is probably the least effective way of understanding how and why people change. It is more how you get them

involved in wanting to change and the mechanisms and levers you use that are important. I think that is an important tool.

In a sense "therapeutic jurisprudence" has become a useful symbolic mechanism. I am amazed how people are picking it up as a statement, as a phrase, without really knowing what it means. What it indicates to me is that we are seeing more and more exasperation and frustration over the failure of current judicial and legal system to deal with ongoing and intractable problems where the underlying issues are social and not legal, and what this does is provide a language and a set of techniques by which we can deal with those issues in a possibly more constructive way than relying on the police, arresting and locking them up and seeing them again, which is precisely what you see with the drug problems, precisely why alcohol problems are an analogue of that and we see in many other areas.

I have a show bag of goodies which I have brought up, which I will leave with the Committee, but there is an article I wrote a couple years ago on problem oriented courts, of which the Drug Court is only one example, and I titled it *Innovative Solutions to Intractable Problems?* Academics always put question marks; it saves them being held to anything. Those kinds of intractable problems that I have mentioned - domestic violence, drugs, alcohol, mental health - require a re-examination of the way the courts and criminal justice system go about dealing with those problems and I think it is quite clear that the current systems have failed us quite dramatically, hence recidivism, hence questions about where do we go from here.

Perhaps with that background about therapeutic jurisprudence as an approach, a symbolic way of thinking about how we go about things is important when we come to a subsequent discussion of what it can do.

ACTING CHAIR: I know that your research is wide-ranging and includes research on what is going on internationally with coercive treatments and in other States. I wonder what evidence internationally there is on coercive treatment.

Prof. FREIBERG: Despite what Dr Weatherburn said before me, I am not an expert on coercive treatments. My strengths are in, if you like, legislative and regulatory design of the kinds of systems in which coercive treatment may or may not be a part. I think there is evidence - and Dr Weatherburn has referred to Wayne Hall's articles and their various other aspects - I think it is quite clear that getting people into a situation where some form of intervention modality is useful. I do not want to use the term "treatment" because there are all sorts of other issues.

If we focus on treatment as some form of medical model it really diverts attention from what is often a fundamental issue with people who have alcohol or drug dependency and their problems are multi-dimensional, they have multi problems and you will having housing problems, you may have mental impairment problems, intellectual disability, co-morbidity, all those kinds of issues. You may have financial problems, you may have all sorts of other issues.

I am now involved in a review of child protection, and, again, all the evidence across a number of social fields is that multi-faceted problems require multi-faceted solutions. What we are lacking is the appropriate structure either administrative, regulatory or legislative to deal with situations both post-conviction, but in a more difficult manner it is pre-conviction or where there has been a conviction and the term of sentence has expired. What do you do about the people who you will predict or know will harm themselves or others? That is one of the major real and intellectual dilemmas. We have to try to find models which will not only coerce, but bring people to a situation where they might seriously think about changing their lives. I think all of us know it is very difficult to change your life, whether it is smoking or going to the gym or losing weight or whatever it is that people grapple with. We want to place them in a situation where some outside help might be needed to help them believe that changing their life is a good idea.

It is also coercing the treatment providers in a sense who are currently funded individually through DoCS or criminal justice or mental health or alcohol and drug. It is getting them to relate to each other both financially and by service delivery and, importantly, in the swapping of information, and that is what you find more and more, that you cannot get information from one agency to another because of privacy confidentially or ethical rules. Getting people together to deal with multi-dimensional problems so that you deal with the housing, so that you deal with the impairment, so that you deal with the alcohol, all of which I think are symptomatic of broad social problems. That is the legislative challenge and it is occurring in a number of places.

To answer your question, I think that the therapeutic jurisprudence literature indicates that you can make use of crucial moments in a person's life, such as when they are arrested, to bring into their lives an intervention which, in a sense, forces them to go through some stages, whether it be detox or something else, and then the longer that you are able to maintain them in the intervention modality, the better your chances are of whatever you are doing having some effect. So, that is why I am reluctant to talk about coercion. It is easier to talk about how do you get people in a situation where the choices that they would rather make, and which you know are bad for them, are choices not really open. I have left another article by a colleague, Richard Fox, on *The Compulsion of Voluntary Treatment*. He makes the point that there is a continuum of coercion and it is really not helpful to make a clear dichotomy. If you said, "Do you want to be locked up in gaol or go on this treatment", is it really voluntary consent? "Do you want to do this or go to gaol?" Is it voluntary? "Do you want to be hung or quartered?" Well, often you do not give people a choice. I do not think you should get hung up about coercive versus non-coercive. I think it is a continuum.

ACTING CHAIR: Would you like to formally table those reports and we can distribute those?

Prof. FREIBERG: I am happy to do so.

