

Portfolio Committee No. 2 - Health and Community Services

Provision of drug rehabilitation services in regional, rural and remote New South Wales

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Terms of reference

That Portfolio Committee No. 2 – Health and Community Services inquire into and report on the provision of drug rehabilitation services in regional, rural and remote New South Wales, and in particular:

1. The range and types of services including the number of treatment beds currently available;
2. Specific details regarding rehabilitation services for those with amphetamine and methamphetamine (“ice”) addictions;
3. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis;
4. Registration and accreditation process required for rehabilitation services to be established;
5. The cost to patients/clients, including fee structures provided to families, for accessing rehabilitation services;
6. The waiting lists and waiting times for gaining entry into services;
7. Any pre-entry conditions for gaining access to rehabilitation services;
8. Investigate the evidence regarding the efficacy and impacts of mandatory detoxification programs for those who self-harm or are subject to an Apprehended Violence Order (AVO);
9. The gaps and shortages in the provision of services including geographical, resources and funding;
10. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services
11. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place;
12. Current and potential threats to existing rehabilitation services;
13. Potential and innovative rehabilitation services and initiatives including naltrexone; and
14. Any other related matters.

The terms of reference were self-referred by the committee on 28 September 2017.¹

¹ *Minutes*, NSW Legislative Council, 10 October 2017, p 1943.

Committee details

Committee members

The Hon Greg Donnelly MLC	Australian Labor Party	<i>(Chair)</i>
The Hon Paul Green MLC	Christian Democratic Party	<i>(Deputy Chair)</i>
Dr Mehreen Faruqi MLC*	The Greens	
The Hon Courtney Houssos MLC	Australian Labor Party	
Mr Scot MacDonald MLC	Liberal Party	
The Hon Dr Peter Phelps MLC	Liberal Party	
The Hon Bronnie Taylor MLC	The Nationals	

* Dr Mehreen Faruqi MLC substituted for Ms Dawn Walker MLC for the duration of the inquiry.

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Chair's foreword

The secret to change is to focus all of your energy not on fighting the old, but on building the new.

- Socrates

In many respects this NSW Upper House inquiry has been a relatively small exercise. It received 43 submissions and had eight hearing days. It visited only six regional locations – Nowra, Batemans Bay, Dubbo, Broken Hill, Grafton and Lismore. This report is barely 100 pages long and the committee resolved to, instead of making a long laundry list of recommendations to the Government, focus on just twelve. One can comfortably read through this report in an hour, and believe, or expect to believe, that they should have a reasonable understanding about alcohol and drug addiction and rehabilitation in regional, rural and remote New South Wales.

In some sense that is true, but in another, this report, indeed I would argue any report, simply cannot capture the utter misery, dysfunction, violence, humiliation, brokenness, despair and in far too many cases, the tragic loss of life caused by alcohol and drug addiction. If anyone doubts this can I invite them to, before reading the report, visit the inquiry's webpage, click on 'Hearings and Transcripts', and make their way through the testimony provided by the witnesses. A study of the submissions made to the inquiry will also provide first-hand insight into the ruination that can be visited upon individuals, families and communities as a result of alcohol and drug addiction. Having read the hearing transcripts and submissions one will understand that the report is like a series of snapshots that has sought to capture the picture of what alcohol and drug addiction and rehabilitation looks like in regional, rural and remote New South Wales. As a picture though, it only reveals so much. Behind that picture are individual lives, indeed humanity, that is profoundly diminished by the scourge of alcohol and drug addiction.

However, as many of the inquiry witnesses who had first-hand experience with alcohol and drugs said, the addiction need not have the final say. It does not have to be the victor. The human spirit and will can prevail in the end; it is the case though that individuals with addiction need treatment, encouragement, guidance, and the knowledge that others care and want them to get better. Without these the future for a person with addiction is grim.

Furthermore, the committee heard time and time again that recovery from addiction is not a once and for all settled matter. As many witnesses attested it is a daily struggle that never ends; it is 'one day at a time'. However, we do know that rehabilitation can and does work. The committee saw and heard, time and time again, cases of addicts' lives being transformed by rehabilitation. As is so often the case with both the provision and access to services in New South Wales and indeed Australia, the further one gets away from the major population centres, the more challenging it becomes in terms of connecting the people who need those services to them. This is neither a new issue or one that will be addressed in one or two budget cycles. However, there is no doubt that more, indeed much more can be done to assist so many in great need who suffer from alcohol and drug addiction in regional, rural and remote New South Wales. Citizens of this state who happen to live away from the major population centres should, in the 21st century, not have to experience such disadvantage.

I thank all those who took part in this inquiry via their written submission or oral evidence. Your professional expertise and your personal experience have very much shaped this report and its recommendations.

May I acknowledge in particular many from our Aboriginal communities across New South Wales who participated in this inquiry. I wish to specifically thank all those Aboriginal men and women who are working so diligently and selflessly to care and support those in their communities suffering from alcohol and drug addiction. Your voices were heard and we must do more to assist you.

I am also very grateful to my committee colleagues for the non-partisan way they approached the evidence, and for their commitment to recommending the best policy framework we can, so as to improve people's lives.

Finally, I thank the committee secretariat, Sharon Ohnesorge, Sam Griffith, Brett Rodgers and Nessa Abad, for their professionalism and resourcefulness at each stage of the inquiry.

I commend this report to the House and to the Government.

A handwritten signature in black ink that reads "Greg Donnelly". The signature is written in a cursive, flowing style.

Hon Greg Donnelly MLC
Committee Chair

Recommendations

Recommendation 1

62

That the NSW Ministry of Health implement, as a matter of urgency, a population-based planning tool, such as the Drug and Alcohol Service Planning model, to ascertain what rehabilitation services and how many beds are required throughout New South Wales, and in which regions.

Recommendation 2

64

That the NSW Government significantly increase funding to drug and alcohol-related health services, and use the data gathered through the population-based planning tool as outlined in recommendation 1, to:

- tender for the establishment of more residential rehabilitation services throughout regional New South Wales, including facilities for women and children, Aboriginal people, and young people including those aged 13 to 16
- tender for the establishment of more detoxification services throughout regional New South Wales, including facilities for Aboriginal people and young people
- investigate the benefits of establishing multi-purpose facilities in regional areas that provide detoxification, residential rehabilitation and outpatient services
- fund local social services and Aboriginal Medical Services in regional, rural and remote New South Wales to assist in transporting patients to and from drug and alcohol treatments
- provide incentives for qualified drug and alcohol professionals to relocate to regional areas and to upskill workers based in regional areas
- work with universities, in collaboration with the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists, on initiatives to develop more specialists in the drug and alcohol field
- investigate the efficacy of subsidising beds in regionally-based private, for-profit residential rehabilitation facilities to ensure more people from regional areas can access rehabilitation.

Recommendation 3

65

That the NSW Ministry of Health, as a matter of urgency, establish a central register for New South Wales of all available beds and facilities for drug and alcohol rehabilitation, which:

- includes real-time data concerning wait lists and wait times
- encompasses private health and medical services
- is publicly available as a resource for service providers, legal professionals and the community.

Recommendation 4

65

That the NSW Government conduct a review of the Drug Court and the Magistrates Early Referral Into Treatment program, including the feasibility of establishing them in additional regional areas.

Recommendation 5

65

That the NSW Government pilot a Drug Court in Dubbo in parallel with an increase in rehabilitation services for the area.

- Recommendation 6** **66**
That the NSW Government:
- commit to providing funding grants to non-government drug and alcohol-related service providers that run for a minimum of three years, with the option for a two year extension
 - advocate through the Council of Australian Governments for the Australian Government to commit to the same practice.
- Recommendation 7** **66**
That the NSW Government establish a standards framework for the private, for-profit residential rehabilitation industry.
- Recommendation 8** **66**
That the NSW Government ensure that public housing tenants who undertake residential drug rehabilitation or detoxification, not exceeding 12 months, do not lose their housing while undergoing treatment.
- Recommendation 9** **66**
That the NSW Government:
- acknowledge the health, social and economic benefits of prevention of drug and alcohol abuse
 - investigate the efficacy of implementing a state-wide school nurse program which includes targeting young people with preventative action and support.
- Recommendation 10** **83**
That the NSW Ministry of Health report to the NSW Parliament annually on the progress of the implementation and outcomes of the Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020 in regards to the drug and alcohol rehabilitation sector.
- Recommendation 11** **83**
That the NSW Government investigate the efficacy of establishing a scheme to establish a full time local Aboriginal trainee position alongside every skilled position recruited in areas with a significant Aboriginal population.
- Recommendation 12** **83**
That the NSW Government:
- trial adult and youth Koori Courts in various regional New South Wales locations for a period of twelve months
 - then conduct a comprehensive review to determine the appropriateness and need for further Koori Courts in other locations in regional New South Wales.

Conduct of inquiry

The terms of reference for the inquiry were self-referred by the committee on 28 September 2017.

The committee received 43 submissions and held eight public hearings. The first and final hearings were held at Parliament House in Sydney, while the other hearings were held in the following regional areas: Nowra, Batemans Bay, Dubbo, Broken Hill, Grafton and Lismore.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents and answers to questions on notice. Lists of all submission authors and hearing witnesses are located at appendices 1 and 2 respectively.

Glossary

ABS	Australian Bureau of Statistics
ACHS	Australian Council on Healthcare Standards
AH&MRC	Aboriginal Health and Medical Research Council
AOD	Alcohol and Other Drugs
AVO	Apprehended Violence Order
BOCSAR	Bureau of Crime Statistics and Research
DASP	Drug and Alcohol Service Planning
EQUIPS	Explore, Question, Understand, Investigate, Practice, Succeed program
MERIT	Magistrates Early Referral into Treatment program
NADA	Network of Alcohol and other Drug Agencies
NARHDAN	NSW Aboriginal Residential Healing and Drug Alcohol Network

Chapter 1 **The current state of play: provision of drug rehabilitation services**

This chapter provides an overview of the current state of play for the provision of drug rehabilitation services in regional, rural and remote New South Wales. This includes a discussion of the problem of drug addiction in regional areas, and information about the services available, funding arrangements and the process for patients to access facilities. While this inquiry has focused on addiction to illegal drugs, it has also encompassed alcohol addiction, as often these addictions go hand-in-hand.

Drug and alcohol addiction in regional New South Wales

- 1.1 The health challenges faced by people who live in rural and remote New South Wales are generally greater than for those living in major cities, with people living in rural and remote communities experiencing poorer health outcomes than those in metropolitan areas.²
- 1.2 These poorer health outcomes are coupled with the fact that there are fewer services available in regional areas to assist people with drug and alcohol addictions. As will be discussed throughout this report, there is a dearth of residential rehabilitation facilities available and fewer resources to assist people to break the drug-crime cycle. The committee visited six regional areas throughout the inquiry and the issues facing these communities will be discussed in detail in the next chapter.
- 1.3 Substance abuse is a complex issue which can have many underlying causes, including: environmental factors such as trauma, abuse, and a chaotic childhood; biological factors including genetics; and mental health disorders. Social factors can also have an impact, including a person's socio-economic status, education and housing security.³
- 1.4 The vast majority of all drug and alcohol treatment clients are poly drug users, who use a number of substances simultaneously.⁴
- 1.5 In fact, the NSW Government noted that alcohol was the most common principal drug of concern in regional New South Wales for people aged 41 years and over, and was also a significant issue for people aged 31-40 years (see Figure 1 below).⁵ People living in rural and remote New South Wales are more likely to drink alcohol at harmful levels, and rates of alcohol-attributable hospitalisations were eight per cent higher in regional areas in 2014-15.⁶
- 1.6 Amphetamine-type substances were the most common principal drug of concern for people aged 21 to 30 years in regional New South Wales, and cannabis was the principal drug of concern for young people under the age of 21.⁷

² Submission 34, NSW Government, p 29.

³ Submission 10, The Royal Australasian College of Physicians, p 3.

⁴ Submission 25, Network of Alcohol and other Drugs Agencies (NADA), p 5.

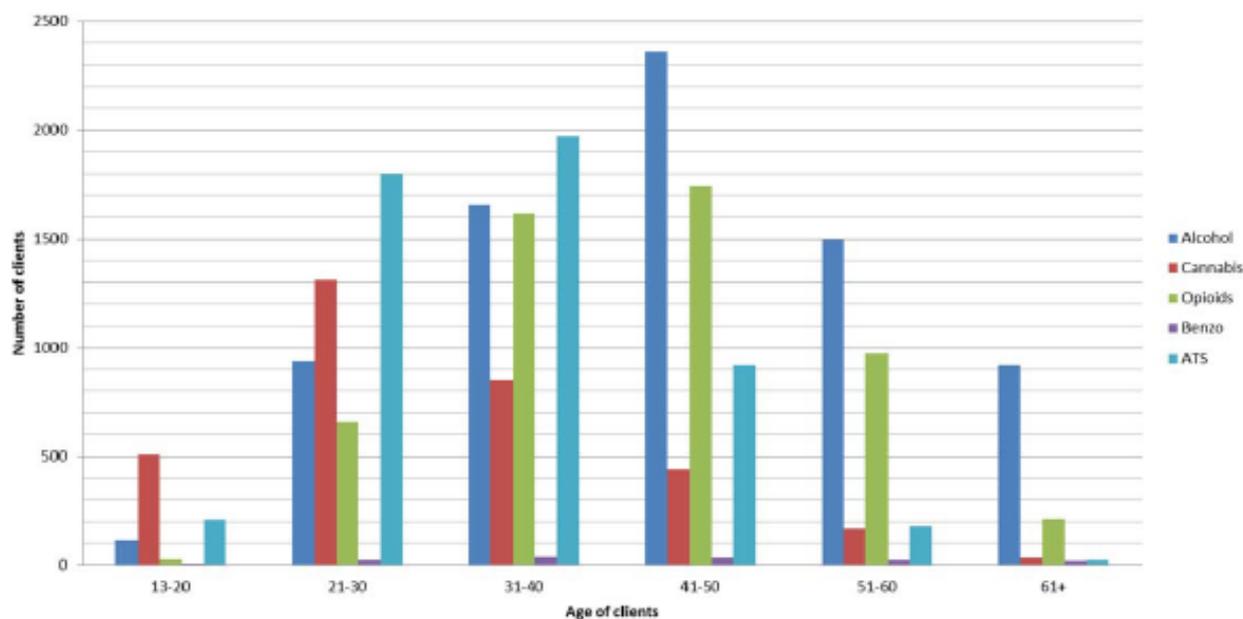
⁵ Submission 34, NSW Government, p 10.

⁶ Submission 34, NSW Government, p 29.

⁷ Submission 34, NSW Government, p 10.

- 1.7 Prescription drug abuse, particularly of benzodiazepines and other opioids, such as Oxycodone and Codeine, are a significant issue and are some of the most common substances present in drug induced deaths in New South Wales. In 2016, they were present in 67.1 per cent of drug induced deaths, excluding alcohol.⁸

Figure 1 Principal drug of concern by age group in regional areas for 2016-17



Submission 34, NSW Government, p 11.

- 1.8 The NSW Network of Alcohol and Other Drug Agencies (NADA), the peak organisation for the non-government alcohol and other drugs sector, provided data from its members regarding the differences in key demographics between drug treatment for New South Wales as a whole, compared with treatment in regional, rural and remote areas (see Table 1 below).⁹
- 1.9 Notably, the figures show that half of all treatments in New South Wales are in regional areas, even though almost 62 per cent of the New South Wales population lives in Greater Sydney. In addition, more patients identify as Aboriginal in regional areas and 69 per cent of regional clients identify either methamphetamine or alcohol as their principal drug of concern.¹⁰

⁸ Submission 34, NSW Government, p 3.

⁹ Submission 25, NADA, p 4.

¹⁰ Submission 25, NADA, p 4.

Table 1 NSW Network of Alcohol and Other Drug Agencies data for 2016-17

Item	All NSW	Regional, Rural, Remote NSW
Treatment services in NADAbase (n)	124	49
Episodes of treatment (n)	14 500	7043
Own substance use	96%	99%
Males	62%	64%
Females	38%	36%
Identify as Aboriginal	16%	21%
English as preferred language	98%	99%
Residential treatment episodes	32%	38%
Community-based (non-residential) episodes	58%	52%
Principal drugs of concern		
Methamphetamine	35%	34%
Alcohol	29%	35%
Cannabis	17%	14%
Heroin	7%	4%

Submission 25, Network of Alcohol and other Drugs Agencies (NADA), p 4.

Methamphetamine addiction

- 1.10** While traditionally alcohol has been considered the most common principal drug of concern, numerous inquiry participants highlighted that methamphetamine addiction has fast become a drug of significant concern for many in regional New South Wales.
- 1.11** Amphetamines are stimulant drugs, which means they speed up the messages travelling between the brain and the body.¹¹ The most potent form is crystal methamphetamine, which is stronger and more addictive, with more harmful side effects. Crystal methamphetamine is commonly referred to as 'ice' as it usually comes in small chunky clear crystals. Ice is typically smoked or injected, but is also sometimes swallowed or snorted.¹²
- 1.12** Mr Michael Higgins, Regional Community Engagement Manager for the Aboriginal Legal Service NSW/ACT, noted that he has received feedback from providers on the increasing prevalence of ice use in regional, rural and remote New South Wales. He described it as an 'insidious drug that is tearing apart families and ruining young lives' and is leading to alarming Aboriginal incarceration rates and much wider social impacts.¹³
- 1.13** Mr Gerard Byrne, Operations Manager, Recovery Services, Salvation Army stated that while for decades alcohol was the most commonly reported drug of use, in his observation 'it sits a distant second to methamphetamine use'. In some areas the Salvation Army reported that people who

¹¹ Alcohol and Drug Foundation, What are amphetamines?, <https://adf.org.au/drug-facts/amphetamines/>.

¹² Alcohol and Drug Foundation, What is ice?, <https://adf.org.au/drug-facts/ice/>.

¹³ Evidence, Mr Michael Higgins, Regional Community Engagement Manager, Aboriginal Legal Service NSW/ACT, 12 March 2018, p 28.

- 1.14** identified alcohol as their main drug has decreased from 55 per cent to 32 per cent. Mr Byrne clarified that there are not fewer people with an alcohol addiction, but rather more people with methamphetamine problems coming into treatment.¹⁴
- 1.15** Clr Stephen Lawrence from Dubbo Regional Council stated that methamphetamine-related hospitalisations in Western New South Wales Primary Health Networks have risen from approximately five hospitalisations per 100,000 in 2008-09, to approximately 110 per 100,000 in 2015-16.¹⁵
- 1.16** Some inquiry participants noted that one reason for the increase in methamphetamine use is its price; buying a cap of ice can be cheaper than buying beer.¹⁶ Ms Tanya Bloxsome, Acting Chief Executive Officer for Oolong Aboriginal Corporation told the committee that she has heard ice can be purchased for as little as \$8, and is being dealt in schools.¹⁷
- 1.17** Dr Michelle Cretikos, Director for Population Health Clinical Quality and Safety at the NSW Ministry of Health explained that overall community use of methamphetamine in New South Wales is declining, although from 2010 to 2016 there was an increase in the harms associated with its use:

It is important to understand that when we talk about overall community use we are talking about a decline in the overall population according to the national survey that has specific information about New South Wales use. However, there is most likely a ... small group of people who are using methamphetamines in more risky ways. That means injecting, using it in a higher purity crystal form, and using it more frequently. We have seen an increase in the harms associated with methamphetamine use since about 2010 in New South Wales. That is very clear in our data. Since 2010 until 2016, there has been a rapid increase in the harms associated with methamphetamine use. We believe that is now stabilising; in fact, across four of our indicators we have seen a reduction since a peak in about 2016.¹⁸

- 1.18** Mr David Reid, Director, Drug and Alcohol Service, NSW Health noted that in 2017, 29.9 per cent of people identified alcohol as their primary drug and 24.7 per cent identified methamphetamine.¹⁹ He explained that while technically there is not an ice 'epidemic' in New South Wales, there are some communities where it is a serious problem:

From our perspective we would not use the term 'epidemic'. I think we need to look at the statistics around ice use and methamphetamine use, and see that it is a serious problem in our community. I agree that there are probably pockets around New South

¹⁴ Evidence, Mr Gerard Byrne, Operations Manager, Recovery Services, Salvation Army, 12 March 2018, p 38.

¹⁵ Evidence, Clr Stephen Lawrence, Dubbo Regional Council, 9 May 2018, p 2.

¹⁶ Evidence, Ms Faye Worner, Chief Executive Officer, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, 5 April 2018, p 22.

¹⁷ Evidence, Ms Tanya Bloxsome, Acting Chief Executive Officer, Oolong Aboriginal Corporation, 5 April 2018, p 23.

¹⁸ Evidence, Dr Michelle Cretikos, Director, Population Health Clinical Quality and Safety, Centre for Population Health, NSW Ministry of Health, 12 March 2018, pp 55-56.

¹⁹ Evidence, Mr David Reid, Director, Drug and Alcohol Service, NSW Health, 5 April 2018, p 7.

Wales and the rest of the country where it is a far greater problem for the community. It is really impacting the social fabric of those communities. It takes up a lot of resources.²⁰

1.19 In 2015-16, the NSW Government invested an additional \$11 million over four years into new services to treat and support people who use crystalline methamphetamine, including:

- \$7 million to fund new stimulant treatment services in the Illawarra Shoalhaven, Mid North Coast, Northern NSW and Western Sydney Local Health Districts
- \$4 million to fund new non-government treatment services to tackle crystalline methamphetamine use in rural and regional areas. Services have been implemented through Lyndon Community and Directions ACT, in partnership with the Ted Noffs Foundation. From early 2016 to end of October 2017, 542 people have been assisted through these services.²¹

1.20 As part of the 2015 'Ice Election Commitment', the NSW Government also committed to the following implemented projects:

- building the capacity of the health system to respond to methamphetamine use
- educating the community on the dangers of methamphetamine use
- mandatory state-wide recording of pseudoephedrine sales in pharmacies.²²

1.21 In addition, at the federal level, in April 2015 the Australian Government established a National Ice Taskforce to provide advice on the development of a National Ice Action Strategy. The taskforce found that Australian families, communities and frontline service workers are struggling with the fallout from a growing number of dependent ice users. The report found that there was a need for coordinated and more targeted efforts to reduce the demand for and supply of ice. The strategy was agreed to at a December 2015 Council of Australian Governments meeting.²³

1.22 As part of the strategy, the Australian Government provided \$298.2 million over four years from 1 July 2016 to reduce the impacts associated with drug and alcohol misuse to individuals, families and communities. The government indicated that this 'investment, together with existing funding in drug and alcohol treatment of \$75 million per annum, demonstrates the Commonwealth's commitment to helping people overcome alcohol and drug misuse'.²⁴

²⁰ Evidence, Mr Reid, 5 April 2018, p 4.

²¹ Submission 34, NSW Government, p 16.

²² Submission 34, NSW Government, p 17.

²³ Australian Government Department of Health, National Ice Action Strategy, <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce>, last updated 14 March 2018.

²⁴ Australian Government Department of Health, National Ice Action Strategy, <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce>, last updated 14 March 2018.

Range and types of drug rehabilitation services

1.23 The term 'drug rehabilitation' refers to a range of drug treatments, including:

- residential rehabilitation programs
- withdrawal management ('detoxification')
- drug counselling
- medication
- opioid treatment
- hospital-based consultation services
- intensive outpatient programs and outreach services.²⁵

1.24 The diversity of treatments reflects the fact that there is not a 'one size fits all' approach, with the needs of patients varying depending on the severity of their addiction and where they are on their treatment journey. For example, some people may only require counselling, while some may need withdrawal management followed by counselling or residential rehabilitation.²⁶

1.25 The following table from the NSW Government's submission provides information regarding the number of people treated using the various types of rehabilitation services in both regional and metropolitan areas.

Table 2 Number of clients treated by NSW-funded alcohol and other drug services in 2016-17

Main service provided	Metropolitan LHDs	Regional LHDs	Total (n)	Total (%)
Counselling	6,302	5,582	11,884	26.4
Maintenance pharmacotherapy (opioid)*	5,031	3,894	8,925	19.8
Consultation activities	3,078	3,730	6,808	15.1
Assessment only	2,277	2,456	4,733	10.5
Residential withdrawal management	3,009	1,261	4,270	9.5
Support and case management only	1,815	2,162	3,977	8.8
Residential rehabilitation activities	1,297	933	2,230	4.9
Ambulatory withdrawal management	533	595	1,128	2.5
Ambulatory rehabilitation (day programs)	229	312	541	1.2
Involuntary drug and alcohol treatment	46	71	117	0.3
Maintenance pharmacotherapy (non-opioid)	29	34	63	0.1
Other	401	22	423	0.9
Total number of clients	24,047	21,052	45,099	100

Source: NSW Alcohol and Other Drug Treatment Services - Minimum Data Set, extracted 21 November 2017.¹

Submission 34, NSW Government, p 9.

²⁵ Submission 34, NSW Government, p 7.

²⁶ Submission 34, NSW Government, p 9.

- 1.26** While there are a range of treatments available, this inquiry has focused on the provision of residential rehabilitation services and detoxification facilities.
- 1.27** Many inquiry participants cited a holistic approach to treatment with 'wraparound services' as a vital part of rehabilitation, to address not only the addiction, but to help change clients' chaotic lifestyles and assist with housing, education, employment, community engagement and mental health.²⁷
- 1.28** Clr Darriea Turley, Mayor, Broken Hill City Council, noted that a holistic approach aims to provide individuals with access to a range of government services including 'health, social services, police, education and family and community services'.²⁸
- 1.29** Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australian College of Physicians agreed that government services should work closely together, as individuals suffering from drug and alcohol addiction often have significant comorbidities, including mental health issues.²⁹
- 1.30** Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South East Sydney Local Health District; and Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney, identified a range of comorbidities from which patients can suffer:

[O]ften we are looking at a 15 to 20 year period of people needing ongoing contact with services. Often it is quite complex in terms of the range of services that they require. Many people will develop physical health problems, such as hepatitis C, chronic pain problems with opiate use disorders, mental health problems, especially with alcohol and methamphetamine problems. There are all these comorbidities.³⁰

- 1.31** While Professor Lintzeris noted that residential rehabilitation services are a very important component of treatment and rehabilitation for a minority of individuals, he argued that it was vital for frontline emergency services to understand the range of available pathways when confronted with an individual with a drug and alcohol addiction:

We are often talking about police, emergency departments, the criminal justice system and mental health services. They are often the front line where they will have someone in front of them with a drug and alcohol problem. The presentation is not necessarily someone saying "I want rehab" or "I want my addiction cured". The presentation is often following either a criminal justice issue, a mental health problem or an ED

²⁷ See for example: Submission 15, Mission Australia, p 8; Evidence, Mr Larry Pierce, Chief Executive Officer, Network of Alcohol and other Drugs Agencies, 12 March 2018, pp 8-9; Evidence, Dr Lynne Magor-Blatch, Executive Officer, Australasian Therapeutic Communities Association, appearing on behalf of We Help Ourselves, 12 March 2018, p 41; Evidence, Ms Bloxsome, 5 April 2018, p 17; Evidence, Mr Andrew House, Social Worker, Broken Hill Correctional Centre, 10 May 2018, pp 11-12; Evidence, Mr David Pullen, Rural Chaplain, Broken Hill and Far West New South Wales, The Salvation Army, 10 May 2018, p 26

²⁸ Evidence, Clr Darriea Turley, Mayor, Broken Hill City Council, 10 May 2018, p 2.

²⁹ Evidence, Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australian College of Physicians, 12 March 2018, p 10.

³⁰ Evidence, Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South East Sydney Local Health District; and Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney, 3 July 2018, p 15

presentation. We need to make sure that we have pathways from those acute services into planned, integrated treatment pathways, better connection between services, ... we actually have a lot of drug and alcohol treatment services but historically they have not been well networked, well communicated.³¹

Residential rehabilitation

- 1.32** Residential rehabilitation is a long-term treatment which aims to assist clients in moving to a stage where they are drug and/or alcohol free, through addressing underlying issues in their life. Most residential services require clients to have already fully withdrawn from substances before admission and to remain drug-free throughout their stay.³² The NSW Government noted that residential treatment is more effective for people with severe deterioration, less social stability and high relapse risk.³³
- 1.33** NSW Government-funded residential rehabilitation is almost exclusively delivered by non-government organisations. These services managed 2,230 clients in 2016-17, with 933 (42 per cent) treated in regional areas.³⁴
- 1.34** The NSW Government indicated that it is difficult to quantify the exact number of publicly funded residential treatment beds, as funding comes from a variety of sources, including the NSW and Australian Governments, philanthropic donations and client contributions.³⁵
- 1.35** At the end of the inquiry, NSW Health advised that, as at July 2018, it is aware of 1,182 residential rehabilitation and withdrawal management beds in New South Wales across non-government and private providers. NSW Health funds 23 non-government organisations that provide 897 beds.³⁶
- 1.36** NADA noted that it has 20 members providing residential rehabilitation services in regional areas. This includes five programs specifically for treating Aboriginal clients, one women's only treatment centre and two youth only facilities. NADA estimated that there are a total of 420 residential rehabilitation beds available in regional, rural and remote New South Wales.³⁷
- 1.37** NSW Health also advised that it is aware of five privately-run residential rehabilitation/wellbeing centres in New South Wales.³⁸ The committee heard from Byron Private, which is a holistic residential treatment centre providing support services for individuals suffering from a range of issues, including drug and alcohol addiction. Byron Private provides a 12 bed, six week, intensive residential program for people who are in a position to pay for private treatment.³⁹

³¹ Evidence, Professor Lintzeris, 3 July 2018, p 19.

³² Submission 34, NSW Government, p 7.

³³ Submission 34, NSW Government, p 33.

³⁴ Submission 34, NSW Government, p 15.

³⁵ Submission 34, NSW Government, p 15.

³⁶ Answers to questions on notice, NSW Health, 20 July 2018, p 2.

³⁷ Submission 25, NADA, p 3.

³⁸ Answers to questions on notice, NSW Health, 10 April 2018, pp 5-6.

³⁹ Submission 13, Byron Private Pty Ltd, p 3.

- 1.38** Aboriginal-specific services in New South Wales, including residential rehabilitation facilities, services for Aboriginal women, and wraparound medical centres are discussed in detail in chapter 4.

Detoxification

- 1.39** Detoxification refers to a patient withdrawing from addictive substances, which can take between five and 10 days.⁴⁰ Detoxification does not address underlying factors that contribute to substance abuse.⁴¹ Some residential rehabilitation services have detoxification facilities onsite, while most require a person to attend a separate detoxification service prior to being admitted.
- 1.40** Dr Julaine Allan, a manager at the residential rehabilitation facility, Lives Lived Well – Lyndon, noted that while hospitals can provide a dedicated detox service, very few do.⁴² The Royal Australian and New Zealand College of Psychiatrists agreed that there are very few designated detoxification units in the public health system, meaning most detoxification occurs in hospital medical wards. In addition, some regional communities have limited or no detox options available in their area, as local hospitals may refuse to detox patients, or only detox for alcohol and not for other drugs.⁴³
- 1.41** Detoxification beds are also not always available on demand⁴⁴ and some participants noted that it may take one to four weeks to access a bed in regional areas.⁴⁵
- 1.42** NSW Health informed the committee that it is not possible to sustain a designated withdrawal management unit in every public hospital, and that 'assigning beds to a designated condition or patient group is a relatively inefficient way to manage beds in a public hospital'. Therefore it is routine to provide withdrawal management services in a non-designated area.⁴⁶
- 1.43** Mr David Reid, Director, Drug and Alcohol Service, NSW Health indicated that many people can also be detoxed at home, providing that their home life is stable enough to support this.⁴⁷

Drug rehabilitation services in the criminal justice system

- 1.44** Acknowledging the strong link between criminality and drug abuse, the NSW Government noted that it is currently operating a number of initiatives to 'break the drug-crime cycle'.⁴⁸

⁴⁰ Evidence, Ms Jenny Lovric, Program Manager, Cooperative Legal Service Delivery Program and Regional Outreach Clinic Program, Legal Aid NSW, 12 March 2018, p 25.

⁴¹ Submission 32, Royal Australian and New Zealand College of Psychiatrists, p 4.

⁴² Dr Julaine Allan, Group Manager, (Research), Program Delivery, Business Development and Clinical Governance, Lives Lived Well – Lyndon, 6 April 2018, p 4.

⁴³ Submission 32, Royal Australian and New Zealand College of Psychiatrists, p 3.

⁴⁴ Submission 17, The Salvation Army, p 8.

⁴⁵ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 9.

⁴⁶ Answers to questions on notice, NSW Health, 20 July 2018, p 9.

⁴⁷ Evidence, Mr Reid, 5 April 2018, p 4.

⁴⁸ Submission 34, NSW Government, p 18.

Magistrates Early Referral Into Treatment (MERIT) Program

- 1.45** The Magistrates Early Referral Into Treatment (MERIT) Program is a voluntary pre-plea, intensive three-month case management program for adult defendants that aims to address health and social welfare issues and break the drug-crime cycle. Progress in the MERIT program is taken into consideration upon sentencing. The program currently operates in 62 of the 150 local courts in New South Wales, 37 of which are in regional, rural or remote areas. In 2015, 33 per cent of MERIT program participants were from regional New South Wales.⁴⁹
- 1.46** MERIT Alcohol also operates for offenders with alcohol abuse issues in seven local courts, all of which are in rural or regional areas: Bathurst, Broken Hill, Coffs Harbour, Dubbo, Orange, Wellington and Wilcannia.⁵⁰

NSW Drug Court

- 1.47** The NSW Drug Court has been operating since February 1999. Its aim is to help adult offenders who have serious drug problems break the drug-crime cycle by providing a highly supervised and intensive program of treatment and rehabilitation involving the health sector and criminal justice system. The Drug Court is a minimum 12-month, primarily metropolitan based program and operates in Sydney, Parramatta and Toronto, near Newcastle.⁵¹ It is available only for offenders who live in those regions. It is not possible to be referred to the Drug Court from another part of New South Wales.
- 1.48** People have to be in custody in order to detoxify as part of the Drug Court program. There is a very high level of juridical supervision where people start by seeing the judge twice a week.⁵²
- 1.49** The Drug Court sits full time at Parramatta, six days a week at Toronto, and one day a week at the Downing Centre in Sydney. The Drug Court caters for up to 280 participants. Approximately 40 per cent utilise rehabilitation centres during the course of their programs. The rehabilitation centres operate independently of the Drug Court, which relies on Justice Health to assess Drug Court participants and determine if a rehabilitation centre is the best treatment option for that individual.⁵³
- 1.50** The Legal Aid's Drug Court team represents all participants through their program, and the Drug Court has a sanction system whereby participants are placed in custody for non-compliance with the program's requirements. Therefore, if a participant is not complying in a rehabilitation centre, the Drug Court can place them in custody for several weeks and readmit them, if appropriate.⁵⁴

⁴⁹ Submission 34, NSW Government, p 12.

