Community Withdrawal and Residential Rehabilitation Facility

- Broken Hill

Document tendered by

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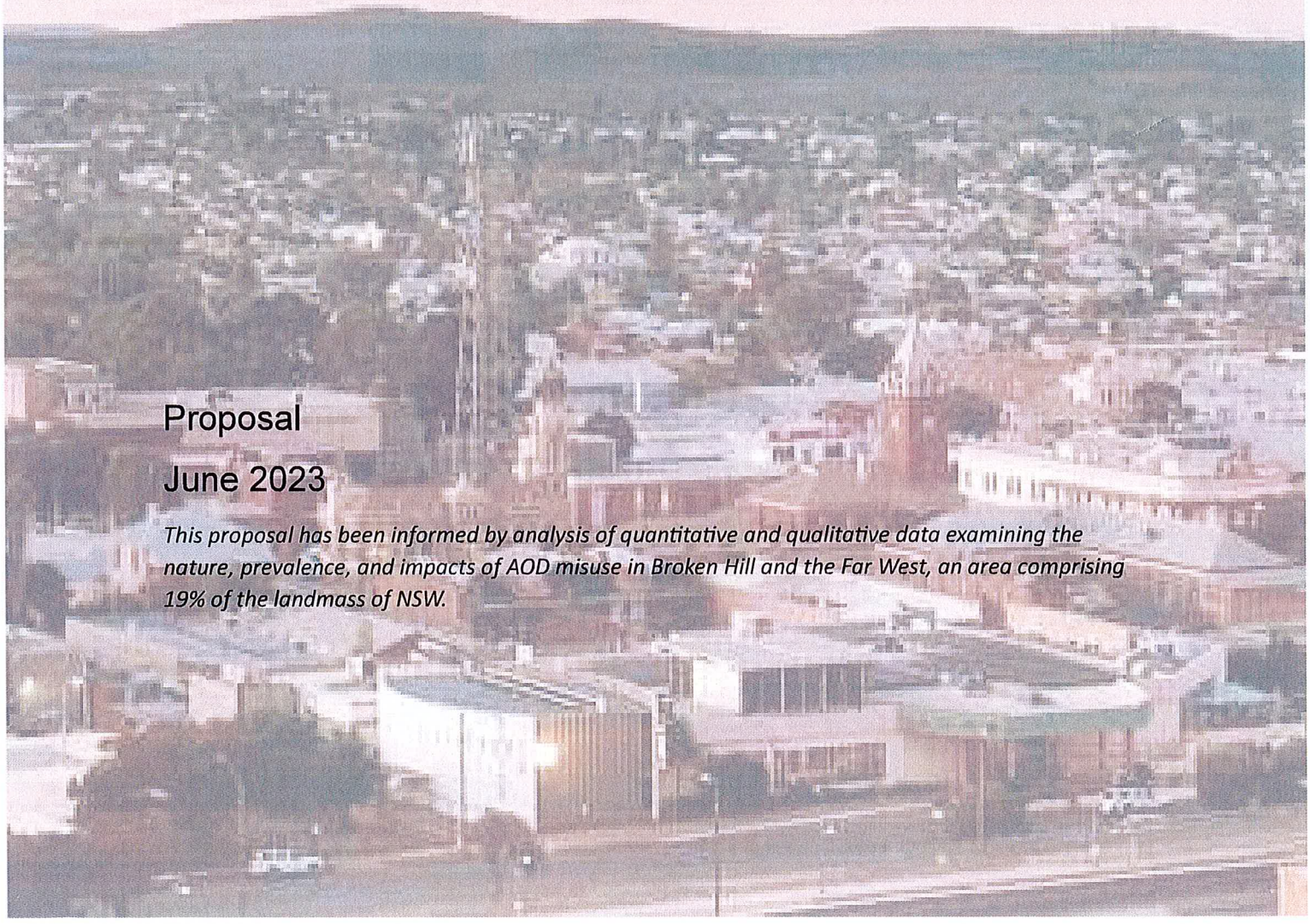

Proposal

June 2023

This proposal has been informed by analysis of quantitative and qualitative data examining the nature, prevalence, and impacts of AOD misuse in Broken Hill and the Far West, an area comprising 19% of the landmass of NSW.

The members of the Broken Hill Alcohol and other Drug Detoxification and Rehabilitation steering committee, their colleagues on the Community Advisory committee and Clinical Advisory committee and the community members that have had input into this comprehensive plan acknowledge that we live and work on the land of the Wilyakali people.

We acknowledge Wilyakali Elders past, present and emerging that carry the knowledge of the oldest living culture here on their country.

The Broken Hill Alcohol and other Drug Detoxification and Rehabilitation steering committee acknowledges the disparities of health experienced by First Nations people and the continuing impacts of colonisation on the health and wellbeing of First Nations people.

The Broken Hill Alcohol and other Drug Detoxification and Rehabilitation steering committee is ensuring that the Rehabilitation centre is inclusive, culturally responsive and culturally informed to create a safe space for First Nations people seeking support to heal.

The Broken Hill Alcohol and other Drug Rehabilitation steering committee see the centre will support the governments approach to Closing the Gap on Alcohol and other Drug issues currently plaguing the many First Nations of Australia.

Letter from Counsellor Joanie Sanderson,
Chair of the Broken Hill AOD Clinic Steering Committee.

In my role as a family counsellor, with over 25 years' experience, I've come across many families directly affected by drugs and alcohol; and in my own personal life I've watched my own family members struggling with alcoholism. I know too well the affects alcohol and other drugs have on loved ones and a community.

Over the years I've watched as small funding proposals and programs have launched sporadically in Broken Hill and it continues to be obvious to me that people with AOD issues are continuing to fall through the cracks. People are sent away to Centres that are over 800kms away and on their return into the community they go straight back into their old patterns. As much as the treatment is important, the process of support when people enter and then come out of a facility, is of equal importance.

Having been involved in the Community Drug Action Team for about 10 years, working with young people trying to reduce the problems of AOD, I hear from many individuals about how their families, sons and daughters and children are being affected by AOD.

For a while now in our discussions, we've been talking about other programs to address these on-going issues, but from my personal experience I know these programs haven't been working and we now more than ever need a facility in the Broken Hill community.

Addressing a person's addiction is only successful when families can work alongside the individual, where everyone can be on the journey together. That's not possible when travelling 100s of kilometres to get that support.

Creating a passion for recovery has to be owned by the community – when there is a personal investment in something, such as the proposed facility, there is a willingness to work as a team to make it happen.

As part of the Steering Committee and working with the Community & Clinical groups, I've seen firsthand the passion that everyone has to make this happen and it is encouraging to see how everybody is contributing to bring a Clinic into the Broken Hill community, so we have a sustainable solution to address AOD issues.

It is also important to focus on the needs of the Aboriginal families. Having worked with a number of Aboriginal families through Mission Australia, I know that when they are going through the healing process, they don't want to leave country. For Aboriginal people to have to leave their families is terrible for them and this can also lead to failure in their healing before they've even started the process.

On the Community Steering group there is representation from lawyers who tell us that, almost everyone that comes through their office has had trauma in their lives and so this Centre has to be one that focuses on trauma care, not just seeing people as a drug addict or alcoholic – we need to understand and acknowledge that these people have got to this place in their lives because of trauma and work to heal from that perspective.

It is time to build a Clinic in Broken Hill. A detox and rehabilitation centre that draws on trauma-based care, hand in hand with a built environment inside and out that creates a safe place to heal, can only benefit this community.

This is a great opportunity for Broken Hill and it's necessary to tackle the AOD challenges we have here in the community.

Sincerely

Joanie Sanderson

The Broken Hill Alcohol and Other Drugs Steering Committee is currently made up of the following members:

Joanie Sanderson, Family Therapist and Chair

Steve Radford OAM, Community Member

Denise Hampton, Aboriginal Community Member

Andrew House, Community Member

Cory Paulson, RFDS

Dionne Devlin, Community Member

Razija Nu'man, Broken Hill City Council

Jodie Miller, Jack Cocking and Tracey Zeiser, Far West Local Health District

Marsha Files, Aboriginal Community Member

Nerida Campbell, Andrew Coe, Ann Grose, Robert Strickland and Damon Parker, Western NSW PHN

The following are among the organisations supporting this proposal:

This proposal has been assembled with the support of the local community of Broken Hill, Maari Ma Health, members of the Far West Local Health District, The Royal Flying Doctor Service, Broken Hill City Council, Alcohol and Other Drugs clinicians, Western PHN, Far West Community Legal Centre, CMC Consolidated, Flourish, Lifeline, Mission Australia, Thrive Medical, Foundation Broken Hill, the local federal and state members of parliament, among other organisations and individuals.

The Steering Committee expresses its gratitude to these people and organisations., including Western PHN for providing support and the research for this proposal.

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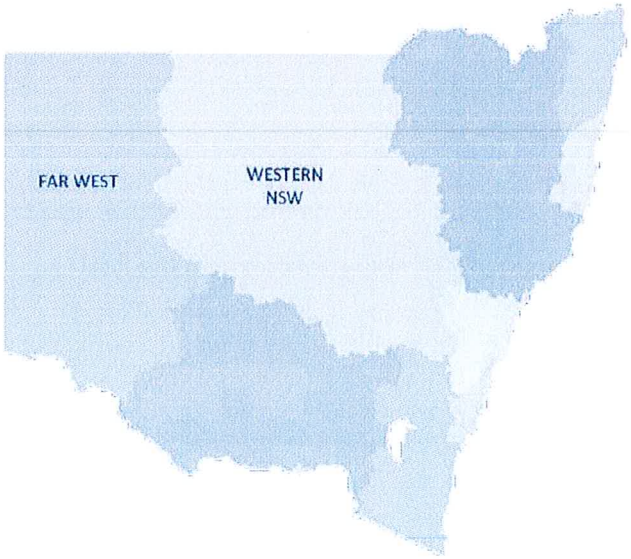
Executive Summary

The Broken Hill Alcohol and other Drug (AOD) Steering Committee is a **community response** to research, identify and lobby for a contemporary solution to treatment for addiction, a known and growing problem affecting the health and wellbeing of people in the Far West of NSW.