ACTING CHAIR: Thank you for adding to our knowledge. It is very useful information.

The Hon. CATHERINE CUSACK: I wanted to clarify therapeutic jurisprudence because the challenge you are talking about is not a new challenge. Corrective services have always been interpreted as correcting behaviour. We have rehabilitation as an old, or a fairly old, concept or traditional approach. How is therapeutic jurisprudence different to the concept of rehabilitation?

Prof. FREIBERG: Rehabilitation assumes that you are going to put somebody back in the state that they were before. That is not always the case. Sometimes you talk about habilitation. You are talking about a homeostatic system where people have wavered from something they were, some perfect situation they were in and you are going to fix them up. What therapeutic jurisprudence asks is: Are the techniques you are using beneficial to the people, whatever the techniques are, rather than making a statement that people should be better or worse. I dislike the notions of corrections or rehabilitation as model because of that problem of where you start from. It makes certain assumptions about the model of why people go wrong, and rehabilitation tends to emphasise medical models, that is if we do something and you have gone wrong and we do something to you, you will be better and become a model citizen. It tends to ignore some of the underlying issues that create deviant behaviour. I think it is too narrow a model. It is not a corrections model; it is a model of how you understand people's behaviour and what legal and the whole other services around the legal model can do. Focusing on courts and corrections is far too narrow.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your objection to rehabilitation, in a sense, is that it is the model of workplace injury even or medical abnormality which corrects to its previous situation?

Prof. FREIBERG: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a very valid objection, even if it has a medical connotation to it. It assumes that the pre-morbid state was okay. When people think about rehabilitation they mean to a state in which you can function in society, whether you could function in the society before or not.

Prof. FREIBERG: I would accept that. I think that is a good point.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that your words "therapeutic jurisprudence" are in fact the new words for rehabilitation or to function in society or a thing that will make people function in society?

Prof. FREIBERG: No, it is broader than that. There is a whole range of aspects to this. I only focused on some. Judicial supervision is not a rehabilitative model; it is a model by which the law can deal with particular aspects of people's behaviour, where those people have broken the law. It is one aspect of trying to get people not to break the law, not to be deviant. Now, whether they were deviant because of medical problems or other problems is another issue. It is not an analogue for rehabilitation; it is an analogue for the way the whole legal system operates. I don't know whether I made that clear. It is not the same thing as rehabilitation. It is an approach to the way the legal system works. A domestic violence court is not about rehabilitation; it is about the way we deal with basic fundamental problems of the way families relate and violence in families. You are not looking to rehabilitate the offender; you are dealing with a problem of family violence, which may be broader than focusing on an offender's assaultive behaviour.

The Hon. CATHERINE CUSACK: This is a problem because so many other agencies or structures in society are failing that it bounces down and eventually it is in the hands of the court.

Prof. FREIBERG: Yes.

The Hon. CATHERINE CUSACK: It has come to the court almost by default of other interventions being in place.

Prof. FREIBERG: If they have been in place, the courts often end up as the rubbish bins because you get dangerous behaviour and the law often intervenes where there is harm, either actual or future harm, to oneself or others, so the law steps in to prevent that harm in the future.

The Hon. CATHERINE CUSACK: It is not ideal for it to be dealing with it at that level?

Prof. FREIBERG: Ideally preventive mechanisms, and so if you are talking health system your best mechanism is good drainage, primary health services, maternal and child health, education and schooling. Where that fails or where there are other problems you end up with the problems in the courts. What therapeutic jurisprudence and problem oriented courts try to do, is to deal with it just withinthe legal system, that is putting somebody in gaol and giving them a short dose of treatment and in Victoria when I looked at what treatment meant, we had a combined custody and treatment order for drug and alcohol dependent people, six months in gaol, six months out. It was a complete and utter failure, it was a farce. In a report I wrote on changes to our criminal justice system, I found it was something like 24 hours over six months of counselling. You are not going to change half a lifetime of drug addiction with 24 hours of treatment. It is farcical.

That is why when we come to talk about the therapeutic gaol it is important to look at what that means. The idea of short term episodic interventions, where you have fundamental problems, is

absolutely ridiculous and then we wonder why there is so much recidivism or so much cycling of these people. It is because what we do, on its face, is ineffective. You cannot expect major changes through ill-resourced, half hearted, episodic, unfollowed up interventions where people are reluctant to become involved.

The Hon. IAN WEST: Can you give us an indication of where the two come together, that is the wish to enable people to be in control of their choices as much as it is humanly and ethically possible to do so, and the need for society for an outcome that is positive to the society? Can you give us an indication as to where those two interact?