⁵⁰ Submission 34, NSW Government, p 12.

⁵¹ Submission 34, NSW Government, p 12.

⁵² Evidence, Mr Martin Dalitz, Solicitor in Charge, Drug Court, Legal Aid NSW, 12 March 2018, p 24.

⁵³ Evidence, Ms Filiz Eminov, Executive Officer and Registrar, Drug Court of New South Wales, 3 July 2018, p 2.

⁵⁴ Evidence, Ms Eminov, 3 July 2018, p 2.

- 1.51 A randomised trial evaluation by the Bureau of Crime Statistics and Research and the Centre for Health Economics Research in 2002 found that the Drug Court is more cost effective than prison in reducing the rate of reoffending among offenders whose crime is drug-related.⁵⁵

Programs in correctional centres

- 1.52 Drug and alcohol addiction programs in correctional centres are delivered by Corrective Services NSW and Justice Health. In the 12 month period from October 2016 to September 2017, Corrective Services NSW staff delivered 162 addiction programs in regional New South Wales, both within correctional centres and in the community. Within correctional centres, the EQUIPS (Explore, Question, Understand, Investigate, Practice, Succeed) Addiction Program is designed to address the addictive behaviour of medium to high risk offenders and to provide participants with a pathway to support services for addictive behaviours. Under this program, 20 two-hour sessions are delivered to participants. From October 2016 to September 2017, 93 EQUIPS programs were delivered to 1,549 offenders across 20 regional centres.⁵⁶
- 1.53 Justice Health also provides a range of services including management of intoxication and withdrawal, counselling and opioid treatment for people within the correctional environment, courts and police cells. Justice Health also runs the post release Connections Program in regional areas to improve the continuity of care for clients with drug and alcohol problems who are being released into the community.⁵⁷
- 1.54 All persons entering custody undergo a comprehensive risk assessment for key concerns, including withdrawal from alcohol or drugs. Any person identified as being at risk is referred to the Drug & Alcohol Service for follow up. Detoxification services are available for any patient in custody that requires this support, regardless of location and on a 24 hour basis. Detoxification is managed according to NSW Health Clinical Guidelines and Justice Health procedures.⁵⁸

Juvenile Justice

- 1.55 Juvenile Justice provides rural residential rehabilitation services at Coffs Harbour and Dubbo. These services offer an intensive program to assist young people to address their alcohol and drug use connected with their offending behaviour.⁵⁹
- 1.56 The services are operated by non-government service providers (currently Mission Australia), selected through an open tender process. Each of the facilities has eight beds and caters for both male and female young people. It is a 12-week residential service with a maximum stay of four months, followed by 12 weeks aftercare support. There is not usually a waiting list for entry, however, entry is often delayed or stalled due to lack of access to detoxification facilities for young people prior to entering the service. A referral committee assesses each young person referred, to determine whether clinically supervised detoxification is required prior to entering

⁵⁵ Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (2008) 121 *Crime and Justice Bulletin*, p 2.

⁵⁶ Submission 34, NSW Government, p 13.

⁵⁷ Submission 34, NSW Government, p 12.

⁵⁸ Answers to questions on notice, NSW Health, 20 July 2018, p 15.

⁵⁹ Submission 34, NSW Government, p 14.

the service. The services accept young people on methadone, buprenorphine and/or other medically supervised medications.⁶⁰

- 1.57 During their residency, young people are required to participate in X-Roads. This is an evidence-based cognitive behavioural/dialectical behaviour intervention for young offenders who have problems with alcohol and other drug use and offending.⁶¹

Funding and accreditation

- 1.58 As noted above, funding for non-government rehabilitation services can come from a variety of sources, including the NSW and Australian Governments, philanthropic donations or client contributions.

Funding for services

- 1.59 For NSW Government-funded services, NSW Health generally undertakes a market testing process to select service providers based on a response to a set of tender criteria. Key principles for allocating funding include ensuring value for money, sustainability and fairness. Prospective service providers must be able to demonstrate that they have the capacity to deliver services effectively at a competitive price. Treatment services require various levels of funding dependent upon their client group and level of intensity of treatment required.⁶²
- 1.60 The NSW Ministry of Health's funding criteria for non-government organisations are set out in the non-government organisation Operational Guidelines. Funding agreements may be reviewed annually, or up to every three years, taking into account the level of compliance with the guidelines and the contractual agreement.⁶³
- 1.61 Under the contractual funding agreements between NSW Health and non-government service providers, payments are linked to achievement of key milestones and key performance indicators. The contracts are managed through regular service and performance reviews to ensure the terms of the contract are being met.⁶⁴
- 1.62 NADA noted that the types of criteria that its members must meet in order to receive government funding include:
- history of entity's operation and corporate size including staffing and locations of operation.
 - detail of the full range of programs and services currently provided including service cohort
 - current financial sustainability including total funding for previous year indicating specific source

⁶⁰ Additional information, Juvenile Justice NSW, July 2017, p 5.

⁶¹ Additional information, Juvenile Justice NSW, July 2017, pp 4-5.

⁶² Submission 34, NSW Government, p 18.

⁶³ Submission 34, NSW Government, p 18.

⁶⁴ Submission 34, NSW Government, p 18.

- provide evidence of effective operation for each program including outcomes measures used by the organisation and examples of good outcomes for participants under the program.
- details of corporate governance arrangements including accreditation, quality assurance, internal controls, incident and risk management systems.
- demonstrate an understanding of clinical governance as it applies to the providers of AOD services you intend linking with.
- details of staff qualifications and skills plus ongoing training and support arrangements.
- an explanation of the data collection system you will put in place to measure program activity and outcomes.⁶⁵

1.63 In the 2016-17 budget, the NSW Government announced a 'NSW Drug Package' to support young people, getting people into treatment, and families. The NSW Government invested \$197 million in 2016-17 for drug and alcohol services, and noted that it is increasing funding by \$75 million over four years.⁶⁶

Accreditation

1.64 According to the NSW Government, public sector alcohol and drug services are accredited as part of the general health services accreditation process.⁶⁷

1.65 Accreditation refers to both organisation and worker accreditation. It is based on recognition from an independent third-party that a service or program meets the requirements of defined criteria or standards. As well as providing quality and performance assurance for owners, managers, staff, funding bodies and consumers, accreditation:

- independently verifies competence and credibility
- builds a service with more efficiency and quality and performance assurance
- confirms quality improvement policies and procedures and their ongoing implementation
- provides international recognition
- enables benchmarking against relevant standards
- informs clients that the highest level of assessment of professionalism has been met
- flags a service's ability to meet mandatory regulatory requirements
- strengthens a service's ability to compete overall.⁶⁸

⁶⁵ Submission 25, NADA, p 5.

⁶⁶ Media release, The Hon Gladys Berejiklian and The Hon Pru Goward MP, NSW budget: \$75m boost to tackle the scourge of drugs, 19 June 2016.

⁶⁷ Submission 34, NSW Government, p 20.

⁶⁸ Submission 7, Community Life Batemans Bay Inc, p 4.

- 1.66** Accreditation for a non-government service can be obtained through generic accreditation and quality frameworks by a certified entity, or through specialised accreditation schemes. The alcohol and drug sector does not have a formal, national agency accreditation process, but a number of organisational accreditation systems are available, including:
- The Australian Council on Healthcare Standards EQUiP5 (5th edition of the ACHS Evaluation and Quality Improvement Program)
 - Quality Innovation Performance or QICSA and the Quality Improvement Council's Health and Community Services Standards 6th edition
 - The Institute for Healthy Communities Australia
 - Australian General Practice Accreditation Limited.⁶⁹
- 1.67** As part of their contractual agreements, NSW Health funded non-government organisations are expected to maintain accreditation and engage in formal quality improvement processes.⁷⁰

Accessing a residential rehabilitation facility

- 1.68** The following section examines the current process for gaining entry into a residential rehabilitation facility, including waiting times, pre-entry conditions and the costs involved.

Wait lists and wait times

- 1.69** The wait time for a bed in a non-government residential rehabilitation program varies greatly, but can be up to six months.⁷¹
- 1.70** Lives Lived Well – Lyndon, a non-government residential rehabilitation provider, noted that its wait time is usually eight to 12 weeks. It keeps a wait list of no more than 25 people as a lengthier list would mean the time frame for entry would be even longer. Lives Lived Well – Lyndon advised that people on the wait list must call every two weeks to confirm that they wish to remain on the list, and if they do not make contact, they are removed from the list.⁷²
- 1.71** The Broken Hill Working Group commented that this process was common amongst providers and considered it a barrier to entry, as calling on a regular basis can be a difficult commitment for an addicted person to make.⁷³
- 1.72** In contrast to non-government residential treatment services, Byron Private indicated that it is generally able to admit clients within seven days of application.⁷⁴ It argued that long waiting lists

⁶⁹ Submission 34, NSW Government, p 19.

⁷⁰ Submission 34, NSW Government, p 19.

⁷¹ See for example: Submission 7, Community Life Batemans Bay Inc, p 7; Submission 12, Broken Hill Working Group, pp 3-4; Submission 15, Mission Australia, p 6; Submission 32, Royal Australian and New Zealand College of Psychiatrists, p 6.

⁷² Submission 14, Lives Lived Well – Lyndon, p 5.

⁷³ Submission 12, Broken Hill Working Group, pp 3-4.

⁷⁴ Submission 13, Byron Private Pty Ltd, p 7.

for admission to a non-government residential treatment service is part of the reason why the numbers of for-profit treatment centres have proliferated.⁷⁵

1.73 The NSW Government identified some of the reasons why non-government services have long waiting lists:

- services may compile a waiting list comprised of all people contacting the service, without assessment or follow-up
- services may assess client eligibility and suitability before adding people to their waitlist
- services may also limit numbers so they are able to provide daily or weekly support
- services may require clients to complete inpatient withdrawal management prior to admission, which may not be clinically necessary for all patients, but can result in a challenge to co-ordinate timing between the withdrawal unit and the service
- services may require a copy of a client's criminal record prior to being considered
- services that offer longer term programs, for example up to nine months, will have longer waiting times as they need current clients to be discharged before a new client can commence treatment.⁷⁶

1.74 The NSW Government advised that consistent waitlist and waiting time information across New South Wales facilities is not available at present.⁷⁷

Pre-entry conditions

1.75 There are two common pre-entry conditions to be accepted into a residential drug rehabilitation program:

- a person must have undergone drug detoxification
- a person must not have been convicted of a serious criminal offence⁷⁸

1.76 Other prerequisites cited include a requirement for the client to have any bail conditions with them when entering a facility, to stabilise any mental health symptoms prior to entry, and to provide a Medicare card.⁷⁹

1.77 Community Life Batemans Bay explained that entering rehabilitation services, especially residential rehabilitation, requires time and personal commitment. This is why they complete an assessment process for all clients prior to entry, to ensure clients are committed and prepared to participate in a long-term program.⁸⁰

⁷⁵ Submission 13, Byron Private Pty Ltd, p 8.

⁷⁶ Submission 34, NSW Government, p 24.

⁷⁷ Submission 34, NSW Government, p 23.

⁷⁸ Submission 4, Far West Community Legal Centre, p 5.

⁷⁹ Submission 37, Oolong House, p 7; Submission 14, Lives Lived Well – Lyndon, p 6.

⁸⁰ Submission 7, Community Life Batemans Bay Inc, p 7.

- 1.78** From a for-profit perspective, Byron Private noted that its only pre-entry conditions for admission are that the client must not be currently suicidal, not have a history of violence or violent crimes and not be actively psychotic.⁸¹

Cost for patients

- 1.79** There are vast differences in terms of cost to attend rehabilitation services, depending on whether the service is privately funded, or government subsidised. Private services and facilities, particularly residential facilities, can be expensive and costs vary from \$5,000 to \$60,000 depending on the duration of stay, service location and support available.⁸² For example, Byron Private indicated that it charges \$950 per day for its services,⁸³ while Gunnebah Addiction Retreat charge \$230 per day.⁸⁴
- 1.80** In contrast, for residential care in the non-government sector, it is common for these services to be free of direct charge but for providers to seek a proportion of a client's Centrelink payment to support the provision of accommodation, meals, entertainment, transport and other non-therapeutic services. This usually amounts to between 50 and 80 per cent of client benefits.⁸⁵
- 1.81** For example, the Salvation Army noted that its clients contribute 80 per cent of their Centrelink benefits. However, if a client cannot meet the contribution percentage, the Salvation Army will consider adjusting or waiving the contribution.⁸⁶
- 1.82** The NSW Government advised that there is currently no official industry-wide fee structuring consensus in the non-government sector. Client charges or fees for service are usually determined by the type of funded service and the income and health insurance status of the individual.⁸⁷
- 1.83** The government indicated that public health services, such as hospital-based services and outpatient programs do not charge a fee. However, there may be costs for patients from rural and remote areas, for example the cost of travel if they need to access non-government drug rehabilitation services located in larger regional centres. The government noted that people travelling long distances for specialist medical treatment may be eligible for the Isolated Patients Travel and Accommodation Assistance Scheme.⁸⁸

⁸¹ Submission 13, Byron Private Pty Ltd, p 8.

⁸² Submission 15, Mission Australia, p 5.

⁸³ Submission 13, Byron Private Pty Ltd, p 7.

⁸⁴ Evidence, Mr Warwick Parer, Managing Director, Gunnebah Addiction Retreat, 26 June 2018, p 5.

⁸⁵ Submission 25, Network of Alcohol and other Drugs Agencies, p 6-7.

⁸⁶ Submission 17, The Salvation Army, p 7.

⁸⁷ Submission 34, NSW Government, p 22.

⁸⁸ Submission 34, NSW Government, p 22.

Committee comment

- 1.84** Drug and alcohol addiction is a critical issue facing regional, rural and remote New South Wales and is exacerbated by a clear shortage of specific health and medical services directed at addressing it. The committee heard that while there might not be an ice 'epidemic' in New South Wales, it is clear that crystal methamphetamine is a huge concern across the states' regional areas and has fast become the drug of choice for many people. The committee also notes that alcohol is the primary drug of concern for many people. It can be legally purchased, is readily available and is relatively cheap to buy.
- 1.85** The need for more services is apparent when the waitlist for many non-government residential rehabilitation facilities can stretch to six months. While the committee understands that there is a range of different types of rehabilitation services that people can access as part of their treatment, this report focuses on the need for more residential rehabilitation services providing holistic support to individuals, as well as the need for more detoxification beds for supervised withdrawal prior to rehabilitation.
- 1.86** In the next chapter, the committee explores the issues facing the regional communities we visited as part of this inquiry. Chapter 3 then examines in detail the key improvements in services delivery that are required.

Chapter 2 Regional snapshots

This chapter provides an overview of each region that the committee visited during the inquiry, noting the services available as well as the gaps that were identified by local inquiry participants. The committee travelled to Nowra and Batemans Bay on the South Coast, Dubbo and Broken Hill in the West and Far West, and Grafton and Lismore on the Far North Coast.

A theme that emerged throughout the inquiry was that many in the community are unaware of all the services available in their local area and broader region. This chapter therefore provides a snapshot of each region to the best of the committee's knowledge. The issue of improving publicly available information about drug rehabilitation services will be explored in the next chapter.

South Coast

- 2.1** On 4 and 5 April 2018 the committee travelled to Nowra and Batemans Bay to hold public hearings and visit the non-government residential rehabilitation facility, Hope House.

Nowra

- 2.2** The Illawarra and Shoalhaven Local Health District Drug and Alcohol Service informed the committee that in 2017, 3,236 clients attended the service for assistance with substance use issues.⁸⁹ Of these, 30 per cent sought help for their alcohol use, 24.7 per cent for amphetamines, 20 per cent for cannabis and 8 per cent for heroin.⁹⁰
- 2.3** Oolong House is the only residential rehabilitation facility located in Nowra. This is a 21-bed facility for adult men and is the only Indigenous rehabilitation service from the South Coast to the Victorian border.⁹¹ While the service is predominately for Aboriginal men, approximately 30 per cent of beds are reserved for non-Aboriginal clients.⁹² The service has a regular wait list of 40 people.⁹³
- 2.4** There is a small number of rehabilitation or detoxification facilities based in, or around Wollongong, which is an hour's drive from Nowra. These services include Watershed, Kedesh House and Triple Care Farm, which is a facility for young people aged 16 to 24 years.⁹⁴
- 2.5** Ms Margot Mains, Chief Executive, Illawarra and Shoalhaven Local Health District Drug and Alcohol Service, noted that it is currently piloting a partnership with the non-government residential rehabilitation service Watershed. The health district has purchased three beds in the

⁸⁹ Answers to questions on notice, NSW Health, 7 May 2018, p 3.

⁹⁰ Evidence, Ms Margot Mains, Chief Executive, Illawarra and Shoalhaven Local Health District Drug and Alcohol Service, 5 April 2018, p 2.

⁹¹ Evidence, Ms Tanya Bloxsome, Acting Chief Executive Officer, Oolong Aboriginal Corporation, 5 April 2018, p 12.

⁹² Evidence, Ms Bloxsome, 5 April 2018, p 22.

⁹³ Evidence, Mr Ivern Ardler, former Chief Executive Officer, Oolong Aboriginal Corporation, 5 April 2018, p 13.

⁹⁴ Evidence, Mr Ardler, 5 April 2018, p 13.

service where clients can be detoxed in a low-risk residential care setting and monitored on a daily basis by district nursing staff. Ms Mains noted that this enables 'a seamless pathway for clients moving from public to non-government organisation services'.⁹⁵

2.6 Ms Mains explained the process of a patient's entry into Watershed to their discharge:

So they come to our service, they see our doctors and nurses, they get assessed as being suitable and they go into Watershed for what is usually about a 10-day detox program. Our nurses will then go in every day and monitor them and so provide the sorts of expertise that a non-government rehabilitation service generally would not be able to afford to provide. At the end of that 10 days a number of things could happen. In some circumstances people will stay on and do a rehab program in the facility that they are in, and that is for about another month or six weeks, depending on the program. They may come back to our service as an outpatient and be followed up by our service or they may be discharged home.⁹⁶

2.7 Mr David Reid, Director, Drug and Alcohol Service, NSW Health indicated that there are no dedicated detox beds in public hospitals in the local area.⁹⁷ In order to detox in a public hospital, patients must have 'a high risk of medical issues'.⁹⁸

2.8 In addition, Mr Reid advised that there are no residential beds in the area providing a detox facility for low risk people.⁹⁹ This was confirmed by Mr Ivern Ardler, the former Chief Executive Officer of Oolong House, who explained that Oolong House therefore uses Watershed to detox clients or even enlists the assistance of Aboriginal medical services in the region to help transport clients to Bathurst or St Vincent's Hospital in Sydney.¹⁰⁰

2.9 Mr Ardler stated that there was an Indigenous service in Bega, but this has closed. Previously Oolong House would work closely with the service and refer clients to detox before entry into the residential rehab facility.¹⁰¹

2.10 The committee also heard from Waminda, which is an Aboriginal Community Controlled Health Organisation providing services for women and Aboriginal families. It operates from Wollongong to Eden, as well as inland. Waminda and Oolong House noted that they had worked together in 2017 to lodge a submission to NSW Health for an Aboriginal women's and children's rehabilitation facility in the area. They explained that they had been lobbying for this facility for many years, and had previously produced a business plan from a feasibility study in 2011.¹⁰²

⁹⁵ Evidence, Ms Mains, 5 April 2018, p 2.

⁹⁶ Evidence, Mr David Reid, Director, Drug and Alcohol Service, NSW Health, 5 April 2018, p 3.

⁹⁷ Evidence, Mr Reid, 5 April 2018, p 5.

⁹⁸ Evidence, Ms Lisa Wellington, Senior Program and Client Service Manager, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, 5 April 2018, p 16.

⁹⁹ Evidence, Mr Reid, 5 April 2018, pp 3-4.

¹⁰⁰ Evidence, Mr Ardler, 5 April 2018, p 13.

¹⁰¹ Evidence, Mr Ardler, 5 April 2018, p 13.

¹⁰² Evidence, Ms Faye Wornor, Chief Executive Officer, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, 5 April 2018, p 13.

Batemans Bay

- 2.11** During its time in Batemans Bay, the committee visited the residential rehabilitation facility Hope House, which is run by Community Life Batemans Bay. Hope House has supported 108 men from January 2016 to 30 November 2017. Of these, 91 have had alcohol and drug addictions, with 86 addicted to amphetamine and/or methamphetamines.¹⁰³

Figure 2 Committee site visit to Hope House, Batemans Bay



- 2.12** Community Life Batemans Bay indicated that ice is a major problem in the area, however there are no other rehabilitation services in or around Batemans Bay for people with amphetamine and methamphetamine addictions. The closest services are in Nowra or Canberra, which have long wait lists. The organisation argued that the supply of rehabilitation beds and services in the area is not keeping up with the demand due to lack of funding, facilities and qualified staff.¹⁰⁴
- 2.13** Southern NSW Local Health District informed the committee that it has integrated mental health and drug and alcohol into a single directorate. There are six community mental health, drug and alcohol teams across the region, based in Queanbeyan, Yass, Goulburn, Batemans Bay, Moruya, Bega and Cooma.¹⁰⁵
- 2.14** Alcohol is still the principal drug of concern in the region, with approximately 50 per cent of clients presenting for alcohol treatment. The MERIT program however has the highest percentage of illicit substance referrals, with 40 per cent for cannabinoids and 26 per cent for methamphetamine.¹⁰⁶

¹⁰³ Submission 7, Community Life Batemans Bay Inc., p 2.

¹⁰⁴ Submission 7, Community Life Batemans Bay Inc., p 2.

¹⁰⁵ Evidence, Ms Fiona Beston, Acting Manager, Strategic Coordinator Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug and Alcohol Service, 6 April 2018, p 29.

¹⁰⁶ Evidence, Ms Beston, 6 April 2018, p 30.

- 2.15** Mr Tim Leggett, A/Executive Director for Mental Health, Drug and Alcohol Service, Southern NSW Local Health District, noted the support in the regional community for the MERIT program and indicated that a top priority should be to expand the program, particularly in the Eurobodalla. He considered that this service could either be government or non-government operated.¹⁰⁷
- 2.16** Unlike in other regions, inquiry participants indicated that hospitals in the Southern NSW Local Health District do have dedicated withdrawal beds.¹⁰⁸
- 2.17** However, Mr Rohan Moreton, an Aboriginal Health Worker for the Katungul Aboriginal Community Corporation and Medical Service argued that one dedicated detox bed per hospital is not enough:
- We have got no detox unit, so we have to access the hospitals. We cover from Batemans Bay to Eden, so each hospital has only one bed for detox. ... So the size of Bega hospital, they have got one detox bed. Moruya has got one detox bed. Batemans Bay has got one detox bed. The mainstream and our service are all fighting over one bed to put our clients in for detox.¹⁰⁹
- 2.18** Ms Ann Kelly, a Clinical Nurse Consultant for Katungul Aboriginal Community Corporation and Medical Service noted that the service therefore often has to refer clients to the ACT in order to detox.¹¹⁰

West and Far West

- 2.19** On 9 and 10 May 2018 the committee travelled to Dubbo and Broken Hill to hold public hearings. Neither Dubbo nor Broken Hill have residential rehabilitation services for adults. There are also no dedicated detox beds in Dubbo, with the closest facility located in Orange.¹¹¹

Dubbo

- 2.20** Dubbo Regional Council noted that since 2013 the region has been actively lobbying the government regarding the lack of any drug rehabilitation service in the Dubbo area. A project group was formed to develop a proposal for government.¹¹² Clr Stephen Lawrence, Dubbo

¹⁰⁷ Evidence, Mr Tim Leggett, Acting Executive Director, Mental Health, Drug and Alcohol Service, Southern NSW Local Health District, 6 April 2018, p 32.

¹⁰⁸ Evidence, Ms Beston, 6 April 2018 p 31; Dr Julaine Allan, Group Manager, (Research), Program Delivery, Business Development and Clinical Governance, Lives Lived Well – Lyndon, 6 April 2018, p 4.

¹⁰⁹ Evidence, Mr Rohan Moreton, Aboriginal Health Worker, Katungul Aboriginal Community Corporation and Medical Service, 6 April 2018, p 40.

¹¹⁰ Evidence, Ms Ann Kelly, Clinical Nurse Consultant, Katungul Aboriginal Community Corporation and Medical Service, 6 April 2018, p 40.

¹¹¹ Evidence, Clr Stephen Lawrence, Dubbo Regional Council, 9 May 2018, p 5.

¹¹² Submission 2, Dubbo Regional Council, p 1.

Regional Council asserted that a promise was made prior to the 2015 state election for a rehabilitation centre and a drug court in Dubbo.¹¹³

2.21 In October 2017, the council again resolved to seek the establishment of a drug court and a residential rehabilitation centre in the area.¹¹⁴ Mr Murray Wood from the Dubbo Regional Council informed the committee that council aims to have a submission ready for the NSW Government in September 2018.¹¹⁵

2.22 As noted in the table below, there are some residential rehabilitation facilities in the West, however most are at least a two-hour drive from Dubbo.

Table 3 Residential rehabilitation services near Dubbo

Name	Type	Beds	Wait list
Mac River, near Dubbo	Rehabilitation for youth operated in conjunction with Juvenile Justice	8	3 months
Orana Haven (Brewarrina Aboriginal Corporation), Brewarrina	Rehabilitation for men. Aboriginal focus, will take non-Aboriginal clients but general population has to be around 60 per cent Aboriginal	18	2 months
Weigelli, Cowra	Rehabilitation, mixed-sex. Aboriginal focus, will take non-Aboriginal clients but general population has to be around 60 per cent Aboriginal	23	2 months
Lyndon Community, Orange	Mixed-sex withdrawal facility Mixed-sex rehabilitation facility Women's and children's rehabilitation facility, with a maximum of two children per woman (opening in 2018)	12 16 8	3 months each

Submission 2, Dubbo Regional Council, p 1

2.23 One key justification for the need for services in Dubbo is that the area suffers from entrenched high crime rates, which are between two and three times higher than the state average in almost all categories.¹¹⁶ The committee heard that Dubbo is also experiencing an increase of interrelated drug, alcohol and mental health problems, with the lack of local services meaning that people are not getting the necessary treatment.¹¹⁷

2.24 Clr Lawrence explained that in addition to the lack of local services, there is also no-one to assist people in accessing residential rehabilitation facilities outside of the area. Rehabilitation centres across the state are not funded for transport and many people are refused by courts to attend

¹¹³ Evidence, Clr Lawrence, 9 May 2018, p 3.

¹¹⁴ Submission 2, Dubbo Regional Council, p 2.

¹¹⁵ Evidence, Mr Murray Wood, Director, Community and Recreation, Dubbo Regional Council, 9 May 2018, p 6.

¹¹⁶ Evidence, Clr Lawrence, May 2018, p 2.

¹¹⁷ Submission 2, Dubbo Regional Council, p 2.

rehab as there is no viable option to get them there. For example, he argued that a court would not bail a person from Wellington Correctional Centre to attend rehabilitation as they would likely need to get a train and bus out to Brewarrina.¹¹⁸

2.25 Similarly, Mr Rod Towney, Chairperson of the Three Rivers Regional Assembly, highlighted that the Orana Haven Centre in Gongolgon and the Weigelli Centre at Cowra are both a long way from Dubbo. This makes it difficult to access the services and to interact with family while in rehab.¹¹⁹

2.26 Clr Lawrence expressed the view that the solution for Dubbo is to establish a detoxification facility, a 30-bed residential rehabilitation facility¹²⁰ and a local Drug Court that all work in tandem:

... NSW Health does not provide detoxification facilities at major hospitals in regional, rural and remote New South Wales. Persons admitted for other reasons may incidentally receive it, but there are no dedicated beds and services in our region for this. Lastly in the list of issues of gaps in service provision, Dubbo does not have a drug court. The need for a drug court has long been recognised. ... A rehabilitation centre and specialist detoxification facilities for that purpose are a key component of such a project. Council is strongly advocating for a suite of all three services so that we can have a drug court in Dubbo that works closely with a rehabilitation centre and withdrawal facilities.¹²¹

2.27 Mr Joe Gordon, a local drug and alcohol caseworker with the Salvation Army, agreed that Dubbo required a multi-purpose rehabilitation centre which covered drug and alcohol addictions, mental health and detoxification. He argued that it is important to have these services locally available as the most difficult part of the treatment journey is often the first step of getting someone into detoxification. He stated that if you cannot get them detoxified 'there and then that day ... you will lose them and you might not see them again for three months, six months'.¹²²

2.28 Mr Bill Dickens, the Solicitor in Charge for Legal Aid NSW in Dubbo indicated that Dubbo is the ideal place for these services as it is known as 'the hub of the west'. Dubbo provides services to a vast area including the townships of Bourke, Brewarrina, Lightning Ridge, Cobar, Nyngan, Warren, Trangie, Narromine, Coonamble, Walgett.¹²³

¹¹⁸ Evidence, Clr Lawrence, 9 May 2018, p 3.

¹¹⁹ Evidence, Mr Rod Towney, Chairperson, Three Rivers Regional Assembly, Member, Dubbo Aboriginal Community Working Party, and Member, Dubbo Local Aboriginal Lands Council, 9 May 2018, p 4.

¹²⁰ Evidence, Clr Lawrence, 9 May 2018, p 13.

¹²¹ Evidence, Clr Lawrence, 9 May 2018, p 3.

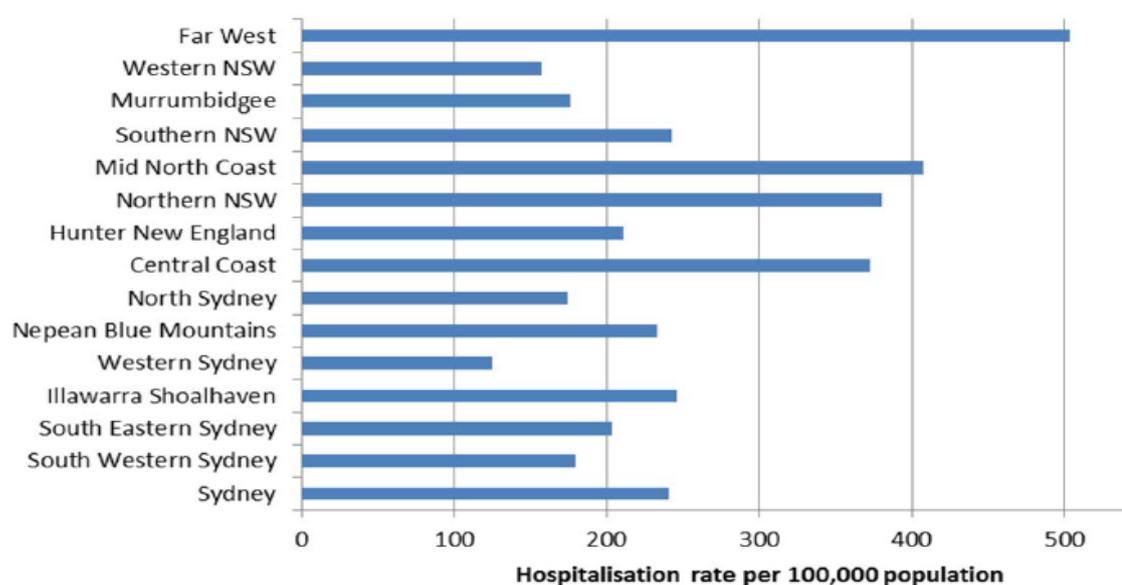
¹²² Evidence, Mr Joe Gordon, Alcohol and Other Drugs Caseworker, Salvation Army, Central West Co-operative Legal Service Delivery, 9 May 2018, p 16.

¹²³ Evidence, Mr Bill Dickens, Solicitor in Charge, Legal Aid NSW - Dubbo Regional Office, member, Orana Law Society, member, Central West Co-operative Legal Service Delivery, 9 May 2018, pp 15-16.

Broken Hill

- 2.29** Drug and alcohol addiction is a very serious issue for the Far West of New South Wales. Figures from the NSW Government, reproduced below, indicate that the Far West region has a much higher rate of hospitalisation for withdrawal or detoxification from alcohol and other substances than other areas in New South Wales.¹²⁴

Figure 3 Rate of hospitalisation for detoxification from alcohol and other substances, for the year 2015-16



Submission 34, NSW Government, p 15.

- 2.30** In December 2017, a working group was established in Broken Hill to respond to this committee inquiry. The group provided a submission and representatives appeared before the committee during the public hearing in Broken Hill on 10 May 2018.¹²⁵
- 2.31** The working group explained that the provision of drug detoxification and rehabilitation services in the Far West is extremely limited. The only residential rehabilitation service in the Far West is the Wiimpatja Healing Centre, which is located about 70 km from Wentworth (over 332 km from Broken Hill). The facility has eight treatment beds and provides services to Indigenous men only. Due to the scarcity of services, clients in Broken Hill are often referred to services either outside the state or in other Local Health Districts, including in Mildura, Adelaide, or Brewarrina.¹²⁶
- 2.32** There are three drug and alcohol counsellors in Broken Hill; at Maari Ma Aboriginal Health Corporation, MERIT and the Royal Flying Doctor Service. The working group expressed concern that these counselling services are insufficient for addicted persons who require full-time detoxification and rehabilitation. The group also noted the ongoing difficulty of attracting

¹²⁴ Submission 34, NSW Government, p 15.

¹²⁵ Submission 12, Broken Hill Working Group.

¹²⁶ Submission 12, Broken Hill Working Group, p 1.

qualified professionals to the Far West and that 'in some instances, people with lesser qualifications are providing services'.¹²⁷

2.33 The working group also identified a lack of services in the region for young people under the age of 18, non-Aboriginal clients and Aboriginal women.¹²⁸

2.34 Ms Rachel Storey, the President of the Far West Law Society, described the main barrier facing Broken Hill as the 'tyranny of distance':

The key issue, of course, facing Broken Hill at any time is the tyranny of distance, and that is in relation to the distance to go to rehabilitation centres but also the ability to stay in rehabilitation centres. Half of my practice, if not more, is now criminal law and I mainly represent inmates from the prison. I hear story after story of wanting to go to rehab but it is too far away.¹²⁹

2.35 Clr Darriea Turley, Mayor of Broken Hill City Council, agreed with this and observed that people have to travel hundreds of kilometres to access both detox and residential rehabilitation facilities:

... [O]ur people have no choice but to travel hundreds of kilometres to undergo drug detoxification. In most cases, a person in need of care needs to have detox from the drug before being eligible to enter a rehab service. Our people then travel hundreds of kilometres more to access those drug rehab services. Such distances impose severe barriers to access, which is exacerbated by the travel cost. For many disadvantaged people, the distance and cost are prohibitive. Further, the distance that people must travel to access drug rehab services displaces people from their local community and client supports to undergo treatment in unfamiliar environments without the benefit of family and friend contact.¹³⁰

2.36 Clr Turley argued that there is a significant need for drug detoxification and rehabilitation services in Far West New South Wales and noted that methamphetamine use in Wilcannia, Menindee, Tibooburra, White Cliffs, Ivanhoe and Dareton is particularly concerning.¹³¹

2.37 The Mayor therefore called for the establishment of a centre in Broken Hill to service the Far West and suggested that this should be an innovative model that is accepting of different demographics:

It needs to be culturally sensitive. It needs to reconsider the pre-entry conditions that a person must undergo drug detox before gaining access to rehabilitation services. It needs to consider that a person who has been convicted of a serious criminal offence is not eligible for treatment—it is often the drugs that have led them to that point. And there needs to be a space for drug users who are under 18. This will be a complex model, but it is a model that can be achieved...¹³²

¹²⁷ Submission 12, Broken Hill Working Group, p 2.

