REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO DRUG AND ALCOHOL TREATMENT

At Sydney on Monday 27 May 2013

The Committee met at 10.15 a.m.

PRESENT

The Hon. M. A. Ficarra (Chair)

The Hon. J. Barham
The Hon. D. J. Clarke
The Hon. J. A. Gardiner
The Hon. S. Moselmane
Reverend the Hon. F. J. Nile
The Hon. H. M. Westwood

CHAIR: I commence by welcoming everyone to the fourth public hearing of General Purpose Standing Committee No. 2 inquiry into drug and alcohol treatment. This inquiry is examining and reporting on the effectiveness of current drug and alcohol policies with respect to deterrence, treatment and rehabilitation. Before we commence, I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay our respects to the elders, past and present, of the Eora nation and extend that respect to other Aborigines who may be present during the course of this inquiry.

Today is the final of four hearings we plan to hold for this inquiry. We will be hearing today from representatives from the Drug and Alcohol Multicultural Education Centre; Life Education; the Mental Health and Drug and Alcohol Office, NSW Ministry for Health; Family Drug Support and the Department of Attorney General and Justice. Before we commence I would like to make some brief comments about procedures for today's hearings.

Copies of the Committee's broadcasting guidelines are available from the Committee staff. Under these guidelines, while members of the media may film or record committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what they publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at this hearing. I therefore urge witnesses to be careful about any comments that they make to the media or to others after they complete their evidence, as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation.

Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to committee witnesses under parliamentary privilege should not be abused during these hearings. I therefore request that witnesses focus on the issues raised by the inquiry's terms of reference and avoid naming individuals unnecessarily. Witnesses are advised that any messages should be delivered to the Committee members through the Committee staff. Mobile phones should be turned off or put on silent for the duration of the hearing. It gives me great pleasure to welcome our first witnesses from the Drug and Alcohol Multicultural Education Centre.

KELVIN CHAMBERS, Chief Executive Officer, Drug and Alcohol Multicultural Education Centre, sworn and examined:

RACHEL SARAH ROWE, Senior Research Officer, Drug and Alcohol Multicultural Education Centre, affirmed and examined:

CHAIR: There is an opportunity for you to make introductory remarks if you wish to do so.

Mr CHAMBERS: I would like to thank the Committee for the opportunity to speak to our submission today. The Drug and Alcohol Multicultural Education Centre [DAMEC] is one of the few agencies that work specifically with culturally and linguistically diverse communities from both a project research and a counselling perspective. I think, in terms of where we have spoken about policy and through the history of the organisation, it has often fallen to us to try and advocate and talk about culturally and linguistically diverse communities; they tend to be hidden, they tend to be isolated and they tend to not necessarily be as well represented within the realms of policy debates.

If you overlay that with dependency, mental health issues and a range of other social impacts, they become further isolated away, and there are very few voices advocating for culturally and linguistically diverse communities across New South Wales. It is DAMEC's mission to reduce the harms associated with the use of alcohol and other drugs for culturally and linguistically diverse communities across New South Wales. We do that with a very dedicated team of staff that have extensive experience working across the sector.

In 2009 DAMEC moved from a community development policy based organisation to actually providing services on the ground and dealing with people impacted by the use of alcohol and other drugs through our counselling service based both in Liverpool and Auburn. It has given us a unique opportunity to see the damage that these communities face first hand and it is pleasing to us to be given the opportunity to discuss these issues with the Committee further.

CHAIR: When you say that DAMEC moved its emphasis to providing services on the ground and that you are based at Liverpool and Auburn, could you outline to us how long that period of providing services on the ground has been, that transition that has occurred, and the nature of the services that you provide?

Mr CHAMBERS: I guess I might have misspoken saying it was a transition; it is actually an addition to what we do. DAMEC was established in 1989, if everyone can think back that far, as part of the drug offensive at that time, and there was recognition from government that culturally and linguistically diverse communities, which were called—from my time then, ethnic communities; frames kept changing—needed some work in terms of alcohol and other drugs. So DAMEC was created predominantly to work with these communities, to empower these communities, to work within a community development approach.

They did that for about four years and then secured ongoing funding through NSW Health at that point of time. After extensive community consultation they felt that perhaps that was not the best outcome and so they decided to work with services themselves, with government departments, on trying to frame access and equity strategies, all within the old culturally diverse implementation charter, all of that work, to make sure that services were accessing these communities.

After about four years again they found that perhaps that approach was not as effective as it should be, and that coincided with my employment with DAMEC—now 16 years; that is too long for anyone, I think. I felt that we should run another series of community consultations, so we had to do both: We had to work within the community structures, the community organisations, the community sectors, plus also be a voice with government and talking about how service delivery needed to be responsive to culturally and linguistically diverse communities.

In 2009 we were given the opportunity—as small NGOs faced ongoing funding pressure, there was a small counselling service that worked within the Cabramatta area working with culturally and linguistically diverse communities and on a grant of $180,000 a year they were not going to be able to provide a service much longer. So the opportunity was provided by NSW Health for us to administer that service, which we did, and we then applied for Commonwealth grants, which gave us a whole new staff of bilingual counsellors, and from that

perspective we started to develop a model, a treatment of care based upon an outpatient counselling model, to work with culturally and linguistically diverse communities.

The three prongs of that service currently are to have bilingual counsellors in place. We deliver a transitions program, which originally focused on Vietnamese community members and targeted them six weeks prior to their prison release and then worked in an intensive case management model to get them integrated back into the community. I should just mention that just recently we have been funded for an extension of that program to work within the Arabic community, mainly because the program has been extremely successful and has been recognised with a series of awards, both from police and the Department of Corrective Services, this case management approach of working intensively with clients.

The third part of that is a family therapy program that is funded through Family and Community Services, and that works within a family structure of working with couples and families in dealing with issues with alcohol and other drugs in a culturally sensitive manner. The model we use within DAMEC has gone through a range of innovations, and I must say the flexibility of us being a non-government agency has given us that ability to be able to tinker with something that works.

We currently have a roughly 12-session outpatient counselling model as our general sort of bread-and-butter provision of service, of which a lot of the first three or four sessions is about working with people from different cultures and explaining the whole concept of treatment. We work from an assumption that people know when they walk through the door what drug and alcohol treatment is. Within culturally and linguistically communities that cannot be a given; they come from cultures different from our Western system of health care—they come from backgrounds where the response to drug and alcohol use is to be locked in prison.