Prof. FREIBERG: Ideally you want those in a lot of transactions that go before the courts where theoretically the consent of the offender is required. If you are put on a bond with conditions, if you are put on a community based order, or whatever your equivalent is here, most of the orders these days, other than going to gaol where they do not ask you your permission, you are required to consent to the conditions and you will have treatment and you will behave yourself and you will not go near X or Y; they are theoretically consensual. They do not work because there is no follow-up. If there is follow-up from the correctional services it tends to be thin and episodic.

Re the Drug Court, Dr Weatherburn gave you some of the efficacy and evaluative data. I am more interested in it as a changed paradigm for what the courts can do where you have got particular social problems which come together through the trigger of a criminal event. What that means is that, first of all, the person has to consent to go to the Drug Court. That means you have to have some willingness. Although this is a coercive element, they are given some choices, some of which are more pleasant than others. Secondly, they have to consent through the process of treatment, which is sometimes hard. They can say, "I am not going to do this any more. I would rather go back to gaol", and some of them do. It is much easier to go to gaol. This is really hard, and changing people's behaviour is really hard at the high end. What it does is to bring together, if you like, an authority figure, and I think that should not be underestimated. When Dr Weatherburn said we don't know what works, there are five dimensions to a Drug Court intervention: The judicial supervision, the multi-disciplinary support, ongoing provision of resources, there are the rewards and sanctions internally - that is if you play up we can put you in gaol or take off some privileges, you are still on the order but there is a little ladder of success and failure internally - importantly, procedural justice, which is the person speaks to the magistrate.

I saw my first Drug Court in Canada and it was a life changing experience because I realised that there were other ways that courts could operate and I came back to proselytise for it because that kind of ordinary interaction where you are up before the court for five minutes and you have Legal Aid saying "my client says he did it", in the Drug Court: "What did you do Freddy? Well, I did blow it this time. I have done something wrong." The job is going well and you come back week after week building up a relationship, which is often lacking in people's life. That is that model. It is a paradigm of mental health courts and the like.

The Hon. IAN WEST: In terms of the weaknesses, limitations?

Prof. FREIBERG: Lots of weaknesses and limitations.

The Hon. IAN WEST: There must be a point where someone is just beyond help.

Prof. FREIBERG: And if they are and they have committed a serious offence, they go to gaol where we pretend to do therapeutic things as well a bit of the time or we lock them up, and, if they are completely hopeless, in Queensland they try to lock them up forever afterwards, after you complete your sentence. There is a continuum of interventions. I have given you a copy of a diagram and perhaps it might be useful. It comes out of a report I wrote for the Victorian Government called

Pathways to Justice, a copy of which is on the web if you have a look at that. That shows a continuum of interventions in relation to drug and alcohol offences and the point of that is that from the least serious offences to the most serious, where you have got a lot of prior offending and subsequent offending, you need to have a full range of measures to provide for interventions. Here I add for both drug and alcohol. I don't see that there should be differences. In the Victorian legislation, our equivalent of your Drug Court legislation, it covers both alcohol and drugs because I don't think there is a conceptual distinction. Leave aside the numbers that are involved, there is no conceptual distinction.

ACTING CHAIR: All of our courts and youth Drug Court have focused on illicit drug use and dependency. Do you see that that should be extended to alcohol abuse and alcohol related crime and that is working in Victoria, is it?

Prof. FREIBERG: We have a Drug Court. Again, they are still under evaluation, they haven't rolled it out yet. I think they intend to. As long as it is contributing to the commission of the offence. It is not an alcoholism treatment court, it is a court where you have committed a crime and if it is alcohol or drugs, or most often a combination, then it is the same problem, it is something contributing, a fundamental problem contributing to the commission of crime. Really, if you look at the data, and you look back a hundred years or further, and look at the date of your Inebriates Act, alcohol is 50 or a 100 times more serious in its prevalence in the commission of crime, especially violent crime, than drugs, and we have ignored it because it is so deeply entrenched in our society it is disingenuous to say otherwise.

ACTING CHAIR: We have heard evidence about how we can translate programs such as MERIT and the Drug Court to deal with alcohol related issues. I just wonder what difficulties you see with that. We have heard from a number of people about violence and how that might be an issue to deal with and I just wonder if you have any comments to make on that. Do you think MERIT could be applied?

Prof. FREIBERG: If you have a look at that diagram, Victoria preceded New South Wales. I always love the way States go; we have CREDIT, you have MERIT. I am sure that someone else will come up with some other wonderful acronym. It is a bail oriented, short term system and I had long debates with the Deputy Chief Magistrate, who is a great proponent of CREDIT, about its role. I believe it has a role, but it has a role in a continuum of services. I have some major criticisms, not of the MERIT concept, but it cannot act alone and I think it should only act for the less serious cases. In fact, one of the other tabled documents that I have for you is a yet to be published article, which I have written with Neal Morgan of the Crime Research Centre in Western Australia, called *Between Bail and Sentence; the Conflation of Dispositional Options* and it makes the argument that bail - not only in New South Wales, because we do have a go at your new orders, I think they are called intervention orders. You have new legislation. It is in the first paragraph.