The Far West region is 147000 sq km, which is 19% of the land mass of the state. The region is over 1000kms from Sydney. Its population is expected to grow.



The prevalence and impacts of alcohol and other drug (AOD) misuse in within the Broken Hill and the Far West communities is well documented. For more than two decades there has been discussion on establishing a purpose-built facility to address the high impacts of the problem.

There have been numerous ad hoc AOD programs implemented to help address this problem. Each program has faced the daunting barrier of sending people to centres that are at least 800kms away from Broken Hill. Due to a lack of after-care integration, upon their return to the Far West, people are at significant risk of relapse, and returning to old patterns.

A co-design process has identified the need for a facility for Broken Hill and the Far West to provide not only clinical withdrawal (detox) and trauma responsive rehabilitation and proactive outreach programs for reintegration and after-care. It must also be a culturally safe and inclusive physical environment. The consultation process recommended that assessment criteria for admission be developed, based on safe practices. The criteria is currently being developed following government guidelines and in consultation with local stakeholders.

The community based withdrawal and residential rehabilitation facility required in the Far West has 23 beds, comprising 8 withdrawal beds and 15 rehabilitation beds.

As part of our submission, we present after-care and re-integration as a critical component of the recovery process with withdrawal and residential rehabilitation.

Data from across multiple agencies identifies the challenges faced by Broken Hill and the Far West:

- Broken Hill LGA is the 5th highest rate of alcohol attributable deaths of any NSW LGA, and 20% higher than that for NSW (24.0 vs. 20.0 per 100,000, for 2017-2018). (Health Stats NSW)
- Rate of drug offences (all) was 1.8 times higher than that for NSW (1141.4 vs. 646.6 per 100,000, for 2019-2020). (BOSCAR)
- 56% of surveyed Broken Hill residents identified drug and alcohol abuse as a serious health concern facing the community (HNA Community Telephone Survey, 2018)
- In regional NSW seven of the 13 statistical areas showed an increase in recorded rates of domestic assault, ranging from a 5.1% increase in New England and the North West to a 26.8% increase in the Far West and Orana. The Far West and Orana also experienced significant increases in motor vehicle theft (up 19.7%), stealing from a dwelling (up 10.2%) and fraud (up 21.5%)
- Over half of people seeking drug and alcohol treatment services indicate that a lack of available services in their area is the main barrier to them accessing treatment.
- The cost of incarceration is approximately $110,000 per individual per year as of 2017; the average cost of residential rehabilitation as of 2014 was $7,348 (Bushnell; Smith et al 2014)

A community based withdrawal and rehabilitation centre is overdue in the Far West of the state.

The Committee intends that this service will be linked to the community via a pledge program, drawing on the resources and expertise of community members from Broken Hill and surrounds and its networks further afield.

The committee notes with pleasure the very robust support provided from Council, the mining sector, the justice sector, regional development, the business sector, the social services sector and private individuals.

In Broken Hill and the Far West, community strength and partnerships are hallmarks of the culture of the community. This is due in part to our history, the isolation and often harsh environment. These factors contribute to a strong sense of social cohesion and the inherent knowledge that we must work together to find solutions to our issues.

Recovery from addiction in the Far West is best facilitated when families are included in education and public health measures along with the person. A family after-care program is an essential tenet of the service.

The path to recovery must also involve the community; referrals to and partnerships with community services and community training and empowerment programs are also essential. This requires linking with and mobilising the resources of welfare and health care groups such as Maari Ma, Alcoholics Anonymous, Salvation Army, Mission Australia, Narcotics Anonymous, and Centacare.

The Aboriginal Medical Services and Community Members articulated that AOD misuse is emblematic of intergenerational trauma continuing to impact Aboriginal families and communities. Thus, at the core of the facility will be the Aboriginal Drug and Alcohol Residential Rehabilitation Network (ADARRN) Model of Care.

"The ADARRN Model of Care is multifaceted and appropriate care outcomes are achieved by individual case management, care navigation, care coordination, primary and community health care, multidisciplinary team approaches – or any combination of these health care modalities as determined for individual client. Regardless of the specific model of delivery, all elements are required in order to provide holistic and appropriate care to Aboriginal people and their communities." (ADARRN MODEL OF CARE IMPLEMENTATION).

The proposed facility will be governed by the ADARRN Model of Care across the patient journey, offering a pro-active and engaged outreach program for intake and assessment. There will be a clinically governed and pharmacotherapeutic detox residential program. There will be an integrated, peer lead (lived experience) clinically governed residential rehabilitation facility. A workforce training program will be established for this purpose. There will be an after-care program for co-ordinated care supporting integration in the community and involving family support.

This facility requires commitment and contribution from all levels of government, non-government agencies, and communities. The proposal relies on the NSW Government providing on-going annual 'appropriated' funding for operational expenses, with the Federal Government providing the capital expenditure to build a facility, and Broken Hill City Council providing the land.

Opportunities

The benefits to community are significant, with a reduction in community health expense, a reduction in crime and costs in the social justice system, and significant financial savings in the provision of health. Significantly, the social benefits that come with resolving AOD misuse with have a major impact on the community of Broken Hill and the wider Far West region will be widely felt and will impact the economic and tourism sector as more people are able to participate fully in the life of the region.

Finally, we note that the Special Commission of Inquiry into the drug Ice has now been concluded, and the government response has been published. The Response has the recommendation "to provide $163.8 million for evidence-based treatment support and early intervention services, especially in regional and rural areas, for key priority populations." We believe this proposal conforms directly to the government's recommendation.

Case For Change

Background

In 2020, in response to a request for support from the Broken Hill Community, the Western NSW Primary Health Network (WNSW PHN) Far West Community Advisory Group established a sub-committee to address inadequate access to Alcohol and Other Drugs (AOD) rehabilitation & detoxification facilities for the people of Broken Hill. In 2021, the sub-committee established a community led AOD Integrated Steering Committee with members from Broken Hill City Council, Far West Local Health District, the Aboriginal community, NSW Police, business community and service providers to identify the gaps and develop a direction for a model of care.

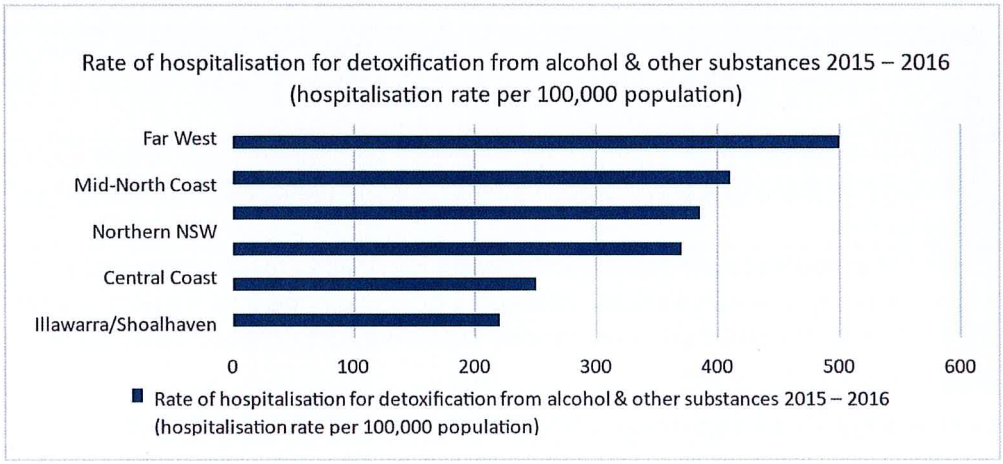
The Network of Alcohol and Other Drugs Agencies' (NADA) submission to the NSW Legislative Council, 2019, identified that NSW AOD facility funding had fallen chronically short at both the state and federal level over the previous two decades. The NSW government acknowledged this problem. The NADA submission states

The NSW Government subsequently provided a formal response to the Committee's No. 49 report, in January 2019. This response noted that AOD misuse contributes significantly to emergency department presentations, hospitalisations, early mortality, and morbidity and has a considerable impact on crime. It also contributes to road accidents, violence, family breakdown and social dysfunction. NADA notes here that the considerable, current, lack of access to treatment, particularly for those with severe substance dependence, mental health issues and physical comorbidity, means that those individuals will, and do, end up in emergency departments, hospitalised and in prison. While the cost of providing adequate access to AOD treatment may be high, the cost of not providing adequate access to treatment is exponentially greater when one considers these multiple ramifications. (NADA, March 2019: 3)

NADA noted that the NSW Government's response included an in-principle agreement to expand funding (ibid: 4).

The Need for Withdrawal and Residential Rehabilitation Services in Broken Hill

The Impact of AOD use in Broken Hill and Far West AOD use is having a devastating impact on children and families. The relationship between AOD misuse and a range of poor social outcomes for the broader Broken Hill community is strong. Deaths attributable to alcohol are 20% higher than that for NSW (Health Stats NSW) and the rate of drug offences is 1.8 times that for NSW (BOSCAR). NSW Family and Community Services data for Far West NSW reports children at risk at almost twice the rate of NSW. 56% of Broken Hill residents surveyed identified alcohol and other drugs abuse as a serious health concern (HNA 2018).