So we spend a lot of time just doing simple psychoeducational approaches in trying to get them to understand concepts of treatment, and then we work through a series of models—it can be cognitive based, we use a brief solution therapy model, we use a narrative model—in terms of working these clients through. We find through our datasets we are keeping at the moment, which includes the MDS dataset—the minimum dataset—that we keep for NSW Health and recently an outcome measure that we have put on, which is a client outcome measure system, that we are getting very good results.

If we look at the transitions program and the two evaluations that have independently been done on those, we have very low recidivism rates from once involvement within the program. So we seem to be getting to know what works and what works within these communities. We provide a counselling service, which is the main focus in Liverpool, we have an outreach office in Auburn and then we have our project and research work based in Redfern.

CHAIR: Mr Chambers, do you think that most people realise that you are a non-government organisation? Because I have got to say I always thought it was a government provision until I read the submission and it was the very first sentence. Does that make a difference to the clients that come if they think you are non-government? Basically, how were you set up in the first place? Who came together to set you all up?

Mr CHAMBERS: Now you are going to rally stretch my history and brain in relation of our setting up. It was actually a group from NSW Health, a couple of community organisations—ethnic-specific community organisations—formed a committee under the auspice, I think, of the Premier's Department to come up with a response to issues of alcohol and other drugs.

CHAIR: It was early times, was it not, when Nick Greiner was the Premier? I remember it.

Mr CHAMBERS: Yes, it was a long time ago. Strangely at the weekend at my son's soccer match I spoke to someone originally on that committee and it was fascinating to hear how things have changed. As for the average client that comes through, I do not think they make a differentiation between a NSW Health service, Corrective Services or a non-government organisation. They just see a service. They do not understand the frameworks we talk about in terms of government funding or non-government agencies. The first thing is they care about, strangely enough, "How much do I have to pay for this?" When we say it is a government funded service they are fine with that. But they do not actually make that differentiation. They are coming in for assistance and help and I do not think whether we were NSW Health or a non-government organisation will make any difference whatsoever.

CHAIR: Do your bilingual counsellors have good relationships with all the community leaders? I know the leaders change often and sometimes solid community leaders remain in their position permanently over many years. What sort of relationship? Do community leaders utilise your services and refer from within?

Mr CHAMBERS: There are a couple of myths I want to talk about in terms of ACAL communities. One thing I should have mentioned in terms of history is something I have just had discussions with staff about lately. The clients have changed. When I first started working in drug and alcohol which was 25 years ago, we would deal with a different client today. The client we are seeing today has complex needs, has a range of issues that are just not substance use related so as practitioners and clinicians in the field we almost have to be a jack of all trades when we are dealing with people like that. I think that was an important point to make.

As for our contact within the community DAMEC works within a social work framework so every community we are working with, or every project we do, community advisory committees are set up by us so people from the community are reflected on those community advisory committees. We are extremely lucky, as I mentioned before, in the transitions Vietnamese project that the worker in there just happens to be also a community leader so we find it very easy to work within the Vietnamese community. It has also given a lot of impotence to the program. We have good relationships with a range of religious leaders at the moment. We work with Christian, Islamic, Buddhist organisations. We have to, especially in terms of transition programs and staff like that.

There is an interesting point—and this is where I come to the myth of working with culturally and linguistically diverse communities—that when you talk about drug and alcohol issues, initially those communities do not want to know. Those communities do not even want to hear that that is happening within their own community. In fact, to the extent we have heard many, many stories of community family members being absolutely isolated from the rest of that community in which they were involved and dealing with. Importantly, part of our resilience work is trying to educate the community and work through those sorts of issues.

We find not a lot of referrals come out of ethnic community organisations at all, hardly any. I can count on my hand how many come from MRC or how many come from Greek Welfare, Arabic-Muslim. And that comes to some of our history and some of the stuff that we have had. Where we are finding is specifically people from culturally and linguistically diverse background do not good access to what are called preventional tertiary services so they are not accessing your general practitioners, Greek Welfare or the Arabic Welfare Association. What is basically happening is, we believe from DAMEC's perspective, they will have a drug and alcohol issue, they will struggle with it. Nine times out of 10 the family stays intact but they are shamed and stigmatised away from the rest of the community and eventually Corrective Services get involved.

The majority of our clients do not access tertiary drug and alcohol treatment but being involved in Corrective Services and coming out either through MERIT programs, Drug Court programs, bonds, a range of ways through their sentence and on probation bonds. In fact, if we look at our data now we would be looking at 65 per cent to 70 per cent coming through Corrective Services.

The Hon. SHAOQUETT MOSELMANE: I am from an Arabic background. I used to work as a social worker many years ago.

Mr CHAMBERS: I think I ran into you at the MRC at one stage.

The Hon. SHAOQUETT MOSELMANE: There are many Arabic, Chinese and Vietnamese organisations that I am sure you could tap into because they have information from within their communities. I commend you for your work because at the moment I see in various areas that drug and alcohol problems is on the rise. I note that you provide services in the Liverpool area. Do you provide services in the southern Sydney area? Do you get referrals from that area from not only migrant communities but also from other services?

Mr CHAMBERS: I think in terms of practicality we are a statewide service so we are supposed to cover New South Wales but we have established centres, predominantly in higher ACAL areas. We can take referrals from anywhere as long as they can get to us. One of the things we have found working with people from ACAL background has been that telephone counselling works okay in language but we get a much better outcome if it is face-to-face. There is a whole lot of interaction that happens within a counselling sessions that really you need to physically be there for. A quick answer to your question, if they can get over to us we will see them. We have no problem with that except in terms of our waiting lists. I am sure you have heard about 1,000

agencies with waiting lists. We have one but what we do is we prioritise language, and the language groups with whom we work, and the staff that are on there. If they refer in we will most probably see them.

In terms of working with ethnic communities themselves, our committees have a good representation of people from other communities. One of the things we also do is training programs. We focus on bilingual workers within those areas. A lot of it is just introduction to drug and alcohol, what it actually is. There are people who do not know, these workers are really skilled and work in migration across cultural issues and that sort of stuff but they are not that skilled in working with drug and alcohol agencies or mental health issues. And we cannot expect them to be either.

The Hon. SHAOQUETT MOSELMANE: These are taboo issues within communities?

Mr CHAMBERS: Yes, but also I think they are taboo issues with a range of workers. To be totally honest to the committee, it is not pretty work. We are dealing with people who are pretty broken. I have a great passion, as all the staff do here, but if you are young social worker coming out of Sydney University the last thing you want to do is work in drug and alcohol at times, and I can understand that. The other thing with communities, as you would know, there is a lot of judgement and bias in communities.