The Hon. CATHERINE CUSACK: Every session has three amendments to the Bail Act.

Prof. FREIBERG: In the Crimes Legislation Amendment, Criminal Justice Interventions Act, you have introduced something called an Intervention Program Order. My argument is not with the intention, which is to provide services to people who might have alcohol or drug or other problems. It is that bail has been asked to do the job that sentencing is supposed to do. I think it is an improper legal foundation for serious interventions in people's lives. At heart I am a civil libertarian. The State can intervene when you have broken the law. Prior to that it can only intervene for certain purposes. Bail is to make sure you come back to court. I have no objections to providing help for people on bail, such as alcohol and drug help, if it is solely for the purpose of ensuring you will turn up for court. If it is a long term intervention, it is an improper legal foundation.

So MERIT is okay as far as it goes but it has been asked to do the job of longer term and

intensive interventions which I think are not wrong in themselves but are inappropriately based on this legislation, which is why my argument in this diagram - Victoria still has not implemented this - is that you need everything from cautioning programs, MERIT or CREDIT type of programs, deferred sentence programs, adjournments, a new type of order which I have suggested which is a community based order, but which has some of the Drug Court models but does not require an alternative to gaol. It also has a mixture of the conditional suspended sentence, which is very much like the proposal you have put forward for the drug gaol which is a mixture of custodial and post-custodial intensive supervision. It bridges the gap between the Drug Court, which is instead of gaol, but you do it in the community. For some who are serious and need serious interventions and need symbolic and actual punishment, then you have a gaol component and post-gaol component. I think that is a useful model and we have not gone down that path yet, but on the condition that you provide the appropriate services in the prison. and I don't think you can guarantee that. We had a combined custody and treatment order. It was supposed to be six months treatment, six months out, a complete and utter shambles. By the time people got into gaol they had served half the six months because they were on remand somewhere else; they never got around to the treatment; they were moved around the gaols; could not guarantee a drug free gaol; and when they got there there was not the supervision and as soon as you blew it you were back in gaol. I recommended its abolition.

I think the theory that in your sentencing range you have a non-custodial, semi-custodial, transitional custodial option and that should make a good set of interventions for your drug and alcohol problems. Then ordinary gaol with parole supervision is another aspect as well. You have to look at it as a whole range of continuum based on the seriousness of offending, the prior history and the kind of services you can provide.

ACTING CHAIR: In your article one of the things you talked about was re-entry courts. We have heard from lots of people that there is no after care. Could you expand on the concept of re-entry courts?

Prof. FREIBERG: This is an American fad that we may not need. America introduced re-entry courts because it abolished parole and it is getting tough on crime and truth in sentencing and let's make sure we can lock people up for as long as possible. They accepted the populist argument that parole was a way of letting people out early and people weren't serving their full time, therefore, it was a travesty and betrayal of the criminal justice system. They found if you let people walk out the door without any supervision, such as paroling people, you were going to blow it. They gave them two bucks to get out, couldn't find a home, met their junky friends outside and they were back inside in no time.

They came to realise that some form of parole or a re-entry court is judicially supervised parole, if you like. In a sense that is what the Drug Court does but after you have been released. I am glad Australia did not abandon parole. We need to resource that because I think the transition mechanism from custody to freedom is extremely difficult, requires all those resources. Now, whether it is judicially or administratively supervised I don't care as long as it as has that supervision. Many people fail because that transition is handled badly. If you want to follow up a colleague of mine, Stuart Ross at the University of Melbourne, Criminology Department, he has done a major piece of evaluative work called *Bridging The Gap* on transition mechanisms and some of the programs in Victoria. He has found again it is very difficult to get people to come from custody outside unless they have got the supports. Re-entry courts are basically judicially supervised parole.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your point about objecting to things being done to people on bail, I can see that is theoretically very sound but we have something like 20 per cent of our prisoners in gaol on remand. In other words, they did not get bail and they are inside, and then of those, 50 per cent are either found not guilty or have served more time on remand than they were sentenced to. Effectively they have been put in gaol when they should not have been or at least

for longer than they should have been, which is a massive infringement from a civil libertarian point of view. If there is a prima facie reasonable fact that they have a drug or alcohol problem and the intervention is to start when they are on bail, presumably by the time they are tried they will have shown contrition and improvement if things go well. While that is an invasion from a civil libertarian point of view, in the New South Wales realistic framework it still might be a far better way of going about things, might it not?