Broken Hill was ranked 4th in the State for Number of recorded domestic violence related assault incidents by Local Government Area, with a total of 231 incidents, at a rate of 1302.6 per 100,000 population. (NSW Recorded Crime Statistics July 2019 to June 2020).

LGA	Domestic Violence	Non- domestic violence assault	Break and enter a dwelling	Robbery with a weapon
Broken	3.3	2.5	3.9	3.2
Dubbo	2.6	2.8	3.2	2.7

The Future Expansion of Broken Hill

Broken Hill will experience a period of rapid population growth from 2023. This growth will be initiated by expansion in the mining industry, will necessitate growth in the service and welfare sectors, and further cascading growth in most sectors.

Preparation for the infrastructure and service need of the population is underway and the provision of social, medical and welfare services to meet local need is in sharp focus. Chief amongst the competing needs is a locally accessible, residential Alcohol and Other Drugs Detoxification and Rehabilitation Centre.

Mining and Large Projects

Four large scale projects will start in the short term, creating 3055 jobs in total and of that total 2444 jobs that will be held by people living in Broken Hill (Broken Hill City Council and ProfileID, 2022).

The population of Broken Hill will reach a peak of at least 19 600 residents in 2025 and stabilise at 18 300 by 2046. The population of Broken Hill was 17814 in 2016 (ABS) and is estimated at 17 661 currently. (Profile ID). People aged from their early 20's to mid-40's living in single occupancy dwellings will lead the mining migration.

The infrastructure required to service an expanded population of residents includes housing, and social and welfare services including health and wellbeing services. Broken Hill City Council has undertaken a Housing Strategy and an Economic Development and Liveability Strategy to identify the current services, identify gaps and inform growth in services in the short, medium and long term.

Broken Hill's Community Strategic Plan, **Your Broken Hill 2040,** was developed after consultation with the Broken Hill community over 18 months between 2020 and 2022 to identify priority areas for action. The need for Alcohol and Other Drug Detoxification and Rehabilitation services was repeatedly identified and is expressed in the plan as action:

1.1.1	Work to connect people, build capacity and create local solutions to solve a range of social and health issues that may impact community wellbeing and vulnerable people
1.6.1	Maintain awareness of and create strategies and partnerships to address the impact of the social and lifestyle factors affecting the health and wellbeing of residents
1.6.3	Provide quality health, medical and allied services to meet community need, particularly disability services and support, 24-hour medical services, paediatric and other specialist services, mental health support services, allied health, and rehabilitation services

Community-Strategic-Plan-Your-Broken-Hill-2040-Adopted-29.06.2022 (1).pdf

The NSW Government's commitment to the Far West, including ensuring that the region has the best access to essential services and infrastructure in regional Australia, should give confidence that identified essential services will be provided. (https://www.nsw.gov.au/regional-nsw/our-regions/far-west).

Rationale For Investment

The prevalence and impacts of alcohol and other drugs (AOD) misuse in Australia are well documented, with research demonstrating an unavoidable correlation between AOD misuse and poor health outcomes, injury and deaths, crime and incarceration, violence, family and community breakdown and risks to workplace safety (MCDS in Australia Institute of Health and Welfare 2016).

Analysis of data from 2014 concluded that the cost of imprisonment for one individual in Australia was

$109,500 per year (Bushnell 2017). By contrast, 2010/11 data analysis by that National Council on Drugs published in 2012 indicates the average costs of treating a person in residential drug treatment was then

$16,110 (ANCD 2012 in Smith et al 2014). Allowing a CPI increase of 2.5% per year, that figure would increase to approximately $17,348 for the 2013/14 financial year. While residential rehabilitation placements are ordinarily significantly shorter than a year (commonly 12 weeks), residential rehabilitation is still significantly cheaper than prison. With research suggesting a relapse rate in the vicinity of 50% (Lee 2018), this still suggests 50% of people successfully recover from addiction through residential treatment.

An Australian Institute of Health and Welfare study found there were 13,849 public hospitalisations and 6,928 private hospitalisations in 2010-11 due to a principal diagnosis related to illicit drugs alone. (Smith et al 2014). With the average cost of a stay in public hospital at that time estimated at $4,649, cessation of harmful AOD use can have significant savings in terms of health, as well as policing, courts, and corrections among other positive outcomes.

Deloitte Access Economic undertook a cost-benefit analysis of the impacts of residential rehabilitation on Aboriginal people with problematic AOD misuse. That study, published by the Australian National Council on Drugs, found savings of $111,458 per offender, in addition to improvements in health and mortality, by diverting offenders from prison to community-based rehabilitation (Deloitte Access Economics 2013). This suggests significant financial as well as social benefits to be gained from the funding of a residential AOD rehabilitation facility in the Broken Hill Council area, and the Far West.

Items	NPV prison Column A	NPV prison Column B	Difference Column B – Column A	Comment
Costs				
Cost of each alternative	$114,832	$18,385	-$96,446	Use of residential rehabilitation represents a saving
Financial Benefits				
Recidivism	$96,348	$84,888	-$11,461	Recidivism is lower with residential rehabilitation, leading to savings in prison
Mental health service usage	$3,278	$0	-$3,278	Residential rehabilitation is not associated with the same adverse impacts on mental health as prison, leading to savings in use of mental health services
Hepatitis C treatment costs	$1,993	$1,747	-$246	Residential rehabilitation is associated with lower rates of contraction of hepatitis C, leading to savings in treatment costs
Costs of drug use for those who relapse	$164	$136	-$28	Residential rehabilitation is associated with lower rates of drug use relapse, leading to savings in healthcare and productivity costs
Subtotal financial	$101,783	$86,771	-$15,012	Savings per offender resulting from use of residential rehabilitation
Net financial benefit of residential rehabilitation	-$111,458	**Savings per offender resulting from use of residential rehabilitation**		

Prison vs residential rehabilitation (Deloitte 2014: xii)

A comprehensive analysis of the annual economic impact of alcohol, illicit drugs and tobacco on Australian society in 2004/05 found that alcohol accounted for costs of $15.3 billion, illicit drugs accounted for $8.2 billion and alcohol and illicit drugs together accounted for another $1.1 billion (Collins and Lapsley 2008:xi).

Given the age of this study, it is likely that those costs have significantly increased.

The obvious challenge for Broken Hill in addressing AOD misuse is the current burden and lack of capacity the LHD has, therefore all clinical requirements are over 800kms away and for the Aboriginal community, "off country".

One of the closer residential rehabilitation facilities is operated by Lives Lived Well in Orange over 830kms away. There is such demand for their service that it only maintains a waitlist for two weeks at a time.

Weigelli Aboriginal Corporation operates a residential AOD facility in Cowra, more than 830 km east of Broken Hill. This service also has such a long waiting list that clients in need are asked to call the centre each fortnight to see if a space has become available.

Community Consultation

Consultation with the Community & Clinical Advisory groups who live and work in Broken Hill and surrounds identified a number of common issues, priorities and challenges that need to be considered in the design of a residential AOD facility to effectively support recovery for people.

An Accessible, Inclusive Service

Key points from the consultation process:

- Supported and accessible transition of care from referral to recovery
- Trauma responsive care with no barriers to access care regardless of a person's unique story or past
- Culturally safe and welcoming for people of all backgrounds
- Ensure health literacy is incorporated into the design and delivery of the model
- Ensure staff are supported to work from their lived experience
- The location of the services needs to be accessible but outside of the CBD with room for outdoor garden and activities
- Further consideration needs to be given to the demographic of the clients including male and female, and other gender or family considerations.

First and foremost was the consensus among stakeholders that, given Broken Hill is a service hub, a rehabilitation facility should accept referrals from the broader far western NSW region.

Aboriginal people who live and work in the Broken Hill regional area emphasised the importance of a facility on country, citing many examples of people who simply will not leave country to engage with essential services.

There was common agreement that care needs to be taken to locate the facility out of town. This was to allow clients to focus on recovery away from family and other commitments, to negate access to alcohol and drugs and to avoid community backlash from residents who may not want a facility near their neighbourhood.

Throughout consultations transport was identified as an essential element of effective rehabilitation, particularly given the facility will be outside of the CBD. Transport is essential to ensure safety for people exiting prison, as well as people who have home-detoxed or are going through drug withdrawal transport is essential to avoid the risk of them 'busting' and accessing drugs.

There was consistency in the view that the facility should cater for both men and women as well, with fewer residential rehabilitation options for women in New South Wales. Safety for women in a mixed gender facility needs to be planned carefully, as research shows that many women with AOD issues and women in the justice system have experienced domestic violence. NSW Health's residential rehabilitation guidelines suggest that programs that cater for both men and women should ideally have separate facilities for men and women and provide opportunities for women-only groups and activities (NSW Health 2007).

While some people who participated in consultation indicated the need for a rehabilitation facility that caters for women with children and whole families, advice from experienced rehab providers and other experts suggests this may be challenging at the outset.

Dual Diagnosis

There was a consensus across a diverse range of stakeholders that dual diagnoses (the co-occurrence of AOD misuse with a mental illness) was prevalent among people who misuse AOD. Health professionals and justice health workers indicated that a significant number of AOD clients have serious mental health issues, including schizophrenia and bi-polar disorder.

Criminal Histories

Many stakeholders also emphasised that the strong association between AOD misuse and incarceration requires a rehabilitation service that will accept people transitioning out of custody and other people with criminal histories.

Medically Supervised Withdrawal ('Detox') and Pharmacotherapeutic Support

Consultation identified the need for a medically supervised, clinically governed service that had provision for withdrawal ('detox') as well as maintenance of pharmacotherapeutic support, which includes opioid substitution, other treatments, and also mental health medication.