¹²⁸ Submission 12, Broken Hill Working Group, p 4.

¹²⁹ Evidence, Ms Rachel Storey, President, Far West Law Society, 10 May 2018, p 3.

¹³⁰ Evidence, Clr Darriea Turley, Mayor, Broken Hill City Council, 10 May 2018, p 3.

¹³¹ Evidence, Clr Turley, 10 May 2018, p 2.

¹³² Evidence, Clr Turley, 10 May 2018, p 3.

Far North Coast

- 2.38** On 25 and 26 June 2018 the committee travelled to Grafton and Lismore to hold public hearings.
- 2.39** The Northern New South Wales Local Health District advised that across the region the primary drug of choice is alcohol at 38 per cent, followed by opioids at 24 per cent, then cannabinoids at 19 per cent, and amphetamines at 15 per cent.¹³³
- 2.40** There are two main residential rehabilitation services in the region: The Buttery and Namatjira Haven. The Namatjira Haven is for Aboriginal men and The Buttery accepts all adults. Clarence Valley Council advised that closer to Coffs Harbour the facilities include Sherwood Cliffs, Adele House and Junaa Buwal Centre for Youth Wellbeing.¹³⁴
- 2.41** Namatjira Haven has 14 beds, including two funded by NSW Health, primarily for participants in the MERIT program, and three beds that are funded by Corrective Services NSW for parolees.¹³⁵ The service can also perform onsite detox for methamphetamine and cannabis addictions, but not for alcohol.¹³⁶
- 2.42** The Buttery has 26 beds, including two for the MERIT program.¹³⁷ Its main campus is near Bangalow. Mr Trent Rees, Residential Programs Manager, The Buttery, noted that the service has also recently opened a private, for-profit program with seven beds operating just outside of Murwillumbah.¹³⁸
- 2.43** The Buttery also offers outreach services through offices around the region and has recently been successful in tendering for the provision of continuous aftercare and caseworker services from the Far North Coast down to Port Macquarie, Kempsey.¹³⁹
- 2.44** The Northern New South Wales Local Health District indicated that it had a good working relationship with The Buttery and Namatjira Haven and organises client detoxification prior to entry into one of the rehabilitation centres.¹⁴⁰ Mr Wayne Jones, Chief Executive of the Northern NSW Local Health District described this as a 'relatively seamless process' thanks to long-term relationships with these organisations.¹⁴¹

¹³³ Evidence, Mr Wayne Jones, Chief Executive, Northern NSW Local Health District, 25 June 2018, p 2.

¹³⁴ Tabled document, Clarence Valley Council, Response to parliamentary inquiry into regional and remote rehabilitation services, 25 June 2018, p 3.

¹³⁵ Evidence, Ms Dian Edwards, Manager, Namatjira Haven Drug and Alcohol Healing Centre, 26 June 2018, p 21.

¹³⁶ Evidence, Ms Edwards, 26 June 2018, p 24.

¹³⁷ Evidence, Mr Trent Rees, Residential Programs Manager, The Buttery, 26 June 2018, p 32.

¹³⁸ Evidence, Mr Rees, 26 June 2018, p 29.

¹³⁹ Evidence, Mr Rees, 26 June 2018, p 30.

¹⁴⁰ Evidence, Ms Corrine Maynard, Manager, Richmond Clarence Drug and Alcohol Services, 25 June 2018, p 4.

¹⁴¹ Evidence, Mr Jones, 25 June 2018, p 9.

- 2.45** There is also a 14-bed inpatient withdrawal unit in Lismore at the Riverlands Drug and Alcohol Centre. It is the only public health inpatient withdrawal unit from Newcastle to Brisbane and provides services for people with substance dependence issues who require a medically supervised detoxification service. There are nursing staff on duty 24/7 with medical support from addiction medical specialists and visiting medical officers.¹⁴²
- 2.46** The local health district also has outpatient opioid treatment programs, stimulant treatment services, MERIT, drugs in pregnancy, drug and alcohol counselling and a community engagement outreach program. This outreach program is for individuals who have a high number of emergency department presentations and/or increasing presentations at various services because of substance use.¹⁴³
- 2.47** While Lismore has a detox unit at Riverlands, Ms Sarah Nash, Community Project Officer, Clarence Valley Council indicated that there are 'huge gaps' in services in the Clarence Valley which has no public detox services. In addition, there are three drug and alcohol positions in Grafton which are all currently vacant.¹⁴⁴
- 2.48** The drug and alcohol addiction specialist, Dr Trish Collie, stated she is likely the 'only fully trained regional addiction medicine physician in the region'.¹⁴⁵ She argued that Grafton and the Mid North Coast have few options for residential rehabilitation, particularly for Aboriginal patients. She noted that Benelong's Haven, which was in Kempsey, has recently been shut down. That service had provided 60 beds and had places for women, partners and people on the opiate treatment program. Although additional rehabilitation services are planned in this region, she stated that they will not cater for women and families, and will not offer programs specifically for Aboriginal patients.¹⁴⁶ NSW Health advised that Benelong's Haven was predominately a Commonwealth-funded facility.¹⁴⁷
- 2.49** Mr Trevor Kapeen, a Drug and Alcohol Addiction Worker for Bulgarr Ngaru Medical Aboriginal Corporation identified the Weigelli service near Cowra as the nearest facility for women. This is approximately a nine-hour drive from the Far North Coast.¹⁴⁸
- 2.50** Mr Hugh van Dugteren, Solicitor in Charge at the Legal Aid Lismore Office stated that from his experience, violent offences in the region tend to be alcohol and/or methamphetamine related and it is actually rare for these offences to not include some form of either untreated mental illness, alcohol or drug abuse.¹⁴⁹ He noted that there is a real gap in services on the Far North Coast for treating people with alcohol abuse, as alcohol is not included as part of the MERIT program.¹⁵⁰

¹⁴² Evidence, Mr Jones, 25 June 2018, p 2.

¹⁴³ Evidence, Mr Jones, 25 June 2018, p 2.

¹⁴⁴ Evidence, Ms Sarah Nash, Community Project Officer, Clarence Valley Council, 25 June 2018, p 46.

¹⁴⁵ Evidence, Dr Trish Collie, Drug and Alcohol Addiction Specialist, Bulgarr Ngaru Medical Aboriginal Corporation, 25 June 2018, p 17.

¹⁴⁶ Evidence, Dr Collie, 25 June 2018, p 18.

¹⁴⁷ Answers to questions on notice, NSW Health, 20 July 2018, p 4.

¹⁴⁸ Evidence, Mr Trevor Kapeen, Drug and Alcohol Addiction Worker, Bulgarr Ngaru Medical Aboriginal Corporation, 25 June 2018, p 23.

¹⁴⁹ Evidence, Mr Hugh van Dugteren, Solicitor in Charge, Legal Aid NSW, Lismore, 26 June 2018, p 42.

¹⁵⁰ Evidence, Mr van Dugteren, 26 June 2018, p 40.

- 2.51** Notwithstanding this evidence, Clarence Valley Council representatives highlighted a number of initiatives in the region for dealing with drug and alcohol addiction, including the highly successful Healthy Clarence initiative¹⁵¹ and the alcohol accord which contributed to a 25 to 30 per cent decrease in alcohol-related violence.¹⁵²
- 2.52** Clr Edwina Lloyd from Lismore City Council, noted that she is the chair of a recently established social justice and crime prevention committee in the region which is exploring the need and demand for 'a Drug Court, youth and adult Koori court, further residential rehabilitation beds, and justice reinvestment initiatives'.¹⁵³

Committee comment

- 2.53** The committee's travels throughout this inquiry have allowed us to hear first-hand the significant drug and alcohol issues affecting regional, rural and remote communities across the state. Everywhere the committee travelled, we heard similar tragic stories regarding the effects of addiction on individuals, families and communities, and the lack of rehabilitation services to support people suffering from addiction. This was perhaps most pronounced in Broken Hill, where the nearest rehabilitation service is well over 300 km away.
- 2.54** The evidence from regional areas indicates that there is a chronic shortage of facilities throughout the state. The next chapter will include key recommendations for the mapping of New South Wales to determine the most appropriate locations for new facilities, and for the NSW Government to significantly increase its funding to provide these critical services to our communities.

¹⁵¹ Evidence, Mr Des Schroder, Director, Environment Planning and Community, Clarence Valley Council, 25 June 2018, p 43.

¹⁵² Evidence, Mr Schroder, 25 June 2018, p 45.

¹⁵³ Evidence, Clr Edwina Lloyd, Lismore City Council, 26 June 2018, p 50.

Chapter 3 Improvements to the provision of drug rehabilitation services

This chapter discusses key improvements to the provision of rehabilitation services in regional, rural and remote New South Wales which have been identified by inquiry participants. Overall, participants considered that there is a lack of funding in drug and alcohol rehabilitation which means that there are a lack of facilities, beds and staff. However, inquiry participants also identified the need for funding to be distributed responsibly. This chapter therefore goes on to consider improvements in the areas of service delivery and publicly available information, as well as data collection, effective planning, measuring success and the oversight of facilities. The chapter concludes by discussing staffing and funding concerns. Issues specific to Aboriginal people living in regional, rural and remote New South Wales are discussed in chapter 4.

Lack of services

3.1 One common theme heard from stakeholders throughout the inquiry was the need to improve the provision of drug rehabilitation services in regional areas. The primary concern is that there are a lack of facilities and services, including:

- residential rehabilitation facilities and beds, including for women and young people
- detoxifications beds
- Drug Courts and the Magistrates Early Referral Into Treatment Program (MERIT)
- services inside correctional centres.

3.2 This section will canvass the lack of these facilities as well as discuss population planning models as a tool to measure where facilities are needed.

Residential rehabilitation facilities and beds

3.3 Many inquiry participants commented on the distinct lack of residential rehabilitation facilities and beds throughout regional New South Wales.¹⁵⁴ As identified in the previous chapter, many key regional areas such as Broken Hill and Dubbo have either no residential rehabilitation services, or very few. This not only results in clients having to travel long distances to access a facility, but also places additional pressures on waiting lists for the limited rehabilitation beds

¹⁵⁴ See for example: Evidence, Clr Stephen Lawrence, Dubbo Regional Council, 9 May 2018, p 2; Evidence, Mr Rod Towney, Chairperson, Three Rivers Regional Assembly, Member, Dubbo Aboriginal Community Working Party, and Member, Dubbo Local Aboriginal Lands Council, 9 May 2018, p 9; Evidence, Dr Mindi Sotiri, Program Director—Advocacy, Policy and Research, Community Restorative Centre—Broken Hill Office, 10 May 2018, p 29; Evidence, Mr Norm Henderson, appearing on behalf of the Dharriwaa Elders Group and Weigelli Aboriginal Corporation, 9 May 2018, p 34; Submission 17, The Salvation Army, p 14.

that are available across the state. As noted in chapter 1, the waiting lists in many non-government, facilities can be up to six months, and in some cases even longer.¹⁵⁵

- 3.4** The Network of Alcohol and other Drugs Agencies called for the establishment of new drug and alcohol treatment services, including residential rehabilitation, with priority given to establishing services in regional areas:

There also needs to be consideration given to the establishment of new treatment service sites in regional, rural and remote NSW. These new sites could be found in the existing spare capacity of Health Department or Local Health District owned and run sites and done in partnership with non-government organisation alcohol and other drug service providers who could more quickly establish new treatment programs including residential and outpatient services which could be run out of the same service infrastructure... A priority could be given to the establishment of new treatment services in regional, rural and remote NSW.¹⁵⁶

- 3.5** Other participants such as the Salvation Army indicated that throughout New South Wales the demand for residential treatment services is far exceeding supply. This is exacerbated in regional areas where there is a lack of available services due to the inadequacy of funding and the increased use of methamphetamine.¹⁵⁷
- 3.6** Legal Aid NSW's Cooperative Legal Service Delivery program identified the lack of detoxification and rehabilitation services in regional areas as a critical issue. In November 2017, the program convened regional planning days in Dubbo, Moree and Broken Hill, which were attended by a variety of justice and health workers. The lack of rehabilitation facilities was identified as a key priority in each of these locations.¹⁵⁸
- 3.7** Ms Jenny Lovric, Program Manager for the Cooperative Legal Service Delivery Program for Legal Aid NSW discussed the added stigma and hurdles for many regional people who must travel long distances to access a facility. This includes owning up to, and leaving family as well as negotiating travel where there are no public transport options, or the individual does not have a driver's licence.¹⁵⁹
- 3.8** The Broken Hill Working Group noted a further barrier, that those who wish to access rehabilitation services may have their access to public housing curtailed in that they would lose their public housing if it were left vacant over certain periods of time.¹⁶⁰

¹⁵⁵ See for example: Submission 7, Community Life Batemans Bay Inc, p 7; Submission 12, Broken Hill Working Group, pp 3-4; Submission 15, Mission Australia, p 6; Submission 32, Royal Australian and New Zealand College of Psychiatrists, p 6.

¹⁵⁶ Submission 25, Network of Alcohol and other Drugs Agencies (NADA), p 13.

¹⁵⁷ Submission 17, The Salvation Army, pp 8-9.

¹⁵⁸ Submission 27, Legal Aid NSW, p 9.

¹⁵⁹ Evidence, Ms Jenny Lovric, Program Manager, Cooperative Legal Service Delivery Program and Regional Outreach Clinic Program, Legal Aid NSW, 12 March 2018, p 25.

¹⁶⁰ Submission 12, Broken Hill Working Group, p 4.

Services for women, including women with children

- 3.9** The committee also heard evidence from a large number of inquiry participants regarding the importance of providing more residential rehabilitation services and beds specifically for women, particularly facilities where women can bring their children.¹⁶¹
- 3.10** Mr Joe Gordon, an Alcohol and Other Drugs Caseworker for the Salvation Army argued that more services for women are required as 'in this day and age, with ice, women are also using the drug the same as the males, and the children are just left to fend for themselves'.¹⁶²
- 3.11** Ms Melinda Plesman for the Family Referral Service, in the Clarence Valley, outlined the importance of having rehabilitation beds available for women where they can bring their children, as often it is not possible to leave a child with their family:

One of the things that I would like to put in about a rehabilitation centre is that I have worked with a lot of young parents, sole parents. The majority of them are women who have young children in child protection and they have drug addictions. It is really hard to find a place where they can go and take the children. That is really an important issue because a lot of the time there are no family supports. They are complex families and for three to six months that that would be necessary, there is nowhere to leave the children. Also, the parents—because of drug use and stuff—are disconnected from their children. Some of the young women I have worked with who have actually got into the one in Brisbane have found it so beneficial because it helps to repair their relationship with their children. It helps them to get on track with their parenting. It really is something that needs to be considered as well when we are looking at what we are going to do, particularly with young people under the age of 25 who have children, because they are out there using amphetamines.¹⁶³

- 3.12** The Broken Hill Working Group agreed with this, noting that the lack of options for women with children means that the children are at risk of being removed from their mother's care by the Department of Family and Community Services.¹⁶⁴

¹⁶¹ Evidence, Ms Kaylene Mallott, Team Leader, Pathways Goulburn, 6 April 2018, p 27; Evidence, Clr Darriea Turley, Mayor, Broken Hill City Council, 10 May 2018, p 8; Evidence, Mr Des Schroder, Director, Environment Planning and Community, Clarence Valley Council, 25 June 2018, p 43; Evidence, Ms Lisa Wellington, Senior Program and Client Service Manager, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, 5 April 2018, p 14; Evidence, Ms Sharon Moore, Community Project Officer, Clarence Valley Council, and, Chair, Community Drug Action Team, 25 June 2018, p 47; Evidence, Ms Dian Edwards, Manager, Namatjira Haven Drug and Alcohol Healing Centre, 26 June 2018, p 23; Evidence, Ms Jillian Heeley, Principal Solicitor, Far West Community Legal Service, 10 May 2018, p 10; Evidence, Ms Julie Perkins, Chairperson, Clarence Valley Aboriginal Healing Centre, Gurehlgam Corporation, 25 June 2018, p 51; Evidence, Ms Jenny McGee, Clinical Manager, The Buttery Private, 26 June 2018, p 29; Evidence, Ms Ann Kelly, Clinical Nurse Consultant, Katungul Aboriginal Medical Service, 6 April 2018, p 44; Evidence, Mr Hugh van Dugteren, Solicitor in Charge, Legal Aid NSW, Lismore, 26 June 2018, p 43; Evidence, Clr Edwina Lloyd, Lismore City Council, 26 June 2018, p 51.

¹⁶² Evidence, Mr Joe Gordon, Alcohol and Other Drugs Caseworker, Salvation Army, Central West Co-operative Legal Service Delivery, 9 May 2018, p 25.

¹⁶³ Evidence, Ms Melinda Plesman, Family Referral Service, Homelessness Youth Assistance Program, Clarence Valley, Social Futures, 25 June 2018, pp 32-33.

¹⁶⁴ Submission 12, Broken Hill Working Group, p 4.

- 3.13** While there are some services available for women and children, such as Kamira Farm on the Central Coast¹⁶⁵ and Odyssey House in Sydney,¹⁶⁶ the committee heard that these programs are few and far between.

Rehabilitation and detoxification services for young people

- 3.14** A number of inquiry participants called for more rehabilitation and detoxification services for young people.¹⁶⁷
- 3.15** Ms Gabriella Holmes, the Program Manager at Triple Care Farm (a residential rehabilitation and treatment program for young people aged between 16 and 24 years located in the Southern Highlands), confirmed that there is an unmet need for young people to access services. Ms Holmes indicated that her service no longer advertises as it cannot meet demand. She explained that the office receives 'upwards of 30 phone calls in a week inquiring for service for young people', and noted that it is generally a three month wait from a young person making an initial inquiry, to entering the program.¹⁶⁸
- 3.16** Ms Holmes indicated that Triple Care Farm recently started a detox service for 16 to 24 year olds, but observed that there is also a demand for detox for people under the age of 16. Ms Holmes stated that Triple Care Farm regularly gets inquiries regarding services for 13 year olds.¹⁶⁹
- 3.17** Mr Luke Butcher, Area Manager, Mission Australia agreed that a significant service gap in New South Wales is that there are no detox beds accessible for 13 to 16 year olds. He indicated that while this age group will generally not have the level of dependence and withdrawal syndrome as older people, there are still 'psychosocial factors at home where mum might be using, dad might be using and brothers might be using, et cetera, which makes home-based detox not necessarily the best option'.¹⁷⁰ Mr Butcher stated that 60 to 70 per cent of young people coming to Mission Australia services have a primary caregiver or parent who uses substances regularly at home.¹⁷¹
- 3.18** Inquiry participants noted that there are some excellent facilities for young people, such as Mac River in Dubbo and Junaa Buwal in Coffs Harbour. However, these are partnered with Juvenile Justice and 'rarely take kids from off the street. They will take them, but the first priority is Juvenile Justice kids'.¹⁷²

¹⁶⁵ Evidence, Ms McGee, 26 June 2018, p 37.

¹⁶⁶ Evidence, Mr Trent Rees, Residential Programs Manager, The Buttery, 26 June 2018, p 37.

¹⁶⁷ Evidence, Clr Turley, 10 May 2018, p 2; Evidence, Mr Ken Dennis, Manager, Broken Hill Aboriginal Legal Service, 10 May 2018, p 20; Evidence, Dr Robbie Lloyd, Community Relationships Manager, Port Macquarie Community College, 25 June 2018, p 41; Evidence, Ms Perkins, 25 June 2018, p 51.

¹⁶⁸ Evidence, Ms Gabriella Holmes, Program Manager, Triple Care Farm and David Martin Place, Mission Australia, 12 March 2018, p 38.

¹⁶⁹ Evidence, Ms Holmes, 12 March 2018, p 38.

¹⁷⁰ Evidence, Mr Luke Butcher, Area Manager, Mission Australia, 12 March 2018, p 46.

¹⁷¹ Evidence, Mr Butcher, 12 March 2018, p 45.

¹⁷² Evidence, Mr Trevor Forrest, Aboriginal Family Well-being and Violence Prevention Caseworker, Central West Cooperative Legal Service Delivery, 9 May 2018, p 22; Evidence, Ms Sonya Mears-

- 3.19** Mr Butcher confirmed that Mac River and Junaa Buwa! are Juvenile Justice funded and work exclusively with Juvenile Justice referred young people. He stated that 85 per cent of the young people accessing the program 'come via a custodial sentence—either on remand or on completion of a control order'.¹⁷³
- 3.20** Mr Hugh van Dugteren, Solicitor in Charge at Legal Aid NSW in Lismore, noted that with the lack of services for young people, a client in the Far North Coast had to travel to Dubbo in order to access a suitable facility:
- The young client of one my solicitors in the office is actually on bail at 16 and said, "I need to go to rehabilitation," which is quite an amazing insight for a 16-year-old. But there is a lack of rehabilitation—I think I have had to have clients go from here out to Mac River at Dubbo to access them. There have been programs at Coffs Harbour but really the only place he could get into from Tweed Heads was Dubbo.¹⁷⁴
- 3.21** Juvenile Justice NSW noted some service delivery challenges, particularly that their centres cannot provide detoxification, and that there is a lack of community-based residential detoxification services suitable for young people who are on a community-based court order.¹⁷⁵
- 3.22** In addition, the majority of referrals to these services are for young males, meaning it is difficult to adequately meet the needs of young women. Juvenile Justice NSW indicated that a female-only residential program is needed to meet the needs of young women, including programs on domestic and family violence, identity and self-esteem and sexual health.¹⁷⁶
- 3.23** Mr Gerard Byrne, for the Salvation Army, informed the committee that NSW Health had recently tendered for the provision of detox and residential treatment for young people, with the outcome yet to be confirmed.¹⁷⁷

Detoxification beds

- 3.24** As discussed in chapter 1, supervised detoxification usually occurs in hospital wards, however in New South Wales very few regional hospitals have dedicated beds or wards for detoxification. This means that in order to detoxify in a hospital, people often have to present to hospital with other acute health concerns.¹⁷⁸
- 3.25** Inquiry participants called for an increase in detoxification beds available in regional areas; whether this be dedicated beds in hospitals, dedicated detox services, or more multi-purpose facilities that can provide detox and rehab (an option discussed later in the chapter).

Lynch, Program Manager–Reconnect, *Getting it Together and Youth on Track*, Social Futures, 25 June 2018, p 31.

¹⁷³ Evidence, Mr Butcher, 12 March 2018, pp 39-40.

¹⁷⁴ Evidence, Mr van Dugteren, 26 June 2018, p 43-44.

¹⁷⁵ Additional information, Juvenile Justice NSW, 6 July 2017, p 5.

¹⁷⁶ Additional information, Juvenile Justice NSW, 6 July 2017, p 5.

¹⁷⁷ Evidence, Mr Gerard Byrne, Operations Manager, Recovery Services, Salvation Army, 12 March 2018, p 46.

¹⁷⁸ Evidence, Clr Lawrence, 9 May 2018, p 3.

Detoxification services also have a similar issue to residential rehabilitation services, where clients may have to travel long distances to access a suitable service.¹⁷⁹

3.26 While detoxification is a physical cleansing and does not address the underlying causes of drug addiction, as noted in chapter 1 most residential rehabilitation services will not accept clients until they have detoxed, making detox a critical step in the recovery process.

3.27 Professor Robert Batey, Clinical Professor of Medicine at the University of Sydney, noted that for many patients, detoxification at home 'is safe, effective and cheaper'.¹⁸⁰ He agreed however that detoxification in general medical beds is not ideal and that some hospitals are looking to find beds in less busy settings to perform detox:

It has happened for a variety of reasons as services have had to look at their funding and determine whether the continuation of a detox unit in a public setting is the most cost-effective way to use money. Certainly, a lot of patients are being detoxed in medical beds. That is perhaps not an ideal situation; they are more expensive and they are not as quiet as you would like for a detox unit. I am aware of some LHDs at this moment negotiating within their areas to try to find beds in less busy hospital settings to enable detox to be carried out in the public system in more appropriate areas.¹⁸¹

3.28 Ms Kaylene Mallott, Team Leader, Pathways Goulburn noted that Goulburn Hospital does not provide detoxification, and often people on ice will instead be detoxed in a mental health facility because of their psychosis:

The other thing is that I found in small communities like Goulburn they do not have a detox bed at the hospital. You cannot go to the Goulburn Hospital and detox. If you are psychotic from using ice you might be assessed as suitable to go into a mental health unit but ... most people can go three days without using ice and without having too many symptoms—and they are just getting out in time to start using again. Again, that is not a detox facility; it is a mental health facility. The hospital will not detox.¹⁸²

3.29 Ms Ann Kelly, a Clinical Nurse Consultant with the Katungul Aboriginal Medical Service, commented that monitored detoxification is important, particularly for people who are on ice:

... there still is a great need for detox and rehab care. When you are looking at the harm minimisation model, it is so necessary to have a facility to be able to put a 19-year-old who is off their head on ice somewhere safe. Then when you see them not on the drug ... they are a completely different person.¹⁸³

¹⁷⁹ Evidence, Mr Rohan Moreton, Aboriginal Health Worker, 6 April 2018, p 40; Evidence, Mr Ivern Ardler, former Chief Executive Officer, Oolong Aboriginal Corporation, 5 April 2018, p 13 and 16; Evidence, Ms Wellington, 5 April 2018, p 16; Evidence, Clr Turley, 10 May 2018, pp 2-3; Evidence, Ms Heeley, 10 May 2018, p 6; Evidence, Clr Lawrence, 9 May 2018, p 3; Evidence, Ms Shirley Diskon, Manager, Hope House, Community Life Batemans Bay, 6 April 2018, p 15; Evidence, Mr Bill Dickens, Solicitor in Charge, Legal Aid NSW - Dubbo Regional Office, member, Orana Law Society, member, Central West Cooperative Legal Service Delivery, 9 May 2018, p 16 and p 20.

¹⁸⁰ Evidence, Professor Robert Batey, Clinical Professor of Medicine, University of Sydney, 12 March 2018, p 54.

¹⁸¹ Evidence, Professor Batey, 12 March 2018, p 54.

¹⁸² Evidence, Ms Mallott, 6 April 2018, p 25.

¹⁸³ Evidence, Ms Kelly, 6 April 2018, p 40.

- 3.30** On the other hand, Mr Norm Henderson observed that some hospitals consider it a waste of resources to detox, as the person will likely be back a few days later in the same condition:

It is a revolving door. This is why hospitals are reluctant to do detox. They say to people like me who are trying to arrange a detox, "Yeah, Norm, we know, we understand, but we know Johnny here, he will be back. If we cannot get him to detox he will back in two days' time in the same state. So it is a waste of time detoxing him".¹⁸⁴

Drug Court

- 3.31** During the inquiry the committee heard evidence that the Drug Court should be expanded to regional areas.¹⁸⁵ As noted in chapter 1, there are currently only three Drug Courts in New South Wales, which are situated in the metropolitan areas of Sydney, Parramatta and Toronto, located near Newcastle. These are only available for offenders who live in those regions. It is not possible to be referred to the Drug Court from another part of New South Wales.
- 3.32** Dubbo's call for a Drug Court was canvassed in the previous chapter, particularly Dubbo City Council's proposal for a rehabilitation centre, detox facility and a Drug Court to be established in the city.¹⁸⁶ Dubbo City Council considered a Drug Court to be an integral part of this three-pronged model as it is a cost-effective tool to reduce the rate of re-offending and intergenerational disadvantage.¹⁸⁷ However, for the model to work, Clr Stephen Lawrence noted that there must be a residential rehabilitation centre as people entering the Drug Court program will have a component of their experience in a residential facility.¹⁸⁸ In fact, the committee heard that 40 per cent of people attending the Drug Court access residential rehabilitation facilities.¹⁸⁹
- 3.33** Ms Filiz Eminov, Executive Officer and Registrar for the Drug Court agreed that the 'Drug Court definitely needs rehabilitation services wherever it may be. It needs more beds, more services'.¹⁹⁰
- 3.34** Mr Martin Dalitz, Solicitor in Charge at the Drug Court for Legal Aid NSW indicated he was aware of community campaigns in 'Dubbo, Wagga Wagga, the Illawarra and Wollongong area and, more recently, the Central Coast to expand the Drug Court'. He argued that in monetary terms, 'it is cheaper to keep people in the Drug Court than it is to keep them in jail, and Drug Court participants are people who would be in jail if not for the fact that they are in the Drug Court program'. However, Mr Dalitz agreed that without more rehabilitation facilities, this expansion will not happen.¹⁹¹ He noted that as it stands, '[a]ll of the rehabs are being used and are bulging at the seams with Drug Court participants'.¹⁹²

¹⁸⁴ Evidence, Mr Henderson, 9 May 2018, p 29.

¹⁸⁵ Evidence, Mr van Dugteren, 26 June 2018, p 49.

¹⁸⁶ Evidence, Clr Lawrence, 9 May 2018, pp 2-3.

¹⁸⁷ Submission 2, Dubbo Regional Council, p 3.

¹⁸⁸ Evidence, Clr Lawrence, 9 May 2018, p 13.

¹⁸⁹ Evidence, Mr Martin Dalitz, Solicitor in Charge, Drug Court, Legal Aid NSW, 12 March 2018, p 19.

¹⁹⁰ Evidence, Ms Filiz Eminov, Executive Officer and Registrar, Drug Court of New South Wales, 3 July 2018, p 8.

¹⁹¹ Evidence, Mr Dalitz, 12 March 2018, p 20.

¹⁹² Evidence, Mr Dalitz, 12 March 2018, p 21.

3.35 Mr Dalitz noted that a further barrier to establishing regional Drug Courts is the need to cater for pharmacotherapy clients, something that many rehabilitation services cannot do:

There is also the complication which is an issue in relation to the availability of medical staff... The reality is that a good percentage of people who are in rehab require pharmacotherapy and unless that facility can cater for pharmacotherapy clients—and most of them cannot—then those clients of ours go untreated. In the absence of more comprehensive rehabs to address all those issues, then the Drug Court cannot expand.¹⁹³

3.36 The Drug Court has been evaluated by the New South Wales Bureau of Crime Statistics and Research (BOCSAR) on four occasions.

- 2002 – A randomised trial evaluation of the cost-effectiveness of the NSW Drug Court program in conjunction with the Centre for Health Economics Research and Evaluation, The evaluation found that the Drug Court was more cost-effective than conventional court sanctions (mostly imprisonment) in reducing the risk of re-offending.¹⁹⁴
- 2005 – The evaluation found that people on the Drug Court program were '37 per cent less likely to be convicted of an offence; 65 per cent less likely to be convicted of an offence against a person; 35 per cent less likely to be convicted of a property offence; and 58 per cent less likely to be re-convicted of a drug offence'.¹⁹⁵
- 2008 – The evaluation compared Drug Court participants with a comparison group and found that the Drug Court program is more effective than conventional sanctions in reducing the risk of recidivism among offenders whose crime is drug-related.¹⁹⁶
- 2011 – The evaluation considered the effects of increased judicial supervision whereby half the Drug Court cohort appeared before the judge once per week (as per usual), and the other half appeared twice a week. The study found that increased judicial supervision had much better outcomes. As a result, the Drug Court changed its program to increase the level of supervision or the appearances before the judge.¹⁹⁷

¹⁹³ Evidence, Mr Dalitz, 12 March 2018, p 21.

¹⁹⁴ Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (2008) 121 *Crime and Justice Bulletin*, p 2.

¹⁹⁵ Evidence, Ms Eminov, 3 July 2018, pp 6-7.

¹⁹⁶ Don Weatherburn et al, 'The NSW Drug Court: A re-evaluation of its effectiveness' (2008) 121 *Crime and Justice Bulletin*, p 12.

¹⁹⁷ Evidence, Ms Eminov, 3 July 2018, pp 6-7.

Magistrates Early Referral Into Treatment Program (MERIT)

- 3.37** Inquiry participants supported the MERIT program, with a number calling for it to be rolled out across all of New South Wales.¹⁹⁸
- 3.38** Mr Michael Higgins, Regional Community Engagement Manager, Aboriginal Legal Service NSW/ACT explained that similar to the Drug Court, MERIT also requires rehabilitation infrastructure to be in place in order to function effectively:
- I think there would very much be support for the expansion of the MERIT program but, again, MERIT is very much based on a wraparound support service system that has to be there as well. You must make sure that the support structure and those resources are there wherever you want to put the program, but certainly the model itself is very reputable. We would certainly support an expansion of it but an appropriate expansion.¹⁹⁹
- 3.39** Ms Jenny Lovric from Legal Aid NSW commented that MERIT is a great program that is supported by magistrates, and that 'magistrates in courts where MERIT does not exist are often bemoaning its absence'.²⁰⁰ She noted that Legal Aid NSW has been lobbying to have MERIT rolled out across all of New South Wales, especially to regions which have high rates of drug and alcohol use, but also acknowledged that this roll-out will require more rehabilitation facilities to be established. In addition, Ms Lovric indicated that MERIT should be expanded to include alcohol in all areas and to allow people with indictable offences to access the program.²⁰¹
- 3.40** Mr Hugh van Dugteren, Solicitor in Charge, Legal Aid NSW was also supportive of MERIT and called for it to be expanded on the Far North Coast to include alcohol, as this is a large problem in the area.²⁰² He observed that many of his clients who accessed MERIT 'are not on the same recidivism treadmill' as clients who have not accessed the program and that many choose to stay in rehabilitation beyond the 12-week program.²⁰³
- 3.41** He explained that MERIT works best when magistrates understand issues relating to addiction and rehabilitation, as many people relapse and are unsuccessful in getting clean on their first attempt. He regarded a zero tolerance policy from magistrates regarding breaches of MERIT bail conditions as unhelpful, as it keeps people in the criminal justice system.²⁰⁴
- 3.42** Mr van Dugteren also discussed the importance of the former Mission Australia program 'Life on Track' which had previously worked hand-in-hand with the MERIT program:

¹⁹⁸ Evidence, Mr David Reid, Director, Drug and Alcohol Service, NSW Health, 5 April 2018, p 9; Evidence, Ms Mallott, 6 April 2018, p 22; Evidence, Mr Tim Leggett, Acting Executive Director, Mental Health, Drug and Alcohol Service, Southern NSW Local Health District, 6 April 2018, p 32.