We have got to be realistic about that. A lot of communities will hold negative and stereo-typed issues like every other community. Most communities see drug and alcohol use as a failure of spirit rather than a health issue. I have been sitting with a range of Sheiks, for instance, who turn around and say, "He should have been stronger". That does not help the client, it does not put him in a supportive environment. Yes, I agree, a lot of our work is done in educating these communities.

Ms ROWE: I just wanted to respond to your question about outreach and capacity of some of our programs. The Vietnamese Transition Program does send a case worker into prisons in regional areas and the capacity, through joint training with Justice Health, for him to visit anywhere where there is a referral of a Vietnamese prisoner. So definitely I have heard from Justice Health workers in prisons in the Hunter down to, I think, there are new contacts in Nowra and Wagga Wagga that there is some interest to have him go out. And he has been out to some of those prisons.

I also want to mention that in the evaluation of that program a lot of Department of Corrective Service workers and drug and alcohol workers within the prisons spoke about the immense value in having a Vietnamese worker going to the prison and explaining to prisoners what are the treatment options. They really feel that a lot of prisoners from culturally diverse backgrounds, particularly, Vietnamese miss out on programs completely. If anything, they will get an English training program but they absolutely miss out on drug and alcohol and workers do not even really know whether they need those programs. That outreach component of our program is really useful in terms of what happens in prisons as well as when the prisoner is released.

CHAIR: Do we need more emphasis on that?

Ms ROWE: Certainly.

CHAIR: This Committee will be recommending to the Government what is needed for these communities. What do you say is needed?

Mr CHAMBERS: One thousand and one needs.

Ms ROWE: Certainly in terms of transitional support programs from the 20-odd stakeholders that were interviewed as part of the evaluation of the program we heard time and time again that the need is not met. Until a Vietnamese worker went into the prison and spoke to prisoners they did not have any idea. Also for their families, to explain to the families what the treatment is and not to be afraid of it and then for him to come out and reach the service where the can have counselling in their language is a huge benefit. I have heard a sense of relief from our clients in evaluating our service, of being able to come to a service where they can speak their own language. That alone is a really big thing.

On top of that, I must add that there are other aspects to culture beyond language. We might just think it is just about language as the determinate but I think there is much more depth to cultural diversity than that. I also want to note that Mr Chambers has mentioned that we have seen an increase in clients referred through mandatory or coercive legal pathways, through the Magistrates Early Referral into Treatment [MERIT] and

through community offender services and whatnot. I want to add that from my perspective, having evaluated the service, we find that those clients have very limited understanding of what counselling is and why they are there. They almost see it as an extension of their punishment.

The Hon. SHAOQUETT MOSELMANE: How many languages are spoken at your centre?

Mr CHAMBERS: Arabic, Vietnamese, Khmer, Chinese, Samoan—

The Hon. SHAOQUETT MOSELMANE: Most of the major communities are covered?

Mr CHAMBERS: Yes. We would love to have Hindi because at the moment we are getting a lot of referrals from Indian referrals and we do not have the language. I must say that in terms of a therapeutic clinical approach, we can use interpreters within the session but it is not the most effective way to deliver an outcome.

The Hon. HELEN WESTWOOD: I am interested about the content of culturally appropriate treatment programs and how they are delivered. Do you have any documentation that looks at what those cultural differences are? We tend to look at diverse ethnic and religious communities in New South Wales as homogeneous. The fact is that they are not; there are different cultural issues depending on which cultural background the person with an addiction comes from. Have you identified those barriers and what we can recommend to Government that could be implemented at the level you are working at that could help to overcome those barriers?

Ms ROWE: I did want to add that one thing I have heard from drug and alcohol workers through conducting various research projects is that they have very limited, if any, capacity to conduct outreach activities. Something they really appreciate about our case work programs is the ability for our workers to go and visit families and people in their homes. I cannot think of any other services that have case worker programs of that nature. Really, our capacity to do that is quite limited. It is a very small program, the transitions program, and it is a component of it. That is definitely something I would suggest is a culturally appropriate element or component to treatment.

The Hon. HELEN WESTWOOD: Has work been done with those communities to clearly identify what would be culturally appropriate?

Mr CHAMBERS: We have done a lot of response work with the clinical team. An example I can give, which is about looking at more money being available for targeted information resources, is that one of the things we found really helpful was introduction of counselling in appropriate community languages. We have got a range of fact sheets that we have translated into language. For instance, one of the key things was that Vietnamese does not have a language concept of what counselling is. We have kind of translated it so it becomes understandable. We are working on some sheets for the Arabic community at the moment and hopefully we will get down to a range of things. But we are responding to those sorts of things.

I cannot remember the last time I saw a new translated resource coming out of the department or anywhere with drug and alcohol. It seems to have dried up as we have worked within budgetary constraints. Some recommendations from this Committee are maybe to look at that publication work and also look at it in terms of innovative styles. You do not need to now go to printers and print out 1,001 pamphlets that we produce stocks from. The web is a fabulous way to just get stuff up there, change it, get it available in language and allow services across New South Wales to download them. One of the key things we will say in terms of those service delivery issues is a recommendation for funding around that sort of information.

As for the cultural barriers and stuff like that, we have done an evaluation on our counselling service and we have done reports on transitions that identify those barriers and also some access barriers. We are happy to forward those to the Committee in terms of what we have charted. But, in summary, when we are talking about those cultural barriers we are talking about what it means to go to a health professional. We have to think what the Western medical model is working within these communities both good and bad, because sometimes they think they are just coming in for playtime. We need to be able to work out a range of those structures that work within that.

The idea of working within the shame and stigma of those communities seems to be much more prevalent and much more impactful. Almost you are having clients coming in that you are just doing self-esteem work on. For the past week they have been kicked around by their community and made to feel awful. When we

are talking about dosing, we advocate that we do not care what treatment modality it is as long as they have equity to treatment modality. When you talk about methadone and buprenorphine dosing and Subutex, et cetera, and they are moving them onto pharmacies the amount of discrimination when they walk into a pharmacy not just because they are a drug user but because they are Arabic or Vietnamese speaking. The amount of times pharmacists sit there watching their stock because they have someone from a Vietnamese background coming in to dose. You are looking at fractured people, damaged people, and they are having to face that. No wonder they are not getting a range of good support outcomes. But we can forward the reports to you that chart all those sorts of things.