Prof. FREIBERG: I think that is right. I think people should not be remanded in custody unless it is absolutely necessary. The point that we are making is if the interventions are reasonably brief and they are directed at ensuring the person re-appears for court and has a reasonable chance of getting an appropriate sentence, we have no objections. What you have done in New South Wales, the order itself is a hybrid between a sentencing order and a pre-intervention order and bail order, and we think it lacks clarity as to its nature and it lacks clarity as to whether it is an alternative to imprisonment or an alternative to bail or some form of treatment modality. So, basically it is a legalistic argument that you have a big mess, the right intentions but trying to mix everything together, and as a sort of purist from way back I figure when you build the structure incorrectly it will fall over ultimately because judges and magistrates will not know what they are doing: sentencing or bailing people or putting them on these orders. And what happens when they fail, as they often do? Do not get me wrong, I think the earlier you deal with people the better, but have the right tools to go with it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should not every intervention, if you are talking about therapeutic jurisprudence, be the construction of a helpful life plan for the rest of their lives from this point? At the moment they are in court accused of X, to which drug and alcohol may have contributed or mental illness or whatever else it is. Now, even if they are subsequently found not guilty, the fact that they are there suggests that an intervention in this area might be a good idea. It seems to me that it is never seen in the context of a life plan. It is interesting that this morning Dr Weatherburn was saying that in these people's unstructured lives the sort of paternalism and direction given by the Drug Court is very valuable. I do not know if that is the general situation but there is always the battle between paternalism and civil liberty, if you want to put it that way, and if Dr Weatherburn is right, then paternalism is not a huge problem really and in bail terms it is not unreasonable to get a reasonable program and follow it. It seems to me the problem of nothing being followed is rather more of a problem than the civil libertarian clumsiness of it being imposed during the bail period.

Prof. FREIBERG: Can I answer that by making the point that New South Wales and Queensland had post-conviction options. Western Australia and South Australia went down the course of their Drug Courts being bail based and they have both agreed that that has been a tremendous failure because they have an inappropriate legal structure to deal with the problems that arise. The review of the Drug Court in Western Australia, in which Neal Morgan was involved, indicated that they needed special legislation, as has been the case in New South Wales, Victoria and Queensland, to deal with those interventions.

To come back to the civil libertarian arguments, I do not disagree there should be interventions but you have to remember that theoretically you ought not be able to coerce or punish people if they have not been convicted of a crime. So it might be good for them to do certain things but they should plead guilty and be convicted before you have major interventions.

The Hon. CATHERINE CUSACK: When you talked earlier about windows of opportunity, critical moments in people's lives, the example you used is when they are arrested, which is prior to them being convicted. With juveniles the sentences are much shorter and our system looks as if most kids are on remand, and why they are all on remand is because by the time they get sentenced they are sentenced to the period they have served on remand and they are released and it distorts the figures. Sex offenders in particular are a problem, in that there can be no interventions for the entire period until

they have been convicted of an offence; in the meantime they are in the population. I guess I am saying can you see that there are some really practical problems with our ”presumed innocent until proven guilty” approach, which means that you have people in a custodial system but you are not able to offer them programs? The other thing about using bail conditions is it gives the individuals an opportunity to demonstrate to the court their willingness to improve themselves which can be important in terms of their sentencing provisions when they have been convicted.

Prof. FREIBERG: I do not disagree with that. I think what has happened is those germs of good ideas; we encourage what has been called bail support programs that have flourished in England and elsewhere which assist people during that time to keep them out of gaol because they have not been convicted yet and if they are not dangerous and they meet the other bail conditions, that is fine. What we have done is evolved it and said, “That is a good idea. Why don’t we do that on bail. Oh, that is an even better idea. Why don't we do that on bail”, and bail has become a major mechanism. I am saying it has a place but now it is time to stand back and say, “Hang on, bail is for this purpose. We can use it for this purpose”, but, as you said, you look at the immediacy post-arrest of having a good opportunity with drug offenders.

The second level up on my diagram is a drug diversion program in Victoria where as soon as people are arrested you can make reference to local support agencies, whether they be health, financial and the police can refer to other agencies and you get them in straight away and they can then release them on bail and give them over to others for short periods. You do have that immediacy but you are not building a whole intervention infrastructure on what should be a temporary measure. I am not arguing against bail. The MERIT program and CREDIT, I wasn't arguing against it.

What we said in Victoria when I looked at the drug legislation is do not build your major system on a bail system in the same way that Western Australia and South Australia did because it is too insubstantial a foundation. It does not give you the tools. Intervention is preferable post-conviction where you have real leverage and where you can put people in gaol when they fail. I had this big civil libertarian argument; I went through nine drafts of the Drug Court legislation. The way that in Victoria we resolved it is when you are punished for breaching the order and you went to gaol it came off your gaol time because it is a suspended gaol sentence.