¹⁹⁹ Evidence, Mr Michael Higgins, Regional Community Engagement Manager, Aboriginal Legal Service NSW/ACT, 12 March 2018, pp 34-35.

²⁰⁰ Evidence, Ms Lovric, 12 March 2018, p 23.

²⁰¹ Evidence, Ms Lovric, 12 March 2018, p 24.

²⁰² Evidence, Mr van Dugteren, 26 June 2018, p 39.

²⁰³ Evidence, Mr van Dugteren, 26 June 2018, p 42.

²⁰⁴ Evidence, Mr van Dugteren, 26 June 2018, p 39.

There was a program in Lismore called Life on Track; it lasted two to three years and then was replaced by another thing called the Elective Offender Management Scheme. I am afraid to say I think it was a very poor decision. Life on Track worked intimately with MERIT and it was a program that was run by Mission Australia. They accessed people through the courts through referrals by the magistrates, and I know that two of the magistrates who had access to the Life on Track program thought it was a fantastic program. It went longer than MERIT. They provided assistance after the court...²⁰⁵

- 3.43** Mr Dickens noted that the MERIT program is currently being reviewed by an interdepartmental steering committee with representatives from Justice, Health, the NSW Police Force and the Chief Magistrate's Office.²⁰⁶

Population planning models to identify need

- 3.44** Mr Robert Stirling, Deputy Chief Executive Officer, Network of Alcohol and other Drugs Agencies noted that drug addiction is 'an emotive issue' and the response from government is often driven by media headlines announcing that there are drug 'epidemics'. He instead called for government to adopt 'a more rational population health model for dealing' with drug addiction.²⁰⁷
- 3.45** The Network of Alcohol and other Drugs Agencies (NADA) indicated that a number of years ago, it had participated in the development of a national modelling tool, now called the Drug and Alcohol Service Planning (DASP) model. This was commissioned by a Council of Australian Governments sub-committee. The work associated was completed and endorsed by the council, but has not been implemented.²⁰⁸ Mr Pierce stated that this was primarily due to budgetary implications.²⁰⁹
- 3.46** Mr Pierce noted that the model is similar to the population planning that the mental health sector has been doing for almost 20 years. It provides a framework for planning for the number of people in need of services, based on population numbers and on the epidemiology around how many people are suffering from a moderate, mild or acute drug and alcohol use and dependency problem. It will then identify what is required in terms of access to detoxification, residential rehabilitation and outpatient treatments. So it could pinpoint for example that in 'Goulburn, we need 35 rehabilitation beds [and] 10 inpatient detox beds'.²¹⁰
- 3.47** Using the model, NADA estimated that New South Wales requires 1,700 residential rehabilitation beds to provide adequate care across the state. Currently, however, there are only approximately 700-800 beds available.²¹¹ In addition, conservative estimates using the modelling indicate that there is 'a deficit in current budget terms across the entire program, of

²⁰⁵ Evidence, Mr van Dugteren, 26 June 2018, p 42.

²⁰⁶ Evidence, Mr Dickens, 9 May 2018, p 23.

²⁰⁷ Evidence, Mr Robert Stirling, Deputy Chief Executive Officer, Network of Alcohol and other Drugs Agencies, 12 March 2018, p 5.

²⁰⁸ Submission 25, NADA, p 9.

²⁰⁹ Evidence, Mr Larry Pierce, Chief Executive Officer, Network of Alcohol and other Drugs Agencies, 12 March 2018, p 4.

²¹⁰ Evidence, Mr Pierce, 12 March 2018, p 4.

²¹¹ Submission 25, NADA, p 10.

approximately \$40 million per annum'. NADA observed that existing waiting lists for services such a residential rehabilitation support this deficit.²¹²

- 3.48** NCOSS endorsed the model and argued that 'funding allocations must be informed by robust and evidence-based assessment of population and community need'.²¹³

Better service delivery

- 3.49** The committee heard evidence regarding a range of logistical matters to assist in improving drug rehabilitation service delivery, including a better transition from detoxification to rehabilitation, the importance of aftercare support, and transportation assistance.

Better transition between detoxification and rehabilitation services

- 3.50** As detoxification is a physical cleansing that does not address the underlying causes of drug addiction, inquiry participants discussed the importance of developing a smoother transition between detoxification and residential rehabilitation, so the patient does not relapse. Currently, due to the lack of rehabilitation beds there is often a lengthy waiting period between detox and rehab.

- 3.51** Clr Edwina Lloyd, Lismore City Council, spoke from personal experience regarding the importance of developing a smoother transition from detox to residential rehabilitation:

Another huge problem I would say is what people have given evidence about, there is no smooth transition from detox into residential rehab. It is very difficult—I can speak from personal experience—to find that small window of opportunity where you have that motivation and willingness to do something about your drug addiction. That point in detox when you have come off those drugs or alcohol for the first time is that moment. It is that moment that we need to seize and make sure that there is a smooth transition straight from detox into rehabilitation. Lots of waiting lists. When I did my submission, regarding The Buttery, that was their waiting list at that time and today we have heard it is seven months long. It is only increasing and getting worse.²¹⁴

- 3.52** Mr David Reid, Director, Drug and Alcohol Service, NSW Health, acknowledged that there can be a wait to get a residential rehabilitation bed following detoxification, sometimes up to four weeks.²¹⁵

- 3.53** Mr Rohan Moreton, an Aboriginal Health Worker based on the South Coast, also noted that there can be a waiting period of about four or five weeks between detox and rehab, and this is even with having good working relationships with services in Canberra and Nowra.²¹⁶

²¹² Submission 25, NADA, p 10.

²¹³ Submission 9, NCOSS, p 2.

²¹⁴ Evidence, Clr Lloyd, 26 June 2018, p 49.

²¹⁵ Evidence, Mr Reid, 5 April 2018, p 6.

²¹⁶ Evidence, Mr Moreton, 6 April 2018, p 41.

- 3.54** Mr Kapeen from Bulgarr Ngaru Medical Aboriginal Corporation commented that some clients have been going to detox and released with no rehab to go to, which he argued 'defeats the purpose of detoxing them'.²¹⁷
- 3.55** Ms Plesman and Ms Mears-Lynch from Social Futures called for detox and rehab services to work together to reduce delays where possible.²¹⁸

Multi-purpose centres

- 3.56** Another option canvassed to address this problem was the establishment of more multi-purpose centres. On the final hearing day, the committee heard from Mr Brendan McCorry, the Manager of Calvary Riverina Drug and Alcohol Centre in Wagga Wagga. This is a one-stop-shop, multi-purpose centre which operates adjacent to Calvary Riverina Private Hospital. The service provides detoxification, residential rehabilitation and outpatient services to both men and women.²¹⁹
- 3.57** There are 32 beds in the residential unit, with 10 specifically dedicated to detox. Both medicated and non-medicated withdrawal is available, and all detox beds are in single rooms to create a stress-free environment. There are then 12-week residential and aftercare programs, which involve 12 weeks living in a cottage next door to the centre in a halfway transition house.²²⁰
- 3.58** The wait list for the residential unit can fluctuate between 15 to 30 people. Currently, the waiting time for men is six to eight weeks and for women it is four weeks. The residential beds are funded by the Australian Government, while the withdrawal beds are funded by NSW Health.²²¹
- 3.59** Mr McCorry advised that in addition, the service has just been commissioned by the Murrumbidgee Primary Health Network to provide an area-wide outpatient service to provide support and counselling to pregnant women and women with young children who have substance abuse problems.²²²
- 3.60** Inquiry participants in both Dubbo and Broken Hill discussed the idea of having a multipurpose centre or 'centre of excellence' in their city to provide detoxification and rehabilitation services for men, women and young people.²²³
- 3.61** Further, Ms Shirley Diskon, Manager, Hope House, Community Life Batemans Bay stated that her recommendation was for services to provide detox and rehabilitation together, so that clients can attend rehabilitation straight after detox to avoid relapse:

²¹⁷ Evidence, Mr Trevor Kapeen, Drug and Alcohol Addiction Worker, Bulgarr Ngaru Medical Aboriginal Corporation, 25 June 2018, p 19.

²¹⁸ Evidence, Ms Sonya Mears-Lynch, Program Manager—Reconnect, Getting it Together and Youth on Track, Social Futures, 25 June 2018, p 33; Evidence, Ms Plesman, 25 June 2018, p 33.

²¹⁹ Evidence, Mr Brendan McCorry, Manager, Calvary Riverina Drug and Alcohol Services, Wagga Wagga, 3 July 2018, p 36.

²²⁰ Evidence, Mr McCorry, 3 July 2018, p 36.

²²¹ Evidence, Mr McCorry, 3 July 2018, p 37.

²²² Evidence, Mr McCorry, 3 July 2018, p 37.

²²³ Evidence, Clr Turley, 10 May 2018, p 2; Evidence, Mr Joe Gordon, Alcohol and Other Drugs Caseworker, Salvation Army, Central West Co-operative Legal Service Delivery, 9 May 2018, p 25.

Then you have got to try to line detox up with rehab, and that is so hard. You just cannot let them out when they have detoxed... My recommendation would be to have a detox centre and a rehab all in one or close together...²²⁴

Improvements to aftercare support following residential rehabilitation

3.62 Because drug and alcohol addiction is categorised as a chronic and relapsing condition, inquiry participants emphasised the importance of appropriate aftercare support being available. This relates to the idea that people require holistic support so that they can be reintegrated into the community after rehabilitation and find housing and employment.

3.63 Dr Trish Collie, Drug and Alcohol Addiction Specialist, Bulgarr Ngaru Medical Aboriginal Corporation, discussed the importance of this kind of holistic, coordinated response following residential rehabilitation, as ineffective aftercare will lead to patients 'going around in circles':

It is really important to have a plan before they go into detox and rehab for when they actually come out of rehab, because that is the hardest bit, finding a coordinated response to somebody when they are coming out and they have done well, to not get them go back into the same environment that they are in and often that is hard because housing is the same. We spent a lot of time with a particular patient... she is homeless, she has no Centrelink benefit, she has no regular general practitioner so that GP cannot provide a Centrelink certificate for her medical conditions. She cannot communicate effectively with the services because of her anger... Until we can actually provide a service on discharge from rehabs to help people, we will just keep going around in circles.²²⁵

3.64 The NSW Government noted that aftercare should routinely be offered following all forms of treatment, including residential rehabilitation. The government advised that patients often discontinue treatment before it is complete, meaning aftercare and holistic support is often very limited.²²⁶

3.65 There is also no standard form of aftercare following a client exiting rehabilitation. Some facilities noted that they text or phone former clients to see how they are doing,²²⁷ while others may visit the client if they remain in the area, or assist in establishing support networks if they move outside the region.²²⁸

3.66 Mr Warwick Parer, Managing Director, Gunnebah Addiction Retreat, noted that he texts former clients once per week to see how they are going. If they write back with anything worrying they are put in touch with a counsellor from the facility.²²⁹ However, Mr Parer also commented that all clients are different; while he still talks to some clients on a weekly basis who left the facility

²²⁴ Evidence, Ms Diskon, 6 April 2018, p 15.

²²⁵ Evidence, Dr Trish Collie, Drug and Alcohol Addiction Specialist, Bulgarr Ngaru Medical Aboriginal Corporation, 25 June 2018, p 22.

²²⁶ Submission 34, NSW Government, p 30.

²²⁷ Evidence, Mr Gary Thomas, Director, Byron Private Holistic Treatment Centre, 26 June 2018, p 13; Evidence, Ms McGee, 26 June 2018, p 29.

²²⁸ Evidence, Ms Holmes, 12 March 2018, p 47.

²²⁹ Evidence, Mr Warwick Parer, Managing Director, Gunnebah Addiction Retreat, 26 June 2018, p 10.

seven months ago, others ask not to be contacted again as soon as they are finished as they have 'shut that door in their life and want to move on and forget it ever happened'.²³⁰

- 3.67** Ms Dian Edwards, the Manager of Namatjira Haven on the Far North Coast, indicated that the facility has tried different types of aftercare, however it can be hard to keep people engaged with the service and that often they 'do not want anything to do with you'.²³¹ Ms Edwards stated that Namatjira Haven's follow-up relies on ex-residents remaining contactable or making contact themselves, and that it is very hard to keep in touch with people 'unless you have got community-based services, and one of our biggest issues is there are not enough community-based drug and alcohol workers in our region'.²³² Community-based services are best placed for this outreach as they are often the ones who refer clients to rehabilitation, so there is already an open pathway and engagement.²³³
- 3.68** Ms Ann Kelly, a Clinical Nurse Consultant on the South Coast, noted that the Katungul Aboriginal Medical Service already has appointment and follow-up systems with people as they are coming out of rehabilitation, with these services calling Katungul when their clients are exiting rehabilitation. She stated that with this system has 'huge potential to do some great good' in terms of follow-up.²³⁴
- 3.69** The Broken Hill Working Group supported a more holistic model with partnerships between rehabilitation providers and employers or vocational education at the end of the rehabilitation to establish goals and routines for patients when they are in the community.²³⁵
- 3.70** Dr Chant, New South Wales' Chief Health Officer, stated that NSW Health is working hard to change the model of care to ensure that non-government services implicitly understand that addiction is a chronic relapsing condition. She agreed that there needs to be 'much more assertive follow-up and engagement ... in the long term [and] to reflect back to the services the outcomes, because we cannot see success as just having completed a program without addressing the fundamental issues'.²³⁶
- 3.71** Ms Fiona Beston, Acting Manager in the Mental Health, Drug and Alcohol Service, noted that in the mental health space there is the Housing and Accommodation Support Initiative, which has had 'fantastic' outcomes in terms of reducing admissions, maintaining people's accommodation and giving them extra wraparound psychosocial support. She explained that drug and alcohol clients could benefit from the adoption of a similar program.²³⁷

²³⁰ Evidence, Mr Parer, 26 June 2018, p 9.

²³¹ Evidence, Ms Edwards, 26 June 2018, p 26.

²³² Evidence, Ms Edwards, 26 June 2018, p 22.

²³³ Evidence, Ms Edwards, 26 June 2018, p 26.

²³⁴ Evidence, Ms Kelly, 6 April 2018, pp 44-45.

²³⁵ Submission 12, Broken Hill Working Group, pp 6-7.

²³⁶ Evidence, Dr Kerry Chant, Chief Health Officer, NSW Health, 3 July 2018, p 19.

²³⁷ Evidence, Ms Fiona Beston, Acting Manager, Strategic Coordinator Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug and Alcohol Service, 6 April 2018, p 30.

Involving families

3.72 A number of inquiry participants discussed the importance of bringing families along in an individual's journey to recovery, so that they can support the individual once they are back in the community.

3.73 The Aboriginal Legal Service indicated that many of its providers cited the urgent need for 'wraparound' services and support to be provided after rehabilitation, not only to the individual but also to the whole family. These services would address the underlying issues that lead to substance abuse and provide support and counselling for the individual and their family to manage possible triggers for relapse.²³⁸

3.74 Ms Kylie Beattie, Director, Byron Private Holistic Treatment Centre, stated that it is important to get families involved as part of the solution, to re-educate them and bring them together:

I think it gets families engaged in becoming a part of a solution. There is a lot of stigma and shame. The way that we view addiction is very different in the Western World. People who struggle in other cultures are not treated the way that we treat people who struggle. ... Sometimes it is just re-educating families, bringing families together. Our family therapist says there are all shades of light and dark. There is addiction everywhere. We are a very addicted society. Parents can then relate that they themselves probably have some level of addiction. We all have some level of dysfunction.²³⁹

3.75 Ms Sonya Mears-Lynch, Program Manager – Reconnect, Getting it Together and Youth on Track, Social Futures agreed with this, noting;

Part of the question around rehabilitation centres is what happens when they do come out of a rehabilitation centre. ... Our families are really perplexed as to why their young people have taken to drugs in the first place. Often there is minimal understanding in families around the use, the effects, long-term effects, other than what they experience from behavioural differences and emotional differences. So the families really struggle on how to support a young person in that predicament. Yes, rehab would be fantastic but I think there also needs to be the supports when people come out of those environments.²⁴⁰

3.76 Conversely however, Dr Lynne Magor-Blatch, Executive Officer of the Australasian Therapeutic Communities Association, indicated that families can often be the source of the problem. This can mean that it may be beneficial for a client to move away from the family post treatment:

Families are the source of the problem, often, in terms of people being unable to go back into the family because of the problems associated with the family, including the fact that it may be the family that introduced them to drugs in the first place and they are continuing to use. All of those things are vitally important in terms of the social fabric and what happens to people as they come through treatment.²⁴¹

²³⁸ Submission 33, Aboriginal Legal Service (NSW/ACT), p 4.

²³⁹ Evidence, Ms Kylie Beattie, Director, Byron Private Holistic Treatment Centre, 26 June 2018, p 16.

²⁴⁰ Evidence, Ms Mears-Lynch, 25 June 2018, p 31.

²⁴¹ Evidence, Dr Lynne Magor-Blatch, Executive Officer, Australasian Therapeutic Communities Association, appearing on behalf of We Help Ourselves, 12 March 2018, p 48.

Transportation assistance

- 3.77** As discussed earlier in this chapter, given that people often have to travel great distances to access detox and rehab facilities in regional areas, a number of inquiry participants discussed the lack of transportation options as a key barrier to accessing services, and the importance of transportation assistance.
- 3.78** Mr Norm Henderson noted that this assistance is often provided in rural and remote communities on an ad hoc basis, indicating that many years ago there was a person in his area who used to drive people to rehabilitation:
- ... the other big problem out there, which is transport, getting people to and from places. I do not know what happened, but years ago there was a fellow named Jack Walker who used to bring people from jails out to rehabs. He was an older Aboriginal fellow. I think they supplied him with a car and a petrol card. I do not think there was a wage, just if he had to stay overnight somewhere. He happily did that for years and all of a sudden that was stopped, no explanation—we have not got the money. There are people who are willing to do this stuff, as long as we get a little bit of help.²⁴²
- 3.79** Other organisations, particularly Aboriginal Medical Services, noted that they currently drive clients to rehabilitation services. For example, Mr Kapeen from Bulgarr Ngaru, stated that he takes clients to rehabs all the time, even driving clients 400 km up to Brisbane. He stated that this was vital as they cannot use a bus or train because they 'are going to get off at the first stop because they have got time to think about getting out'.²⁴³
- 3.80** Dr Trish Collie, a Drug and Alcohol Addiction Specialist who works with Mr Kapeen, was supportive of the Aboriginal Medical Service model and thought that it could be considered for non-Aboriginal patients.²⁴⁴
- 3.81** As noted in chapter 1, patients may be eligible for the NSW Government's Isolated Patients Travel and Accommodation Assistance Scheme. This is an initiative designed to provide financial assistance towards travel and accommodation costs when a patient needs to travel lengthy distances for specialist medical treatment that is not available locally.²⁴⁵

Other innovations

Mandatory detoxification

- 3.82** As part of the inquiry's terms of reference, the committee considered the efficacy of mandatory detoxification programs, particularly in relation to people subject to apprehended violence orders (AVOs) or at risk of self-harming. There was a general consensus among most inquiry participants that mandatory detoxification is generally not an appropriate method of treatment as it does not address the underlying causes of addiction. In addition, the committee heard that

²⁴² Evidence, Mr Henderson, 9 May 2018, p 34.

²⁴³ Evidence, Mr Kapeen, 25 June 2018, p 24.

²⁴⁴ Evidence, Dr Collie, 25 June 2018, p 24.

²⁴⁵ Submission 34, NSW Government, p 22.

there are already insufficient beds for people who voluntarily wish to undergo detoxification; imposing mandatory treatment may simply exacerbate this problem.²⁴⁶

- 3.83** The Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network did not support mandatory detoxification programs 'as evidence strongly suggests these programs are not effective'.²⁴⁷ In addition they stated that there is no evidence that mandatory detoxification for clients who are subject to an AVO will be effective in reducing family violence. The organisations concluded that given there are already long wait lists and limited access to existing detox beds, mandatory detoxification will only increase waiting times for clients who wish to seek treatment.²⁴⁸
- 3.84** The residential rehabilitation facility Lives Lived Well – Lyndon acknowledged that there is a strong link between domestic and family violence and drug and alcohol consumption. However, as detoxification is a physical treatment only, it is unlikely to achieve a change in behaviour. Further, Lives Lived Well – Lyndon considered that people who self-harm require a sensitive treatment approach to the underlying reasons for their actions, rather than mandatory detoxification.²⁴⁹ Dr Julaine Allan from the organisation commented that as detox is merely a physical process of clearing a person's body of drugs, 'it does not necessarily have any relationship to your likelihood of being violent or self-harming'.²⁵⁰
- 3.85** Based on available evidence, the Australasian Therapeutic Communities Association did not support the introduction of mandatory treatment and noted it would require a complex partnership between health, justice and social services. In addition, most residential facilities have a strong stance on issues of violence, and may be hesitant to accept persons subject to AVOs.²⁵¹
- 3.86** Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australasian College of Physicians noted that there should only be a very limited role for mandatory treatment as there is inadequate evidence that it changes the course of drug and alcohol dependence and is very expensive.²⁵²
- 3.87** The NSW Government advised that treatment is predominantly voluntary because addiction is a chronic disorder. Although people can be successfully managed through a period of drug withdrawal, this does not address the underlying disorder.²⁵³

²⁴⁶ See for example: Evidence, Ms Lovric, 12 March 2018, p 25; Submission 27, Legal Aid NSW, p 17; Submission 6, We Help Ourselves, p 5; Submission 7, Community Life Batemans Bay, p 8.

²⁴⁷ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 10.

²⁴⁸ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, pp 10-11.

²⁴⁹ Submission 14, Lives Lived Well – Lyndon, p 7.

²⁵⁰ Evidence, Dr Julaine Allan, National Research Manager, Lives Lived Well—Lyndon, 6 April 2018, p 7.

²⁵¹ Submission 29, Australasian Therapeutic Communities Association, p 8.

²⁵² Evidence, Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australasian College of Physicians, 12 March 2018, p 17.

²⁵³ Submission 34, NSW Government, p 26.

3.88 The government also advised that there are involuntary inpatient programs available as a last resort for people with severe substance use issues, provided under the *Drug and Alcohol Treatment Act 2007*.²⁵⁴ Involuntary treatment operates from two sites, one in Northern Sydney Local Health District (four beds in a detoxification unit) and the other in Western NSW Local Health District (eight beds in a unit at Bloomfield Hospital in Orange). The inpatient treatment component generally lasts for up to 28 days. The program has both inpatient and community based care components.²⁵⁵ The effectiveness of involuntary treatment was informed by an evaluation, which found that such treatment:

- provided the opportunity for medical conditions and physical health to be properly assessed and addressed and enabled patients to complete an extended period of abstinence
- led to a reduction in mental health symptoms such as depression
- led 80 per cent of involuntary patients to take up post-discharge voluntary aftercare.²⁵⁶

3.89 In addition, the majority of patients were observed by an aftercare service to have better general, mental and physical health than in the six months previous.²⁵⁷ However, the government acknowledged that the evaluation had significant limitations, and that a further evaluation, funded by NSW Health, is currently underway.²⁵⁸

Naltrexone treatment

3.90 Naltrexone is a prescription drug referred to as an opioid antagonist. These block the effects of heroin and other opioid drugs. Naltrexone is used in pharmacotherapy, where a drug of dependence is replaced with a prescribed drug. Naltrexone may be used to treat people with alcohol dependence or to help people who have withdrawn or detoxified from opioids, such as heroin.²⁵⁹

3.91 The NSW Government indicated that there is emerging evidence regarding the effectiveness of alternative pharmacotherapies such as naltrexone to treat opioid dependence. These alternatives may improve the efficiency of treatment delivery by only requiring weekly or monthly dosing instead of daily medication. It noted that long-acting naltrexone depot injections (Vivitrol) are currently not registered for treatment in Australia.²⁶⁰

3.92 The government stated that NSW Health is currently evaluating a program to increase the accessibility of naloxone for opioid addiction. It also noted that oral naltrexone is an effective medication for alcohol dependence. However, uptake by general practitioners for patients is poor across Australia.²⁶¹

²⁵⁴ Submission 34, NSW Government, p 26.

²⁵⁵ Submission 34, NSW Government, p 26.

²⁵⁶ Submission 34, NSW Government, p 26.

²⁵⁷ Submission 34, NSW Government, p 26.

²⁵⁸ Submission 34, NSW Government, p 27.

²⁵⁹ Alcohol and Drug Foundation, *What is naltrexone?* (19 June 2018), <https://adf.org.au/drug-facts/naltrexone/>.

²⁶⁰ Submission 34, NSW Government, p 37.

²⁶¹ Submission 34, NSW Government, p 37.

- 3.93** The NSW Government provided information on several international and Australian studies regarding the efficacy of naltrexone:

Rusan Pharmaceuticals (India) has used a naltrexone depot in a clinical trial with the National Addiction Centre, UK. Recruitment for the study was disappointing (10 patients in the UK in one year). Currently, naltrexone implants are an experimental product for opioid detoxification. The Therapeutic Goods Administration is yet to approve them for use in Australia, as evidence for their safety and efficacy has not been presented to enable registration. ... Overseas experience and the outcomes of a program conducted in the Australian Capital Territory show that easier availability of naloxone will decrease the proportion of opioid overdoses that result in death.²⁶²

- 3.94** NADA did not consider that there is sufficient evidence for the inclusion of Naltrexone-based treatment interventions as a priority. It argued that this was 'based on the widely held view within the public and NGO clinical community, and the relevant international literature, that this specific pharmacological intervention is not in and of itself a curative treatment option'.²⁶³

- 3.95** Along similar lines, the Salvation Army stated that naltrexone has 'a place in the continuum of treatment approaches, although it is not a treatment in and of itself and should be supported by additional treatment options'. Further it considered that 'rigorous clinical trials should be undertaken prior to Naltrexone being included in the range pharmacotherapies available for addiction treatment'.²⁶⁴

Measuring success, data collection and accountability

- 3.96** This section discusses data collection by non-government residential rehabilitation providers and considers how the success of the services they provide should be measured. The section also considers the need for more publicly available information on services and beds, and the issue of whether private rehabilitation providers should be better regulated.

Measuring success and data collection

- 3.97** The World Health Organisation categorises addiction as a chronic relapsing disease.²⁶⁵ Because of this, many inquiry participants considered that measuring success is a complex issue, and often depends on the individual's goals.²⁶⁶
- 3.98** NSW Health takes a harm minimisation approach when defining success.²⁶⁷ Mr Mitch Dobbie, Manager for the Tweed Byron Drug and Alcohol Service, noted that all its programs are run from a harm minimisation perspective. He explained that 'people do not want to necessarily stop, so what we are encouraging them to do is to manage their drug use to a point where they

²⁶² Submission 34, NSW Government, p 37.

²⁶³ Submission 25, NADA, p 14.

²⁶⁴ Submission 17, The Salvation Army, p 15.

²⁶⁵ Evidence, Mr Henderson, 9 May 2018, p 32.

²⁶⁶ Submission 17, The Salvation Army, p 13.

²⁶⁷ Evidence, Dr Chant, 12 March 2018, p 52; Evidence, Ms Beston, 6 April 2018, p 33.

can make a choice whether they may go to abstinence, but also in regards to how they might manage reducing their drug use'.²⁶⁸

3.99 Mr David Beattie from the Byron Private Holistic Treatment Centre, agreed that success is not necessarily abstinence, and indicated that success could be classed as 'increased connections with their community and their family, being able to function in their everyday lives, having the ability to look after themselves'.²⁶⁹

3.100 A number of rehabilitation services providers commented on the complexities involved in measuring the success of the services they provide.

3.101 Community Life Batemans Bay observed that rehabilitation does not always work the first time and it may take a number of visits before a client improves. The organisation considered success to include:

- reducing consumption of alcohol and other drugs or completely abstain from use
- improving health status
- reducing criminal behaviour
- improving psychological wellbeing
- improving participation in the community.²⁷⁰

3.102 Ms Shirley Diskon, Manager, Hope House, Community Life Batemans Bay provided an example of a success story which included these important social and health factors:

Outcomes to me or our service are measured on individuals. We had a gentleman come who was highly addicted to Valium. He had been in and out of jail since he was 16. He deliberately trashed a police car so he could go back to jail. He had a son and a girlfriend but he had lost contact with his son because of his drug use. He was also into ice and all the other drugs that go along with it. He lost contact with them. He came back to us out of Corrections. He had been in and out of jail for petty thieving and all that sort of stuff. He came back to us, we took him back in again, we helped him again and his girlfriend made contact. He saw his son and now he has got a daughter. He has got a job. He has got a car. He has moved to Canberra. To me, that is an outcome. He wanted to get back with his son. He has achieved that and a lot more. To me, that is an outcome.²⁷¹

3.103 Ms Diskon remarked that because success is difficult to measure, it makes it hard to quantify when filling in grant application for more funding.²⁷²

3.104 Lives Lived Well – Lyndon observed that reducing substance use is the same as quitting smoking; it is hard to do and takes a substantial period of time. Returning to treatment should be encouraged and multiple episodes expected. For example, less than 60 per cent of individuals

²⁶⁸ Evidence, Mr Mitch Dobbie, Manager, Tweed Byron Drug and Alcohol Services, 25 June 2018, p 5.

²⁶⁹ Evidence, Mr David Beattie, Business Owner, Byron Private Holistic Treatment Centre, 26 June 2018, p 15.

²⁷⁰ Submission 7, Community Life Batemans Bay Inc, p 9.

²⁷¹ Evidence, Ms Diskon, 6 April 2018, pp 13-14.

²⁷² Evidence, Ms Diskon, 6 April 2018, p 14.

who receive treatment for alcohol dependence become abstinent or show significant improvement in functioning following treatment, while more than half will relapse in the first year after treatment.²⁷³

- 3.105** Lives Lived Well – Lyndon viewed that the current reporting systems are useful for identifying how many people enter and exit treatment services, but not to measure success. It suggested that positive outcomes should be linked to an individual's goal when they entered treatment. However, they admitted that it would be difficult to report on these individualised factors.²⁷⁴
- 3.106** The Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network were of the view that there is little evidence of what constitutes success of a residential rehabilitation service.²⁷⁵
- 3.107** As the peak body for non-government drug rehabilitation providers, NADA explained that since 2008 it 'has promoted a culture of outcome measurement among its members via an online client data management platform – NADAbase, that is supported by training and consultation'. In addition, all NADA members who provide residential treatment and provide data also collect outcomes data (see table below).²⁷⁶

Table 4 NADAbase outcomes data measurements

Outcome domains measured	Tool used
Alcohol and Drug use frequency and dependence	<ul style="list-style-type: none"> • Alcohol and drug use frequency (AATOM and BTOM elements) • Severity of Dependence Scale (SDS)
Mental Health	<ul style="list-style-type: none"> • Kessler-10
General Health and Wellbeing	<ul style="list-style-type: none"> • WHO Quality of Life – 8 (EURHOS) • Current court matters • Living arrangements
Blood Borne Virus and Overdose Risk	<ul style="list-style-type: none"> • BTOM-C elements

Submission 25, Network of Alcohol and other Drugs Agencies (NADA), p 12.

- 3.108** NADA noted that residential rehabilitation services use validated self-reported improvements measures in conjunction with program completion and length of stay to measure success. Each NSW Health-funded residential rehabilitation service also reports client outcomes to funding bodies, and client data is usually accompanied by case studies of client experience to provide context. In addition, approximately 60 per cent of residential rehabilitation services have engaged either internal or external evaluation processes of their programs which are either detailed in annual reports and/or peer reviewed journals.²⁷⁷
- 3.109** For example, We Help Ourselves stated that it collects data to ensure its services achieve the best outcomes, taking into account factors such as improvements in health, psychosocial

²⁷³ Submission 14, Lives Lived Well –Lyndon, p 8.

²⁷⁴ Submission 14, Lives Lived Well –Lyndon, p 8.

²⁷⁵ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 13.

²⁷⁶ Submission 25, NADA, pp 11-12.

²⁷⁷ Submission 25, NADA, p 12.

functioning and other key wellbeing areas.²⁷⁸ We Help Ourselves also regularly contributes data to NADAbase and provides regular service and financial reports to the New South Wales and federal health departments.²⁷⁹

- 3.110** From a Justice perspective, Mr Jason Hainsworth, Acting Assistant Commissioner, Community Corrections, noted that if a person completes a drug program then this is considered a success.²⁸⁰ Ms Eminov said that the Drug Court defines success as those who finish the program without a custodial sentence; whereas if people finish the program and go back to jail, they may 'have better health outcomes and lots of intangibles [but they] are not counted in the statistics'.²⁸¹
- 3.111** Mr Reid said that NSW Health is focused 'on the issue that we need to have better outcome studies' and is working with clinicians to develop an outcome tool. He noted that there are 'various tools around that people are using at the moment but I think the ministry is looking at a consistent tool ... to be able to provide some tangible evidence of improvement as a result of treatment'.²⁸²
- 3.112** The NSW Government noted that NSW Health mandates that all government and non-government services receiving funding collect and report the 'NSW Minimum Data Set for Drug and Alcohol Treatment Services', which consists of 44 separate items. Data is reported monthly, with annual reporting on a financial year basis. The government indicated that this data collection makes it possible to compare and aggregate information across New South Wales on drug problems, service utilisation and treatment programs. NSW Health is also currently developing an implementation, monitoring and evaluation framework to measure progress in achieving its alcohol and other drug related objectives.²⁸³

Information for service providers and the public

- 3.113** It became clear during evidence that it is difficult to find out exactly what services are available in New South Wales, as well as the total number of available detoxification and rehabilitation beds. In other words, there is no central register or publicly available resource in New South Wales which lists this information, making it difficult for individuals, families and service providers to find accurate information.
- 3.114** As noted in chapter 1, the NSW Government indicated that it is difficult to quantify the exact number of publicly-funded residential treatment beds, as funding comes from a variety of sources.²⁸⁴ Further, the government acknowledged that it is not aware of current waitlist and waiting time information across facilities.²⁸⁵

²⁷⁸ Submission 6, We Help Ourselves, pp 5-6.

²⁷⁹ Submission 6, We Help Ourselves, p 6.

²⁸⁰ Evidence, Mr Jason Hainsworth, Acting Assistant Commissioner, Community Corrections, 3 July 2018, p 4.

²⁸¹ Evidence, Ms Eminov, 3 July 2018, p 4.

²⁸² Evidence, Mr Reid, 5 April 2018, p 10.

²⁸³ Submission 34, NSW Government, p 35.

²⁸⁴ Submission 34, NSW Government, p 15.

²⁸⁵ Submission 34, NSW Government, p 23.