The Hon. HELEN WESTWOOD: In the past I predominantly worked in Bankstown with diverse communities. I know that one of the issues, particularly for the Muslim community, around the issue of addiction is that there is a sense of not wanting to acknowledge it is a problem, particularly if it is about alcohol. Have you found any way to work with those communities around substance abuse or substance addiction when there is not even an acknowledgment that the substance is used within those communities? Have you found that to be an even greater barrier to overcome?

Mr CHAMBERS: Absolutely. All our work within the Islamic community is recognising that within their community framework and within their paradigms alcohol is not allowed to be used. But then we always go with a "but" and talk about how people can fall outside their religious doctrine and what they are trying to do and that we need to bring them back. We tend to get the religious leaders recognising those sorts of issues. It depends who we are talking to too. There are some stalwarts within the community that will not change regardless of what information you provide them with. It usually works better if we talk about it in a health issue framework. Often they talk about the weakness of will; we try to talk about a health issue that is actually masking another more complex issue. That tends to work relatively well when we have those conversations.

It is interesting that we have had to change the way that we work. It is not just issues about the alcohol itself; it can also be gender issues and it can also be a range of cultural issues. For instance, it is interesting when we have Arabic counsellors that some of the female counsellors turn around and talk about not trying to take their manhood. That is a different sort of aspect of working within that framework that allows us to work with that client. It is also recognition that we cannot get everyone through the door and there are limitations even for people as marvellous as we are.

Reverend the Hon. FRED NILE: I note that in 2012 you had 234 clients. Can you give us a breakdown of the ethnic groupings of those clients? You might have it in your report.

Ms ROWE: By country of birth? That is another thing to note as well: The minimum data set does not count anything other than country of birth, so we cannot tell you anything about the background of people in our service other than the country they were born in.

Mr CHAMBERS: To follow up on that, in terms of the department and the department way of data collection to change that and put three or four extra items in costs close to $100,000. To keep it in perspective, we cannot get good data.

Ms ROWE: We can tell you that 51.6 per cent of our clients were born overseas. Sixteen per cent of our clients were born in Vietnam over this period, 3.4 per cent in Lebanon, 3.1 per cent in Iraq, 3.1 per cent in New Zealand, 2.8 per cent in Yugoslavia, and 2.4 per cent in China and Fiji both. Two per cent were born in Cambodia and 1.1 per cent each in East Timor, the Philippines and England. In terms of language background, we see that 15 per cent are preferring to speak Vietnamese, 7.7 per cent are preferring to speak Arabic, and a range of other languages in smaller proportions.

Reverend the Hon. FRED NILE: It sounds as though there is a fair percentage from Asia?

Ms ROWE: Well, it is Liverpool.

Mr CHAMBERS: And we are on Cabramatta-Fairfield, so we are pulling in a lot of the Indochinese countries around there.

Reverend the Hon. FRED NILE: In your submission in response to our terms of reference you mentioned that a range of treatment options should be available, et cetera, including the use of naltrexone. Then you said, "However, research has shown better outcomes with alternative medical treatments." What research

are you referring to, and can you supply us with that research, because the Committee is trying to find out the value of different treatment options?

Mr CHAMBERS: I will let Ms Rowe follow it up as well, but I think in summary we are just talking about the other pharmacotherapies that have been out there. Methadone, Subutex, buprenorphine has got a lot research in terms of the efficacy associated with it.

Reverend the Hon. FRED NILE: I am just wondering whether you were referring to any specific research.

Ms ROWE: Pharmacotherapy that is currently available, obviously there is much more research that has been conducted as to the efficacy of that. In terms of naltrexone in culturally diverse communities, as far as I know there is no research from an Australian context at all that gives us a sense of whether this form of treatment would be effective for a broad range of culturally diverse communities in Australia.

Reverend the Hon. FRED NILE: In your submission you mention that some clinics that use naltrexone do not apply the World Health Organization [WHO] definition. What clinics are you referring to? Are these clinics in Australia, Vietnam, China or somewhere else?

Mr CHAMBERS: There is a range of established principles in terms of using that. One of those clinics has been closed down in terms of New South Wales. Is the Committee familiar with that service? Yes, so I do not need to name them and get sued. I question some of the stuff that is done in Perth in terms of the protocols that they have established at the moment. I am not saying that they are bad protocols, but they are not fitting in from what we have looked at from the WHO standards. They would be the two that we would be focusing on specifically.

Reverend the Hon. FRED NILE: Do you have material from the clinic in Perth?

Mr CHAMBERS: Yes. I was out there 12 to 18 months ago and speaking with George and having a look at the range of stuff that they provide and making recommendations accordingly. I also want to comment to the Committee that the approach of the Drug and Alcohol Multicultural Education Centre to this is that we are not against or for any one treatment process; we just want equity to it. If we are talking in terms of naltrexone or Subutex or anything like that, we want to make sure that the protocols that are set up are not culturally discriminatory against them. That is because we find that a whole range of things work for a whole range of different people and it is people's journey to try to find those sorts of things.

Reverend the Hon. FRED NILE: You specialise with different ethnic groups. You have nothing to do with the Aboriginal community; the Aboriginal community has its own medical service.

Mr CHAMBERS: Absolutely. If someone arrives at the service we do not deny them service but we try and refer them onwards. Our specialty is not working with Aboriginal and Indigenous clients.

The Hon. JAN BARHAM: In your submission you refer to day treatment programs. Will you explain in a little more detail why you think that is a necessary addition to the service you currently provide?

Mr CHAMBERS: Rachel smiled because that is my little bugbear at the moment. What we have found with culturally and linguistically diverse communities is that—and we are making very big generalisations, but we can go community by community—overall they do not do well in TCs. The reason why they do not well in TCs is because there is an area of containment and they are separated from family. The day clinic model is intensive—you have got them there from 8.00 a.m. to 5.00 p.m.—but they get to go home, they get to go back to that community structure and they do not see it as a punishment.

The Hon. JAN BARHAM: Why is that different to the current service model and why would there need to be a different source of funding to provide that?

Mr CHAMBERS: The current service model we provide is outpatient, counselling based. It is based on a series of interventions that can vary from as frequently as twice a week to maybe three or four times a week. What we are talking about with a day clinic is an intensive treatment program. People will be having treatment three to four days per week over an eight-hour period.

The Hon. JAN BARHAM: What sort of treatment would you be providing?