Accordingly, it is argued that a rehabilitation facility should provide for pharmacotherapy if it is to meet the needs of the broader community.

Many health professionals and other stakeholders recognised that some people are not able to engage with residential rehab due to family commitments or other issues. It was suggested that there is a need for access to a range of detox options, including ambulatory (in-home) detox, and for a broad education strategy to address the apparent gaps in knowledge of good detox practice among general practitioners in the region.

Supportive Intake, Holistic Person-Centred Rehabilitation and After Care Support

It is clear from the consultations that people who live and work in the region are seeking a structured rehabilitation facility, that provides pro-active intake support, trauma informed holistic person-centred rehabilitation and co-ordinated after-care to support successful community reintegration.

The in-take processes, which will be undertaken by rehab workers through an outreach program and onsite, will build trust to encourage clients to feel safe engaging with rehabilitation. This would also support clients to overcome several barriers and the stigma associated with engaging with rehabilitation.

The concept of holistic, trauma informed, person-centred rehab is consistent with evidence that AOD misuse is symptomatic of underlying social and psychological causes, including mental health and primary health issues, trauma, poverty, criminalisation, and social marginalisation.

Many, if not all, stakeholders indicated willingness to deliver programs and support within a rehab facility. It is expected that vocational skills and employment programs will partner with the rehab so that clients can transition to employment in the community.

Many stakeholders emphasised that co-ordinated after-care is key to the residential rehabilitation component of recovery. This will involve linking clients with outreach AOD counsellors, other health service providers, working with them to ensure stable housing and welfare and linking them with men's groups, women's groups and other cultural supports.

Trauma-Responsive, Culturally Safe Therapeutic Support

AOD misuse is symptomatic of the intergenerational trauma that impacts Aboriginal families and communities. Cultural identity and connectedness for Aboriginals has been eroded, manifesting in family breakdown, entrenched disadvantage, substance misuse, violence, offending and incarceration, child abuse and neglect.

Challenges Faced by the Population Living and Working In Broken Hill

Analysis of input from stakeholder identified common concerns about the nature and prevalence of AOD misuse in the area.

Intergenerational Trauma

AOD misuse is symptomatic of the intergenerational trauma that impacts Aboriginal families and communities. Cultural identity and connectedness for Aboriginals has been eroded, manifesting in family breakdown, entrenched disadvantage, substance misuse, violence, offending and incarceration, child abuse and neglect.

Research though suggests that trauma, triggered by different factors, is a common reality for other people in the criminal justice system and people with mental illness and cognitive disability.

Alcohol

While many stakeholders voiced greater concern about the social impacts of 'ice', it is generally recognised that alcohol is most commonly associated with problematic AOD misuse in the region. Alcohol is strongly associated with violent offending, with Bureau of Crime Statistics and Research (BOCSAR) data indicating that 33.7% of domestic violence offences and 29% of non- domestic violence related assaults in the Broken Hill region were alcohol related. The average attributable to alcohol crimes was 32%. (BOCSAR accessed 2020).

Cannabis

Whilst cannabis is the most prevalent substance misused in Broken Hill when reviewing the BOSCAR data. While people with problematic cannabis use generally engage with outreach AOD counselling support, it was suggested it is not likely to be a key motivator for engagement with residential AOD rehabilitation. This is evidenced in a national study of AOD treatments in Australia in 2016-17, which found that cannabis was more commonly treated as the primary drug of concern in non-residential treatment and outreach facilities, while residential facilities were the second most common treatment setting for amphetamine, heroin and alcohol (Australian Institute of Health and Welfare 2018).

Crystal Methamphetamine ('ice')

Although alcohol is generally considered the most prevalent substances misused in the area, many stakeholders identified 'ice' (crystal methamphetamine) as the drug of priority concern. Bureau of Crime Statistics and Research (BOCSAR) crime data demonstrates a 39% increase in the detection of amphetamine possession offences in the Broken Hill Council Area in the five years up until 2020.

Aside from devastating effects on health and well-being, methamphetamine is associated with an increased risk of crime, particularly violent crime and property offences (Goldsmid and Willis 2016). The relationship between ice and crime is evidenced in the findings of the ongoing Drug Use Monitoring in Australia (DUMA) project finding methamphetamine use among police detainees increased 14% in 2009 to 37% in 2014 (Goldsmid and Brown in Goldsmid and Willis 2016). A national study of AOD treatments in Australia found that between 2012/13 and 2016/17 the number of 'closed treatment episodes' where amphetamine was the principal drug increased by 123% (AIHW 2018). The Australian Crime Commission has deemed methamphetamine to be 'the illicit drug posing the greatest risk to the Australian community' (Australian Institute of Health and Welfare 2016:7)

Poor Social Outcomes

Aside from the health impacts of AOD misuse and the significant burden that AOD use places on our health system, consultation and research identifies the relationship between AOD misuse and a range of poor social outcomes for the broader Broken Hill region.

Intergenerational Trauma Response

The rehabilitation will need to provide cultural safety for Aboriginal people, which requires recognition of Aboriginal healing approaches that balance therapeutic support with strengthening of cultural identity and connectedness. This can be achieved through the recruitment and professional development of Aboriginal staff, consideration of Indigenous culture and country in the design of the premises, strong partnerships with Aboriginal health, community networks and other support services and the inclusion of Aboriginal cultural healing programs within the service. The facility will also be basing its service on the ADARRN Model of Care.

Crime

There is a significant body of evidence that demonstrates the relationship between alcohol and drug use and crime (Goldsmid and Willis 2016). Evidence from the Drug Use Monitoring in Australia (DUMA) project, which involves self-reporting surveys and urinalysis with police detainees at multiple sites across Australia, provides us with insights into the levels of substance misuse among offenders and the relationship between different substances and specific crime types (Australian Institute of Criminology 2018).

Children, Families and Domestic Violence

AOD use has a devastating impact on children and families. The relationship between AOD misuse and a range of poor social outcomes for the broader Broken Hill community is strong.

NSW Family and Community Services data for Far Western Region reported children at risk at almost twice the rate of NSW. Consultations also identified a link between AOD misuse and suicide and self-harm.

Strategic Alignment

The Broken Hill AOD proposal aligns with the Commonwealth of Australia National Drug Strategy 2017- 2026 aim to provide local services appropriately connected through established referral pathways. It aligns with the Strategy's priority area of addressing the suffering of Aboriginal and Torres Strait Islander people due to alcohol and other drug use with an emphasis on disconnection from culture and country.

The Broken Hill AOD proposal aligns with the Commonwealth of Australia National Alcohol Strategy 2019- 2028 recognition that people in remote areas significantly more likely to consume more drinks at least monthly.

The Broken Hill AOD proposal aligns with the NSW Ministry of Health Rural Health Plan: Towards 2021 Final Progress Review commitment to "high quality infrastructure…critical for health outcomes to be maintained and improved" (p.39).

The Broken Hill AOD proposal aligns with the NSW Ministry of Health NSW State Health Plan key priority area of addressing drug use.

Proposed Model

The Built Facility

To meet the needs of the Broken Hill community it is proposed to develop a purpose-built 18 bed rehabilitation facility with a separate Detox residential building. The new facility, whilst servicing the Broken Hill and wider community, will be built outside of residential areas.

It will be a culturally inclusive physical environment that underpins positive health outcomes. The capital investment will be ~$6million and the recurrent annual operational funding is expected to be ~$1.5million. The capital investment is to be funded by the Federal Government with the operating budget funded by NSW State Government. The capital amount takes into consideration the purchase of land and the significantly higher building costs in Broken Hill. The amount will also cover project & program costs from inception to delivery.

Consultation has identified the need for a medically supervised, clinically governed service that has provision for withdrawal ('detox') as well as maintenance of pharmacotherapeutic support which includes opioid substitution, other treatments, and also mental health medication.

Proposed Model of Care Guiding Principles

The model will be a supported and accessible transition of care from referral through to recovery.

- An adaptable model that focuses on harm minimisation and abstinence with residential and outreach support
- An empowered lived experience and peer support with open and transparent guidelines
- Consideration of the input and ownership of the services by peer workers and the clients
- Importance to be given to the demographic of the clients including male and female, and other gender or family considerations.
- Development of an education program in tandem to the service reduce the stigma and community unease.
- Respect for confidentiality and privacy of clients
- The location of the services needs to be accessible but outside of the CBD with room for outdoor garden and activities; not in a residential area.

Overview of Proposed Service

The proposed model will be culturally safe and welcoming facility for people of all backgrounds, especially for Aboriginal people accessing care off country.

- An accessible physical environment conducive to positive health outcomes with pleasurable surroundings with inclusion front and centre
- Trauma responsive care with no barriers to access care, regardless of a person's unique story or past
- A recovery focused, holistic, trauma and healing informed, inclusive, and culturally respectful environment
- The model of care includes Registered Nurses and Aboriginal Health Practitioners covering 24 Hour shifts over 365 days per year, Outreach staff (Mon to Fri), under the supervision of a Facility Manager and a supervising Medical Officer (7 days a week).
- Strong connections with existing services – health, police, justice, social, community etc. to facilitate a broad reach of AOD services to the community

The table below provides a snapshot of five residential rehabilitation services and their operational budgets, which excludes rental costs for facilities unless otherwise stated. Most of these programs are funded by government and supplemented by client fees, Medicare rebates and in some instances philanthropic contributions. Research found that the average income from government for a residential rehab in NSW was around 78% (NSW Department of Health 2005). It should be noted that for government supported facilities, user fees do not cover all costs and are supplemented significantly by government funds.