- 3.115** Ms Jenny Lovric, Program Manager, Cooperative Legal Service Delivery Program and Regional Outreach Clinic Program, Legal Aid NSW, expressed her frustration with the current system, describing it as chaotic as there is no one source to find out what is available:

Trying to navigate what is available at any given point is really problematic. I have been in a location in remote New South Wales where a solicitor would say, "I would like to have an online register to know when beds are available and where," so that they can make appropriate representations to the court in terms of referrals to treatment. That is a problem; it is chaotic. We heard evidence about the link between Commonwealth and State and NGOs. Local health districts might run their own lists of what is available, but that may not suit our clients who travel around different areas. As far as we understand, there is no one source to find out what is available. ... It is very difficult to find out what is available ... You can imagine how frustrating it is for us, as lawyers, trying to find diversions. But imagine how much more frustrating it is families and people who are looking for these services. It is almost impossible..²⁸⁶

- 3.116** Ms Lovric noted that many people, including herself, keep their own directories, which is a less than perfect system. She recommended that an audit be conducted to determine what is available.²⁸⁷
- 3.117** Representatives from Clarence Valley Council informed the committee that the council plays a role as a directory of information for the community.²⁸⁸ Mr Des Schroder, the Director for Environment Planning and Community, stated that strategic work is often lacking and providers 'need others to lift above the day to day and have the time to do the mapping, do the gaps and that is where council plays a role'. However, he expressed the view that NSW Health should play a greater role in this space.²⁸⁹
- 3.118** Dr Chant stated that NSW Health has noted the concerns raised in this regard at the committee's first hearing, and is looking at making bed availability more visible. She agreed that it should be easier for service providers or people interested in accessing rehabilitation to understand what is currently available.²⁹⁰
- 3.119** At the end of the committee's inquiry, NSW Health noted that it has started to work on improving patient access to information about residential rehabilitation and withdrawal management services. Summary information on all NSW Health-funded designated withdrawal management units and residential rehabilitation service organisations, locations, websites and phone numbers has been uploaded to the NSW Ministry of Health website.²⁹¹
- 3.120** NSW Health also indicated that it does not currently have a mechanism to require private health facilities to provide information regarding bed numbers and bed availability.²⁹²

²⁸⁶ Evidence, Ms Lovric, 12 March 2018, p 25.

²⁸⁷ Evidence, Ms Lovric, 12 March 2018, p 25.

²⁸⁸ Evidence, Ms Moore, 25 June 2018, p 48.

²⁸⁹ Evidence, Mr Schroder, 25 June 2018, p 48.

²⁹⁰ Evidence, Dr Chant, 3 July 2018, p 17.

²⁹¹ Answers to questions on notice, NSW Health, 20 July 2018, p 10.

²⁹² Answers to questions on notice, NSW Health, 20 July 2018, p 11.

- 3.121** Professor Lintzeris advised that there is the Alcohol Drug Information Service, which is a 24/7 telephone service, predominantly funded by NSW Health. This provides a telephone service for people in the community to have a confidential and anonymous discussion with a counsellor about available services. It is run out of St Vincent's Hospital in Darlinghurst and the service maintains a database.²⁹³

Regulation of private rehabilitation facilities

- 3.122** While the majority of this chapter has focused on services delivered by government-funded NGOs, the committee heard evidence regarding the lack of regulation in place for private for-profit services. The committee heard from two wholly private facilities: Gunnebah Addiction Retreat and Byron Private Holistic Treatment Centre.
- 3.123** Gunnebah Addiction Retreat's Managing Director, Mr Warwick Parer, informed the committee that 'there is almost zero regulation of private facilities' and anyone can hang up a sign to say that they are a rehabilitation facility.²⁹⁴
- 3.124** He indicated that government should have a role in the quality control of private facilities and accreditation²⁹⁵ and thought that any such oversight should ensure that facilities, at a minimum, 'include a clinical director and a doctor being part of the program in some sort of sign-off capacity'.²⁹⁶
- 3.125** However, Mr Parer cautioned that he did not want regulation to include 'a large amount of bureaucracy' that might be time consuming and negate any financial benefit. He indicated that his facility is 'happy to be under scrutiny, but let us get the job done and then scrutinise us rather than scrutinise us from the beginning and all of the good intentions disappear in paperwork'.²⁹⁷
- 3.126** Mr Parer's suggestion for regulation was tied to a recommendation for government to partially subsidise private beds to allow more people to access the service. He indicated that there is currently no middle ground between expensive private facilities and NGOs, which only require participants to provide a portion of their Centrelink benefits. While many people cannot afford the \$7,000 a month it costs to access Gunnebah Addiction Retreat, according to Mr Parer, if the government assisted to close the gap then more people can access private services, ensuring there are more available beds in regional New South Wales. Mr Parer also considered that people should be allowed to use their private health insurance to access private rehabilitation facilities, as currently there is no provision to do so.²⁹⁸
- 3.127** Mr David Beattie, owner of Byron Private Holistic Treatment Centre, gave evidence that there is a disconnect between the standards for private healthcare facilities and private hospitals. The private healthcare model is underpinned by the Australasian Healthcare Facility guidelines,

²⁹³ Evidence, Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, South East Sydney Local Health District; and Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney, 3 July 2018, p 17.

²⁹⁴ Evidence, Mr Parer, 26 June 2018, p 6.

²⁹⁵ Evidence, Mr Parer, 26 June 2018, pp 10-11.

²⁹⁶ Evidence, Mr Parer, 26 June 2018, p 7.

²⁹⁷ Evidence, Mr Parer, 26 June 2018, p 7.

²⁹⁸ Evidence, Mr Parer, 26 June 2018, pp 5-6.

which regulates the hospital environment, however there is no relationship between private treatment centres and private hospitals.²⁹⁹

- 3.128** Mr Gary Thomas, Director, Byron Private Holistic Treatment Centre, indicated that, were a regulatory framework to be developed, it should be done in collaboration with private operators. He agreed that overregulation could be a source of concern, however, 'the public should be protected from operators that are unscrupulous and lack the professional staffing and framework within which they operate'.³⁰⁰

Funding and staffing

- 3.129** Inquiry participants generally considered that increased funding and more qualified staff are required in the drug and alcohol field. This section examines these issues, including a suggestion to provide service providers with longer term funding grants.

Funding for services

- 3.130** Throughout the inquiry the committee heard that drug and alcohol services are under-funded.³⁰¹ As noted earlier in the chapter, according to population planning modelling, NADA identified that there is a funding deficit of at least \$40 million per annum across the program.³⁰² Mr Pierce for NADA observed that drug and alcohol services is not well-funded in New South Wales, receiving approximately \$250 million, compared with the mental health budget which he stated is \$1.2 billion.³⁰³
- 3.131** NADA indicated that the most significant threat to the sustainability of the residential rehabilitation is the lack of any new resourcing for bed capacity and the associated costs. NADA stated that no new state or federal funding has been made available to expand the number of rehabilitation beds since the early 2000s.³⁰⁴
- 3.132** From a service provider perspective, Lives Lived Well – Lyndon stated that funding security remains the biggest threat to the future of existing services. In addition, growing expectations that service providers will provide wrap-around or holistic care that is inclusive of mental illness, physical illness and socio-economic deprivation, have expanded the scope of services without additional expansion in funding.³⁰⁵
- 3.133** The Salvation Army identified the central threat to rehabilitation services as being the lack of additional funding to meet growing demand and provide high quality services to clients with multiple and complex needs.³⁰⁶

²⁹⁹ Evidence, Mr Beattie, 26 June 2018, p 18.

³⁰⁰ Evidence, Mr Thomas, 26 June 2018, p 12.

³⁰¹ Submission 37, The Oolong Aboriginal Corporation, p 10.

³⁰² Submission 25, NADA, p 10.

³⁰³ Evidence, Mr Pierce, 12 March 2018, p 4.

³⁰⁴ Submission 25, NADA, pp 12-13.

³⁰⁵ Submission 14, Lives Lived Well – Lyndon, p 9.

³⁰⁶ Submission 17, The Salvation Army, p 13.

- 3.134** ONE80TC saw the lack of adequate funding of rehabilitation services as a threat to their survival. They told the committee that many services rely completely on government funding and that many staff positions are advertised as 'subject to continuance of government funding'.³⁰⁷
- 3.135** Similarly, the Broken Hill Working Group considered that the lack of government funding is a major threat to existing rehabilitation services, remarking that the government's focus seems to be on law and order campaigns rather than rehabilitation services.³⁰⁸
- 3.136** Ms Shirley Diskon, the manager of the non-government service, Hope House, discussed how difficult it was keeping the service operating as they have just a single paid employee and '30-odd volunteers'. Because of the difficulties with their funding arrangements it is impossible to employ more paid staff.³⁰⁹
- 3.137** Australasian Therapeutic Communities Association noted that a lack of any investment in residential rehabilitation treatment centres impacts on service sustainability, the increasingly complex and multiple needs of clients, cost escalation and demand increase. It described the NSW Government's funding commitment to residential rehabilitation treatment centres as 'inadequate and in real need of funding' commitments.³¹⁰
- 3.138** Ms Gabriella Holmes, the Program Manager at Triple Care Farm stated that funding for the drug and alcohol sector is 'something that has not had anybody look at it with a consistent long-term view ever'. According to Ms Holmes, the \$75 million NSW Drug Package announced last year is the only new funding for the sector in almost the 17 years.³¹¹
- 3.139** Mr Pierce from NADA noted that funding from the Commonwealth's National Ice Action Strategy was largely spent in metropolitan and high population centres along the coast, and was primarily for outpatient services, 'not really the kinds of services that you would need for people who are in the grip of a serious dependency on either ice or other drugs along with that'.³¹²
- 3.140** Mr Sterling agreed, asserting that while the National Ice Action Strategy did not actively exclude residential rehabilitation, it did not prioritise beds, and was focused on outpatient treatment services. Similarly, the NSW Drug Package was not focused on funding for beds.³¹³

Long-term funding grants

- 3.141** A number of residential rehabilitation services providers were of the view that the short-term nature of many funding grants pose a serious problem, as it means uncertainty for the service, its staff and clients, and imposes an extra burden on an already stretched workforce to regularly prepare the necessary paperwork.

³⁰⁷ Submission 5, ONE80TC, p 4.

³⁰⁸ Submission 12, Broken Hill Working Group, p 6.

³⁰⁹ Evidence, Ms Diskon, 6 April 2018, p 12.

³¹⁰ Submission 29, Australasian Therapeutic Communities Association, p 12.

³¹¹ Evidence, Ms Holmes, 12 March 2018, p 42.

³¹² Evidence, Mr Pierce, 12 March 2018, p 3.

³¹³ Evidence, Mr Sterling, 12 March 2018, p 3.

- 3.142** The committee heard that NSW Health grants tend to be for three years, while some Australian Government grants can be for as little as one year.³¹⁴ Ms Gabriella Holmes, the Program Manager at the facility Triple Care Farm noted the problem of funding instability for many services. She explained that there have been a number of reviews in the sector which have resulted in contracts being three years at most, and often only up to 12 months. Ms Holmes argued that it is very hard for a sector to respond to the complex needs of its clients while at the same time managing funding instability, which in turn creates difficulties in recruitment.³¹⁵
- 3.143** Ms Holmes described it as a 'house of cards' scenario and called for more longevity in funding:
- Everybody has just been looking at whether or not they could cut it and it has just hobbled along as best it could. It is a bit of a house of cards when it comes to funding stability, so it really is a sector that requires longevity to be able to plan a service response, to be able to plan a workforce and to be able to then have a stable sector to respond to these complex needs.³¹⁶
- 3.144** Ms Holmes and Dr Lynne Magor-Blatch, Executive Officer of the Australasian Therapeutic Communities Association, strongly advocated for five-year contracts at a minimum, with Ms Holmes going further, stating that such contracts should also come with the option of a three-year extension. She noted that these long-term contracts would ease the administrative burden and assist in the hiring and retention of qualified staff.³¹⁷
- 3.145** Dr Julaine Allan also advocated for five-year contracts. She noted that last year, Lives Lived Well had to close two Aboriginal drug and alcohol programs, one of which was for young people, because the funding contract came to an end.³¹⁸
- 3.146** Mr Luke Butcher, the Area Manager for Mission Australia said that another issue with short contracts, particularly in rural New South Wales, is that it might take six to 12 months to be able to fully staff a project with skilled, qualified and experienced staff. The facility may therefore 'have already burnt through that time and you are up for another tender process when you have just found your feet'.³¹⁹
- 3.147** Drug and Alcohol Addiction Specialist, Dr Trish Collie, stated that short-term funding from the federal primary health care network makes continuity of service problematic and makes it 'difficult to attract professionals to a service when they have only got 12 or 18 months' worth of guaranteed funding'.³²⁰
- 3.148** Dr Mindi Sotiri, Program Director for the Community Restorative Centre in Broken Hill, indicated that short-term funding is one of the biggest barriers to staff retention. It also imposes a significant administrative burden as Community Restorative Centres have 16 sources of funding from federal, state and local levels. She commented that it is considered 'lucky when

³¹⁴ Evidence, Dr Allan, 6 April 2018, p 4.

³¹⁵ Evidence, Ms Holmes, 12 March 2018, p 39.

³¹⁶ Evidence, Ms Holmes, 12 March 2018, p 42.

³¹⁷ Evidence, Ms Holmes, 12 March 2018, p 43; Evidence, Dr Magor-Blatch, 12 March 2018, p 43.

³¹⁸ Evidence, Dr Allan, 6 April 2018, p 4.

³¹⁹ Evidence, Mr Butcher, 12 March 2018, p 44.

³²⁰ Evidence, Dr Collie, 25 June 2018, p 17.

[they] get a three-year pot of money', but often it is only one-year rollovers which makes it hard to create stability.³²¹

3.149 Me Brendan McCorry, Manager, Calvary Riverina Drug and Alcohol Services noted that his funding is tied to a three-year cycle, and that even this can create uncertainty, as if the funding is not renewed many people will be out of work.³²²

3.150 Dr Magor-Blatch commented that non-government services keep losing good staff because there is no certainty in their employment. Because of this lack of security they often move to the public sector.³²³

Recruiting qualified drug and alcohol professionals

3.151 Many inquiry participants noted the distinct lack of qualified drug and alcohol professionals, particularly in regional New South Wales.³²⁴

3.152 NSW Health informed the committee that there are two training program pathways to gain specialist addiction medicine expertise for doctors:

- The Chapter of Addiction Medicine, Royal Australasian College of Physicians
- The Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists.³²⁵

3.153 As of June 2018, there were 43 trainees currently enrolled in the Chapter Training Program across Australia. Of those, 19 were based in New South Wales. There are currently 21.6 full time equivalent addiction psychiatry trainee positions across New South Wales. There are 31 advanced trainees in these positions.³²⁶

3.154 The NSW Government advised that qualification requirements for staff at non-government community-based services and rehabilitation services vary according to the type of service provided. However, most have a minimum requirement of Certificate 3 or 4 in Drug and Alcohol studies obtained through TAFE or the Open Training Education Network NSW.³²⁷

3.155 NADA noted that almost half (48 per cent) of the alcohol and other drug workforce hold a university qualification, and 40 per cent hold a specific alcohol and other drug qualification.

³²¹ Evidence, Dr Sotiri, 10 May 2018, p 33.

³²² Evidence, Mr McCorry, 3 July 2018, pp 38-39.

³²³ Evidence, Dr Magor-Blatch, 12 March 2018, p 43.

³²⁴ Submission 17, The Salvation Army, pp 11 and 14; Submission 7, Community Life Batemans Bay Inc, p 9; Submission 10, The Royal Australasian College of Physicians, p 5; Submission 15, Mission Australia, p 12; Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, pp 12-13.

³²⁵ Answers to questions on notice, NSW Health, 20 July 2018, p 4.

³²⁶ Answers to questions on notice, NSW Health, 20 July 2018, p 4.

³²⁷ Submission 34, NSW Government, p 32.

Other staff will generally possess qualifications in community services, psychology, social work or counselling.³²⁸

3.156 Mr David Reid, Director of the Drug and Alcohol Service, advised that drug and alcohol medicine is now a sub-specialty of the College of General Practitioners. However, as it is a very small workforce in New South Wales and Australia, finding properly qualified specialists is a challenge.³²⁹

3.157 Lives Lived Well – Lyndon noted that experienced drug and alcohol practitioners are particularly difficult to recruit in rural and regional areas. In addition, there are no undergraduate university courses with drug and alcohol subjects relevant to clinical practice and 'few social work, psychology and similar allied health courses with any drug and alcohol content at all'.³³⁰

3.158 Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australasian College of Physicians, noted that the amount of training undergraduate medical students are required to do in the drug and alcohol space is minimal:

I am not aware of any mandatory requirement. To my knowledge, universities that have undergraduate or postgraduate medical degrees in New South Wales do, and there was a curriculum—They have a set of learning objectives that they can choose to use, but the amount of training is small. For example, at Newcastle University, which I am connected to, there is about 20 hours of teaching across the course.³³¹

3.159 He concluded that it would be 'great' if there could be more graduating medical practitioners, psychologists and nurses with exposure to drug and alcohol problems through training positions.³³²

3.160 Community Life Batemans Bay noted the difficulties of employing appropriately qualified professionals and noted that there is no national minimum qualification strategy for alcohol and other drug specialist workers.³³³

3.161 Mission Australia observed that an added complexity for the recruitment of staff in regional areas is that it often requires people to relocate to take up critical roles. In addition, private and public sector organisations usually offer better remuneration and conditions than non-government providers. Mission Australia argued that regional drug and alcohol workers should be upskilled and reskilled and provided with incentives to remain in the region.³³⁴

³²⁸ Submission 25, NADA, pp 10-11.

³²⁹ Evidence, Mr Reid, 5 April 2018, p 7.

³³⁰ Submission 14, Lives Lived Well – Lyndon, p 7.

³³¹ Evidence, Professor Dunlop, 12 March 2018, p 17.

³³² Evidence, Professor Dunlop, 12 March 2018, pp 17-18.

³³³ Submission 7, Community Life Batemans Bay Inc, p 6.

³³⁴ Submission 15, Mission Australia, p 12.

- 3.162** The Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network noted that it can take up to 12 months for their members to fill an empty position. In addition, Aboriginal residential rehabilitation services have comparatively low salaries, with a study indicating that 'Aboriginal drug and alcohol workers in non-government organisations were the lowest paid in the sector'.³³⁵
- 3.163** The Broken Hill Working Group discussed the difficulties the Far West region has experienced in attracting appropriately qualified staff. One health provider advised that less qualified entrants were sometimes appointed, as properly qualified individuals did not apply for positions. The group expressed concern regarding the long-term outcomes for clients if services were providing care with staff who have received minimal training.³³⁶
- 3.164** A social worker in Broken Hill, Mr Andrew House, considered that in order to attract more workers to the drug and alcohol field there is a need to change the way patients are viewed:
- I know if we treated cancer patients the way we treat people addicted to alcohol and other drugs there would be an uproar. I guess again it is how do we change the conversation. To attract people with qualifications ... How do we make it attractive? I suppose if we celebrate the recovery and we celebrate the achievements people will want to be involved in that and people will want to participate in that and it will be something that people can help out with, rather than, "Oh, I have to work with these addicts". We are a difficult group, do not worry. I have lived with myself for a long time. It is difficult. I think celebrate it and make it attractive to get clean.³³⁷
- 3.165** Professor Lintzeris advised that there are between 10 and 20 registrar training positions for the drug and alcohol specialty across New South Wales. He explained that if the rest of Australia had comparable levels of registrars, New South Wales would be producing sufficient specialists for the state.³³⁸ However, currently New South Wales is training the vast majority of addiction medicine specialists in the country, with seven or eight addiction medicine trainees and at least that number of addiction psychiatry trainees, whereas, Victoria has only one addiction medicine trainee and Queensland has one or two. Professor Lintzeris did however acknowledge that there are some barriers in terms of training pathways into addiction medicine and that these need to be addressed at the college level.³³⁹
- 3.166** Dr Chant recognised the need for enhanced training and noted that NSW Health has identified a particular gap for youth and adolescent specialists. NSW Health is also funding training programs for general practice which has been contracted to the University of Sydney.³⁴⁰
- 3.167** The NSW Government acknowledged that there are staffing barriers in the Far West, but noted that the local health district is exploring the merits of a number of innovative programs to address a lack of qualified staff and non-government service, such as:

³³⁵ Submission 24, Aboriginal Health & Medical Research Council NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, pp 12-13.

³³⁶ Submission 12, Broken Hill Working Group, p 5.

³³⁷ Evidence, Mr Andrew House, Social Worker, Broken Hill Correctional Centre, 10 May 2018, p 18.

³³⁸ Evidence, Professor Lintzeris, 3 July 2018, pp 27-28.

³³⁹ Evidence, Professor Lintzeris, 3 July 2018, p 24.

³⁴⁰ Evidence, Dr Chant, 3 July 2018, p 24.

- addiction medicine specialist support via video-conference
- drug and alcohol day rehabilitation program
- naloxone self-administration as a harm minimisation strategy.³⁴¹

Importance of lived experience

3.168 While acknowledging that clinical experience is imperative, many inquiry participants stated that there is an important role for 'lived experience' among drug and alcohol workers.³⁴² Mr Alan Bennett, Chief Executive Officer of Orana Haven, even stated that he preferred all his staff to have lived experience.³⁴³

3.169 Ms Kylie Beattie, Director for Byron Private Holistic Treatment Centre commented that workers at the centre all had some form of lived experience as well as the necessary qualifications:

I just did a six-year degree. Whilst it was helpful, I feel that my ability to meet people and to meet them on a level that brings about some sort of connection and change has not come from reading those textbooks. ... it is not so much in the letters after someone's name that brings about real change for people. But also I am qualified, our clinical director is a psychologist and there is merit in having that training. People do need to go through those processes, but all of the people in our centre have lived experience. All of our therapists have some form of lived experience. There is not one that does not.³⁴⁴

3.170 Dr Sotiri, Program Director for the Community Restorative Centre in Broken Hill, stated that locally the organisation has a policy of only accepting students with lived experience in the criminal justice system:

We have a policy within our organisation that we only take students ... who have lived experience of incarceration or criminal justice system involvement because they cannot get placements anywhere else and through those placements often there might be jobs opportunities at the end of it. I am not sure if there are ways of acknowledging that in any kind of formal sense. We are just trying to it at a local level and acknowledge that someone having been to prison themselves and having come through that equips them in ways that I, for instance, am not equipped to deal with people.³⁴⁵

3.171 NSW Health advised that its Guideline to Consumer Participation in NSW Drug and Alcohol Services highlights the 'value of engaging consumers and carers with lived experience in the delivery of services'.³⁴⁶

³⁴¹ Submission 34, NSW Government, p 32.

³⁴² Evidence, Professor Dunlop, 12 March 2018, p 11; Evidence, Dr Lloyd, 25 June 2018, p 41.

³⁴³ Evidence, Mr Alan Bennett, Chief Executive Officer, Orana Haven Drug and Alcohol Rehabilitation Centre, NSW Aboriginal Residential Healing and Drug and Alcohol Network, 12 March 2018, p 30.

³⁴⁴ Evidence, Ms Beattie, 26 June 2018, p 20.

³⁴⁵ Evidence, Dr Sotiri, 10 May 2018, p 37.

³⁴⁶ Answers to questions on notice, NSW Health, 20 July 2018, p 7.

Committee comment

- 3.172** From the evidence received both in submissions and at the committee's eight public hearings, it is clear to the committee that funding for drug and alcohol rehabilitation services is severely lacking in regional, rural and remote New South Wales. This has created a shortage of facilities, beds and staff.
- 3.173** The committee heard from many regional communities that are crying out for drug and alcohol rehabilitation services. Wait periods to access current services can stretch to six months, and many regional communities are affected by high crime rates and continuing problems with methamphetamine addictions. There is also a scarcity of services in regional areas targeted at particular groups, such as women with children, and young people.
- 3.174** While it is clear that some regional areas such as Dubbo and Broken Hill urgently require services, the committee is of the view that the most appropriate first step is for the NSW Ministry of Health to implement a population-based planning tool, such as the Drug and Alcohol Service Planning model, to geographically map the state in order to ascertain exactly what rehabilitation services and how many beds are required throughout New South Wales, and in which regions.

Recommendation 1

That the NSW Ministry of Health implement, as a matter of urgency, a population-based planning tool, such as the Drug and Alcohol Service Planning model, to ascertain what rehabilitation services and how many beds are required throughout New South Wales, and in which regions.

- 3.175** The committee considers that once the state has been effectively mapped, the government should then responsibly increase its funding in drug and alcohol rehabilitation to establish more residential rehabilitation and detoxification services throughout regional New South Wales, including facilities for women and children, Aboriginal people, and young people including those aged 13 to 16. The NSW Government should also investigate the efficacy of establishing multi-purpose facilities in regional areas that provide detoxification, residential rehabilitation and outpatient services, as such facilities will eliminate the wait time between detoxification and rehabilitation as well as any transportation issues between services. The government should examine closely the Calvary Riverina Drug and Alcohol Centre in Wagga Wagga which appears to be an effective model of comprehensive care.
- 3.176** Regarding transportation, the committee heard compelling evidence of the tireless work of Aboriginal Medical Service staff who drive patients long distances to access services. The committee is of the view that this practice should be appropriately funded and available to any person in a regional area who requires assistance.

- 3.177** We also received evidence that there is a shortfall in the number of qualified drug and alcohol professionals in regional New South Wales. The government cannot merely increase the number of facilities without also increasing the number of qualified staff who can manage and provide these important services. The NSW Government should therefore use the increased funding to provide incentives for qualified drug and alcohol professionals to relocate to regional areas and to upskill workers in regional areas. In addition, the government should work with universities, in collaboration with the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists, on initiatives to increase the pool of specialists in the drug and alcohol field.
- 3.178** As there is currently a severe shortage of beds, and the establishment of new services may take time, we recommend that the government investigate the evidence provided by the private, for-profit residential rehabilitation service, Gunnebah Addiction Retreat, for the government to subsidise regionally-based private beds. This is so that more people in regional areas can access residential rehabilitation, at least in the short term, before more services are established.
- 3.179** In summary, the committee therefore recommends that the NSW Government significantly increase funding to drug and alcohol-related health services, and use the data gathered through the population-based planning tool as outlined in recommendation 1, to:
- tender for the establishment of more residential rehabilitation services throughout regional New South Wales, including facilities for women and children, Aboriginal people, and young people including those aged 13 to 16
 - tender for the establishment of more detoxification services throughout regional New South Wales, including facilities for Aboriginal people and young people
 - investigate the benefits of establishing multi-purpose facilities in regional areas that provide detoxification, residential rehabilitation and outpatient services
 - fund local social services and Aboriginal Medical Services in regional, rural and remote New South Wales to assist in transporting patients to and from drug and alcohol treatments
 - provide incentives for qualified drug and alcohol professionals to relocate to regional areas and to upskill workers based in regional areas
 - work with universities, in collaboration with the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists, on initiatives to develop more specialists in the drug and alcohol field
 - investigate the efficacy of subsidising beds in regionally-based private, for-profit residential rehabilitation facilities to ensure more people from regional areas can access rehabilitation.

Recommendation 2

That the NSW Government significantly increase funding to drug and alcohol-related health services, and use the data gathered through the population-based planning tool as outlined in recommendation 1, to:

- tender for the establishment of more residential rehabilitation services throughout regional New South Wales, including facilities for women and children, Aboriginal people, and young people including those aged 13 to 16
- tender for the establishment of more detoxification services throughout regional New South Wales, including facilities for Aboriginal people and young people
- investigate the benefits of establishing multi-purpose facilities in regional areas that provide detoxification, residential rehabilitation and outpatient services
- fund local social services and Aboriginal Medical Services in regional, rural and remote New South Wales to assist in transporting patients to and from drug and alcohol treatments
- provide incentives for qualified drug and alcohol professionals to relocate to regional areas and to upskill workers based in regional areas
- work with universities, in collaboration with the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists, on initiatives to develop more specialists in the drug and alcohol field
- investigate the efficacy of subsidising beds in regionally-based private, for-profit residential rehabilitation facilities to ensure more people from regional areas can access rehabilitation.

3.180 A crucial issue identified throughout the inquiry is that no one knows the exact number or precise location of rehabilitation beds available in New South Wales. In other words, there is currently no central register where members of the community, service providers, and legal representatives can navigate the exact number of beds and services that are available in their region. This is simply unacceptable.

3.181 While we recognise that there are complexities involved in working out precise numbers of beds funded by different levels of government, this hurdle is not insurmountable, and the government should ensure that this vital information is publicly available online and through an appropriate phone service. The committee therefore recommends that the NSW Ministry of Health, as a matter of urgency, establish a central register for New South Wales of all available beds and facilities for drug and alcohol rehabilitation, which: includes real-time data concerning wait lists and wait times; encompasses private health and medical services; and is publicly available as a resource for service providers, legal professionals and the community.

Recommendation 3

That the NSW Ministry of Health, as a matter of urgency, establish a central register for New South Wales of all available beds and facilities for drug and alcohol rehabilitation, which:

- includes real-time data concerning wait lists and wait times
 - encompasses private health and medical services
 - is publicly available as a resource for service providers, legal professionals and the community.
-

3.182 Throughout the inquiry, the committee heard evidence regarding the intersection between drug and alcohol abuse and crime. The committee is pleased that the government has recognised this and has in place a number of programs to divert people away from the criminal justice system in order to break the drug-crime cycle. Both the Drug Court and MERIT program were strongly supported by inquiry participants. However, the Drug Court is not currently available regionally and the MERIT program is only available in some regional areas. In addition, it has now been 10 years since the effectiveness of the Drug Court model was last comprehensively evaluated.

3.183 As a practical matter, rolling out these programs in regional areas will require an increase in drug rehabilitation services, facilities and beds. Accordingly, the committee recommends that the NSW Government conduct a review of the Drug Court and MERIT, including the feasibility of establishing them in additional regional areas. Further, given the unanimity of support for a Drug Court and other rehabilitation services to be established in Dubbo, the committee recommends that the NSW Government pilot a Drug Court in Dubbo in parallel with an increase in rehabilitation services for the area.

Recommendation 4

That the NSW Government conduct a review of the Drug Court and the Magistrates Early Referral Into Treatment program, including the feasibility of establishing them in additional regional areas.

Recommendation 5

That the NSW Government pilot a Drug Court in Dubbo in parallel with an increase in rehabilitation services for the area.

3.184 We also received evidence that funding grants for non-government rehabilitation services, and in particular Australian Government grants, are too short. Grants can last only a single year, meaning that an overstretched workforce is spending significant amounts of time preparing grant applications. Moreover, the service providers are in a constant state of uncertainty, unsure if they can remain in operation in the future, making it hard to plan, recruit and retain good staff. The committee therefore recommends that the NSW Government's funding grants to non-government drug and alcohol-related health services run for a minimum of three years, with the option for a two year extension. The NSW Government should also advocate through the Council of Australian Governments for the Australian Government to commit to the same practice.

Recommendation 6

That the NSW Government:

- commit to providing funding grants to non-government drug and alcohol-related service providers that run for a minimum of three years, with the option for a two year extension
 - advocate through the Council of Australian Governments for the Australian Government to commit to the same practice.
-

- 3.185** While only hearing from a small number of private rehabilitation providers, the committee was concerned that this industry is completely unregulated: anyone can effectively set up shop as a rehabilitation service in this state. In order to protect vulnerable people in our community, the committee recommends that the NSW Government establish a standards framework for the private, for-profit residential rehabilitation industry.
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Recommendation 7

That the NSW Government establish a standards framework for the private, for-profit residential rehabilitation industry.

- 3.186** The committee notes that a barrier for public housing tenants who wish to access residential rehabilitation is that they may lose their housing if it were left vacant over certain periods of time. The committee therefore recommends that the NSW Government ensure that public housing tenants who undertake residential drug rehabilitation or detoxification, not exceeding 12 months, do not lose their housing while undergoing treatment.
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Recommendation 8

That the NSW Government ensure that public housing tenants who undertake residential drug rehabilitation or detoxification, not exceeding 12 months, do not lose their housing while undergoing treatment.

- 3.187** The committee also recommends that the NSW Government acknowledge the health, social and economic benefits of prevention of drug and alcohol abuse and investigate the efficacy of implementing a state-wide school nurse program which includes targeting young people with preventative action and support.
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Recommendation 9

That the NSW Government:

- acknowledge the health, social and economic benefits of prevention of drug and alcohol abuse
 - investigate the efficacy of implementing a state-wide school nurse program which includes targeting young people with preventative action and support.
-

Chapter 4 Provision of drug rehabilitation services for Aboriginal people

This chapter examines the provision of drug rehabilitation services for Aboriginal people in regional, rural and remote New South Wales. It commences by discussing the relationship between Aboriginal disadvantage and drug and alcohol addiction, before providing an overview of the drug and alcohol services currently available to Aboriginal people in regional New South Wales. The chapter then discusses the need for more Aboriginal-specific services, including treatment that is available on country. Finally, this chapter explores Aboriginal staffing levels and training, and the Koori Court.

Aboriginal disadvantage and drug and alcohol addiction

- 4.1 The committee heard that drug and alcohol related harm contributes to disparities in health and life expectancy between Aboriginal people and other Australians.³⁴⁷
- 4.2 The NSW Government reported that among Aboriginal people who drink alcohol, a higher proportion drink to an extent that places their long-term health at risk.³⁴⁸ In addition, national surveys consistently report higher levels of 'recent' illicit drug use among Aboriginal people than non-Aboriginal people.³⁴⁹ The government advised that in 2014-15 Aboriginal people represented 15 per cent of all clients using drug and alcohol treatment services³⁵⁰, but make up only 2.9 percent of the total population of New South Wales as at the 2016 Census.³⁵¹
- 4.3 The Aboriginal Health and Medical Research Council of NSW (AH&MRC) and the NSW Aboriginal Residential Healing and Drug Alcohol Network (NARHDAN) stated that Aboriginal people continue to have a disproportionately high representation in drug and alcohol data by at least two times that of the non-Aboriginal population.³⁵² They noted that under the National Drug and Alcohol Strategy 2017–2026, the NSW Drug and Alcohol Action Plan and the National Ice Action Plan, Aboriginal people are considered a priority population.³⁵³

³⁴⁷ Submission 34, NSW Government, p 28, citing Intergovernmental Committee on Drugs 2015, *National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014-2019, A substrategy of the National Drug Strategy 2015*, <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/natsipds2014-19>.

³⁴⁸ Submission 34, NSW Government, p 28, citing NSW Ministry of Health 2016, *Trends in Alcohol use and health-related harms in NSW: Report of the Chief Health Officer 2016*, <http://www.health.nsw.gov.au/hsnsw/Publications/chief-healthofficers-report-2016.pdf>.