Mr CHAMBERS: It would be based on the solution-focused brief therapy model again, based on building resilience. It would be a 12-week staged program. The program will use elements of cognitive behaviour therapy, which is motivating a move towards change. A lot of our therapy work is based on narrative interventions. It works really well within CALD community members because it allows them to tell their story and we can then start to re-author aspects of that story. It will work within a peer model—the group we have is working towards positive change and working towards dealing with drug use.

The Hon. JAN BARHAM: Will it also allow for other family members to come in?

Mr CHAMBERS: Absolutely. That is one of the subtle differences. I have not got the program in front of me at the moment but three to four weeks in we are actually bringing families in as part of that treatment model.

The Hon. JAN BARHAM: I would like to follow-up your key interest in this. If you could provide any more information on that I would be grateful.

Mr CHAMBERS: No problem.

The Hon. JAN BARHAM: Are you using social media and the idea of recorded early intervention support for people? Do you think that has a place in what you do? You say no to the printed or website stuff but what about the idea of using smartphones with the young people?

Mr CHAMBERS: One of the interesting projects we did about two or three years ago was a web-based program for Arabic young people. An information portal where they could get information, in appropriate languages, about amphetamine use—Using Ice? Seek Advice—and that was followed-up with a series of USB armbands. Once they were plugged in it would go to the site and then they could use it for a range of other things like that. It worked really well; really effective. Interestingly, what we have found now within a clinical model is that there are a lot of smartphone apps—especially amongst our clients a lot of them use smartphones. So there is a range of things. I work clinically on Fridays as well and a range of my generalised anxiety patients are now using a smartphone app that works as a step-down to dealing with their anxiety. So there is a whole range of fantastic stuff.

The Hon. JAN BARHAM: In different languages that would be so much easier.

Ms ROWE: Another thing I have noticed is the role that community radio plays as a way for people to model how they can have conversations about drug and alcohol in their language.

The Hon. JAN BARHAM: Is there a role for art therapy and those sorts of things so that people can step aside from being them and have that detached sort of storytelling or something that illustrates who they are? Is that a tool that you use?

Ms ROWE: Within our own therapy there are similar things.

The Hon. JAN BARHAM: On the North Coast we have a community that uses art as a really good way for people to detach.

Mr CHAMBERS: We are always looking for new and innovative ways to deal with treatments but the issue that I have present every time is funding limitations. So we design programs and then we need to build on them.

The Hon. JAN BARHAM: What sort of funding would be required to provide a day clinic service?

Mr CHAMBERS: We have budgeted just under $500, I think.

The Hon. JAN BARHAM: To treat how many people?

Mr CHAMBERS: We are working on 15 per 12 sessions and roughly I think we set it at about $400 a year.

The Hon. SHAOQUETT MOSELMANE: Where do you get your funding from?

Mr CHAMBERS: A variety of sources. Our primary funding comes through NSW Health. We then get two grants from the Commonwealth in terms of ngo programs and the diversity fund—I have forgotten what they call it. We have just acquired a New South Wales tender that was part of the $20 million program: Working with Complex Clients. That is funding the transitions program and the expansion into the Arabic community.

The Hon. SHAOQUETT MOSELMANE: Do you get anything from the community groups in terms of volunteering?

Mr CHAMBERS: No. I think agencies that do really well are WHOS and Odyssey and people like that. It is a really hard sell talking about funding for drug and alcohol stuff when you are talking within community. You can get stuff in terms of migration and community support groups and stuff like that but a lot of fundraisers do not want to touch you when you start talking about drug and alcohol.

The Hon. SHAOQUETT MOSELMANE: I might contact you.

Mr CHAMBERS: Absolutely. I will be happy.

CHAIR: Thank you for appearing before the Committee today. The Committee has resolved that answers to any questions taken on notice are to be returned within 21 days. The Committee secretariat will contact you about the return of those answers.

Ms ROWE: Would you like me to prepare a package of the documents that we have flagged for you or will you contact us?

CHAIR: No, the Committee secretariat will.

The Hon. JAN BARHAM: Your annual report is on the website?

Mr CHAMBERS: Yes. I will send one across for you to keep.

(The witnesses withdrew)

(Short adjournment)

JAY RAYMOND BACIK, Chief Executive Officer, Life Education, sworn and examined:

CHAIR: We welcome Mr Jay Bacik, who is representing Life Education as its chief executive officer. Mr Bacik, there is an opportunity to make introductory remarks to the Committee, if you wish.

Mr BACIK: Sure. Firstly, thank you for the opportunity and the kindness you express in inviting us in. I know that the primary purpose of the group is to look at treatment, but in your reference guidelines at point four you refer to effective education. That is critical as far as we in Life Education are concerned because if there is no demand, there is no necessity for supply. I am not a Walter Mitty kind of guy who believes in fairies and in a perfect work. We understand, as Jesus said about the poor, that there are some things that are always going to be with us. Part of your job as legislators is to help us ordinary voters, if you like—community people—to navigate the mire of things that can hurt and damage people, and bring as much health and wellbeing and security for families and young people particularly as you can. You are vested with a very challenging job. I am glad you are addressing these issues here, today at least.

Pardon my voice. I was conducting talkback radio last night for four hours. I hope you can put up with the occasional cough. Many of you know that Life Education was started in 1979 by Reverend Ted Noffs at the Wayside Chapel. Ted was finding people dropping other people off on his doorstep at the chapel, many of whom were in a comatose state or in an intoxicated state, either from alcohol or drug use. Of course back in those days the government of the day, the police department and other people said, "No, no such thing as drug use. It's in New York or in Los Angeles. It's not in Sydney." Well it was in Sydney. Ted made representation time after time. Finally, the apocryphal story goes, he went to Neville Wran's office with 19 syringes in a plastic bag that he had picked up in the laneway where our office, or my office, used to be. Neville was kind enough to give him an opportunity to talk, and he said, "Mr Premier, we've got a problem."

To his credit and the credit of governments subsequently in New South Wales, Life Education has had significant support. We see 300,000 children in New South Wales. I should have brought a model. I do not if you have seen the Life Education van, but Ted's idea was to talk to children in a theatre which involved information but also experiential education. It started at the Wayside Chapel and they wanted to help, and it started in primary school. Research indicates that the sooner you get to people about attitudes—not about drugs and alcohol early on—but about things like hygiene and responsible behaviour, which comes into bullying, and a lot of kids get into trouble because somebody bullies them or seduces them into it. We started talking to kids at a very young age about that. In the theatre in the Wayside Chapel, they had all kinds of ways of communicating to kids, but they used an animal. The only animal that they could find that would work so that everyone could see it was a giraffe.