Comparable Sites	Annual operational budget	Capacity	Staffing	Eligibility	User Costs
A	$1.2M	15 (men and women)	6.5FTE +psychologist and GP brokered	Accepts dual diagnosis; Does not accept inmates exiting prison; GPs supervise pharmacotherapy on site.	$240 pw
B	$1.5M includes lease	18 (14 men and 4 women)	12- all staff min Cert IV in Mental Health	Accepts dual diagnosis, inmates exiting prison, most criminal histories. Does not support pharmacotherapy	75% of welfare
C	$1.1M	18 beds- men only in shared rooms	11 including 2 counsellors	Accepted dual diagnosis, inmates exiting prison, most criminal histories. Does not support pharmacotherapy	$200 pw
D	$1.2M approx	10 beds	Not stated	Accepts dual diagnosis, inmates exiting prison, most criminal histories. Pharmacotherapy unknown	Not stated
E	$2.2M includes operations costs for farm	8 beds for men and women	6 staff	Not stated	Free of charge

A budget of $1.5 million is suggested to enable a facility that can provide addictions specialist medical support and accredited psychological services for clients with dual diagnosis. While this model does require a higher budget than some 'therapeutic community' models, research that shows service models that provided individual counselling, had adequate levels of therapeutic staff, had lower counsellor caseloads, better staff to client ratio, fewer beds and single rooms resulted in better client retention and program completion rates (Meier and Best 2006).

The following proposed **budget breakdown** draws from a NSW guideline on residential rehabilitation funding models (2005) as well as the advice of some current rehab providers. Note that additional funds to enhance allied health and provide life skill programs could be obtained through a user fee of 75% of welfare payments, and potentially from Commonwealth Primary Health Network and other funding streams.

Indicative Rehabilitation Budget breakdown

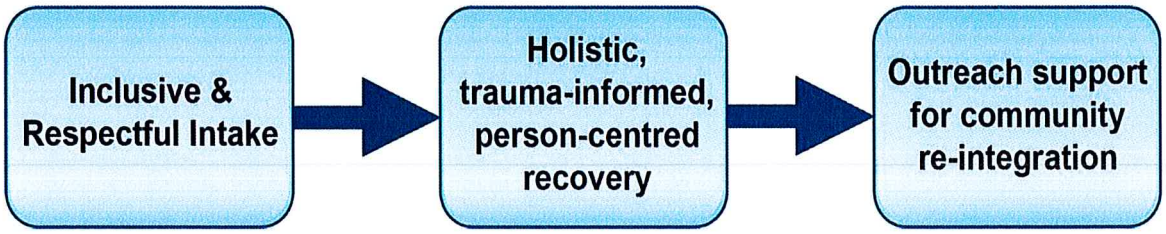
Item	% of budget	Comment
Salaries and related expenses	65%	Salaries and leave entitlements for Mgr, rehab workers, admin officer, cook & maintenance staff
Staff development and professional support	10%	Includes training courses, membership of professional associations, clinical case practice and professional supervision
Health brokerage/contract funds	8%	For allied health and GP support (offset my Medicare)
Food and sundries	10%	
Administration, office supplies, IT insurance & miscellaneous program costs	3.5%	IT equipment depreciates over 4 years
Utilities, maintenance and vehicles	3.5%	Water, electricity, vehicle hire and fuel (grounds/maintenance staff in salaries budget)

There is an expectation across the Far West service provider network that the NSW Government should provide recurrent operational costs for the facility.

Expected Outcomes

The Service Model

As stated, a three-staged approach to support AOD recovery is recommended for the Broken Hill City Council and Central Darling Shire Council areas (Far West NSW):



Supportive, Inclusive Intake

Inclusive program criteria is encouraged to ensure the program is accessible to men and women with mental illness, those who need to sustain pharmacotherapy, people with cognitive disability and criminal histories, including those exiting prison.

There are precedents for rehabilitation providers that implement client risk assessment on a case-by-case basis rather than adopt extensive exclusion criteria.

Assessment and intake processes will seek to maintain a balanced dynamic that supports recovery, avoiding a disproportionate number of high needs clients at any one time.

Effective in-take should seek to overcome identified barriers to engaging in rehabilitation, which include sustaining housing, support to arrange childcare, transport to the facility and pre-entry engagement with clients transitioning from custody.

Patient Journey

Referral – (No wrong door approach)

- self
- support service
- health service
- justice service

Assessment – AOD Staff to complete

Rehabilitation Care Phases

- Consumer detoxification period
- Transition to the residential community
- Beginning of consumer-led therapeutic supported recovery journey

Transition from residential community stay to community

- Voluntary supported aftercare within facilities programs
- Referrals to community-based support services within the harm minimisation continuum

Holistic, Person-Centred AOD Recovery

The residential rehab component should provide person-centred support for individuals to not only manage cravings and/or triggers for AOD use, but to address the factors that underlie addiction.

Partnership with GPs will facilitate on-site pharmacotherapeutic support if the service is not able to employ an addiction medicine specialist.

Best practice models provide access to both one-on-one counselling support, which could be provided by allied health professionals, as well as group work, which could be supported by rehab workers with counselling qualifications and experience.

Aboriginal rehab workers will facilitate Aboriginal specific men's and women's groups with support from Aboriginal cultural knowledge holders, cultural practitioners, and expert service providers.

Program providers will provide literacy and numeracy education and partner with TAFE and other further education providers to build vocational skills in computer literacy, small motors, carpentry, operating machinery, agriculture, art and print-making, and didgeridoo making.

Exit-planning will commence with clients from the moment they enter rehabilitation. This can require rehab workers to provide casework support, linking clients with a range of service providers to ensure stable housing, health support, welfare or employment pathways and other supports to enable successful transition. This ideally involves workers from programs engaging with clients in rehabilitation to build trust, so they are more likely to connect when they exit.

After-Care to Support Community Reintegration

NSW Health rehabilitation guidelines highlight the importance of establishing links between clients and 'continuing care services and support networks' (NSW Health 2007:27). It is planned that the "After-Care Support" will be overseen by care workers, who bring lived experience to the role. A Peer Led Service Model will be overseen by a Governance Group, made up of Local Council, NGOs and AMS organisations, allowing for a breadth and depth of experience and existing services that can support 'reintegration' into the community. Prior to moving back into the community, a key step will be to develop individualised plans that take a whole of person view to ensure all aspects of their life back into the community is 'safe' and 'supportive'.

It is recommended that a male and female after-care worker be recruited to support a smooth transition from rehabilitation to community-based after-care.

Engagement with Aboriginal Land Councils, Aboriginal Affairs and Aboriginal Medical Services

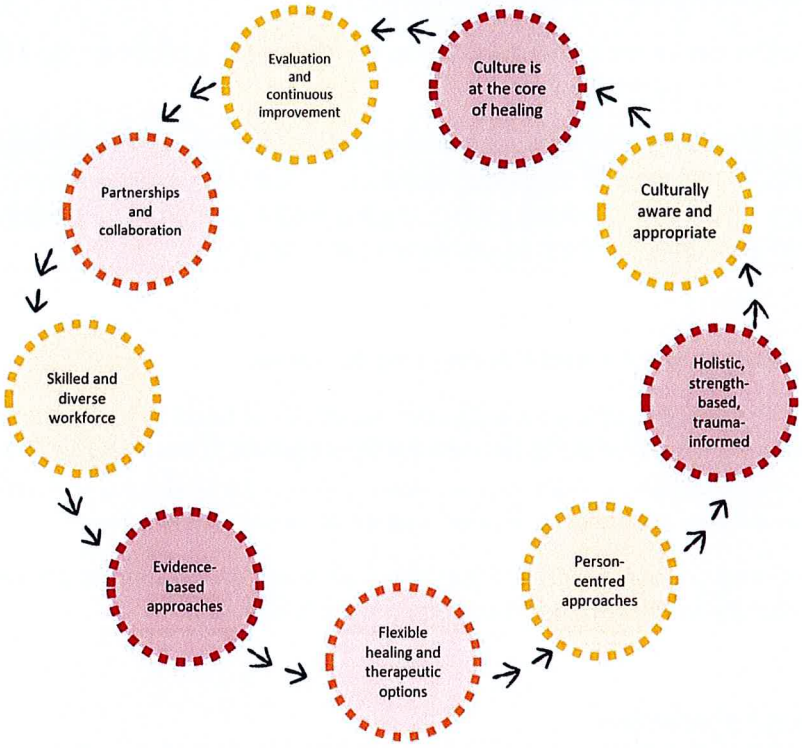
Throughout the discovery phase, consultation was conducted with a range of Aboriginal members. The feedback was supportive but clear that more work will need to be down to firm up working relationships and to ensure the voice of the local Aboriginal community and services are brought into the clinic's overall design and Model of Care. Ensuring close ties to these organisations for the outreach program is also key.

Example organisations:

- Broken Hill Murdi Paaki Regional Assembly
- NSW Aboriginal Land Council
- Marri Ma Health Aboriginal Corporation
- Aboriginal Affairs NSW Government

The ADARRN Model of Care will be the foundation for services delivered in the facility and by the integrated care team.

The ADARRN multi-faceted model is shown below, highlighting the cyclical motion of continuous progression through the model ensuring perpetual adaption, improvement and evaluation. (the following is a summary from the ADARRN Model of Care Document 14th April 2021).



The ADARRN model puts culture at the centre of healing, including cultural identity and culturally informed practice. Aboriginal culture identity is unique for each individual and each family and each community. The ADARRN model provides a supportive and individualised pathway for client to connect deepen or, in many cases discover their Aboriginal cultural identity and connections.

This model has been proven suitable and effective for all cultures and individuals within a community.