³⁴⁹ Submission 34, NSW Government, p 28, citing MacRae A and Hoareau J 2016, *Review of illicit drug use among Aboriginal and Torres Strait islander people*, Australian Indigenous HealthInfoNet, <http://www.healthinfonet.ecu.edu.au/uploads/docs/Illicit-drugs-review-2015-web.pdf>.

³⁵⁰ Submission 34, NSW Government, p 28.

³⁵¹ Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Population, 2016* (11 July 2018) <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20Article~12>.

³⁵² Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 2.

³⁵³ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 2.

- 4.4 AH&MRC and NARHDAN commented that the causes of drug and alcohol misuse in the Aboriginal community are deeply rooted in complex historical, social, cultural and economic disadvantage.³⁵⁴
- 4.5 The Dharriwaa Elders Group listed a number of issues that contribute to entrenched disadvantage in the Aboriginal community:
- Drug, alcohol and gambling addictions are present in feedback loops also containing unemployment, inadequate housing, low incomes, childhood trauma, cognitive impairment, mental illness, family violence, low education outcomes, distance from services, past denial of services, separation from family members, Country and languages.³⁵⁵
- 4.6 The NSW Government, along with several other inquiry participants, also highlighted the significant impact that dispossession and intergenerational trauma continue to have on the health and wellbeing of Aboriginal people.³⁵⁶ For example, Oolong House explained that intergenerational trauma means that many in the Aboriginal community have lost their sense of connection to their culture, language, arts, stories, land, people, and ultimately their identity.³⁵⁷ This loss of cultural identity can contribute to a negative and false sense of self, which has a major impact on drug and alcohol addiction.³⁵⁸
- 4.7 In addition, there is a disproportionately high representation of Aboriginal people in the criminal justice system.³⁵⁹ The Central West Cooperative Legal Service and Clr Edwina Lloyd of Lismore City Council informed the committee that according to the 2017 NSW Bureau of Crime Statistics and Research (BOCSAR) crime report, the incarceration of Aboriginal people in New South Wales has increased by an average of 25 per cent since 2013.³⁶⁰ The Aboriginal imprisonment rate in the state is currently 13.5 times higher than for non-indigenous people.³⁶¹

³⁵⁴ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 2 citing National Indigenous Drug and Alcohol Committee, *Locally designed and operated Indigenous community models*, http://www.nidac.org.au/index.php?option=com_content&view=article&id=92%3Alocallydesigned-and-operated-indigenous-community-models&catid=37%3Apublications-and-reports&Itemid=63.

³⁵⁵ Submission 23, Dharriwaa Elders Group, p 1.

³⁵⁶ Submission 34, NSW Government, p 28; Evidence, Mr Rohan Moreton, Aboriginal Health Worker, Katungul Aboriginal Medical Service, 6 April 2018, p 42; Evidence, Ms Julie Perkins, Chairperson, Clarence Valley Aboriginal Healing Centre, 25 June 2018, pp 52 and 56; Evidence, Ms Janelle Brown, Coordinator, Clarence Valley Aboriginal Healing Centre, 25 June 2018, p 53; Submission 33, Aboriginal Legal Service, p 10.

³⁵⁷ Submission 37, The Oolong Aboriginal Corporation (Oolong House), p 5.

³⁵⁸ Submission 37, The Oolong Aboriginal Corporation (Oolong House), p 5.

³⁵⁹ Submission 30, Central West Cooperative Legal Service Delivery, p 4; Submission 3, Orana Law Society, p 1; Evidence, Clr Edwina Lloyd, Councillor, Lismore City Council, 26 June 2018, p 48.

³⁶⁰ Submission 30, Central West Cooperative Legal Service Delivery, p 4; Submission 36, Clr Lloyd, p 12.

³⁶¹ Submission 30, Central West Cooperative Legal Service Delivery, p 4.

4.8 The Central West Cooperative Legal Service commented that this disproportionate representation should be considered against a background of many of those people abusing drugs and alcohol, as well as the unavailability of detoxification and rehabilitation services in remote areas when courts attempt to address drug and alcohol issues in sentencing.³⁶²

4.9 Clr Lloyd referred to her experience as a duty lawyer with the Aboriginal Legal Service when discussing her experience with Aboriginal drug and alcohol related crime:

My experience as a duty lawyer for Aboriginal Legal Service is consistent with the statistics of drug and alcohol-related crime and I can count on one hand the number of Aboriginal people I have represented who have not been charged with a crime related to a substance abuse disorder.³⁶³

4.10 At the committee's hearing in Broken Hill, Dr Mindy Sotiri, Program Director for the Community Restorative Centre, provided a case study of one of the centre's clients, which illustrated the devastating connection between family dysfunction, drugs and crime:

I was eight years old when my father first used me to assist him with break and enters by putting me into open windows that I could unlock the back door for him. I learnt from a very young age how to break into houses and take what wasn't mine. Dad sold or traded the stuff we stole to buy drugs for him and his mates. I was 12 years old when I first started using drugs. I used drugs to forget about the things I had done and the things that were done to me. My mother was also an addict and mum and dad were constantly fighting. My father would bash my mother, end up in jail and then come out and do the same thing over and over. I am now 20 years old. I sat in jail for five months waiting for an opportunity to have a bed available in a rehab.³⁶⁴

4.11 Stakeholders also highlighted the sense of stigma and shame associated with drug and alcohol addiction in Aboriginal communities. The Aboriginal Legal Service (NSW/ACT) informed the committee that participants in the NSW Young People in Custody Survey reported feeling ashamed and judged because of their drug or alcohol dependency issues.³⁶⁵ Ms Janelle Brown from the Clarence Valley Aboriginal Healing Centre provided the following perspective about stigma and shame related to substance abuse in the Aboriginal community:

That can be a reason why people do not seek treatment when they know that they need to. It is not just because of shame on their family but because it reflects poorly on them, and not wanting to share that with people. It would be a big thing to admit to yourself and to others that you do have a problem where you need to seek treatment. It can be a really shameful thing.³⁶⁶

³⁶² Submission 30, Central West Cooperative Legal Service Delivery, p 4.

³⁶³ Submission 36, Clr Edwina Lloyd, Lismore City Council, pp 12-13.

³⁶⁴ Evidence, Dr Mindy Sotiri, Program Director – Advocacy, Policy and Research, Community Restorative Centre, Broken Hill Office, 10 May 2018, p 30.

³⁶⁵ Submission 33, Aboriginal Legal Service (NSW/ACT), p 3.

³⁶⁶ Evidence, Ms Brown, 25 June 2018, p 55.

Aboriginal-specific rehabilitation services

- 4.12 The committee heard about the range of different drug and alcohol rehabilitation services available specifically for the Aboriginal community, including residential rehabilitation, healing centres and Aboriginal Medical Services.

Residential rehabilitation

- 4.13 The majority of residential facilities that cater to Aboriginal people are members of NARHDAN and are supported by the AH&MRC. These provide a mechanism for Aboriginal drug and rehabilitation managers to share information, and a forum for stakeholders to access knowledge and advice.³⁶⁷
- 4.14 NARHDAN and AH&MRC advised the committee that there are six members of the network in total, all located in regional and remote locations.³⁶⁸ The scope of the services provided by facilities within the network, along with the size of the client base and programs available, is diverse, but there is a focus on services for Aboriginal men over 18 years of age, as illustrated in Table 5.

Table 5 Summary of NARHDAN members and available services

Name	Location	Target Group	Beds
Namatjira Haven	Alstonville, Far North Coast	Men aged 18 and over	14-16
'Ngaimpe' The Glen	Chittaway Bay, Central Coast	Men aged 18 and over	20 program beds, 18 transition beds
Oolong House	Nowra, South Coast/Illawarra	Men aged 18 and over	21
Orana Haven	Brewarrina, Central North West	Men aged 18 and over	16-18
Weigelli Corporation	Cowra, Lower Central West	Men, women and couples aged 16 and over	18
Maayu Mali	Moree, Central Tablelands	Men and women aged 18 and over	18 (4 female, 14 male)

Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 6.

- 4.15 NARHDAN and AH&MRC advised that its members' programs are based on a trauma informed, client centred approach encompassing a flexible care plan that addresses individual needs, and can include the involvement of family and community. Programs can include access

³⁶⁷ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 4.

³⁶⁸ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 5.

to life skills and education through TAFE, cognitive behaviour therapy, motivational interviewing, narrative and reality counselling, GP consultations, individual case work and group work. Residential rehabilitation services in the network can also include cultural therapy.³⁶⁹ In addition, all services within the network provide some form of post-treatment follow up ranging from a telephone conversation to transitional programs from three to twelve months in length. Two of the six services also provide detoxification services.³⁷⁰

4.16 Importantly, the committee heard that residential treatment programs also incorporate culturally specific practices to ensure the cultural safety of their clients. This includes education about Aboriginal cultural values, ceremonies, connection to land, family and spiritual and healing techniques. NARHDAN and AH&MRC noted that compared to other residential drug and alcohol services, these treatment models are a practical expression of Aboriginal peoples' capacity for self-determination.³⁷¹

4.17 Ms Lisa Wellington from the Waminda South Coast Women's Health and Welfare Aboriginal Corporation described what 'holistic', culturally appropriate wraparound services should include:

... it would be culturally appropriate at meeting the needs of our people, to ensure that there is that holistic service, that it wraps around with the community services that are on the ground, but also taking into account the cultural issues that our people deal with when we talk about racism, when we talk about the stolen generation—looking at all of those underlying issues as to reasons why people may use substances.³⁷²

Healing centres

4.18 Aboriginal healing centres are community owned and operated facilities that support healing for Aboriginal people to address intergenerational trauma, improve wellbeing, and reduce rates of suicide, incarceration, domestic and family violence, and drug and alcohol abuse.³⁷³

4.19 The committee visited the Clarence Valley Aboriginal Healing Centre as part of this inquiry and heard from representatives of the centre at its public hearing in Grafton. Ms Janelle Brown, Coordinator at the centre, explained that the healing centre works to facilitate the healing of Aboriginal people either individually or collectively, noting that it could for example 'sponsor an Indigenous Alcoholics Anonymous or Narcotics Anonymous group'.³⁷⁴ She also commented that the centre was always looking for new and innovative ways to promote healing.³⁷⁵

³⁶⁹ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 5.

³⁷⁰ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 5.

³⁷¹ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 5.

³⁷² Evidence, Ms Lisa Wellington, Senior Program and Client Service Manager, Waminda South Coast Women's Health and Welfare Aboriginal Corporation, 5 April 2018, pp 14-15.

³⁷³ Healing Foundation, *Healing Centres*, <http://healingfoundation.org.au/community-healing/healing-centres/>.

³⁷⁴ Evidence, Ms Brown, 25 June 2018, p 54.

³⁷⁵ Evidence, Ms Brown, 25 June 2018, p 54.

- 4.20** The committee also heard from Dr Sotiri that Aboriginal healing centres tend to take 'an incredibly holistic ... perspective',³⁷⁶ commenting:

They really acknowledge the history of trauma and intergenerational trauma for Indigenous people and, I guess, take the perspective that in order to shift or to change or to build pathways out of whatever problematic behaviour or problematic involvement in the criminal justice system might be, that there needs to be an acknowledgement of what has happened historically. Most healing centres also will ensure that Indigenous culture and language is front and centre of the approaches that people are taking in order to respond to things like drug and alcohol use.³⁷⁷

Aboriginal Medical Services

- 4.21** Aboriginal Medical Services are managed by Aboriginal people, for Aboriginal people, and provide holistic 'one stop shop' health and medical services to their local community.
- 4.22** There was strong support for regional Aboriginal Medical Services among inquiry participants.³⁷⁸ For example, the Aboriginal Legal Service (NSW/ACT) informed the committee that Aboriginal Medical Services have excellent drug and alcohol sections that are culturally appropriate, and provide other related services such as mental health counselling that are free to clients.³⁷⁹
- 4.23** Ms Ann Kelly, a Clinical Nurse Consultant at the Katungul Aboriginal Medical Service located in Batemans Bay, advised the committee that having worked in three Aboriginal Medical Services, she was a great advocate for them. This is because they provide a 'one stop shop' model with a mixture of Aboriginal and non-Aboriginal doctors, nurses and health workers available in the one place. Ms Kelly observed that Aboriginal Medical Services are 'part of the community'.³⁸⁰
- 4.24** Ms Kelly's colleague, Mr Rohan Moreton, provided the committee with the following insight derived from five years' experience working in these services:

... you can look at an Aboriginal medical service in a number of ways: It is a place where Aboriginal people feel safe that they can come to and get their health needs addressed by a GP, a health worker or a psychologist, or some other issues through our community team. I have seen Katungul grow from five years ago. We have grown heaps to have three centres on the coast now—that speaks for itself. Not only that, non-Indigenous people are starting to use the Aboriginal medical service too, so that is really good.³⁸¹

³⁷⁶ Evidence, Dr Sotiri, 10 May 2018, p 33.

³⁷⁷ Evidence, Dr Sotiri, 10 May 2018, p 33.

³⁷⁸ Submission 33, Aboriginal Legal Service (NSW/ACT), p 12; Evidence, Ms Ann Kelly, Clinical Nurse Consultant, Katungul Aboriginal Medical Service, 6 April 2018, p 39, Evidence, Mr Moreton, 6 April 2018, p 39.

³⁷⁹ Submission 33, Aboriginal Legal Service (NSW/ACT), p 12.

³⁸⁰ Evidence, Ms Kelly, 6 April 2018, p 43.

³⁸¹ Evidence, Mr Moreton, 6 April 2018, p 43.

- 4.25** The NSW Government informed the committee that the NGO Ministerial Grants Program funds seven Aboriginal Medical Services to deliver drug and alcohol services across regional New South Wales, located in Albury Wodonga, Wagga Wagga, Taree, Bourke, Kempsey, Nowra and Walgett.³⁸²

Need for more funding for Aboriginal-specific services

- 4.26** The need for increased funding for regional drug and alcohol rehabilitation services is discussed in detail in chapter 3. However, the committee also received evidence about the need to fund Aboriginal-specific treatment services that allow Aboriginal clients to remain on country and close to their families and communities.³⁸³
- 4.27** A key finding from the Aboriginal Legal Service (NSW/ACT)'s recent community survey was that 94 per cent of respondents said that it was important to have separate, specialised drug rehabilitation services for Aboriginal and Torres Strait Islander men and women. Participants spoke of women being forced to leave their families and children to attend rehabilitation in metropolitan cities, or avoiding attending rehabilitation due to this barrier. Almost all respondents (96 per cent) said that it was important to have separate, specialised drug rehabilitation services for Aboriginal and Torres Strait Islander youth, as there are almost no services available for this group in regional and remote areas.³⁸⁴
- 4.28** While there are several rehabilitation facilities in regional New South Wales for Aboriginal men, the committee heard that there are currently no drug and alcohol rehabilitation services specifically for Aboriginal women and children, noting that one such facility, Benelong's Haven, has very recently closed.³⁸⁵ Mr Blunden, Acting Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW, noted that Benelong's Haven used to take in 'the whole family – mum, dad and the children'. Now that this is closed there is a 'massive need' for facilities that allow 'the family to go on the healing journey together'.³⁸⁶
- 4.29** Inquiry participants informed the committee that they have tried to establish such services. The Dharriwaa Elders Group with the assistance of the Walgett Aboriginal Medical Service, Orana Haven Aboriginal Corporation Drug & Alcohol Rehabilitation, Weigelli Centre Aboriginal Corporation and University of New South Wales researchers, made a tender application to NSW Health for a new residential drug and alcohol rehabilitation service for Aboriginal women and children to be located near Walgett, however the application was not

³⁸² Answers to questions on notice, NSW Health, 11 April 2018, pp 10-11.

³⁸³ See for example: Evidence, Mr Alan Bennett, Chief Executive Officer, Orana Haven Drug and Alcohol Rehabilitation Centre, NSW Aboriginal Residential Healing and Drug and Alcohol Network, 12 March 2018, p 29; Evidence, Ms Wellington, 5 April 2018, p 14; Submission 12, Broken Hill Working Group, p 5.

³⁸⁴ Submission 33, Aboriginal Legal Service (NSW/ACT), pp 2 and 4.

³⁸⁵ Evidence, Ms Dian Edwards, Manager, Namatjira Haven, 26 June 2018, p 23.

³⁸⁶ Evidence, Mr Stephen Blunden, Acting Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW, 12 March 2018, p 34.

successful.³⁸⁷ As noted in chapter 2, Waminda and Oolong House also submitted a proposal for such a facility in 2017.³⁸⁸

- 4.30** Mr Steven Roberts, a concerned parent, argued that there should be rehabilitation facilities available for young Aboriginal people that are not involved in the criminal justice system, to address behaviour prior to this escalation:

My other point is that there is a total lack of rehabilitation for children. There is one in Coffs Harbour and one in Dubbo but both are for kids who are already involved in the criminal justice system. We desperately need a facility up here to be purpose built for young people to either self-refer or be referred as per above, to deal with their drug addiction. This needs to be available for kids before they start committing crimes. Waiting till then is detrimental to all our community and it is unacceptable given the amount of drug abuse there is within our community even our schools.³⁸⁹

- 4.31** Mr Bennett, Chief Executive Officer of Orana Haven, indicated that while there are some outpatient services available in rural and remote areas, there are not enough residential facilities for Aboriginal people. He stated that 'drug and alcohol goes 24/7 when you have addiction' and that outreach services can only offer so much.³⁹⁰
- 4.32** There was also concern about the ability for smaller Aboriginal organisations to compete for funds with larger and more established organisations who have the capacity to prepare large tenders, which smaller service providers do not.³⁹¹
- 4.33** Ms Tanya Bloxsome, Acting Chief Executive, Oolong House, considered that where possible, funding should be provided to frontline Aboriginal-specific services. She noted that ice taskforce money primarily went to mainstream organisations that often only have one or two Aboriginal staff members employed.³⁹²
- 4.34** As noted above, the NSW Government currently funds Aboriginal Community Controlled Health Services delivering drug and alcohol services through the NGO Ministerial Grants Program. This funding, which covers both residential and non-residential drug and alcohol treatment programs, complements funding provided by the Department of Prime Minister and Cabinet, Primary Health Networks and the Commonwealth Department of Health.³⁹³

³⁸⁷ Submission 23, Dharriwaa Elders Group, p 2.

³⁸⁸ Evidence, Ms Faye Worner, Chief Executive Officer, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, 5 April 2018, p 13.

³⁸⁹ Submission 42, Mr Steven Roberts, p 1.

³⁹⁰ Evidence, Mr Bennett, 12 March 2018, p 29.

³⁹¹ Evidence, Mr Bennett, 12 March 2018, p 33.

³⁹² Evidence, Ms Tanya Bloxsome, Acting Chief Executive, Oolong Aboriginal Corporation (Oolong House), 5 April 2018, p 20.

³⁹³ Answers to questions on notice, NSW Health, 10 April 2018, pp 10-11.

- 4.35** The NSW Government advised the committee that it has committed \$90 million over four years to provide 900 places per year through intensive family preservation and restoration services aimed at keeping families together. Half of the 900 places will be for Aboriginal children and their families.³⁹⁴

Importance of staying on country

- 4.36** Many inquiry participants emphasised the importance of Aboriginal people's connection to country, including in the context of treatment. The committee heard that drug and alcohol services for Aboriginal people are most effective when they acknowledge their deep connection to their land and community by allowing them to remain on country and close to family.³⁹⁵
- 4.37** Ms Kelly from the Katungul Aboriginal Medical Service encapsulated this idea when she told the committee:

In my experience family is so strong it is hard to verbalise it. Family and community are everything to the Aboriginal people, and the land. It is everything. They are better off home, better off on country. Absolutely.³⁹⁶

- 4.38** Mr Rod Towney, Chairperson, Three Rivers Regional Assembly, Member, Dubbo Aboriginal Community Working Party and Member, Dubbo Local Aboriginal Lands Council, informed the committee why remaining on country is so important for Aboriginal people and why this may differ from the non-Indigenous population:

It is how we operate. Family is important to us, including the extended family. If you divide or take two or three members away, it upsets the rest of the family. Having people altogether in one place is better for us ... There is a big difference and gap that people do not understand because they are thinking of a non-Aboriginal world view.³⁹⁷

- 4.39** Dr Sotiri provided the following case study to demonstrate the impact on Aboriginal people of having to go off country to receive treatment.

³⁹⁴ Submission 34, NSW Government, p 38.

³⁹⁵ Submission 4, Far West Community Legal Centre, p 4; Submission 23, Dharriwaa Elders Group, pp. 1-2; Evidence, Ms Darriea Turley, Mayor, Broken Hill City Council, 10 May 2018, p 2; Evidence, Dr Sotiri, 10 May 2018, pp 30 – 31; Evidence, Mr Rod Towney, Chairperson, Three Rivers Regional Assembly, Member, Dubbo Aboriginal Community Working Party and Member, Dubbo Local Aboriginal Lands Council, 9 May 2018, p 4; Evidence, Clr Stephen Lawrence, Dubbo Regional Council, 9 May 2018, p 3; Evidence, Mr Norm Henderson, Dharriwaa Elders Group and Weigelli Aboriginal Corporation, 9 May 2018, p 32; Submission 12, Broken Hill Working Group, p 4.

³⁹⁶ Evidence, Ms Kelly, 6 April 2018, p 42.

³⁹⁷ Evidence, Mr Towney, 9 May 2018, p 13.

Case study – Young Barkanji woman

The Community Restorative Centre made arrangements for a young Barkanji woman to travel from Broken Hill to Sydney for rehabilitation as a consequence of court-ordered rehabilitation. The Sydney rehabilitation centre was the only facility that could take her.

This was the first time that rehabilitation had ever been arranged for her despite having been an intravenous drug user since the age of 13. She had also been in and out of detention and prison since that time.

The Community Restorative Centre arranged and funded flights, clothes and travel bags. In the days leading up to her admission she became incredibly stressed at the thought of not seeing her children, leaving country and everything that she knew. She had never flown on an aeroplane before or been to a city as large as Sydney. Her drug use spiralled in the few days prior to arriving at the rehabilitation centre. She was incredibly distressed while travelling to the airport and on the flight to Sydney. Her family was also distressed with her leaving. The experience of being disconnected from her family in this way and away from country resulted in her only lasting 48 hours in the Sydney rehabilitation centre. She was trying to detoxify from ice at the same time as being disconnected from everybody she knew and loved and everything that was familiar. She ended up being incredibly displaced, highly vulnerable and very unwell. The Community Restorative Centre urgently organised for her to fly home again.³⁹⁸

- 4.40 Ms Fiona Beston from the Mental Health, Drug and Alcohol Service in Batemans Bay stated that they are learning from their clinical leader that the trauma impact of being off country compounds the recovery process of Aboriginal people even more. The clinical leader has been educating staff about the importance of remaining on country.³⁹⁹

Aboriginal staffing and training

- 4.41 Another key issue discussed by inquiry participants was the importance of having Aboriginal staff in public and non-government services, training and upskilling Aboriginal staff, and providing awareness training for all staff.
- 4.42 In relation to Aboriginal staff in the public health system working in drug and alcohol, the committee was provided with the following information from the local health districts that gave evidence.
- The Shoalhaven and Illawarra Drug and Alcohol Services have two workers that identify as Aboriginal, one in each area.⁴⁰⁰
 - The Southern NSW Local Health District Mental Health, Drug and Alcohol Service has one full time equivalent Aboriginal clinical leader based in Bega Valley who works across the district providing consultation and high-level clinical support for mental health, drug and alcohol clients. The position commenced in January 2018.⁴⁰¹

³⁹⁸ Evidence, Dr Sotiri, 10 May 2018, pp 30-31.

³⁹⁹ Evidence, Ms Fiona Beston, Acting Manager, Strategic Coordinator Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug and Alcohol Service, 6 April 2018, p 33.

⁴⁰⁰ Evidence, Mr David Reid, Director, Drug and Alcohol Service, NSW Health, 5 April 2018, p 7.

⁴⁰¹ Evidence, Ms Beston, 6 April 2018, p 30.

- The Northern NSW Local Health District has one drug and alcohol worker specifically for Aboriginal people in the region, but no Aboriginal-identifying staff working in drug and alcohol.⁴⁰²

4.43 Ms Faye Worner, Chief Executive Officer of Waminda stated that Shoalhaven Hospital has only one Aboriginal Liaison Officer, and that because it is 'a very big hospital', she often 'cannot find an Aboriginal staff member at that hospital to support people' when required.⁴⁰³

4.44 The peak non-government body, the Network of Alcohol and other Drug Agencies (NADA), advised that only seven per cent of staff working in the state's non-government drug and alcohol sector identify as being of Aboriginal or Torres Strait Islander background.⁴⁰⁴

4.45 Mr Bennett highlighted the importance of employing Aboriginal staff:

Really it is that relationship and that kinship, how they feel about us, how we talk to each other. You just have to understand us, how we relate to each other, how we welcome each other, how we make each other feel comfortable and relaxed.⁴⁰⁵

4.46 Mr Towney agreed that a lot more Aboriginal staff is required in the sector and there needs to be more Aboriginal people trained to be in decision making roles.⁴⁰⁶

4.47 In relation to the issue of staff training, Aboriginal rehabilitation providers discussed the difficulties arising from having to travel to major cities to receive vital training in the drug and alcohol sphere. Mr Trevor Kapeen from the Bulgarr Ngaru Aboriginal Corporation described how he obtained training for his role as a drug and alcohol worker:

I did block release in Sydney... It was tough for my wife. Look, you have got to do what you have to do. If you want to work in that field you are going to have to go and do the training.⁴⁰⁷

4.48 The Dharriwaa Elders Group advocated for highly skilled professionals to be pro-actively recruited to work alongside local Aboriginal positions, recommending that for every skilled position recruited to Walgett, a full time local Aboriginal trainee position should be provided to build local knowledge and two-way learning.⁴⁰⁸

4.49 Mr Norm Henderson, speaking on behalf of the Dharriwaa Elders Group and Weigelli Aboriginal Corporation, elucidated on this proposal and discussed the importance of hiring and upskilling Aboriginal people:

⁴⁰² Evidence, Mr Wayne Jones, Chief Executive, Northern NSW Local Health District, 25 June 2018, p 5.

⁴⁰³ Evidence, Ms Worner, 5 April 2018, p 18.

⁴⁰⁴ Submission 25, Network of Alcohol and other Drugs Agencies (NADA), p 10.

⁴⁰⁵ Evidence, Mr Bennett, 12 March 2018, p 30.

⁴⁰⁶ Evidence, Mr Towney, 9 May 2018, p 12.

⁴⁰⁷ Evidence, Mr Trevor Kapeen, Drug and Alcohol Addiction Worker, Bulgarr Ngaru Aboriginal Corporation, 25 June 2018, p 17.

⁴⁰⁸ Submission 23, Dharriwaa Elders Group, p 3.

Well, the University of New South Wales is most probably better placed to explain that, but the concept is a very good concept. We have a fly in, fly out psychologist that goes to Walgett. If we could have an Aboriginal mental health worker tag along with that person, we could get that person upskilled. Maybe we would end up with an Aboriginal psychologist. There are a few of them around, but not a lot. The same in the hospitals. The hospitals seem reticent to hire people and skill them, especially Aboriginal people. They might hire an Aboriginal person and then they put them over here and say, "Well, anyone who looks like an Aboriginal we will just spear them to you." They do not teach them anything. I think we need to look at upskilling Aboriginal people. The whole community benefits. It is a no-brainer to me.⁴⁰⁹

4.50 Mission Australia raised concerns that Aboriginal workers in the field are 'usually employed in comparatively low-status, lower paid positions such as health workers or community workers'.⁴¹⁰ This view was supported by NARHDAN and AH&MRC, which noted research indicating that Aboriginal drug and alcohol workers in non-government organisations were the lowest paid in the sector despite a comparable level of responsibility to their government colleagues.⁴¹¹

4.51 The committee also heard about the limited capacity of the public health system to provide culturally appropriate care to Aboriginal people, including to those seeking treatment for drug and alcohol issues. For example, representatives from Waminda and Oolong House discussed the experience of some of their clients when seeking medical or drug and alcohol care from their local hospital. Ms Worner described systemic issues with racism and commented that they have a 'long way to go in terms of being culturally appropriate',⁴¹² telling the committee:

We will have people—women in our instance or women and families—who will present up at the hospital and be treated appallingly and not be respected how they should be in order for them to feel that they can stay there and receive the service. I am trying to put that as clearly as I possibly can. It is an incredibly racist experience that most Aboriginal people have at this local hospital.⁴¹³

4.52 Ms Bloxsome explained that this can make it difficult to get an Aboriginal person to go to hospital to seek treatment in the first place: most would 'rather just not go'.⁴¹⁴

4.53 Mr Ken Dennis from the Broken Hill Aboriginal Legal Service identified cultural awareness and cultural training as a significant area for improvement. He noted that 'it does not matter if they are not Aboriginal people, but as long as they know our culture. They have to know the culture and respect our culture as well'.⁴¹⁵ This matter was also identified by the Broken Hill Working Group.⁴¹⁶

⁴⁰⁹ Evidence, Mr Henderson, p 35.

⁴¹⁰ Submission 15, Mission Australia, p 12.

⁴¹¹ Submission 24, Aboriginal Health & Medical Research Council of NSW and NSW Aboriginal Residential Healing and Drug Alcohol Network, p 12.

⁴¹² Evidence, Ms Worner, 5 April 2018, p. 16.

⁴¹³ Evidence, Ms Worner, 5 April 2018, p. 17.

⁴¹⁴ Evidence, Ms Bloxsome, 5 April 2018, p. 17.

⁴¹⁵ Evidence, Mr Ken Dennis, Manager, Broken Hill Aboriginal Legal Service, 10 May 2018, p 21.

⁴¹⁶ Submission 12, Broken Hill Working Group, p 5.

- 4.54** The NSW Government acknowledged that culturally appropriate strategies are required to support effective health service delivery and better health outcomes, and identified three key elements in improving the provision of drug and alcohol treatment to Aboriginal communities:
- accessibility in the sense of being culturally safe and appropriate for Aboriginal people
 - being physically accessible, especially for those living in regional areas
 - the complexity of issues faced by Aboriginal clients which require longer duration of services, and at a higher intensity which may require family-centred, rather than individually-focused treatment approaches.⁴¹⁷
- 4.55** The NSW Government advised that although the Aboriginal drug and alcohol workforce in New South Wales has grown rapidly, it is still relatively small. There are no Aboriginal doctors specialising in addiction medicine in New South Wales, and few Aboriginal psychologists or nurses with this speciality.⁴¹⁸
- 4.56** In light of this, the NSW Government acknowledged that the Aboriginal drug and alcohol workforce needs to continue to grow across the state to assist both mainstream services and Aboriginal community controlled organisations, and that rehabilitation services need to improve the cultural competency of non-Aboriginal health service staff to work with Aboriginal clients.⁴¹⁹
- 4.57** In answers to questions on notice, Dr Kerry Chant, Chief Health Officer, NSW Health, drew the committee's attention to the Hunter New England Local Health District Drug and Alcohol Clinical Services, which has approximately 10 per cent staff identifying as Aboriginal.⁴²⁰ NSW Health attributed this to the district implementing employment, education and support strategies, noting that the district will provide advice and guidance on how to build Aboriginal staffing capacity to other local health districts via the NSW Health Drug and Alcohol Program Council.⁴²¹
- 4.58** At the end of the inquiry, NSW Health advised that its Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020 is an overarching Aboriginal workforce plan which is intended to support Local Health Districts, Specialty Health Networks and other NSW Health organisations to grow and to develop their Aboriginal workforce.⁴²²
- 4.59** The framework sets out the Aboriginal workforce development priorities and desired outcomes (reproduced in the table below).⁴²³

⁴¹⁷ Submission 34, NSW Government, p 28.

⁴¹⁸ Submission 34, NSW Government, p 28.

⁴¹⁹ Submission 34, NSW Government, p 28.

⁴²⁰ Answers to questions on notice, NSW Health, 10 April 2018, p 6.

⁴²¹ Answers to questions on notice, NSW Health, 20 July 2018, p 7.

⁴²² Answers to questions on notice, NSW Health, 20 July 2018, p 8.

⁴²³ Answers to questions on notice, NSW Health, 20 July 2018, p 8.

Table 6 NSW Health: Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020

No.	Key Priority	Outcome
1	Lead and plan Aboriginal workforce development	Leaders understand and demonstrate their commitment to promoting Aboriginal workforce development and planning
2	Build cultural understanding and respect	All NSW Health organisations understand, respect, honour and celebrate Aboriginal cultures, heritage and identity
3	Attract, recruit and retain Aboriginal staff	Grow the Aboriginal workforce and create culturally safe workplaces and spaces for Aboriginal staff, utilising recruitment practices that are appropriate for Aboriginal people
4	Develop the capabilities of Aboriginal staff	Aboriginal staff have increased skills, qualifications and development opportunities
5	Work with others to achieve workforce development priorities	Collaborative partnerships with education and training providers and local Aboriginal organisation to strengthen career pathways and opportunities for current and future Aboriginal workforce
6	Track our achievements and improve results	Leaders ensure accuracy of Aboriginal workforce data and implement effective monitoring and evaluation practices

NSW Health, NSW Health - Great Jobs: Aboriginal Workforce Strategic Framework 2016 – 2020 (November 2016), https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_053.pdf.

4.60 NSW Health also informed the committee that Local Health Districts have local arrangements with TAFE and other non-government organisations to provide further training and upskilling for Aboriginal staff.⁴²⁴

Koori Courts

4.61 Koori Courts facilitate a culturally appropriate and offender focused program that aims to address the criminogenic needs of Aboriginal offenders including issues relating to drug and alcohol addiction.⁴²⁵

4.62 The only Koori Court currently operating in New South Wales is the Youth Koori Court, which is attached to the Parramatta Children's Court and which is for Aboriginal children aged

⁴²⁴ Answers to questions on notice, NSW Health, 20 July 2018, p 8.

⁴²⁵ New South Wales Department of Justice, *Youth Koori Court* (2015), http://www.childrenscourt.justice.nsw.gov.au/Documents/Youth%20Koori%20Court%20A4_Accessible.pdf.

10 to 17 years.⁴²⁶ The Youth Koori Court operates one day a week and recently completed a twelve month trial. As at 31 May 2018, 92 young Aboriginal offenders have participated in the Youth Koori Court program.⁴²⁷

- 4.63** The Youth Koori Court has the same powers as the Local or Children Courts but utilises a less formal process and allows family, community members and Aboriginal elders to participate and be heard. A Magistrate or Children's Registrar leads a collaborative effort to create an 'Action and Support Plan' to improve the offender's cultural connections and implement strategies to address health, drug and alcohol issues. This plan forms the basis of a six month program. Upon successful completion of the program a progress report is provided to a Magistrate for consideration in sentencing.⁴²⁸
- 4.64** Clr Lloyd and Legal Aid NSW advised the Committee that a significant proportion of the Aboriginal children that participate in the Youth Koori Court have drug and alcohol addiction problems.⁴²⁹ Clr Lloyd, who also practices as a criminal lawyer, advised that while the formal evaluation of the Youth Koori Court in Parramatta is not yet complete, reports indicate a successful reduction of criminal recidivism in many participants.⁴³⁰
- 4.65** Legal Aid NSW provided the following case study of a client who has recently been assisted by participation in the Youth Koori Court.