That was the birth of Healthy Harold, who is very iconic everywhere I go; it does not matter where. I was looking at a car on Saturday and the salesman saw my card with a giraffe on it and said, "Is that Healthy Harold?" That has been a very strong cultural messaging point for Life Education that is unique. It amazed me when I came into Life Education 12 years ago. I mention parenthetically that my first trade was in theology. I have been in the ministry and I have done other things. I have worked for the Sydney City Mission Foundation. I headed that up with Bob Hawke, John Singleton, Alan Jones and a few other people. Then I was involved in working and helping a friend in Diabetes Australia to raise some money and then I went to America. Then I came back and was conned into coming to Life Education. Eventually my 12-year-old son picked up a fax that was sent to me by someone and said, "Dad, this is Health Harold. Here's a job for you. Three of those four things you'd be terrific at. The last one you'd be hopeless at." I had already said no to this job, by the way; it is quite interesting. So I pulled it off him, and the thing I am hopeless at is information technology [IT]. But he said, "You could do that."

A lot of water went under the bridge. The Hon Bob Ellicott QC was the Chairman of Life Education at that stage and the commitment of our volunteer group was very strong. Ted moved Life Education from the chapel because someone said, "In Murwillumbah, we want to have the message of prevention", which underlines all the things we do: Get to kids first about themselves; teach them that they are unique, if they do not already know that; and then help them to be able to make a decision for themselves, not influenced by the pressure of peer groups and other people around them. The first Life Education van was a caravan that was converted into a technology unit. We now have 41 of those in New South Wales. We see 300,000 kids, as I said, at 1,400 schools. We see over 600,000 Australia-wide—but New South Wales is the engine room, and we are in 10 other countries as well.

In terms of support from the Government, the New South Wales Government, it costs us $20 per child. The most expensive part of that, 76 per cent of our costs, comes from the salaries of our educators. Our educators have a degree. They are not all teachers but they have to have a degree in some related field. There are people with physical education backgrounds and health sciences, which is now a big thing whereby people talk about nutrition and the like. We employ people who are nurses and who have physiotherapy backgrounds and things that relate to health. The most important thing—and Ted set this down almost in concrete—is that they must be able to communicate. We have all sat in lectures, in Parliament, in churches where we have been bored witless by whoever it was that was speaking. I am sure that does not happen here in New South Wales, eh? I have not actually been to question time in the upper House yet, although I have been here a few times. But you know what I mean: even at schools.

We wanted someone who had the intellectual capacity to know about nutrition, to know about exercise, to know about the human body, to know about the psychology of relationships—because that is very important in terms of kids making choices—to know about issues like alcohol and its impact on children, parents and society, to know about the issues of drugs later on as they get into years 5, 6 and 7. We have just introduced a brand-new program this year on cyber safety because that is where parents are saying, "Help. How do we know our kids aren't being seduced in a variety of ways?" When I was at school in Brisbane our mates took us down behind what we used to call the dunnies—I am sorry if that is an offensive word to some people; that is the way we talked—and you were offered your first cigarette at about nine or 10. You were told that everybody in high school smokes and this is your way to be the big guy when you get to high school.

Our community life now is much more sophisticated and we cannot depend on just doing things the way we used to do them. We have moved into the cyber safety field at the request of parents and we are rolling this out as we speak at a cost of $20 per child. The people we select bring kids into a van, a classroom, for 90 minutes and talk about one of the nine modules we have, it is a very important component. If a child is there from grade 1 right through to grade 6 or 7, we have a high school program. It is not funded because we do not get as many people and other people are doing things in high schools. It looks to us like—and we have been doing this for 30-something years—the primary school area is a really critical way of getting down to the attitudes that children have from their families and their peers about issues related to drugs and health.

In relation to the $20 cost factor, parents pay. We believe in partnerships. In some ways it is kind of forced on us because we do not think the Government should pay for this. We think it is a community-initiated program. It is community supported by a smart Government—and they have all been smart so far since Neville Wran—that has contributed to the ongoing development of Life Education. The parents pay $10 of that $20. Governments pay $6 per child. That is $1.8 million, but it is an investment that sees 300,000 children that significant time, effort and energy. Other than the 90 minutes in the van, we give the classroom teacher, who is there with his or her class, up to 10 hours ongoing work to take back to classroom a workbook that they take back and use for the development of the child.

I think that leaves, if my maths is good—and I was never good at maths—$4 per child that Life Education raises. Our fundraising target is $4 by 300,000 and it is over $1 million. My point is that I think partnerships are very important. I am concerned as a general person that too many charities act as if they are a division of the Government and they expect the Government to pick up the whole tab. In our case we have taken the view for a long time—Alan Cadman is the chairman of Life Education New South Wales. Mary Eason—just in case you think the Labor people did not have a representative—is very committed when she was the chair.

CHAIR: You cover all bases.

Mr BACIK: What people do not understand about you, and I have done a lot of talkback radio, is that there is a lot of angst and push and shove in politics, but what people do not know is the kind of relationships and trust that people have over your side of the fence. Mary Eason nominated Alan Cadman to be chairman because he had nominated her five years before. Why have we picked those people? Because they have both been passionate community people, looking after families and kids, and that is where we are coming from. What we have got there is what I call not a hand-out or a hand up; it is a handshake. It is a partnership between parents, Life Education itself, which is willing to raise money in the community so groups like Rotary and Lions get in and help us.

I got an old guy of 92 came to my office the other day from Murwillumbah, where they built the first van. He has got me to buy it back. We had sold it to somebody. We have bought it back. It is in dreadful

condition. But he, at 92—he drove down, by the way—is going to have it restored because he was involved in it to start with. It is a very strong community base. I think we can do nothing to help people on the issue of drugs unless we have strong community support. There is no point in legislating things if the community does not wear it. There is no point in trying to force people to do things or not do things unless you have community support. We already know that something like 90 per cent of people in the community disapprove of the use of illicit drugs, other than marijuana; 76 per cent disapprove of the use of marijuana.

What we have to do is listen to the community and work with the community and educate the community, as we do with our family programs, to bring kids to an awareness of this. That is where we are coming from. A few weeks ago I was involved in a debate at Sydney university and I think the push for decriminalisation and legalisation is to push something which the community does not need certainly and does not want. Look at the numbers: 81 per cent of people in Australia, according to the national household survey in 2010—I am sure you have read that much more than I have backwards—use alcohol, 18 per cent use tobacco—and congratulations to you and governments of all persuasions on that issue; I think that has been magnificent. I went overseas last year on a trip and I could not believe how many people were smoking in the places I went to. So we are having some great success here.