Culturally Aware and Culturally Appropriate Service Delivery

Aboriginal people and communities have unique perspectives, distinctive cultures, varying traditions and practices, embedded kinship and relationship protocols, and diverse histories. Respect for these elements is at the core of culturally safe practices and responsive service delivery. Family and kinship ties, coupled with relationships with land and country lie at the heart of many Aboriginal people's identities.

Holistic, Strength Based, Trauma Informed Approaches

Aboriginal people and families cannot be viewed in isolation from their extended family, their communities, and the mental, physical, environmental, social and spiritual dimensions of their lives. Resilience and strength-based approaches lie at the core of ADARRN service approaches and provide practical effect to each of these dimensions.

Person Centred Approaches with a Family and Community Framework

Taking a person-centred approach (i.e. looking at the whole person and involving the person in their own care) not only ethically allows patients to be directly involved and empowered in their care, but takes into account the client's cultural and individual needs, preferences, beliefs, values as well as their comfort and surroundings.

This approach will improve the patient's experience and health outcomes, and benefit health services clinically and organisationally.

Successful residential treatment for substance misuse is, from an Aboriginal perspective, not limited to a philosophical view of continued abstinence. Rather, it is a journey of healing, a reconnection with oneself and the things that are important to improving an individual's quality of life and the ability for them to meet their full potential.

Flexible Therapeutic Options and Healing Opportunities

ADARRN member services represent a diverse spectrum of healing and treatment philosophies, ranging from flexible socio-cultural approaches to modified 12 Step frameworks to social learning processes. As such, there is no single over-arching treatment or healing philosophy, or modality replicated across all member services.

The fundamental and cohesive element that binds all services together is the core principle of Aboriginal culturally-informed and Aboriginal program delivery.

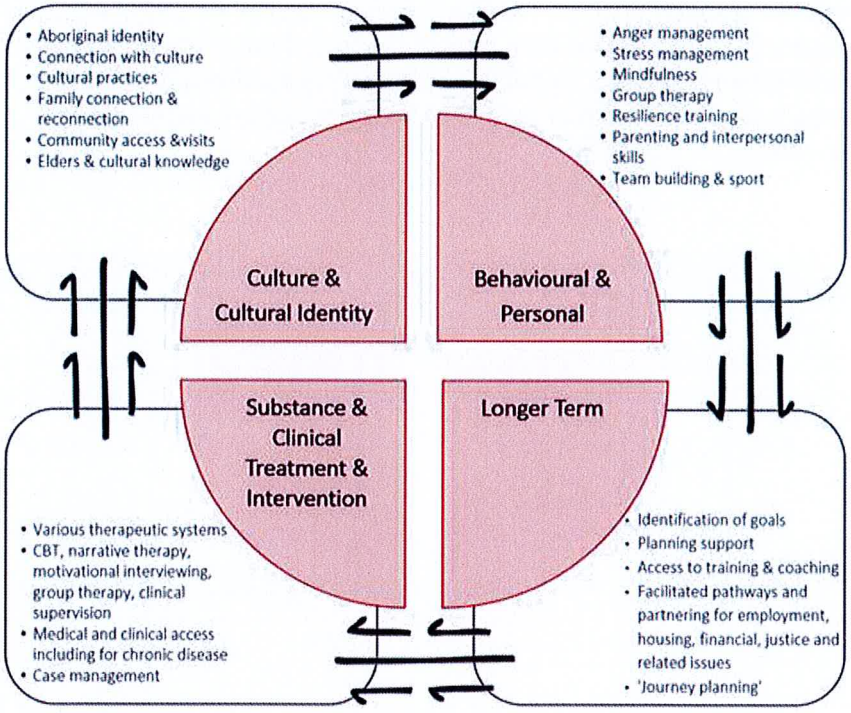
Evidence Based Approaches

What differentiates the ADARRN Model of Care from many others in the AOD residential treatment field is the openness to develop empowering coping and resilience building strategies that affect lifelong behavioural and attitudinal change amongst Aboriginal clients. The model has a discrete mode of operation, however, clients progress through their own healing journey which may include returning to residential treatments or additional support.

The model includes flexibility for return residential stays, ongoing support, and deep personal healing remain cohesive features of the network. Each ADARRN service undertakes a comprehensive assessment, case management and review process to ensure that clients are provided with the appropriate healing and treatment options. These options can include (but are not limited to) cultural practices, dance, exercise, CBT, mindfulness, narrative therapy, motivational interviewing, resilience training, anger management, stress management, family functioning and relationships, stepped approaches, step down methods all in which are customised to Aboriginal approaches. Continuing best practice guidelines are assessed and incorporated where appropriate within individual service parameters and capacities.

Definitions of "success" vary widely but ADARRN services combine adherence to any relevant sentencing or bail conditions with individually-focused development goals and healing measures.

The ADARRN Model of Care



Skilled and Diverse Workforce

ADARRN member services represent a significant collection of experience, skills, connections and qualifications. Services aspire to include staff and managers with high level qualifications across a range of disciplines, sector specific AOD qualifications and many other associated capacities such as counselling, mediation, coaching, life skills, planning, employment, training and relationships.

Due to the nature of work with clients experiencing complex AOD and associated issues the workplace can be extremely challenging and demanding. Consequently, the ADARRN workforce is provided with continual improvement opportunities, access to training, professional development, clinical supervision as well as cultural supervision and mentoring.

Partnerships and Collaborative Service Networks

No single organisation can provide all the required services that a resident may need to address substance misuse and associated issues. Given the complex, multi-faceted needs of people with AOD issues, coupled with the comparatively poor socio-economic status of many Aboriginal communities, the ADARRN Model of Care focuses on ensuring services are well integrated with other services.

These partnerships also entail formal arrangements, co-management approaches and referral processes with local and regional service providers across the range of relevant service areas. Not all services have access to resources to address the social determinants of health, this includes critical aspects such as housing, trauma, mental health, family violence, employment, training, justice, and family relationships – essentially all relevant areas to the individual client's healing and ongoing improvements in quality of life.

Partnerships established through the ADARRN Model of Care transfer to clients, creating their own connection with services they are able to draw upon throughout their recovery.

This collaborative and flexible approach ensures that the common cyclical nature of AOD challenges, poverty and ongoing cultural dislocation resulting from colonisation can be addressed in a timely and effective manner. The holistic approach to service delivery that ADARRN exemplify ensures that a continuum of care is provided for each resident, often well beyond their in-house tenure.

Stakeholder And Community Support

Consultation with the Community & Clinical Advisory groups who live and work in Broken Hill and surrounds identified several common issues, priorities and challenges that need to be considered in the design of a residential AOD facility to effectively support recovery for people.

Key points from the consultation process:

- Supported and accessible transition of care from referral to recovery
- Trauma informed care will no barriers to access care regardless of a person's unique story or past
- Culturally safe and welcoming for people of all backgrounds
- Ensure health literacy is incorporated into the design and delivery of the model
- Ensure staff are supported to work from their lived experience
- The location of the services needs to be accessible but outside of the CBD with room for outdoor garden and activities
- Further consideration needs to be given to the demographic of the clients including male and female, and other gender or family considerations.

First and foremost was the consensus among stakeholders that, given Broken Hill is a service hub, a rehabilitation facility should accept referrals from the broader far western NSW region.

Aboriginal people who live and work in the Broken Hill regional area emphasised the importance of a facility on country, citing many examples of people who simply will not leave country to engage with essential services.

There was common agreement that care needs to be taken to locate the facility out of town. This was to allow clients to focus on recovery away from family and other commitments, to negate access to alcohol and drugs and to avoid community backlash from residents who may not want a facility near their neighbourhood.

Throughout consultations transport was identified as an essential element of effective rehabilitation, particularly given the facility will be outside of the CBD. Transport is essential to ensure safety for people exiting prison, as well as people who have home-detoxed or are going through drug withdrawal transport is essential to avoid the risk of them 'busting' and accessing drugs.

There was consistency in the view that the facility should cater for both men and women as well, with fewer residential rehabilitation options for women in New South Wales. Safety for women in a mixed gender facility needs to be planned carefully, as research shows that many women with AOD issues and women in the justice system have experienced domestic violence. NSW Health's residential rehabilitation guidelines suggest that programs that cater for moth men and women should ideally have separate facilities for men and women and provide opportunities for women-only groups and activities (NSW Health 2007).

While some people who participated in consultation indicated the need for a rehabilitation facility that caters for women with children and whole families, advice from experienced rehab providers and other experts suggests this may be challenging at the outset.

Dual Diagnosis

There was a consensus across a diverse range of stakeholders that dual diagnoses (the co-occurrence of AOD misuse with a mental illness) was prevalent among people who misuse AOD. Health professionals and justice health workers indicated that a significant number of AOD clients have serious mental health issues, including schizophrenia and bi-polar disorder.

Criminal Histories

Many stakeholders also emphasised that the strong association between AOD misuse and incarceration requires a rehabilitation service that will accept people transitioning out of custody and other people with criminal histories.

Medically Supervised Withdrawal ('Detox') and Pharmacotherapeutic Support

Consultation identified the need for a medically supervised, clinically governed service that had provision for withdrawal ('detox') as well as maintenance of pharmacotherapeutic support, which includes opioid substitution, other treatments, and also mental health medication.

Accordingly, it is argued that a rehabilitation facility should provide for pharmacotherapy if it is to meet the needs of the broader community.

Many health professionals and other stakeholders recognised that some people are not able to engage with residential rehab due to family commitments or other issues. It was suggested that there is a need for access to range of detox options, including ambulatory (in-home) detox, and for a broad education strategy to address the apparent gaps in knowledge of good detox practice among general practitioners in the region.