Case study – Conrad

Conrad is a young man Aboriginal man who was removed from his family due to concerns around substance abuse, transience and neglect. Conrad and his siblings were placed with his grandparents, but experienced a breakdown of this placement, which resulted in spending time in foster care, crisis accommodation and residential out-of-home-care. Most of Conrad's placements have broken down because his carers were unable to provide the therapeutic care that his complex needs required.

Conrad has often had to couch-surf with friends or sleep on the streets, where he was exposed to further violence and alcohol and drug use. He has also spent time in juvenile detention, which he has indicated was often preferable to sleeping on the street. He also has had interactions with the child protection system as a parent with his own child removed from his care.

Conrad struggles with drug and alcohol issues, as well as mental health issues which has included incidents of self-harm. His homelessness has impacted on his education, employment, contact with his child, maintaining professional appointments to address his drug use and mental health, and his experiences have engendered a mistrust of welfare agencies. Conrad was referred to the Youth Koori Court. With the assistance of Legal Aid NSW's Children's Civil Law Service he has been referred to Alcohol and Other Drug (AOD) counselling, as well as mental health services to ensure that he received sufficient support around his mental health and risk of suicide.⁴³¹

⁴²⁶ Submission 36, Clr Edwina Lloyd, Lismore City Council, p 15.

⁴²⁷ Media release, Hon Dominic Perrottet MP, Treasurer and Hon Mark Speakman SC MP, Attorney General, 'NSW Budget: Youth Koori Court expands to Surry Hills', 31 May 2018.

⁴²⁸ New South Wales Department of Justice, *Youth Koori Court* (2015), http://www.childrenscourt.justice.nsw.gov.au/Documents/Youth%20Koori%20Court%20A4_Accessible.pdf.

⁴²⁹ Submission 36, Clr Edwina Lloyd, Lismore City Council, p 14; Submission 27, Legal Aid NSW, p 6.

⁴³⁰ Submission 36, Clr Edwina Lloyd, Lismore City Council, p 14.

⁴³¹ Submission 27, Legal Aid NSW, p 6.

- 4.66** Clr Lloyd advocated for the expansion of the Koori Court model, noting that there are more than enough Aboriginal people in the Lismore region to warrant the establishment of both adult and youth Koori Courts in the region.⁴³²
- 4.67** On 31 May 2018, the Attorney General, the Hon Mark Speakman SC MP and the Treasurer, the Hon Dominic Perrottet MP, announced that the 2018-19 NSW Budget will include \$2.7 million over three years to fund the expansion of the Youth Koori Court to the Surry Hill Children's Court. The ministers noted that this will effectively double the Youth Koori Court's capacity.⁴³³
- 4.68** Other states and territories currently have or did have versions of Koori Courts. Victoria in particular currently has ten Koori Courts for both adults and children, with several being located in regional areas of the state.⁴³⁴

Committee comment

- 4.69** During our travels throughout the state, the committee has heard about how the impacts of dispossession, intergenerational trauma and socio-economic disadvantage continue to contribute to the high levels of drug and alcohol misuse in regional Aboriginal communities, which in turn contributes to the overrepresentation of Aboriginal people in the criminal justice system. This cycle must be taken into account when considering how to improve drug rehabilitation services for Aboriginal people in this state.
- 4.70** The committee was particularly concerned about the lack of Aboriginal-specific rehabilitation services throughout regional New South Wales. The committee heard that while there are some services available specifically for Aboriginal men, there are no services that cater specifically to Aboriginal women and children. This is why we have recommended in chapter 3 that the NSW Government significantly increase funding to drug and alcohol-related health services, including more detoxification and residential rehabilitation services for Aboriginal people and for women and children throughout regional New South Wales.
- 4.71** The committee recognises that remaining on country and close to family is a core component in providing effective drug and alcohol treatment to Aboriginal people. Separating Aboriginal people from their family, culture and land causes serious distress and affects the overall success of rehabilitation. The recommended increase to the available services would reduce the need for Aboriginal people to be sent off country for treatment.
- 4.72** The committee notes NSW Health's Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020, which identifies the importance of expanding the Aboriginal workforce, developing the capabilities of Aboriginal staff and building cultural understanding and respect. While the committee is pleased that NSW Health has instigated this initiative, evidence from inquiry participants suggests that more work needs to be done both specifically in the drug and alcohol sphere and more generally in the public health system.

⁴³² Evidence, Clr Edwina Lloyd, Lismore City Council, 26 June 2018, p 48.

⁴³³ Media release, Hon Dominic Perrottet MP, Treasurer and Hon Mark Speakman SC MP, Attorney General, 'NSW Budget: Youth Koori Court expands to Surry Hills', 31 May 2018.

⁴³⁴ Magistrates Court of Victoria, *Koori Court*, www.magistratescourt.vic.gov.au/koori-court.

- 4.73** The committee therefore recommends that that the NSW Ministry of Health report to the NSW Parliament annually on the progress of the implementation and outcomes of the Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020 in regards to the drug and alcohol rehabilitation sector.

Recommendation 10

That the NSW Ministry of Health report to the NSW Parliament annually on the progress of the implementation and outcomes of the Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020 in regards to the drug and alcohol rehabilitation sector.

- 4.74** In addition, the committee recommends that the NSW Government investigate the efficacy of establishing a scheme to establish a full time local Aboriginal trainee position alongside every skilled position recruited in areas with a significant Aboriginal population.

Recommendation 11

That the NSW Government investigate the efficacy of establishing a scheme to establish a full time local Aboriginal trainee position alongside every skilled position recruited in areas with a significant Aboriginal population.

- 4.75** Finally, given the clear relationship between Aboriginal drug and alcohol addiction and the over-representation of Aboriginal people in the criminal justice system, a unique and targeted approach is required to try and break this insidious cycle. We believe the Koori Court model, which includes family, Aboriginal elders and community members and aims to strengthen cultural links and address underlying health, drug and alcohol issues that contribute to offending, has the potential to make a real difference. The committee therefore recommends that the NSW Government trial Koori Courts for both adults and children in various locations throughout regional New South Wales for a specific period. The government should then conduct a comprehensive review of the model to determine whether it is appropriate to be rolled out in more areas throughout the state.

Recommendation 12

That the NSW Government:

- trial adult and youth Koori Courts in various regional New South Wales locations for a period of twelve months
 - then conduct a comprehensive review to determine the appropriateness and need for further Koori Courts in other locations in regional New South Wales.
-

Appendix 1 Submissions

No.	Author
1	Mr Jeff Pearce
2	Dubbo Regional Council
3	Orana Law Society
4	Far West Community Legal Centre
5	ONE80TC
6	We Help Ourselves (WHOS)
7	Community Life Batemans Bay Inc
8	The Hon Thomas George MP
9	NSW Council of Social Service (NCOSS)
10	The Royal Australasian College of Physicians
11	ACON
12	Broken Hill Working Group
13	Byron Private Pty Ltd
14	Lives Lived Well - Lyndon
15	Mission Australia
16	Name suppressed
17	The Salvation Army
18	Public Health Association of Australia
19	WentWest Western Sydney Primary Health Network
20	Tenterfield Social Development Committee Inc
21	Yfoundations
22	NSW Nurses and Midwives' Association
23	Dharriwaa Elders Group
24	Aboriginal Health & Medical Research Council of NSW (AH&MRC) and NSW Aboriginal Residential Healing and Drug Alcohol Network (NARDAN)
25	The Network of Alcohol and other Drugs Agencies (NADA)
26	Gunnebah Health and Addiction Recovery
27	Legal Aid NSW
28	Mr Grant Mistler (<i>partially confidential</i>)
29	Australasian Therapeutic Communities Association
30	Central West Cooperative Legal Service Delivery
31	Just Reinvest NSW

No.	Author
32	Royal Australian and New Zealand College of Psychiatrists
33	Aboriginal Legal Service (NSW/ACT)
34	NSW Government
35	Orana Regional Organisation of Councils
36	Clr Edwina Lloyd, Lismore City Council
37	The Oolong Aboriginal Corporation (Oolong House)
38	Port Macquarie Community College Inc.
39	The Buttery
40	Ms Jennifer Saunders
41	Laughing Mind
42	Mr Steven Roberts
43	Human Nature Adventure Therapy Ltd

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Monday 12 March 2018 Macquarie Room, Parliament House, Sydney	Mr Larry Pierce	Chief Executive Officer, Network of Alcohol and Other Drugs Agencies
	Mr Robert Stirling	Deputy Chief Executive Officer, Network of Alcohol and Other Drugs Agencies
	Professor Adrian Dunlop	Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australasian College of Physicians
	Ms Jenny Lovric	Program Manager, Cooperative Legal Service Delivery Program & Regional Outreach Clinic Program, Legal Aid NSW
	Mr Martin Dalitz	Solicitor In Charge, Drug Court, Legal Aid NSW
	Mr Michael Higgins	Regional Community Engagement Manager, Aboriginal Legal Service NSW/ACT
	Mr Stephen Blunden	A/Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW
	Mr Alan Bennett	Chief Executive Officer, Orana Haven Drug & Alcohol Rehabilitation Centre, NSW Aboriginal Residential Health Drug and Alcohol Network
	Mr Luke Butcher	Area Manager, Mission Australia
	Ms Gabriella Holmes	Program Manager, Triple Care Farm and David Martin Place, Mission Australia
	Mr Gerard Byrne	Operations Manager, Recovery Services, Salvation Army
	Major Gavin Watts	Manager, Dooranlong Transformation Centre, Salvation Army
	Dr Lynne Magor-Blatch	Executive Officer, Australasian Therapeutic Communities Association, appearing on behalf of We Help Ourselves
Dr Kerry Chant	Chief Health Officer, NSW Health	

Date	Name	Position and Organisation
	Mr Daniel Madeddu	Director, Alcohol & Other Drugs, Centre for Population Health
	Dr Michelle Cretikos	Director, Population Health Clinical Quality and Safety Centre for Population Health
	Professor Robert Batey	Clinical Professor of Medicine, Sydney University
Thursday 5 April 2018		
Gallery Room, Shoalhaven Entertainment Centre, Nowra	Ms Margot Mains	Chief Executive, Illawarra and Shoalhaven Local Health District Drug & Alcohol Service
	Mr David Reid	Director, Drug and Alcohol Service, NSW Health
	Ms Tanya Bloxsome	A/Chief Executive Officer, The Oolong Aboriginal Corporation (Oolong House)
	Mr Ivern Adler	Former Chief Executive Officer, Oolong Aboriginal Corporation (Oolong House)
	Ms Faye Worner	Chief Executive Officer, Waminda – South Coast Women’s Health & Welfare Aboriginal Corporation
	Ms Lisa Wellington	Senior Program & Client Service Manager, Waminda – South Coast Women’s Health & Welfare Aboriginal Corporation
Friday 6 April 2018		
Small Auditorium, Batemans Bay Soldiers Club, Batemans Bay	Dr Julaine Allan	National Research Manager, Lives Lived Well – Lyndon
	Ms Shirley Diskon	Manager - Hope House, Community Life Batemans Bay Inc
	Mr Dennis John Hughes	President, Community Life Batemans Bay Inc
	Ms Glenda McCarthy	Team Leader, Pathways Eurobodalla
	Ms Stephanie Stephens	Acting Chief Executive Officer, Directions Health Services
	Ms Kaylene Mallott	Team Leader, Pathways Goulburn
	Ms Fiona Beston	A/Manager, Strategic Coordinator Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug & Alcohol Service, Southern NSW Local Health District

Date	Name	Position and Organisation
	Mr Tim Leggett	Acting Executive Director, Mental Health, Drug & Alcohol Service, Southern NSW Local Health District
	Ms Joanne Grant	Branch Manager, Batemans Bay Office, Katungul Aboriginal Community Corporation and Medical Service
	Mr Rohan Moreton	Aboriginal Health Worker, Katungul Aboriginal Community Corporation and Medical Service
	Ms Ann Kelly	Clinical Nurse Consultant, Katungul Aboriginal Community Corporation and Medical Service
	Ms Michelle Davison	Aboriginal Support Worker, Katungul Aboriginal Community Corporation and Medical Service
Wednesday 9 May 2018 Starlite Room, Dubbo RSL, Dubbo	Clr Stephen Lawrence	Councillor, Dubbo Regional Council
	Mr Rod Towney	Chairperson, Three Rivers Regional Assembly; Member, Dubbo Aboriginal Community Working Party; and Member, Dubbo Local Aboriginal Land Council
	Mr Murray Wood	Director, Community and Recreation, Dubbo Regional Council
	Mr Bill Dickens	Solicitor In Charge, Legal Aid NSW – Dubbo Regional Office; Member, Orana Law Society; and Member, Central West Cooperative Legal Service Delivery
	Mr Mark Davies	Member, Orana Law Society
	Mr Joe Gordon	Alcohol and Other Drug Caseworker, Salvation Army, appearing on behalf of Central West Cooperative Legal Service Delivery
	Mr Trevor Forrest	Aboriginal Family Well-being and Violence Prevention Caseworker, appearing on behalf of Central West Cooperative Legal Service Delivery

Date	Name	Position and Organisation
Thursday 10 May 2018 Broken Hill City Council Chambers, Broken Hill	Mr Norm Henderson	Speaking on behalf of the Dharriwaa Elders Group and Weigelli Aboriginal Corporation
	Ms Darrica Turley AO	Mayor, Broken Hill City Council
	Ms Rachel Storey	President, Far West Law Society
	Ms Jillian Heeley	Principal Solicitor, Far West Community Legal Service
	Mr Andrew House	Social Worker, Broken Hill Correctional Centre
	Mr Ken Dennis	Manager, Broken Hill Aboriginal Legal Service
	Major David Pullen	Rural Chaplain, Broken Hill and Far West NSW, The Salvation Army
	Captain Paul Kurth	Corps Officer, Broken Hill and Far West NSW, The Salvation Army
	Mr Ian Harvey	Team Leader - Transition Programs, Far Western NSW, Community Restorative Centre – Broken Hill Office
	Dr Mindy Sotiri	Program Director – Advocacy, Research & Policy, Community Restorative Centre – Broken Hill Office
Monday 25 June 2018 Clarence Valley Aboriginal Healing Centre, Grafton	Mr Wayne Jones	Chief Executive, Northern NSW Local Health District
	Ms Dee Robinson	General Manager, Mental Health, Drug and Alcohol Services, Northern NSW Local Health District
	Mr Mitch Dobie	Manager, Tweed/Byron Drug and Alcohol Services
	Ms Corinne Maynard	Manager, Richmond / Clarence Drug and Alcohol Services
	Dr Trish Collie	Drug and Alcohol Addiction Specialist, Bulgarr Ngaru Medical Aboriginal Corporation

Date	Name	Position and Organisation
	Mr Trevor Kapeen	Drug and Alcohol Addiction Worker, Bulgarr Ngaru Medical Aboriginal Corporation
	Ms Sonya Mears-Lynch	Program Manager - Reconnect, Getting it Together and Youth on Track, Social Futures
	Ms Melinda Plesman	Family Referral Service, Homelessness Youth Assistance Program, Clarence Valley, Social Futures
	Dr Robbie Lloyd	Community Relationships Manager, Port Macquarie Community College
	Mr Des Schroder	Director, Environment, Planning and Community, Clarence Valley Council
	Ms Sharon Moore	Project Officer, Clarence Valley Council
	Ms Sarah Nash	Project Officer, Clarence Valley Council
	Ms Janelle Brown	Coordinator, Clarence Valley Aboriginal Healing Centre, Gurehlgam Corporation
	Ms Julie Perkins	Chairperson, Clarence Valley Aboriginal Healing Centre, Gurehlgam Corporation
Tuesday 26 June 2018 Lismore City Hall, Lismore	Mr Warwick Parer	Managing Director, Gunnebah Addiction Retreat
	Ms Kylie Beattie	Director, Byron Private Holistic Treatment Centre
	Mr David Beattie	Business Owner, Byron Private Holistic Treatment Centre
	Mr Gary Thomas	Director, Byron Private Holistic Treatment Centre
	Ms Dian Edwards	Manager, Namatjira Haven Drug and Alcohol Healing Centre
	Ms Jenny McGee	Clinical Manager, The Buttery Private
	Mr Trent Rees	Residential Programs Manager, The Buttery

Date	Name	Position and Organisation
	Mr Hugh van Dugteren	Solicitor in Charge, Legal Aid NSW, Lismore Office
	Clr Edwina Lloyd	Councillor, Lismore City Council
Tuesday 3 July 2018 Macquarie Room, Parliament House, Sydney	Ms Filiz Eminov	Executive Officer and Registrar, Drug Court
	Mr Jason Hainsworth	A/Assistant Commissioner, Community Corrections
	Ms Heather Jackson	A/Director, State-wide Operations, Community Corrections
	Dr Kerry Chant	Chief Health Officer, NSW Health
	Mr Gary Forrest	Chief Executive, Justice Health and Forensic Mental Health Network
	Mr Daniel Madeddu	Director, Alcohol & Other Drugs, Centre for Population Health
	Dr Michelle Cretikos	Director, Population Health Clinical Quality and Safety Centre for Population Health
	Professor Nicholas Lintzeris	Director, Drug and Alcohol Services, South East Sydney Local Health District; and Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney

Appendix 3 Minutes

Minutes no. 41

Thursday 28 September 2017

Portfolio Committee No. 2 – Health and Community Services

Room 1136, Parliament House, Sydney, at 11.04 am.

1. Members present

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair* (via teleconference)

Dr Faruqi (substituting for Ms Walker for the duration of the inquiry into drug rehabilitation services)

Mrs Houssos (via teleconference)

Mr Pearce (substituting for Mr MacDonald)

Dr Phelps (via teleconference)

Mrs Taylor

2. Draft minutes

Resolved, on the motion of Mrs Houssos: That draft minutes nos. 37, 38, 39 and 40 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received:

- 25 September 2017 – email from Dr Mehreen Faruqi to secretariat advising that she will be substituting for Ms Dawn Walker for the duration of the inquiry into drug rehabilitation services.

4. Consideration of terms of reference

The Chair tabled a letter enclosing a previously circulated terms of reference.

Discussion ensued.

Resolved, on the motion of Mr Green: That the committee adopt the terms of reference:

Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

That Portfolio Committee No. 2 – Health and Community Services inquire into and report on the provision of drug rehabilitation services in regional, rural and remote New South Wales, and in particular:

1. The range and types of services including the number of treatment beds currently available;
2. Specific details regarding rehabilitation services for those with amphetamine and methamphetamine (“ice”) addictions;
3. The qualification to receive funding as well as the funding arrangements for services be they public, not-for-profit, for profit or on any other basis;
4. Registration and accreditation process required for rehabilitation services to be established;
5. The cost to patients/clients, including fee structures provided to families, for accessing rehabilitation services;
6. The waiting lists and waiting times for gaining entry into services;
7. Any pre-entry conditions for gaining access to rehabilitation services;

8. Investigate the evidence regarding the efficacy and impacts of mandatory detoxification programs for those who self-harm or are subject to an Apprehended Violence Order (AVO);
 9. The gaps and shortages in the provision of services including geographical, resources and funding;
 10. Issues relating to the provision of appropriately qualified health professionals to fill positions in rehabilitation services
 11. Evidence of rehabilitation services that have had both successful and unsuccessful outcomes, including what characteristics constitute a successful outcome and how reliable is the data collection and reporting mechanisms currently in place;
 12. Current and potential threats to existing rehabilitation services;
 13. Potential and innovative rehabilitation services and initiatives including naltrexone; and
 14. Any other related matters.
- 5. Conduct of the inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales**
- 5.1 Closing date for submissions**
Resolved, on the motion of Mrs Houssos: That the closing date for submissions be 8 December 2017.
- 5.2 Stakeholder list**
Resolved, on the motion of Mr Green: That the secretariat circulate to members the Chairs' proposed list of stakeholders to provide them with the opportunity to amend the list or nominate additional stakeholders, and that the committee agree to the stakeholder list by email, unless a meeting of the committee is required to resolve any disagreement.
- 5.3 Hearing dates**
Resolved, on the motion of Dr Faruqi: That the committee hold 2-3 hearings in March/April 2018, the dates of which are to be determined by the Chair after consultation with members regarding their availability.
- 6. Adjournment**
The committee adjourned at 11.15 am, until Friday 13 October 2017 (Road tolling report deliberative).

Stewart Smith
Committee Clerk

Minutes no. 46

Wednesday 14 February 2018
Portfolio Committee No. 2 - Health and Community Services
Members' Lounge, Parliament House, Sydney, at 10.32 am

1. Members present

Mr Donnelly, *Chair*
Mr Green, *Deputy Chair*
Dr Faruqi
Mrs Houssos
Mrs Maclaren-Jones (substituting for Mr MacDonald from 10.32 am to 10.38 am)
Mr MacDonald (from 10.38 am)
Mrs Taylor

2. Draft minutes

Resolved, on the motion of Mrs Houssos: That draft minutes no. 45 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received:

- 11 October 2017 – Email from Ms Jo Gardner, Australian Institute of Health and Welfare to secretariat, declining the invitation to make a submission to the inquiry and offering to respond to any specific questions the committee may have
- 16 October 2017 – Email from Ms Jenny Lovric, Legal Aid NSW to secretariat, regarding Legal Aid NSW's Cooperative Legal Service Delivery Program and inviting the committee to visit the program's partnerships in Dubbo, Moree, Broken Hill, the Northern Rivers, Taree and Kempsey
- 30 October 2017 – Email from Mr Edward Cooper, Aboriginal Legal Service (NSW/ACT) Ltd to secretariat, advising that they are conducting community forums in various locations including Broken Hill, Walgett, Wagga Wagga, Coffs Harbour, Tweed Heads and Moree to inform their submission and requesting a submission extension
- 1 November 2017 – Email from Mr Grant Mistler to secretariat, requesting that the committee consider broadening the terms of reference to include metropolitan areas
- 30 November 2017 – Letter from Mr Lesley Turner, Aboriginal Legal Service (NSW/ACT) to Chair, requesting a meeting about the drug rehabilitation inquiry
- 8 December 2017 – Letter from Katie Acheson, CEO, Youth Action to secretariat, endorsing the submission of Mission Australia
- 22 December 2017 – Letter from Mr Lesley Turner, Aboriginal Legal Service (NSW/ACT) to Chair, regarding a roundtable with senior NSW Government representatives and peak Aboriginal community-controlled organisations and service providers
- 2 January 2018 – Email from Grant Mistler to secretariat, providing further comment on travelling long distances to receive drug treatment
- 5 February 2018 – Email from Jenny Lovric, Legal Aid NSW, to secretariat, inviting committee to hold a hearing in Dubbo.

4. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

4.1 Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 1-15, 17-27, 29-34.

4.2 Partially confidential submissions

Resolved, on the motion of Mr Green: That the committee keep the following information confidential, as per the request of the author: names and/or identifying and sensitive information in submissions no. 16.

Resolved, on the motion of Mrs Houssos: That the committee authorise the publication of submission nos. 28, with the exception of potential adverse mention which is to remain confidential, as per the recommendation of the secretariat.

4.3 Proposed witness list for Sydney hearing

Resolved, on the motion of Dr Faruqi: That:

- the Chair's proposed witness list for the hearing on 12 March 2018 at Parliament House be amended by adding We Help Ourselves (submission 6) to the panel of non-government rehabilitation service providers
- the secretariat investigate whether there are academics specialising in drug-related research specific to regional, rural and remote areas, and if so, circulate these to the committee for consideration as to inclusion on the witness list.

Resolved, on the motion of Mrs Taylor: That the witnesses on the Chair's proposed witness list, as amended, be invited to the hearing on 12 March 2018 at Parliament House.

4.4 Regional hearing locations

Resolved, on the motion of Mrs Taylor: That the committee conduct:

- the first regional hearings on 5-6 April 2018 in Nowra and either Batemans Bay or Bega, depending on the viability of travel arrangements
- the second regional hearings on 9-10 May 2018 in Dubbo and Broken Hill
- further regional hearings over two days in late May/early June in Lismore and Grafton, with hearing dates to be determined by the Chair after consultation with members regarding their availability.

5. Inquiry into child protection

5.1 Request for access to a partially confidential submission by the submission author

Resolved, on the motion of Mr MacDonald: That an unredacted copy of partially confidential submission no. 134 to the inquiry into child protection be made available to the submission author.

6. Adjournment

The committee adjourned at 10.58 am, until Monday 12 March 2018 (hearing for inquiry into drug rehabilitation services in regional, rural and remote New South Wales).

Sharon Ohnesorge
Committee Clerk

Minutes no. 47

Wednesday 12 March 2018

Portfolio Committee No. 2 - Health and Community Services

Members' Lounge, Parliament House, Sydney, at 9.20 am

1. Members present

Mr Donnelly, *Chair*

Dr Faruqi

Mrs Houssos

Mr Mallard (substituting for Mr MacDonald) (left 10.15 am and returned 2.00 pm)

Dr Phelps

Mrs Taylor

2. Apologies

Mr Green, *Deputy Chair*

3. Draft minutes

Resolved, on the motion of Mrs Houssos: That draft minutes no. 46 be confirmed.

4. Correspondence

The committee noted the following item of correspondence:

Received:

- 1 March 2018 – Dr Catherine Yelland PSM, The Royal Australasian College of Physicians, to the secretariat confirming Professor Adrian Dunlop FACHAM will represent the college at the drug rehabilitation services inquiry hearing on 12 March 2018.

5. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

5.1 Regional hearing dates

The committee noted the following confirmed regional hearing dates:

- Nowra and Batemans Bay – 5 and 6 April
- Dubbo and Broken Hill – 9 and 10 May
- Lismore and Grafton – 25 and 26 June.

5.2 Proposed witness list for Nowra and Batemans Bay hearings

Resolved, on the motion of Dr Phelps: That the witnesses on the Chair's proposed witness list be invited to the hearings on 5 and 6 April 2018 in Nowra and Batemans Bay.

5.3 Public submissions

Resolved, on the motion of Dr Phelps: That the committee authorise the publication of submission no. 35.

5.4 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Larry Pierce, Chief Executive Officer, Network of Alcohol and Other Drugs Agencies
- Mr Robert Stirling, Deputy Chief Executive Officer, Network of Alcohol and Other Drugs Agencies.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australian College of Physicians.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Jenny Lovric, Program Manager, Cooperative Legal Service Delivery Program & Regional Outreach Clinic Program, Legal Aid NSW
- Mr Martin Dalitz, Solicitor In Charge, Drug Court, Legal Aid NSW.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Stephen Blunden, A/Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW
- Mr Alan Bennett, Chief Executive Officer, Orana Haven Drug & Alcohol Rehabilitation Centre, NSW Aboriginal Residential Health Drug and Alcohol Network
- Mr Michael Higgins, Regional Community Engagement Manager, Aboriginal Legal Service NSW/ACT.

Mr Blunden tendered the following documents:

- Briefing paper, prepared by the Aboriginal Health and Medical Research Council of NSW, outlining key points and information about the services provided of the organisation
- Report entitled 'Understanding clients, treatment models and evaluation options for the NSW Aboriginal Residential Healing Drug and Alcohol Network (NARHDAN)
- Framework proposal for evaluating aboriginal drug and alcohol residential rehabilitation services
- Paper by Douglas James et al, 'Understanding the client characteristics of six aboriginal residential alcohol and other Drugs Rehabilitation Services on NSW'

- Report, 'Rapid Review of the Business Case for Designated Aboriginal Women's and Children's Specific Drug Treatment Service'
- Literature review, An evidence informed approach for models of drug and alcohol care for aboriginal women

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Luke Butcher, Area Manager, Mission Australia
- Ms Gabriella Holmes, Program Manager, Mission Australia
- Mr Gerard Byrne, Operations Manager, Recovery Services, Salvation Army
- Major Gavin Watts, Manager, Dooranlong Transformation Centre, Salvation Army
- Dr Lynne Magor-Blatch, Member, We Help Ourselves.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Kerry Chant, Chief Health Officer, NSW Health
- Mr Daniel Madeddu, Director, Alcohol & Other Drugs, Centre for Population Health
- Dr Michelle Cretikos, Director, Population Health Clinical Quality and Safety Centre for Population Health
- Professor Robert Batey, Clinical Professor of Medicine, Sydney University.

The evidence concluded and the witnesses withdrew.

The public withdrew.

The public hearing concluded at 4.03 pm.

5.5 Tendered documents

Resolved, on the motion of the Dr Phelps: That the committee accept and publish the following documents tendered during the public hearing:

- Briefing paper, prepared by the Aboriginal Health and Medical Research Council of NSW, tendered by Mr Stephen Blunden outlining key points and information about the services provided of the organisation
- Report, tendered by Mr Stephen Blunden, entitled 'Understanding clients, treatment models and evaluation options for the NSW Aboriginal Residential Healing Drug and Alcohol Network (NARHDAN)
- Policy document, tendered by Mr Stephen Blunden, Framework proposal for evaluating aboriginal drug and alcohol residential rehabilitation services
- Paper by Douglas James et al, tendered by Mr Stephen Blunden, entitled 'Understanding the client characteristics of six aboriginal residential alcohol and other Drugs Rehabilitation Services on NSW'
- Report, tendered by Mr Stephen Blunden, entitled 'Rapid Review of the Business Case for Designated Aboriginal Women's and Children's Specific Drug Treatment Service'
- Literature review, tendered by Mr Stephen Blunden, entitled 'An evidence informed approach for models of drug and alcohol care for aboriginal women'.

5.6 Further hearing

Resolved, on the motion of Dr Faruqi: That, following the three regional hearings, a further hearing be held with the NSW Department of Justice and if necessary NSW Health, with the date of the hearing to be determined by the Chair after consultation with members regarding their availability.

6. Adjournment

The committee adjourned at 4.11 pm, until Thursday 5 April 2018 (travel from Sydney to public hearing in Nowra).

Samuel Griffith
Committee Clerk

Minutes no. 48

Thursday 5 April 2018

Portfolio Committee No. 2 - Health and Community Services

Outside the NSW Parliament guardhouse, Macquarie Street, Sydney at 6.45 am

1. Members present

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair* (from 10.40 am until 1.15 pm)

Dr Faruqi

Mrs Houssos (until 1.15 pm)

Mr MacDonald

Dr Phelps

Mr Fang (substituting for Mrs Taylor) (from 10.45 am)

2. Draft minutes

Resolved, on the motion of Mrs Houssos: That draft minutes no. 47 be confirmed.

3. Correspondence

The committee noted the following item of correspondence:

Received:

- 20 March 2018 – Email from Mr Joel Lahene, Youth Care Coordinator, Headspace Nowra to secretariat, advising that Headspace declines the committee's invitation to give evidence in Nowra.

4. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

4.1 Proposed witness list for Dubbo and Broken Hill hearings

Resolved, on the motion of Dr Phelps: That:

- the witnesses on the Chair's proposed witness list be invited to the hearings on 9 and 10 May 2018 in Dubbo and Broken Hill
- the Warra Warra Legal Service and Community Restorative Centre be added to the list of witnesses for the Broken Hill hearing.

4.2 Travel arrangements for Dubbo and Broken Hill hearings

Resolved, on the motion of Dr Phelps: That the committee approve the cost of \$23,595 for a charter flight to Dubbo and Broken Hill for the public hearings on 9 and 10 May 2018.

4.3 Public submissions

Resolved, on the motion of Dr Faruqi: That the committee authorise the publication of submission no. 36.

4.4 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Margot Mains, Chief Executive, Illawarra and Shoalhaven Local Health District Drug & Alcohol Service
- Mr David Reid, Director, Drug and Alcohol Service, NSW Health.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation (Oolong House)
- Mr Ivern Adler, Former Chief Executive Officer, The Oolong Aboriginal Corporation (Oolong House)
- Ms Faye Worner, Chief Executive Officer, Waminda – South Coast Women’s Health & Welfare Aboriginal Corporation
- Ms Lisa Wellington, Program & Client Service Manager, Waminda – South Coast Women’s Health & Welfare Aboriginal Corporation.

Ms Bloxsome tendered the following documents:

- *Family and Relationship Services Australia 2016 E-journal Edition 1*, dated 1 December 2016
- Presentation, Oolong House Residential Rehab
- James, D., Shakeshaft, A., Munro, A., Courtney, R. J., *A systematic review of Indigenous drug and alcohol residential rehabilitation services: moving from description to establishing their effectiveness*, pp 1-38.

Ms Worner tendered the following documents:

- Waminda South Coast Women’s Health & Welfare Aboriginal Corporation, Schedules RFT HAC 17 386 Drug & Alcohol Package
- Coordinare, *Rapid Review of the Business Case for a Designated Aboriginal Women and Children’s Specific Drug Treatment Service within South Eastern NSW Primary Health Network*, dated February 2017
- Business Plan for the NSW South Coast Aboriginal Women’s Rehabilitation Service, dated March 2011.

The evidence concluded and the witnesses withdrew.

The public and the media withdrew.

The public hearing concluded at 12.46 pm.

5. Site visit to Hope House, Batemans Bay

The committee conducted a site visit of the residential rehabilitation facility, Hope House in Batemans Bay, guided by Ms Shirley Diskon, Manager, Hope House.

6. Adjournment

The committee adjourned at 4.30 pm, until 10.00 am, Friday 6 April 2018, Small Auditorium, Batemans Bay Soldiers Club, 6 Beach Road, Batemans Bay (public hearing).

Samuel Griffith
Committee Clerk

Minutes no. 49

Thursday 6 April 2018

Portfolio Committee No. 2 - Health and Community Services

Small Auditorium, Batemans Bay Soldiers Club, 6 Beach Road, Batemans Bay at 10.00 am

1. Members presentMr Donnelly, *Chair*Mr Green, *Deputy Chair*

Dr Faruqi

Mr MacDonald

Dr Phelps

2. Apologies

Mr Fang (substituting for Mrs Taylor)

Mrs Houssos

3. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales**3.1 Public hearing**

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Dr Julaine Allan, Group Manager (Research), Program Delivery, Business Development and Clinical Governance, Lives Lived Well – Lyndon.