Cocaine use is 2 per cent; speed and ice, 2 per cent; ecstasy, 3 per cent—that has gone up a bit—heroine, 0.2 per cent; and cannabis, 10 per cent, up from 9 per cent in 2007. We are very concerned about that. I am talking myself out of a job because I want the Government to help fund more the individual children who are coming to Life Education, but I am talking myself out of a job in the sense of saying that I think we are seeing some good results with the combination of what the Government has done, what the private sector has done with families and organisations like ourselves, plus the health Department, schools and the like. You would think, by reading the *Daily Telegraph* every now and again, that there is a drug epidemic. Having said that, I can take you to places in Sydney, and you know these, where there is an epidemic, where you can go and get drugs easily and a lot of people are using in that community. But if our job is the holistic view of looking after the total community, I think we need to be involved in the preventative side.

I think rehabilitation is important and all the other things you are hearing are important. My push is to say let us keep trying to prevent kids from taking drugs and let us give them credit. When I first came to Life Education I was appalled at the figures of deaths of heroin overdose. They were up around 1,100 people; now it is down to about 300. People say it is a drought. What about giving the kids some credit? What about saying could it be that our community, our society, is saying that this is a dumb and dangerous thing? Even if I have had too many drinks—we already know that alcohol is a gateway to some drugs, and I am concerned about that—let us give the kids some credit and say that this is a stand that we as a community, as government, as a private sector health organisation have helped kids make. I am up for questions. There may be some stuff I have missed but I wanted to give you a bit of a brief about where Life Education stands.

CHAIR: What sort of interaction is there with, say, the Department of Education and Communities? Primarily Life Education is providing primary school programs, worthwhile programs, and you did mention some high school programs as well and the shift to cyberbullying. What is the interaction with government schools and non-government schools?

Mr BACIK: Firstly, we see all kinds of schools. Primarily 80 per cent of the people we see—we go by invitation. We are not forced on them.

CHAIR: Can you explain that?

Mr BACIK: It is almost—how do you say this in commercial terms? It sort of starts as a small thing, like throwing a stone into the pond. It is rippled out. We started off seeing local schools and then more local schools. In a report done by the Federal health Department about 2005, which I was involved in, it is called the Erebus report—I am happy to make that available to you.

CHAIR: That would be good, thank you.

Mr BACIK: It was an analysis of the process of the way we do the educational programs. But doing some surveys, something like 93 per cent to 95 per cent of schools that have us want us back. If you are running a business you would be happy to have that kind of response rate. Each lesson, there is an evaluation made by the classroom teacher. That comes back into us and through to the national office. So we are very mindful of making sure that the work we do is the kind of work that happens in a school. We go to a school first and say

before we go, "What do you want us to deal with? Which of the 9 modules do you want to deal with?" They determine that. Right now we get a lot of pressure to do the cyber safety module because it is the flavour of the year. It may be the flavour of the future I think. So that is where we are strong.

Our relationship with the education department—and I do not understand this—has not been strong. We have started—Ron Mulock was the first guy who was the health Minister with Neville Wran who got involved and from that perspective they built a big centre out at Colyton, which is our New South Wales headquarters, and you will see Neville Wran's name there and Newlock and the like. That is where we do all our van reconstructions and the like. So it has been much more working with the health department. In the last couple of years I have got involved a bit with the education department. They have had a program. I do not want to offend anybody but I just say what I think. You can discount that.

CHAIR: We want to hear it.

Mr BACIK: Sometimes people come up with ideas and say, "This will look good. We're going to cover every school in New South Wales". Through the Department of Education the school areas were broken up into 10 or 12 regions, they had 10 or 12 consultants. The idea was that there would be one consultant who would go to Bathurst. They would go and spend a day with one person from each of the Bathurst schools and then that person upgraded them on their PDHPE, drugs and alcohol, and then they would teach the teachers in the schools. The Government put $2.6 million into that but they could not tell you how many children were seen in the program. I thought it was inept and it was not measurable. At least I can tell you that we see physically more than 300,000 children. If a kid turns up at school—and this is an increasing issue for us. The cost to the parents at $10 is too high in many places. If I could get your help on that, that would be terrific. If a kid turns up at school and he does not have $10 to spend on this program, I am not going to shut the door on him.

CHAIR: So that is what happens—they are accepted if they cannot pay?

Mr BACIK: Except that the principal may have a policy to say, "You know what, if we take these three kids here who haven't paid, down at the tuck shop when the mums are talking and those three mums have paid $10 they raise the question 'Why are we paying?'" Then the issue comes, "Oh well, they'll spend money on this." I do not care where people spend their money. I would see every child in New South Wales for free if we could do that because the impact that we observe—there has been no longitudinal study on drug and alcohol use anywhere so when you get the academic elite saying that education does not work, we have no evidence that is evidence based that it works. My argument is, "Let's try ignorance." What would those figures be like if we withdrew all the education things we did on prevention? Indeed, when we look at things like drink-driving, speeding, governments have made enormous benefits to the community in those sort of things. So the education department, I am reinitiating that. They are now, as you know, offloading decision making to local schools and we await to see what that looks like.

CHAIR: So you would like to have more consultation with the department of education in its drug and alcohol and healthy lifestyle programming?

Mr BACIK: I think so. I do not know whether I would want more because I think they think I am driving them mad, because I think we should be in partnership. Departments should not be working in silos. We see more children, 50 per cent of children in New South Wales are involved in this program.

CHAIR: It speaks for itself.

Mr BACIK: Why would you want to crank up a new program on bullying or some other aspect to do with drugs and alcohol when you have an organisation that has the infrastructure, the training, the people, the compliance with curricula throughout every State in Australia? That is there to go. I am saying to the department, "Why don't you use someone like us to help that?"

CHAIR: So with Life Education do you expend your own internal funds to research and develop new programs? You were talking about the new module on cyberbullying. That module and any other modifications to older modules or research what is needed—do you fund all of that?