In Victoria we were more conscious of the fact that it was a major intervention, in that you can only do two years in Victoria. Whatever the combination of in and out of gaol, two years is the maximum, whereas here you can stay on your Drug Court indefinitely. When Don said people spend as much time inside as they would have spent had they got the order, you cannot do that in Victoria. We did not follow your model. We said there is a limit on the combination of therapy, treatment and gaol and that means it has to be related to the seriousness of the offence. So there is no support from the legislation.

ACTING CHAIR: So you would see what is happening in Victoria as being a model that we should follow?

Prof. FREIBERG: I would like to see what I proposed in Victoria, which the Government has not acted on, as a possible model for the kind of continuum of interventions that is required. We have gaps in our model and you have gaps in your model. Your proposed drug gaol is plugging the gaps which I have identified under our conditions of suspended sentence. There are variations to the theme and I think that is important. It is an important program.

ACTING CHAIR: Can I just flesh out what you see as being similarities and differences between alcohol and drug dependent offenders? Can you elaborate on that?

Prof. FREIBERG: I am not a medical person. I am not going to talk about the aetiology of the drug and alcohol problems or the clinical issues. To me, a lawyer, the key is that you have a substance

abuse problem, whether it be drug or alcohol related. If that is a contributing factor to the commission of offences, then whatever the treatment is, whether it is detox or methadone, whatever it is, it is the reduction of the criminal behaviour, and one hopes improvement of the health outcomes, which is the key. I do not see any theoretical difference between the two.

If somebody is violent to their spouse, or outside a club or anywhere else, because of drugs or alcohol, it is the violence which is the symptom and the rest of it we have to deal with, but in our legislation there has to be a nexus between the substance abuse or addiction and the criminal behaviour. So the Drug Court is not a drug treatment court for people who happen to be alcohol or drug affected. It is a court where you are convicted of an offence of which drug or alcohol, or both, is a contributing factor. So that is a model which only deals with criminal behaviour, which will then lead us to the question of what about the non-convicted people, and that is something else.

The Hon. CATHERINE CUSACK: We do not want a criminal aristocracy. We can end up with an aristocracy of people who get all the services by virtue of having committed offences.

Prof. FREIBERG: Indeed. That is only one of the problems. Certainly, the Drug Courts and the like are rationing tools. Apart from the efficacy, I think it is a marginal cost efficacy. I think they represent a different paradigm than the therapeutic jurisprudence, and I recommend to you a new book *Judging in a Therapeutic Key*, written by Bruce Winnick and David Wexler, which provides a whole range of examples of how this approach operates and I think it is a useful tool. But it is not just rationing, an aristocracy getting privileged access to services. That is a debate always, you are treating criminals better than you are ordinary citizens. I think you have got three paradigms. One is the criminal justice system, and in a sense this problem falls into a therapeutic approach, which starts to bring services, a range of services into that. It is going to be coerced, and I use coercion here, by probably agencies required to provide the services and coercion to the person. Then you have got the voluntary services, mental health, alcohol, and there are hundreds and hundreds of those, and a lot of those resourcing and access problems. We should make those more available.

The really difficult intellectual problem that we are all grappling with is what do you do with the people who are pre-criminal, about to harm themselves or others, or post-criminal in the sense that they have served their sentence, but you know if there are still problems. Here is where we get to this interesting model which has been developed in Victoria. As I mentioned before, I am involved with child protection and this has been analogised by different people as a mechanism dealing with those really hard end cases which cycle in and out of re-notifications, the people who you may not want to send to court but they are too difficult for just the voluntary services, even when they are co-operating. The Human Services Complex Needs Act, which came in in 2003 after two or three years is a non-conviction, semi-coercive mechanism where they are aiming to facilitate the delivery of welfare services, health services, mental health services, disability services, drug and alcohol treatment services and housing support services to certain people with multiple and complex needs by providing for the assessment of such circumstances and the development and implementation of appropriate care plans through the mechanism of a multiple and complex needs panel. That is not a court, but it deals with people who have these prerequisites: if you have a mental disorder within the meaning of the Mental Health Act or acquired brain injury or intellectual impairment or are alcohol or drug dependent within the meaning of our Act, and the person has exhibited violence or dangerous behaviour that has caused serious harm to himself or herself or some other person, is exhibiting such behaviour and risks serious harm and is in need of intensive supervision and support and would derive benefit from receiving co-ordinated services in accordance with a care plan. Believe me, this took years, and I am not sure it is right, and I was only tangentially involved in its development, but this is an intermediate step between what you have got in the Inebriates Act or the Intoxicated Persons Act and we have got in our Alcoholic and Drug Dependent Persons Act, the same kind of legislation. We have no institutions mentioned in the Act to service it; you have got no powers; it is barely used; it has got all the range of problems that you have identified, except this is a new generation model of trying to get people to work together, some rationing mechanism which is between the use of

courts, not conviction based, which is in civil libertarian terms quite dangerous, and there were debates about its coercive quality.