Supportive Intake, Holistic Person-Centred Rehabilitation and After Care Support

It is clear from the consultations that people who live and work in the region are seeking a structured rehabilitation facility, that provides pro-active intake support, trauma informed holistic person-centred rehabilitation and co-ordinated after-care to support successful community reintegration.

The in-take processes, which will be undertaken by rehab workers through an outreach program and onsite, will build trust to encourage clients to feel safe engaging with rehabilitation. This would also support clients to overcome several barriers and the stigma associated with engaging with rehabilitation.

The concept of holistic, trauma informed, person-centred rehab is consistent with evidence that AOD misuse is symptomatic of underlying social and psychological causes, including mental health and primary health issues, trauma, poverty, criminalization, and social marginalization.

Many, if not all, stakeholders indicated willingness to deliver programs and support within a rehab facility. It is expected that vocational skills and employment programs will partner with the rehab so that clients can transition to employment in the community.

Many stakeholders emphasised that co-ordinated after-care is key to the residential rehabilitation component of recovery. This will involve linking clients with outreach AOD counsellors, other health service providers, working with them to ensure stable housing and welfare and linking them with men's groups, women's groups and other cultural supports.

The Service and the Community

Withdrawal and rehabilitation services concentrate on attaining better health and wellbeing of the person with addiction, restoring an opportunity to continue that path after treatment. Often if an addict returns to an unchanged immediate community setting, the option to embed a changed lifestyle is lost.

Taking a person from an environment that influences the conditions that lead to addiction to alcohol and other drugs and providing withdrawal and rehabilitation services is one step in the care of the individual. Success on an individual level, for many people, depends on the environment they came from and that which they return to.

The community must have the knowledge to support people returning from detox and/or rehab to continue the path of better health and wellness.

Broken Hill's Community Withdrawal and Rehabilitation centre will provide opportunities for whole of community education that is suitable for families and friends, employers, educators, medical staff and community groups.

The Broken Hill Community Withdrawal and Rehabilitation Centre will be known in the community as a centre of excellence and a source of quality information. Engagement with the wider community will be culturally competent and trauma responsive.

The therapeutic care model adopted within the centre will be offered to the community as various mechanisms for community members to support each other, and educational opportunities to learn how to support someone who is addicted to alcohol or another drug.

The engagement undertaken as part of the centre's operations follows the IAP2 model, ensuing that the community is involved in a continual conversation with the centre staff and volunteers and takes advantage of educational resources to better enable support of the client when they leave residential services.

The Broken Hill Community Withdrawal and Rehabilitation centre has developed programs to support people reintegrate into the community post residential care. Educational providers and employers will play a role in partnering with the centre to pledge their support.

The Pledge Program

I (individual or a business name) pledge to support the work of the Broken Hill Detoxification and Rehabilitation Centre, to educate myself and those around me about the issues present in addiction and to be an ally for those on a journey of health and wellbeing.

My pledge is my commitment to engage, based on my resources.

Industry, businesses, schools, employer and business groups, Council, and the wider community will be asked to join the Pledge Program.

To join the Pledge Program, an entity or individual must be committed to their own education on the issues of addiction and committed to supporting the work of the Centre in the community in whatever capacity they choose.

Pledge Program Partners will have an opportunity to network, join a monthly educational webinar and play a leadership role in the community.

Letters Of Support

The committee has received more than 30 local letters of support for the service, including from:

Far West Local Health District

Maari Ma Health Aboriginal Corporation

Roy Butler MP

Barrier Industrial Council

Broken Hill City Council

Royal Flying Doctor Service

Mark Coulton MP

Communities and Justice

Community Restorative Centre

Headspace

Far West Community Legal Centre

Lifeline

Mission Australia

Thrive

Perilya

In addition are letters from businesspeople and private individuals.

The response to the service proposal within the Broken Hill community has been uniformly positive and encouraging, indicating that the service can become a source of pride for the town and the region.

Development Proposal

Land

Broken Hill Local Council is working to provide a land package to accommodate a residential facility within the LGA.

A location will be chosen that has the capacity for the initial 15-bed rehabilitation facility and 8 bed detox facility. The property will be outside of the CBD for reasons outlined. Transport from the town to the facility will be a key consideration.

The budget in this Business Case incorporates a contingency of ~$0.7 million for land acquisition. Identified sites are as follows:

Site #1: Pony Club site, corner Wentworth Road and Kanandah Road

Owned by Perilya Mining

Preliminary informal conversations have taken place with Mr Byrne by a member of the steering committee. Long term lease arrangement most likely.

Power and water accessible on Wentworth Road (over the road) Area: 46 907 sq metres

Perimeter: 877 metres Part: Lot 7456/1182980

Authority: Crown

Nil Licences, Nil Leases, No ALCs

NT – NCD2015/001 (Barkandji Traditional Owners #8A) – Native Title Extinguished (16/06/2015)

WH R2421 – Willyama Temporary Common – 50/50 Management: Willyama Common Trust, Broken Hill City Council – Gaz. 04/09/1886

Site #2: Wentworth Road

Broken Hill City Council city boundary

Part of Regeneration Area (neighbouring 74 Wentworth Road) Not Crown Lands nor Willyama Commons

Subject to Native title

Power and water accessible on Wentworth Road Area: 23 153 sq metres

Perimeter: 611 metres

Lot 2 DP 227743 / Lot 3 DP 227743

Authority: Freehold

Nil Crown Interests, Nil ALCs, NT Extinguished on Freehold Lands

Site #3: Privately Held Site #1

Privately held land under 3 Crown lands titles

Owner willing to donate a suitably sized parcel of land if property can be converted from Crown lands to freehold title

Power and water accessible on Wentworth Road Lot 3 DP 1083729

Authority: Crown Lands Nil Licences, Nil ALCs

Lease: Subject to Lease Acc 96431 (WLL 108) known as "White Leeds Station" – CBH Pastoral – Purpose

"Grazing" – Granted 23/05/1903 (Extended to perpetuity 09/08/1935)

NT – NCD2015/001 (Barkandji Traditional Owners #8A) – Native Title Extinguished (16/06/2015) (Perpetual WLLs deemed to have extinguished NT)

RE: Freehold Conversion: as per Section 5.9 of the CLMA 2016, to meet eligibility to apply to convert to freehold there are a number of criteria that must be met - https://legislation.nsw.gov.au/view/html/inforce/current/act-2016-058#sec.5.9

This leasehold area, while meeting the initial criteria of being a rural area for residential/business purposes (being run as a grazing holding), the area must also meet requirements under points (e) and (f), regarding the LSC present on the lease, or cultivation consents in place.

Site #4: Privately Held Site #2

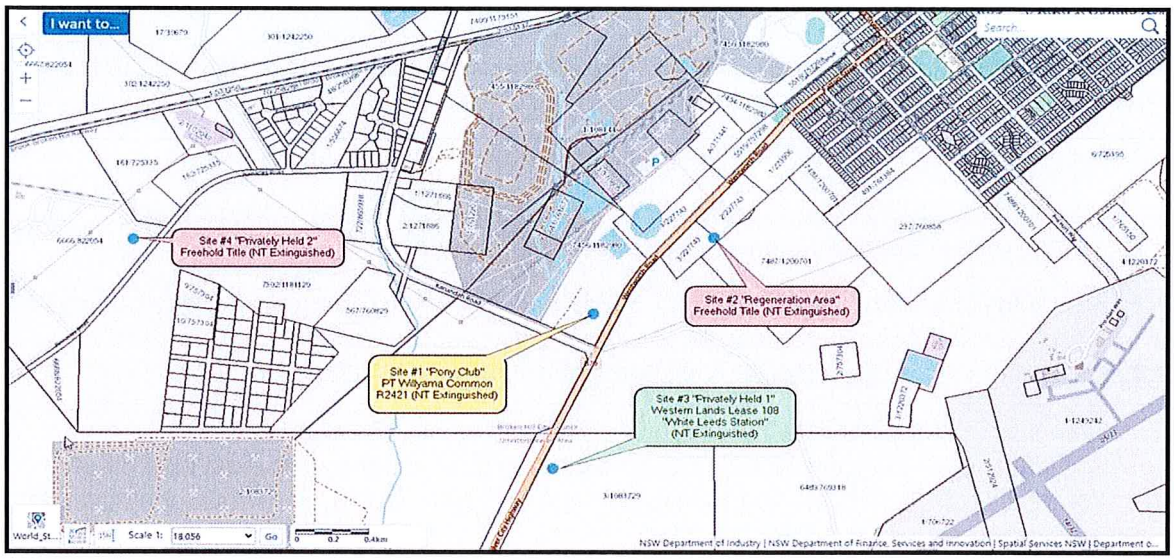
Lot 6666 DO 822054

Authority: Freehold

Nil Crown Interests, Nil ALCs, NT Extinguished on Freehold Lands

NT – NCD2015/001 (Barkandji Traditional Owners #8A) – Native Title Extinguished (16/06/2015)

Potential Broken Hill AOD sites



Capital Works – Specifications

A professional builder would have to be engaged to scope specific costs for the capital works. However, advice from existing service providers suggests the costs of building a residential facility with capacity for 15 rehabilitation patients and 8 detox patients would be in the vicinity of $6.3 million. It is recognised that the cost of capital works will be higher due to the remote location of the facility.

The purpose of this Business Case is to work with the Commonwealth Government to fund the capital works. The Steering Committee will also pursue the potential for philanthropic support.