Dr Allan tendered the following documents:

- Corrected page from Lives Lived Well – Lyndon submission to the inquiry, p 3.
- Extract from *Alcohol and other drug treatment services in Australia 2015-16*, Australian Institute of Health and Welfare, p 12.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Dennis Hughes, President, Community Life Batemans Bay
- Ms Shirley Diskon, Manager, Hope House, Community Life Batemans Bay

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Glenda McCarthy, Team Leader, Pathways Eurobodalla
- Ms Stephanie Stephens, Director of Service Delivery, Directions Health Services
- Ms Kaylene Mallott, Team Leader, Pathways Goulburn.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Fiona Beston, A/Manager, Strategic Coordinator Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug & Alcohol Service
- Mr Tim Leggett, Southern NSW Local Health District, Acting Executive Director, Mental Health, Drug & Alcohol Service.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Rohan Moreton, Aboriginal Health Worker, Katungul Aboriginal Community Corporation and Medical Service
- Ms Ann Kelly, Clinical Nurse Consultant, Katungul Aboriginal Community Corporation and Medical Service
- Ms Michelle Davison, Aboriginal Support Worker, Katungul Aboriginal Community Corporation and Medical Service.

Ms Kelly tendered the following document:

- Drug and Alcohol Stay Strong Program.

The evidence concluded and the witnesses withdrew.

The public and the media withdrew.

The public hearing concluded at 2.57 pm.

3.2 Tendered documents

Resolved, on the motion of the Dr Phelps: That the committee accept the following documents tendered during the public hearing on 5 April 2018 and defer consideration regarding their publication until these organisations have advised of their publication preferences:

- *Family and Relationship Services Australia 2016 E-journal Edition 1* dated 1 December 2016, tendered by Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation
- Presentation, *Oolong House Residential Rehab*, tendered by Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation
- James, D., Shakeshaft, A., Munro, A., Courtney, R. J., *A systematic review of Indigenous drug and alcohol residential rehabilitation services: moving from description to establishing their effectiveness*, pp 1-38, tendered by Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation.
- Waminda South Coast Women's Health & Welfare Aboriginal Corporation, *Schedules RFT HAC 17 386 Drug & Alcohol Package*, tendered by Ms Faye Worner, Chief Executive Officer, Waminda South Coast Women's Health & Welfare Aboriginal Corporation Schedules
- Coordinare, *Rapid Review of the Business Case for a Designated Aboriginal Women and Children's Specific Drug Treatment Service within South Eastern NSW Primary Health Network* dated February 2017, tendered by Ms Faye Worner, Chief Executive Officer, South Coast Women's Health & Welfare Aboriginal Corporation Schedules
- Business Plan for the NSW South Coast Aboriginal Women's Rehabilitation Service dated March 2011, tendered by Ms Faye Worner, Chief Executive Officer, South Coast Women's Health & Welfare Aboriginal Corporation Schedules.

Resolved, on the motion of the Dr Phelps: That the committee accept and publish the following documents tendered during the public hearing today:

- Corrected page from *Lives Lived Well – Lyndon* submission to the inquiry, p 3, tendered by Dr Julaine Allan, Group Manager (Research), Program Delivery, Business Development and Clinical Governance, Lives Lived Well – Lyndon
- Extract from *Alcohol and other drug treatment services in Australia 2015-16*, Australian Institute of Health and Welfare, p 12, tendered by Dr Julaine Allan, Group Manager (Research), Program Delivery, Business Development and Clinical Governance, Lives Lived Well – Lyndon
- Drug and Alcohol Stay Strong Program, tendered by Ms Ann Kelly, Clinical Nurse Consultant, Katungul Aboriginal Community Corporation and Medical Service.

3.3 Letter to the Victorian Department of Health & Human Services

Resolved, on the motion of the Dr Faruqi: That the Chair write to the Victorian Department of Health & Human Services to seek information regarding the Victorian model of providing drug treatment solely through non-government services, and in particular:

- how long has this model been in place?
- why this model was adopted?
- how effective the model has been?
- how do non-government services receive their funding?
- what are the services available in regional, rural and remote areas of Victoria?

4. Adjournment

The committee adjourned at 2.58 pm, until Wednesday 9 May 2018 (public hearing in Dubbo).

Samuel Griffith

Committee Clerk

Minutes no. 50

Wednesday 9 May 2018

Portfolio Committee No. 2 – Health and Community Services

Starlite Room, Dubbo RSL, Cnr Brisbane Street and Wingewarra Street, Dubbo at 9.45 am

1. Members present

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair*

Dr Faruqi

Mrs Houssos

Mr MacDonald

Dr Phelps

Mrs Taylor

2. Previous minutes

Resolved, on the motion of Dr Phelps: That draft minutes nos 48 and 49 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 23 April 2018 – Email from Just Reinvest to secretariat advising that representatives are not available to give evidence on 9 May 2018
- 24 April 2018 – Email from Orana Regional Organisation of Councils to secretariat advising that the organisation is declining the committee's invitation to give evidence on 9 May 2018
- 27 April 2018 – Email from Mr Brian Hill, Chief Executive Officer, Laughing Mind Pty Ltd to committee regarding Clean M8 initiative.

Sent

- 16 April 2018 – Letter from Chair to Shirley Diskon, Manager, Hope House thanking Hope House for allowing the committee to conduct a site visit of the facility
- 17 April 2018 – Letter from Chair to Ms Kym Peake, Secretary, Department of Health & Human Services, Victoria seeking information regarding the Victorian model of providing drug treatment solely through non-government services.

4. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

4.1 Public submissions

Resolved, on the motion of Mr Green: That the committee authorise the publication of submission no. 38.

4.2 Answers to questions on notice, supplementary answers and additional information

The committee noted that the answers to questions on notice, answers to supplementary questions and additional information from the following organisations were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Network of Alcohol and Other Drugs Agencies, received 12 March 2018
- Mission Australia, received 6 April 2018
- Royal Australasian College of Physicians, received 6 April 2018
- NSW Health, received 10 April 2018.

Resolved, on the motion of Mr Green: That the committee authorise the publication of the answers to questions on notice provided by:

- Legal Aid NSW, received 13 April 2018
- NSW Health, received 7 May 2018.

4.3 Report deliberative date

Resolved, on the motion of Mrs Houssos: That the committee hold its report deliberative at 12.00 pm on Monday 30 July 2018.

4.4 Proposed additional witness for Sydney hearing

Resolved, on the motion of Dr Faruqi: That:

- the committee invite Laughing Mind to give evidence at the half day hearing in Sydney on 3 July 2018.
- the secretariat investigate the viability of the committee visiting a Drug Court sitting on 3 July 2018.

4.5 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Clr Stephen Lawrence, Dubbo Regional Council
- Mr Murray Wood, Director, Community and Recreation, Dubbo Regional Council
- Mr Rod Towney, Chairperson, Three Rivers Regional Assembly; Member, Dubbo Aboriginal Community Working Party; and Member, Dubbo Local Aboriginal Land Council.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Bill Dickens, Solicitor in Charge, Legal Aid NSW – Dubbo Regional Office; Member, Orana Law Society; and Member, Central Cooperative Legal Service Delivery.
- Mr Mark Davies, Member, Orana Law Society; and Crown Prosecutor.
- Mr Joe Gordon, Alcohol and other Drug Case Worker, Salvation Army, appearing on behalf of Central West Cooperative Legal Service Delivery.
- Mr Trevor Forrest, Aboriginal Family Wellbeing and Violence Prevention Caseworker, appearing on behalf of Central West Cooperative Legal Service Delivery.

Mr Dickens tendered the following document:

- Table indicating rehabilitation facilities in Western NSW.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Mr Norm Henderson, speaking on behalf of the Dharrriwaa Elders Group and Weigelli Aboriginal Corporation.

The evidence concluded and the witness withdrew.

The public and the media withdrew.

The public hearing concluded at 2.03 pm.

5. **Adjournment**

The committee adjourned at 2.03 pm, until Thursday 10 May 2018 (public hearing in Broken Hill).

Samuel Griffith

Committee Clerk

Minutes no. 51

Thursday 10 May 2018

Portfolio Committee No. 2 – Health and Community Services

Broken Hill Council Chambers, 240 Blende Street, Broken Hill at 9.00 am

1. **Members present**

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair*

Dr Faruqi

Mrs Houssos

Mr MacDonald

Dr Phelps

Mrs Taylor

2. **Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales**

2.1 **Public hearing**

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Darria Turley AO, Mayor, Broken Hill City Council
- Ms Rachael Storey, President, Far West Law Society
- Ms Jillian Heeley, Principal, Far West Community Legal Service
- Mr Andrew House, Social Worker, Broken Hill Correctional Centre.

Ms Turley withdrew at 10.19 am.

The evidence concluded at 11.07 am and the witnesses withdrew.

The following witness was sworn and examined by teleconference:

- Mr Ken Dennis, Manager, Broken Hill Aboriginal Legal Service.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Major David Pullen, Broken Hill and Far West NSW, The Salvation Army
- Captain Paul Kurth, Broken Hill and Far West NSW, The Salvation Army.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Mindy Sotiri, Program Director, Advocacy, Research and Policy, Community Restorative Centre – Broken Hill Office
- Mr Ian Harvey, Team Leader, Transition Programs, Far Western NSW, Community Restorative Centre – Broken Hill Office.

Dr Sotiri tendered the following document:

- Report entitled 'Indigenous Healing in Far Western NSW', dated June 2015.

The evidence concluded and the witnesses withdrew.

The public and the media withdrew.

The public hearing concluded at 1.48 pm.

2.2 Tendered documents

Resolved, on the motion of Mr Green: That the committee accept the following documents tendered during the public hearings on 9 and 10 May 2018:

- Table indicating rehabilitation facilities in Western NSW, tendered by Mr Bill Dickens, Solicitor in Charge, Legal Aid NSW – Dubbo Regional Office; Member, Orana Law Society; and Member, Central Cooperative Legal Service Delivery.
- Report entitled 'Indigenous Healing in Far Western NSW', dated June 2015, tendered by Dr Mindy Sotiri, Program Director, Advocacy, Research and Policy, Community Restorative Centre – Broken Hill Office.

3. Adjournment

The committee adjourned at 1.50 pm, until Monday 25 June 2018 (public hearing in Lismore).

Samuel Griffith
Committee Clerk

Minutes no. 53

Monday 25 June 2018

Portfolio Committee No. 2 - Health and Community Services

Clarence Valley Aboriginal Healing Centre, Grafton at 9.51 am

1. Members present

Mr Donnelly, *Chair*
Mr Green, *Deputy Chair*
Dr Faruqi
Mrs Houssos
Mr MacDonald
Dr Phelps
Mrs Taylor

2. Draft minutes

Resolved, on the motion of Mr Green: That draft minutes 50 and 51 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received

- 17 May 2018 – Email from Mr Dale Hansson, World Breastfeeding Trends Initiative to the secretariat, advising of its report and seeking support for the initiative
- 1 June 2018 – Email from Mr Grant Mistler to the secretariat concerning accreditation at Phoebe House Inc regarding the inquiry into drug rehabilitation services
- 6 June 2018 – Email from Mr Ross Broad, Assistant Director, Department of Health and Human Services, Victoria to secretariat advising the department is not able to assist the committee with its inquiry into drug rehabilitation services.

4. Inquiry into the implementation of the National Disability Insurance Scheme and the provision of disability services in New South Wales

Resolved, on the motion of Mrs Houssos: That the title and terms of reference for the inquiry be amended by inserting 'and the provision of disability services' after 'National Disability Insurance Scheme'.

5. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

5.1 Answers to questions on notice and supplementary questions

The committee noted that answers to questions on notice and additional information from the following organisations were published by the committee clerk under the authorisation of the resolution appointing the committee:

- NSW Health, received 8 May 2018
- Directions Health Services, received 18 May 2018
- Legal Aid NSW, received 5 June 2018.

5.2 Return of answers to questions on notice

Resolved, on the motion of Dr Phelps: That witnesses appearing at the hearings in Grafton and Lismore on 25 and 26 June 2018 be requested to return answers to questions on notice and supplementary questions within 10 days.

5.3 Invitation to witness – 3 July 2018

Resolved, on the motion of Mr Green: That Calvary Riverina Drug and Alcohol Centre, Calvary Riverina Hospital be invited to give evidence at the public hearing on Tuesday 3 July 2018.

5.4 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mr Wayne Jones, Chief Executive, Northern NSW Local Health District
- Ms Dee Robinson, General Manager, Mental Health, Drug and Alcohol Services, Northern NSW Local Health District
- Mr Mitch Dobbie, Manager, Tweed/Byron Drug and Alcohol Services
- Ms Corinne Maynard, Richmond/Clarence Drug and Alcohol Services.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Trish Collie, Drug and alcohol addiction specialist, Bulgarr Ngaru Medical Aboriginal Corporation
- Mr Trevor Kapeen, Drug and alcohol addiction worker, Bulgarr Ngaru Medical Aboriginal Corporation.

Dr Collie tendered the following document:

- Brochure, Stories about addiction and getting help, Bulgarr Ngaru Medical Aboriginal Corporation.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Sonya Mears-Lynch, Program Manager – Reconnect, Getting it Together and Youth on Track, Social Futures
- Ms Melinda Plesman, Family Referral Service Officer, Homelessness Youth Assistance Program, Clarence Valley, Social Futures.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Dr Robbie Lloyd, Community Relationships Manager, Port Macquarie Community College.

The evidence concluded and the witness withdrew.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Des Schroder, Director, Environment, Planning and Community, Clarence Valley Council
- Ms Sharon Moore, Project Officer, Clarence Valley Council
- Ms Sarah Nash, Project Officer, Clarence Valley Council.

Mr Schroder tendered the following document:

- Clarence Valley Council response to parliamentary inquiry into regional and remote rehabilitation services, dated 25 June 2018.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Janelle Brown, Manager, Clarence Valley Aboriginal Healing Centre
- Ms Julie Perkins, Chairperson, Clarence Valley Aboriginal Healing Centre.

Ms Brown tendered the following documents:

- Brochure, Clarence Valley Healing Centre
- Brochure, Healing Garden, Clarence Valley Aboriginal Healing and Support Service.

The evidence concluded and the witnesses withdrew.

The public and the media withdrew.

The public hearing concluded at 3:26 pm.

6. Tour of Clarence Valley Aboriginal Healing Centre

The committee conducted a tour of the Clarence Valley Aboriginal Healing Centre, guided by Ms Janelle Brown, Manager, Clarence Valley Aboriginal Healing Centre.

7. Adjournment

The committee adjourned at 3.45 pm, until 9.00 am, Tuesday 26 June 2018, Fountain Room, Lismore City Hall, 1 Bounty Street, Lismore (public hearing).

Samuel Griffith
Committee Clerk

Minutes no. 54

Tuesday 26 June 2018

Portfolio Committee No. 2 – Health and Community Services

Lismore City Hall, 1 Bounty Street, Lismore at 9.00 am

1. Members present

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair*

Dr Faruqi

Mrs Houssos

Mr MacDonald

Dr Phelps

Mrs Taylor

2. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales**2.1 Public hearing**

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witness was sworn and examined:

- Mr Warwick Parer, Managing Director, Gunnebah Addiction Retreat

Mr Parer tendered the following document:

- Brochure, Gunnebah Addiction Retreat.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Kylie Beattie, Director, Byron Private Holistic Treatment Centre
- Mr David Beattie, Business Owner, Byron Private Holistic Treatment Centre
- Mr Gary Thomas, Director, Byron Private Holistic Treatment Centre.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Dian Edwards, Manager, Namatjira Haven.

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Ms Jenny McGee, Clinical Manager, The Buttery
- Mr Trent Rees, Residential Program Manager, The Buttery.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Mr Hugh van Dugteren, Solicitor in Charge, Legal Aid NSW, Lismore Office.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Cllr Edwina Lloyd, Councillor, Lismore City Council.

Clr Lloyd tendered the following document:

- Documents regarding the 'Life on Track' program.

The evidence concluded and the witness withdrew

The public and the media withdrew.

The public hearing concluded at 2.36 pm.

2.2 Tendered documents

Resolved, on the motion of Mr Green: That the committee accept the following documents tendered during the public hearings on 25 and 26 June 2018:

- Brochure entitled 'Stories about addiction and getting help', Bulgarr Ngaru Medical Aboriginal Corporation, tendered by Dr Trish Collie, Drug and alcohol addiction specialist, Bulgarr Ngaru Medical Aboriginal Corporation
- Clarence Valley Council response to parliamentary inquiry into regional and remote rehabilitation services, dated 25 June 2018, tendered by Mr Des Schroder, Director, Environment, Planning and Community, Clarence Valley Council
- Brochure entitled Clarence Valley Healing Centre, tendered by Ms Janelle Brown, Manager, Clarence Valley Aboriginal Healing Centre
- Brochure entitled Healing Garden, Clarence Valley Aboriginal Healing and Support Service, tendered by Ms Janelle Brown, Manager, Clarence Valley Aboriginal Healing Centre
- Brochure entitled Gunnebah Addiction Retreat, tendered by Mr Warwick Parer, Managing Director, Gunnebah Addiction Retreat
- Documents regarding the 'Life on Track' program, tendered by Clr Edwina Lloyd, Councillor, Lismore City Council.

2.3 Public submission

Resolved, on the motion of Dr Phelps: That the committee publish submission no. 39, received from The Buttery.

3. Adjournment

The committee adjourned at 2.40 pm, until 9.10 am, Tuesday 3 July 2018, Macquarie Room, NSW Parliament House, Macquarie Street, Sydney (public hearing).

Samuel Griffith
Committee Clerk

Minutes no. 55

Tuesday 3 July 2018

Portfolio Committee No. 2 – Health and Community Services

Macquarie Room, NSW Parliament, at 9:12 am

1. Members present

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair* (from 9.15 am to 12.58 pm)

Dr Faruqi

Mrs Houssos

Mr MacDonald

Dr Phelps

Mrs Taylor

2. Previous minutes

Resolved, on the motion of Mr MacDonald: That draft minutes nos 52, 53 and 54 be confirmed.

3. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales

3.1 Public submission

Resolved, on the motion of Dr Phelps: That the committee publish submission no. 40.

3.2 Return of answers to questions on notice

Resolved, on the motion of Mrs Houssos: That members have one day from receipt of the transcript to lodge supplementary questions, and that witnesses appearing at the hearing be requested to return answers to questions on notice within 5 days.

3.3 Public hearing

Witnesses, the public and the media were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Ms Filiz Eminov, Executive Officer and Registrar, Drug Court
- Mr Jason Hainsworth, A/Assistant Commissioner, Community Corrections
- A/Director, State-wide Operations, Community Corrections.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Kerry Chant, Chief Health Officer, NSW Health
- Mr Gary Forrest, Chief Executive, Justice Health and Forensic Mental Health Network
- Mr Daniel Madeddu, Director, Alcohol and Other Drugs, Centre for Population Health
- Dr Michelle Cretikos, Director, Population Health Clinical Quality and Safety Centre for Population Health.
- Conjoint Professor Nicholas Lintzeris MBBS FACHAM PhD, Director, Drug and Alcohol Services, South East Sydney Local Health District; and Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney.

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Mr Brian Hill, Chief Executive Officer, Laughing Mind.

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mr Brendan McCorry, Program Manager, Calvary Drug and Alcohol Centre, Calvary Riverina Hospital.

Mr McCorry tendered the following document:

- Schedule of fees for Calvary Drug and Alcohol Centre.

The evidence concluded and the witness withdrew.

The public and the media withdrew.

The public hearing concluded at 1.02 pm.

3.4 Public submission

Resolved, on the motion of Dr Phelps: That the committee publish submission no. 41, received from Mr Brian Hill, Chief Executive Officer, Laughing Mind.

3.5 Tabled document

Resolved, on the motion of Dr Phelps: That the committee accept and publish the document 'Schedule of fees for Calvary Drug and Alcohol Centre' tabled by Mr Brendan McCorry, Program Manager, Calvary Drug and Alcohol Centre, Calvary Riverina Hospital.

4. Adjournment

The committee adjourned at 1.04 pm, until 12.00 pm, Monday 30 July 2018, McKell Room, NSW Parliament House, Macquarie Street, Sydney (report deliberative).

Samuel Griffith
Committee Clerk

Draft minutes no. 56

Monday 30 July 2018

Portfolio Committee No. 2 – Health and Community Services

McKell Room, NSW Parliament, at 12.03 pm

1. Members present

Mr Donnelly, *Chair*

Mr Green, *Deputy Chair*

Mr Clarke (substituting for Mr MacDonald) (from 12.05 pm)

Dr Faruqi

Mrs Houssos

Dr Phelps

Mrs Taylor

2. Previous minutes

Resolved, on the motion of Mrs Taylor: That draft minutes no. 55 be confirmed.

3. Correspondence***Received:***

- 9 July 2018 – Email from Mr Grant Mistler, attaching NSW Users and AIDS Association's Users News Magazine.

4. Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales**4.1 Public submission**

Resolved, on the motion of Dr Phelps: That the committee publish submission nos 42 and 43.

4.2 Answers to questions on notice and supplementary questions

Resolved, on the motion of Mrs Houssos: That the committee publish answers to questions on notice, supplementary answers and additional information from the following organisations:

- Clarence Valley Council, received 26 June 2018
- Juvenile Justice, received 6 July 2018
- NSW Justice, received 12 July 2018
- The Buttery, received 12 July 2018

- Northern NSW Local Health District, received 13 July 2018
- NSW Health, received 20 July 2018.

4.3 Tabled documents from 5 April 2018

Resolved, on the motion of Mrs Houssos: That the committee publish the following tabled documents tendered on 5 April 2018:

- *Family and Relationship Services Australia 2016 E-journal Edition 1* dated 1 December 2016, tendered by Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation
- Presentation, *Oolong House Residential Rehab*, tendered by Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation
- James, D., Shakeshaft, A., Munro, A., Courtney, R. J., *A systematic review of Indigenous drug and alcohol residential rehabilitation services: moving from description to establishing their effectiveness*, pp 1-38, tendered by Ms Tanya Bloxsome, A/Chief Executive Officer, The Oolong Aboriginal Corporation.

Resolved, on the motion of Mrs Houssos: That the committee keep the following tabled documents confidential, tendered on 5 April 2018:

- Waminda South Coast Women's Health & Welfare Aboriginal Corporation, *Schedules RFT HAC 17 386 Drug & Alcohol Package*, tendered by Ms Faye Worner, Chief Executive Officer, Waminda South Coast Women's Health & Welfare Aboriginal Corporation Schedules
- Coordinare, *Rapid Review of the Business Case for a Designated Aboriginal Women and Children's Specific Drug Treatment Service within South Eastern NSW Primary Health Network* dated February 2017, tendered by Ms Faye Worner, Chief Executive Officer, South Coast Women's Health & Welfare Aboriginal Corporation Schedules
- Business Plan for the NSW South Coast Aboriginal Women's Rehabilitation Service dated March 2011, tendered by Ms Faye Worner, Chief Executive Officer, South Coast Women's Health & Welfare Aboriginal Corporation Schedules.

4.4 Consideration of Chair's draft report

The Chair submitted his draft report entitled *Provision of drug rehabilitation services in regional, rural and remote New South Wales*, which, having been previously circulated, was taken as read.

Chapter 1

Resolved on the motion of Dr Faruqi: That the following new paragraph be inserted after paragraph 1.6:

'Prescription drug abuse, particularly of benzodiazepines and other opioids, such as Oxycodone and Codeine, are a significant issue and are some of the most common substances present in drug induced deaths in New South Wales. In 2016, they were present in 67.1 per cent of drug induced deaths, excluding alcohol.' [FOOTNOTE: Submission 34, NSW Government, p 3.]

Resolved on the motion of Dr Faruqi: That paragraph 1.9 be amended by omitting 'methamphetamine addiction has fast become the primary drug of concern for many' and inserting instead 'methamphetamine addiction has fast become a drug of significant concern for many'.

Resolved on the motion of Mrs Houssos: That paragraph 1.45 be amended by inserting at the end: 'It is available only for offenders who live in those regions. It is not possible to be referred to the Drug Court from another part of New South Wales.'

Resolved on the motion of Dr Phelps: That paragraph 1.78 be amended by omitting 'it is common practice for these services to be free of charge and for providers to seek' and inserting instead 'it is common for these services to be free of direct charge but for providers to seek'.

Dr Faruqi moved: That the following new paragraphs be inserted after paragraph 1.81:

'Harm minimisation

Some witnesses felt that there was too much emphasis on the law and order approach to dealing with drugs, which had little effect on drug use and advocated for a focus on health and harm minimisation.

Professor Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australasian College of Physicians, stated that the 'majority of funding in Australia is spent on policing and interdiction. Unfortunately, there is little evidence that there is an effect from those interventions'. He went on to state that the College had previously made a submission to the Victorian Government to 'reduce the emphasis on the criminal response to drug problems in our society and a greater consideration of harm reduction and the health problems of patients, and that is the broad concept of not just medical health but mental health and, importantly, social health and connection to communities and families'. [FOOTNOTE: Evidence, Professor Adrian Dunlop, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australian College of Physicians, 12 March 2018, pp 12-13].

Jenny Lovric, Program Manager, Cooperative Legal Service Delivery Program and Regional Outreach Clinic Program, Legal Aid NSW also stated that she thought that 'from a harm minimisation approach and also from a cost-benefit approach clearly diverting people away from the criminal justice system, the health system and prison is absolutely something worth exploring'. [FOOTNOTE: Evidence, Ms Jenny Lovric, Program Manager, Cooperative Legal Service Delivery Program and Regional Outreach Clinic Program, Legal Aid NSW, 12 March 2018, p 22.]

Question put.

The committee divided.

Ayes: Dr Faruqi, Dr Phelps.

Noes: Mr Clarke, Mr Donnelly, Mr Green, Mrs Houssos, Mrs Taylor.

Question resolved in the negative.

Dr Faruqi moved: That the following new committee comment be inserted after paragraph 1.83:

'Committee comment

The committee notes with concern the decline of dedicated detoxification wards in public hospitals, meaning most detoxification now occurs in general wards. The committee does not accept NSW Health's explanation that assigning beds to particular conditions or patient groups is inefficient. It is very clear that assigning wards to particular groups is common practice, for example psychiatric wards, maternity wards or oncology wards. There is therefore no reason why dedicated detoxification wards could not be re-established in public hospitals.'

Question put and negatived.

Chapter 3

Resolved on the motion of Dr Faruqi: That the following new paragraph be inserted after paragraph 3.7:

'The Broken Hill Working Group noted a further barrier, that those who wish to access rehabilitation services may have their access to public housing curtailed in that they would lose their public housing if it were left vacant over certain periods of time. [FOOTNOTE: Submission 12, Broken Hill Working Group, p 4].'

Resolved on the motion of Mrs Houssos: 'That paragraph 3.30 be amended by inserting at the end: 'These are only available for offenders who live in those regions. It is not possible to be referred to the Drug Court from another part of New South Wales.'

Resolved, on the motion of Mrs Houssos: 'That paragraph 3.81 be amended by inserting 'generally' before 'not an appropriate method of treatment'.

Resolved, on the motion of Dr Phelps: 'That:

a) paragraphs 3.86 and 3.87 be omitted:

'The NSW Government advised that treatment is predominantly voluntary because addiction is a chronic disorder. Although people can be successfully managed through a period of drug withdrawal, this does not address the underlying disorder. The government also advised that there are involuntary inpatient programs available as a last resort for people with severe substance use issues, provided under the *Drug and Alcohol Treatment Act 2007*. Involuntary treatment operates from two sites, one in Northern Sydney Local Health District (four beds in a detoxification unit) and the other in Western NSW Local Health District (eight beds in a unit at Bloomfield Hospital in Orange). The inpatient treatment component generally lasts for up to 28 days. The program has both inpatient and community based care components.

The effectiveness of involuntary treatment was informed by an evaluation, which found that such treatment:

- provided the opportunity for medical conditions and physical health to be properly assessed and addressed and enabled patients to complete an extended period of abstinence
- led to a reduction in mental health symptoms such as depression
- led 80 per cent of involuntary patients to take up post-discharge voluntary aftercare'

b) the following paragraphs be inserted instead:

'The NSW Government advised that treatment is predominantly voluntary because addiction is a chronic disorder. Although people can be successfully managed through a period of drug withdrawal, this does not address the underlying disorder.

The government also advised that there are involuntary inpatient programs available as a last resort for people with severe substance use issues, provided under the *Drug and Alcohol Treatment Act 2007*. Involuntary treatment operates from two sites, one in Northern Sydney Local Health District (four beds in a detoxification unit) and the other in Western NSW Local Health District (eight beds in a unit at Bloomfield Hospital in Orange). The inpatient treatment component generally lasts for up to 28 days. The program has both inpatient and community based care components. The effectiveness of involuntary treatment was informed by an evaluation, which found that such treatment:

- provided the opportunity for medical conditions and physical health to be properly assessed and addressed and enabled patients to complete an extended period of abstinence
- led to a reduction in mental health symptoms such as depression
- led 80 per cent of involuntary patients to take up post-discharge voluntary aftercare'.

Resolved, on the motion of Dr Faruqi: 'That recommendation 2 be amended by inserting at the end of the first bullet point ', including those aged 13 to 16'.

Mrs Taylor moved: 'That recommendation 2 be amended omitting 'fund local social services' in the fourth bullet point and inserting instead 'consider funding local social services'.

Question put and negatived.

Resolved, on the motion of Mrs Houssos: That recommendation 3 be amended by inserting ', legal professionals' after 'a resource for service providers'.

Dr Faruqi moved: That the following new recommendation be inserted after recommendation 3:

'Recommendation X

That the NSW Government establish dedicated detoxification units in the public health system, including hospitals, in regional areas of high demand.'

Question put and negatived.

Resolved, on the motion of Dr Faruqi: That recommendation 4 be amended by omitting 'more regional areas' and inserting instead 'additional regional areas'.

Resolved, on the motion of Dr Faruqi: That the following new recommendation be inserted after recommendation 4:

'Recommendation X

That the NSW Government pilot a Drug Court in Dubbo in parallel with an increase in rehabilitation services for the area.'

Dr Phelps moved: That paragraph 3.184 and recommendation 6 be omitted:

'While only hearing from a small number of private rehabilitation providers, the committee was concerned that this industry is completely unregulated: anyone can effectively set up shop as a rehabilitation service in this state. In order to protect vulnerable people in our community, the committee recommends that the NSW Government establish a regulatory framework for the private, for-profit residential rehabilitation industry.

Recommendation 6

That the NSW Government establish a regulatory framework for the private, for-profit residential rehabilitation industry.'

Question put and negatived.

Mrs Taylor moved: That recommendation 6 be amended by omitting 'regulatory framework' and inserting instead 'standards framework'.

Question put.

The committee divided.

Ayes: Mr Clarke, Mr Green, Dr Phelps, Mrs Taylor.

Noes: Mr Donnelly, Dr Faruqi, Mrs Houssos.

Question resolved in the affirmative.

Dr Faruqi moved: That the following new recommendation be inserted after recommendation 6:

'Recommendation X

That the NSW Government ensure that public housing tenants who undertake residential drug rehabilitation or detoxification do not lose their housing while undergoing treatment.'

Dr Phelps moved: That the motion of Dr Faruqi be amended by inserting ', not exceeding 12 months,' after 'drug rehabilitation or detoxification'.

Amendment of Dr Phelps put.

The committee divided.

Ayes: Mr Clarke, Mr Donnelly, Mr Green, Mrs Houssos, Dr Phelps, Mrs Taylor.

Noes: Dr Faruqi.

Question resolved in the affirmative.

Original question of Dr Faruqi, as amended, put and passed as follows:

'Recommendation X

That the NSW Government ensure that public housing tenants who undertake residential drug rehabilitation or detoxification, not exceeding 12 months, do not lose their housing while undergoing treatment.'

Resolved, on the motion of Mrs Taylor: That the following new recommendation be inserted after recommendation 6:

'Recommendation X

That the NSW Government:

- acknowledge the health, social and economic benefits of prevention of drug and alcohol abuse
- investigate the efficacy of implementing a state-wide school nurse program which includes targeting young people with preventative action and support.'

Chapter 4

Resolved, on the motion of Dr Faruqi: That the following new paragraph be inserted after paragraph 4.31:

'There was also concern about the ability for smaller Aboriginal organisations to compete for funds with larger and more established organisations who have the capacity to prepare large tenders, which smaller service providers do not. [FOOTNOTE: Evidence, Mr Alan Bennett, Chief Executive Officer, Orana Haven Drug and Alcohol Rehabilitation Centre, NSW Aboriginal Residential Healing and Drug and Alcohol Network, 12 March 2018, p 33.]'

Resolved, on the motion of Dr Faruqi: That the following new recommendation be inserted after recommendation 7:

'Recommendation X

That the NSW Government investigate the efficacy of establishing a scheme to establish a full time local Aboriginal trainee position alongside every skilled position recruited in areas with a significant Aboriginal population.'

Dr Faruqi moved: That the following new recommendation be inserted after recommendation 7:

'Recommendation X

Establish an additional and separate funding scheme that is only open to Aboriginal organisations to provide drug rehabilitation services to their communities.'

Mr Green moved: That the motion of Dr Faruqi be amended by omitting 'Establish an additional' and inserting instead 'That the NSW Government investigate establishing an additional'.

Amendment of Mr Green put and negated.

Original question of Dr Faruqi put.

The committee divided.

Ayes: Dr Faruqi.

Noes: Mr Clarke, Mr Donnelly, Mr Green, Mrs Houssos, Dr Phelps, Mrs Taylor.

Question resolved in the negative.

Dr Phelps moved: That paragraph 4.73 and recommendation 8 be omitted:

'Finally, given the clear relationship between Aboriginal drug and alcohol addiction and the over-representation of Aboriginal people in the criminal justice system, a unique and targeted approach is required to try and break this insidious cycle. We believe the Koori Court model, which includes family, Aboriginal elders and community members and aims to strengthen cultural links and address underlying health, drug and alcohol issues that contribute to offending, has the potential to make a real difference. The committee therefore recommends that the NSW Government trial Koori Courts for both adults and children in various locations throughout regional New South Wales for a specific period. The government should then conduct a comprehensive review of the model to determine whether it is appropriate to be rolled out in more areas throughout the state.

Recommendation 8

That the NSW Government:

- trial adult and youth Koori Courts in various regional New South Wales locations for a period of twelve months
- then conduct a comprehensive review to determine the appropriateness and need for further Koori Courts in other locations in regional New South Wales.'

Question put.

The committee divided.

Ayes: Dr Phelps.

Noes: Mr Clarke, Mr Donnelly, Dr Faruqi, Mr Green, Mrs Houssos, Mrs Taylor.

Question resolved in the negative.

Resolved, on the motion of Mrs Houssos: That:

- The draft report, as amended, be the report of the committee and that the committee present the report to the House;
- The transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry be tabled in the House with the report;
- Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- Dissenting statements be provided to the secretariat within 24 hours after receipt of the draft minutes of the meeting;
- That the report be tabled on 6 August 2018;
- That the Chair hold a press conference on 6 August 2018.

5. Adjournment

The committee adjourned at 2.32 pm.

Samuel Griffith
Committee Clerk