Some of the earlier drafts said, "We can force you to stay in custody". Previous to this they were using guardianship orders as forms of civil imprisonment. So people were unhappy. The Public Advocate wasn't happy that he was using guardianship orders as a surrogate because there were people who required around the clock care. It was costing something like a quarter of a million dollars to provide care for one person for people who were dangerous but had not committed offences.

The Hon. CATHERINE CUSACK: Is there power for detention in your studies?

Prof. **FREIBERG**: Not in such terms. It is the power to provide services, but ultimately they are voluntary.

The Hon. CATHERINE CUSACK: Why is there a need for an Act?

Prof. FREIBERG: To bring together the services and to have the panel set up to do the assessments and to co-ordinate the delivery of services, because, as you know, lots of agencies say, "Our Act says this. We have only got money for that. It is not our problem. It is mental health." They are alcohol. There is alcohol, there is mental health, there is disability.

ACTING CHAIR: Where do the resources come from?

Prof. FREIBERG: They are specially funded under the Act and then you pool the funds with one budget holder, whereas previously you had to get money out of people, or if you put money into a program, people still hung jealously onto their money.

ACTING CHAIR: So that compulsory nature allows for the ability to detain people for a period of detoxication?

Prof. FREIBERG: Alcohol and drugs are just one part of it, but it is not specifically designed for immediate services where people are in crisis. It is a longer term care plan for people who have basically lived between each of the agencies and have cycled again and again and again through the system. It may only cover 50 or 70 people, but they are the ones who may use a particular agency.

The Hon. CATHERINE CUSACK: In Canberra I notice they have now 29 children whom they have catered for the costs of services and education. Basically, there are 29 children, they worked out what would be the welfare resources and law and order resources. They got special funding in negotiating the terms from information across agencies intensively for 29. They didn't need an Act for that. I am just wondering how you come under the provisions of such an Act, which I presume would need that intensive support.

Prof. FREIBERG: There are referrals to the complex needs panel, there are assessment teams, there is a panel system for eligibility, you have got to meet the criteria and then the care plans have to be done. It is not under way yet and it is highly experimental, but my own reflections on what I have seen in child protection, it is not my area of expertise, is that again small groups where intensive multi-disciplinary non-judicial intervention, above the purely voluntary, by agencies and people, but below if you like our child protection application. It is only one of half a dozen ideas that we are playing around with, but in each of the systems, the criminal justice, the alcohol and drug system, the child protection system, what is emerging is that just below court but above voluntary something special is needed, and in a sense that is what the Inebriates Act is about and a whole lot of other Acts are about, domestic violence, drugs, although they are court supervised. There is an intermediate step which we need which crosses the boundary between coercion and non-coercion, voluntary and non-voluntary, and we do not have a good

legal model because the law says if you commit a crime, then we can intervene. Failure is problematic. Then if you stop committing crime, what do we do, and that is problematic. The criminal law is based on commission of crimes. We do not have other good laws other than civil and voluntary commitment or mental health commitment to deal with it.

The Hon. IAN WEST: In reading the Inebriates Act of 1912, there seems to be some very good wording, there seems to be some great thought in regard to therapeutic jurisprudence, possibly way ahead of its time. No doubt you read the Inebriates Act in making your submission.

Prof. FREIBERG: Briefly.

The Hon. IAN WEST: The clauses regarding the powers and duties of the guardian seem to me to have a lot to do with exactly what you are talking about in terms of that half way house between--

Prof. FREIBERG: Yes, but we never had - I mean I don't know the history here, but the whole notion of guardianship is I think probably not as useful any more in terms of multi-disciplinary intervention, in terms of the kind of people who act as guardians. In fact, the public advocate who acts as guardian for these people mostly, people with intellectual disabilities amongst others, doesn't feel that it is appropriate that the powers of guardianship and the like are the appropriate tools for his office to have. I think the idea is right. The idea of getting these people earlier into institutions doesn't help if you don't have institutions.

The Hon. IAN WEST: I think the word "guardianship" in the Inebriates Act is in the language.

Prof. FREIBERG: I don't think we create new ideas over the years; we just recycle different ones.

The Hon. IAN WEST: I am just wondering if you are able to give us your advice as to how the wording of the Inebriates Act is not sufficient?

Prof. FREIBERG: I would have to plead guilty to not really looking at every clause. I thought that was something you have to do in your jurisdiction. But I am just not sure that the model it develops can be updated. I think you need to look at new intervention models generally.

The Hon. CATHERINE CUSACK: I understand in Pennsylvania under the Drug and Alcohol Youth Control Act they allow parents to commit their children or to go to a court and have their child admitted to an institution for drug rehabilitation. Parents go through a court process and it is all warranted by the court officer. How does that sort of concept strike you?