Design Specifications

Perimeter fencing

Single/limited vehicle access

Security fencing/lighting/CCTV

Significant frontage/boundary setbacks for surveillance

Residential Rehabilitation

Car parking for staff/visitors/buses/emergency vehicles

Administration building - possibly central

Staff rooms/amenities/night quarters

Commercial kitchen

Dispensary

Consultation rooms - 2 rooms

Residential Buildings - 15 Rooms/Beds

Central shared gender-specific amenities/facilities/gym/recreation areas

Large multi-purpose space

Outdoor weatherproof space

Area for expansion

Detox Facility

Residential Buildings – 8-10 Rooms/Beds

Consultation Room - 1 room

Central/shared amenities/facilities/recreation areas

Area for expansion

Landscaping

Courtyards

Healing Garden (to be designed and established with Aboriginal clients with support from community members)

Working gardens & possibly agricultural fields

Maintenance/grounds keeping/farming facilities

Design Principles

- Safe healthcare facility design (suicide prevention)
- Commercial food design - public health
- Fully disabled accessible
- Secure Design & Surveillance - CPTED (possibly even reference to prison design principles for surveillance).
- Indigenous design principles - views/cultural features

Staffing

Prospective rehab service providers will develop their own staffing proposal. Building local capacity should be a priority.

The consensus is that at a minimum there should be:

3 Rehab workers, a male and a female after care coordinator, an administration officer, a cook, and a maintenance/programs officer. The facility will have staff overnight, thus offering a 24x7 service.

Care should be taken to recruit suitable Aboriginal rehab workers with other services suggesting people should be recruited for integrity and suitability along with appropriate life experience primarily.

2 x Aboriginal male and one Aboriginal female rehab worker be recruited. Aboriginal people should be strongly encouraged to apply for all positions in the facility.

The detox unit requires 24/7 qualified medical staff, with the need to employ a full-time psychologist in addition to a clinical nurse, though economies of scale will be achieved with medical staff shared across rehab and detox. Advice suggests a detox unit with 8 beds would require 7 – 8 FTE staff.

The remote location of Broken Hill has been an on-going discussion due to the challenges of accessing staff. To address this, the Steering Committee is looking to provide 'lifestyle' opportunities for potential staff. This will include, but not be limited to:

Building local capacity at every opportunity

Partnerships with universities to provide training & development opportunities to staff at all levels –with the inclusion of research funding and access to relevant Alumni

Focus needs to be given to building a local workforce. This could be achieved through encouraging local educators to offer programs that are focused on AOD supports

Offering of trainee positions through existing medical and allied health organisations to up skill local workforce – particularly Aboriginal Health Workers

Accommodation options through philanthropic opportunities

Advertising roles which outline sporting, family, housing, and other opportunities for partners

Looking to embrace the gig/fluid workforce to attract short term opportunities that are well funded with the provision of accommodation & training with 6 – 12 months contracts on offer. The staff would be expected to embrace technologies that inform possible candidates of the benefits and value of working short term benefits of working remotely.

Projected Costs

Project Capital Costs

Rehabilitation & Detox Facility Operational Costs (Nov 2022)

Consultation revealed there is no consistent funding model or staff to client ratio for residential rehabilitation in New South Wales or elsewhere. Similarly, user pay fees varied across providers that were consulted, as did the streams of government funding that supported them.

A recurring budget of ~$3 million is suggested to enable the facility to provide addictions specialist medical support and accredited psychological services for clients with dual diagnosis and an outreach program.

The costs incorporate the staffing of the Detox Clinic which will require 24x7 clinical governance.

Please note that additional funds to enhance allied health and provide life skill programs could be obtained through a user fee of 75% of welfare payments, and potentially from Commonwealth Primary Health Network and other funding streams. It should be noted that for government supported facilities, user fees do not cover all costs and are supplemented significantly by government funds.

Cost Line	Cost Estimate	Potential Funding Source(s)
Land	~$700,000	Philanthropic investment Commonwealth Funding
Facility – capital works 15 bed rehab & 8 bed detox	$6.3 million (accounting for higher costs in a remote area)	Commonwealth Funding Philanthropic Investment
Recurrent operational costs (rehab)	$1.6 million	NSW Government
Recurrent operational costs (detox)	$1.4 million	NSW Government
Additional costs	TBC	Client user fees

While it is expected that the lead agency will be selected through a competitive tender or commissioning process, there is potential for a consortium advisory group comprising program partners. This would include partners whose support is essential for successful AOD recovery and community reintegration such as, social housing providers, AMSs and other primary and mental health services, child and family services, Community Corrections, and employment providers.

Economic and Community Benefits of Alcohol and Other Drugs Treatment

A number of studies suggest significant costs benefits from rehabilitation as a means of breaking the costly cycle of repeat incarceration.

AOD is proven to provide a positive return for community. For every $1 spent in alcohol and other drugs treatment, society gains $7 (Etner et al., 2006). Other studies in Australia, found that each person treated in residential rehabilitation generates an average benefit to the community of $1 million based on economic output, reduced public spending on social security, lower property crime, and reduced loss of life.

AOD treatment has been shown to:

- Reduce consumption of alcohol and other drugs
- Improve health status
- Reduce criminal behaviour
- Improve psychological wellbeing
- Improve participation in the community

The savings which accrue to governments from AOD treatment occur largely through direct savings in future health care costs, reduced demands on the criminal justice system, and productivity gains. The wellbeing gained for individuals and families in immense, as clients reduce the harms from alcohol and /or drug use.

Analysis of data from 2014 concluded that the cost of imprisonment for one individual in Australia was

$109,500 per year (Bushnell 2017). By contrast, 2010/11 data analysis by that National Council on Drugs published in 2012 indicates the average costs of treating a person in residential drug treatment was then $16,110 (ANCD 2012 in Smith et al 2014).

Allowing a CPI increase of 2.5% per year, that figure would increase to approximately $17,348 for the 2013/14 financial year. While residential rehabilitation placements are ordinarily significantly shorter than a year (commonly 12 weeks), residential rehabilitation is still significantly cheaper than prison. With research suggesting a relapse rate in the vicinity of 50% (Lee 2018), this still suggests 50% of people successfully recover from addiction through residential treatment.

An Australian Institute of Health and Welfare study found there were 13,849 public hospitalizations and 6,928 private hospitalizations in 2010-11 due to a principal diagnosis related to illicit drugs alone. (Smith et al 2014). With the average cost of a stay in public hospital at that time estimated at $4,649, cessation of harmful AOD use can have significant savings in terms of health, as well as policing, courts, and corrections among other positive outcomes.

Deloitte Access Economic undertook a cost-benefit analysis of the impacts of residential rehabilitation on Aboriginal people with problematic AOD misuse. That study, published by the Australian National Council on Drugs, found savings of $111,458 per offender, in addition to improvements in health and mortality, by diverting offenders from prison to community-based rehabilitation (Deloitte Access Economic 2013). This suggests significant financial as well as social benefits to be gained from the funding of a residential AOD rehab in the Broken Hill City Council area.

Investment in community infrastructure to enable service access in regional, rural and remote communities will also provide valuable jobs and economic stimulus during construction phases as well as ongoing operational jobs, with the further stimulus effect that this would have on commerce in the broader regions.

The Broken Hill AOD Integrated Steering Committee is continuing to develop the detailed care model and projected ROI for the proposed facility.

Conclusion

The committee believes that there are very strong economic, social, and cultural arguments for the establishment of an AOD facility in Broken Hill. The need is demonstrable and acute. All indications suggest that the Broken Hill community will be actively involved in supporting the facility and the service, and that its existence will be a source of pride for the town and the region.

The history of the town of Broken Hill has been one of ongoing struggle with the formidable challenges of distance and climate. Unlike gold mining towns such as Bendigo and Ballaratt, where wealth can be seen in elaborate, grand architecture of the city, for Broken Hill the wealth largely left for the capitals of Sydney, Melbourne and Adelaide. The character of the town has been of a rough, hard drinking place, isolated from the world.

This has changed. The town now reaches out. Broken Hill's identity is now more inclusive, more diverse, and more open to change than at any time in its history. An AOD facility in Broken Hill is a critical part of this new journey to care for the community, and to make a statement of intent about the kind of community life to which the town aspires; the kind of community life the town deserves.

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Letters of Support

The following links will take you to copies of the letters of support from community and stakeholder organisations for this proposal.

Barrier Industrial Council

Broken Hill City Council

Broken Hill High School

Roy Butler MP – Member for Barwon

NSW Department of Communities and Justice Community Restorative Centre

Mark Coulton MP – Member for Parkes

Royal Flying Doctor Service – South Eastern Section MHADO & AOD

NSW Department of Education

Dionne Devlin – Broken Hill Alcohol and Other Drugs Detoxification and Rehabilitation Centre Steering Committee

Justin Field – proud Darkinjung / Awabakal man Flourish Australia services Far West Foundation Broken Hill

Far West Community Legal Centre

Andrew House – Broken Hill AOD Clinician

Joblink Plus

Cr Tom Kennedy – Broken Hill Mayor

Cameron Leiper – Broken Hill AOD Clinician Lifeline Broken Hill

Dean Lloyd - Lived Experience Consultant

Maari Ma Health Aboriginal Corporation

Mission Australia – Regional West Mission Australia – Far West

Neil Pigot - Lived Experience

Stephen Radford – Consolidated Mining & Civil Pty Ltd Regional Development Australia Far West NSW

Royal Flying Doctor Service – South Eastern Section

Joanie Sanderson - Broken Hill Alcohol and Other Drugs Detoxification and Rehabilitation Centre Steering Committee

Royal Flying Doctor Service – South Eastern Section AOD Thrive Medical Broken Hill

Far West Community Legal Centre Limited

Far West Local Health District Mental Health Drug and Alcohol Service