Prof. FREIBERG: Off the top of my head, I find it pretty loathsome a notion of that kind, third party commitment to whether it be mental health or those kinds of institutions. It fails to buy in the co-operation of the person who is involved. Mum and dad are tearing their hair out because the kids are addicted and stealing. I understand all that but you are not going to get the change by a third party intervention where the kid not only hates the world but then hates the parents for dobbing them in.

The Hon. CATHERINE CUSACK: Tonight, as every night, there will be between 10 and 20 parents going through Kings Cross looking for their children, finding them working as prostitutes and all of those sort of situations, finding the children, trying to get them to come home, trying to do something to help them, asking the Government to help them. I just feel really frustrated that as the children alone don't seem to have any ability to change their situation, for parents it is stressful that they have not got no power to do anything.

Prof. FREIBERG: I am very scared of civil commitment orders where people have not

committed crimes and using those as mechanisms for committing children. I think mental health has some pretty powerful foundations, although psychiatrists and psychologists tell you all the pitfalls of making sure that people do fall within the criteria of mental illness and the treatability aspects and they are reluctant to keep people for a long time. There are dangers in all the other criteria. But I think we have gone down that path previously and our own alcohol and drug offenders Acts are the equivalent of that kind of provision. They never worked and I just do not think they are an appropriate therapeutic justice kind of intervention when you deal with the ways that you might be able to help people help themselves. It may be a trigger mechanism but I am not sure it is the right one. I don't know anything about that.

The Hon. CATHERINE CUSACK: So would you support the right to drink yourself to death?

Prof. FREIBERG: In my notes that I prepared I quote from one of the authors of a book, *Should Patients be Allowed to Rot with Their Rights On?* I am not sure that I would want people to have the right to kill themselves. There are some rights of self-determination, but before the State steps in I want to make sure that we have pretty good legal and scientific foundation, that we know what we can do with them, because the danger in the past has been that we thought we could intervene and people were left to rot in therapeutic institutions while cures were ineffective, and what Don said before was that you have to make sure the intervention is not greater than the particular harmful behaviour triggering intervention. The history of past treatments and rehabilitation was that the intervention took far longer than anything that was warranted by anything anybody did, and that is why there is such caution about what legal mechanism to use, because if you rely on the doctors, frankly, they have no tools for pronouncing cures and when there are doubts they will keep them in institutions. I think that is a travesty in relation to people's rights to live and even their rights to kill themselves. You have got to be very careful that the State's rights, the State's powers do not become more dangerous than the problem you are seeking to solve, and there is a long history of that.

ACTING CHAIR: What safeguards do you want to see if that sort of process is followed then?

Prof. FREIBERG: That particular process?

ACTING CHAIR: Yes.

Prof. FREIBERG: I have absolutely no idea what that legislation says but I would want to see appropriate time limits, interventions, court supervision, clear criteria. There is a thousand criteria of good legislation and it would take me far longer than we have now to design one good civil commitment legislation, but it could be a mental health kind of legislation and the like. It could be analogous of non-conviction, compulsory commitment to custody legislation.

ACTING CHAIR: Have you got anything you would like to add?

Prof. FREIBERG: I probably want to say finally that I think you need to look beyond the legal issue of people's alcohol problems. Ms Cusack was saying before about domestic violence. It is not the alcohol that makes the problem. The development, for example, of a domestic violence court, one of the questions was do I agree with your chief magistrate's comments. Again, it misses the point that to send somebody on a bond - putting a treatment condition on it and you go away and you fix it, there is some eight week course, an hour a week on how to behave yourself and not get angry, I don't think you have got a great chance of being effective. You need mechanisms to bring the people together for a longer period of time and a domestic violence court under judicial supervision where people come back to court, report on progress, and it is not only the defendant who is involved, because if the man is going to go back to the family, there is a family dynamic problem as well, because treating one of the issues is not enough.

What I plead with you is look at this wholistically, look at different kinds of court models and

intervention models which are multi-disciplinary, wholistic, long term and well resourced and do not pick on the symptoms, otherwise you are going to have the same failure as Inebriates Act which was poorly resourced. Some of the ideas were good. We are beyond that. I think, as I make the argument, the problem-oriented approach tried to look at innovative ways, and the Drug Court is only one example, of dealing with these semi-intractable problems.

The other thing I would ask you to do is look very broadly at this non-conviction, semi-coercive, multi-disciplinary approach to dealing with social problems. It if it means throwing out the Inebriates Act or keeping bits of it but updating it, there are ways that everyone is groping for those hard cases that reflect the modern views about the rights to treatment people have, but the rights to be protected from other people's bad behaviour as well. That balance is hard to find, but I do not think you will find it in the current legislation.

(The witness withdrew)

(The Committee adjourned at 4.25 pm)