Mr BACIK: Yes. In my time, and I have run both the national and the New South Wales for a number of years, and now I am running New South Wales operationally because it needed some attention. But yes, we have funding. I went to the ASMI, which is a combination of the big drug companies for the 'on-shelf'

medicines and they have done a model for us on using drugs in the home, Mind Your Medicines. We put out a program with Ernie Dingo in a video. Then we went to BUPA Health, which has helped us develop a program which is now in the vans of taking children on a spaceship through the body. Kids love it. It goes right through and a kid walks into a room where there is smoke and all of a sudden the people in the spaceship are tossed around. So Bupa has put up $200,000 for that and McAfee has just stumped up with $300,000. We approached them to help us do the development work. We hire outside consultants to do this cyber safety. There are two components of that. At a breakfast this Thursday in the Strangers Room I will be showing that to about 60 parliamentarians who are signing up as Harold ambassadors. They will actually see what is happening in their communities. We actually rejig and develop our programs more often than, say, the education department is redeveloping its programs. We think it is important.

CHAIR: How much funding do you get from the New South Wales Government?

Mr BACIK: We get $6 per child multiplied by 300,000 children is $1.8 million.

CHAIR: Has that kept up with CPI? How has it developed over the years?

Mr BACIK: There was a period where we did not get it. We get it now. It is not a huge amount of money in the scheme of things. My argument is this: If parents are paying $10 as in investment in their child's future—as I say, three cappuccinos; at least where I get a cappuccino it is about $3.

CHAIR: That is very good value for a cappuccino.

Mr BACIK: Do you value your kid's life that much? Of course. I think the Government should be stomping and saying, "You know what, we're in partnership with parents about this." We have been on $6 for a while. I put up a proposal and, of course, everybody is broke at the moment. It is funny governments can find money to do different things. This would be a smart move in policy. It would be a smart move in politics. I am not telling you how to run your business, but if the Government said, "You know what, we're in partnership with you parents. We're going to pay what you're paying to make sure your children get good support".

We cannot drug proof kids. Anybody who says they can is just talking rubbish because we all know kids who have had the best things in life, all the protection they need, then one fateful, sad, terrible decision has cost them their life or their future. We all know people who grew up in the working class, housing commission areas, like myself with no father and not much of a mother, can make choices and make a go of it. We are not making any claims about that but we say that we give children enough awareness and knowledge—self-knowledge as well—for them to have the capacity to make the right healthy decision, a smarter, safer decision.

The Hon. SHAOQUETT MOSELMANE: Earlier we heard from the Drug and Alcohol Multicultural Education Centre. How much do you focus in your life education program on the various multicultural backgrounds of students?

Mr BACIK: Thank you for that question. I think a lot. We go to some schools not far from where our centre is at Colyton. We actually bus in some of those kids from school; a Harold bus comes into the theatre at Colyton. You watch the kids folding into the classroom, it would be, you know, spot the Anglo because it is just a wonderful mixture of the richness of ethnicities out there. We go to Muslim schools and other schools that have particular ethnic or religious factors. Somebody said, "Why don't you translate the programs into various languages?" I could ask the same thing about the State school system. That is a bridge too far.

I think there is a sense that if kids are dealing with pressure in a primarily English-speaking environment, they really need to be equipped in that environment to deal with that as well. I am not squibbing out on it. I have been in the van, I do not force myself; it is important for me to sit in the van in the lesson with the children once every three months to find out what is going on in the place. It is just gorgeous to see kids—some of whom are almost brand new and struggling with English because they have just turned up—responding to the emotional, interactive Harold thing. It communicates to all children. It is very important.

The Hon. HELEN WESTWOOD: The Hon. Jan Barham and I are on another committee inquiry about young people and alcohol, and one piece of evidence we have received in both committees is that alcohol addiction is the greatest problem, certainly in New South Wales, but throughout Australia, and there is the cost to public health. Are your programs designed specifically to address alcohol and illicit drug addiction? The other

issue we are coming across, of course, is prescription medication to which people become addicted and combine with other drugs. Could you explain to the Committee how your work covers that ambit?

Mr BACIK: Sure. Let me try to address those one at a time. On household medicines that is very important. About six years ago I approached the pharmaceutical industry to put up some money for Mind Your Medicines. We take children with Harold into a home and look at medicine left lying around and what to do with it. That is very important. It is fundamental to start where the children are—that is in their homes. Children aged eight to nine, it is terrible to think, but most of them are not being exposed to alcohol and drug abuse. Some of them are, but most of them are not. So we deal with that issue very specifically. Then there is smoking. That is the one thing that we are very well aware is the most addictive drug available, including alcohol and other things. So we are very strong about that. I get into trouble. People ring me up and say, pardon my language, "Your bloody giraffe told my kid I'm going to die if I don't stop smoking." In my early youthful days, which is like 10 years ago, I would get very technical and say, "Well, the research indicates" but they were not interested in that.

So eventually I got to the point of saying, "Well, Ms Barham, I'm sorry to hear that." Firstly, our giraffe does not talk. So that is a furphy. He talks through the educator. One good thing about that is that he is never going to say anything inappropriate. Then we say, "Well, what would you like us to teach your child about smoking?" Almost invariably people say, "Well, you know, I wish I didn't smoke" and eventually "Anything you can do to help us will be great." Often they will send me a cheque for $20 just to get on side. Engaging with the parent at those younger ages is very important. Our alcohol policy is very clear. We talk to kids about what it does. We show them on what is called a TAM—transparent anatomical model—which has veins and shows what happens when you smoke, how your nervous system slows down. When you smoke it activates—it is a stimulant. When you drink alcohol we show the kids the heart rate slowing down because it is a sedative. So they are actually seeing what the substances are doing in the body.

For alcohol this can be a very dangerous thing. Sometimes you get some horror stories from kids talking about what happens in their homes. That is a bit awkward for us to deal with, but we have to listen to them. Alcohol is available in the community, 81 per cent of people drink, but it can be very dangerous if misused and you must not use it if you are a child. The new evidence coming out now about children's brains not developing until they are 24 or 25 is pretty sobering, pardon the pun, in terms of legislation. We are kidding ourselves about 18. But we say to kids, "You must not do that." We are not finger waving "must not". It is, "This is not what you should be doing." The kid says, "My father drinks, my mother drinks" We say, "Okay, there's nothing wrong with that, but if you're going to drink you need to wait until you're old enough." With illicit drugs, again we show them what it is like. But that does not happen. What we do is very progressive.

Many years ago I interviewed a guy called Robert Fulghum, who wrote *All I Really Need to Know I Learned in Kindergarten*. It was the number one best seller in the *New York Times* 25 years ago. I am sure you have all read it. What he said made common sense. You start with things like washing your hands. A lot of children do not know this. We go to Stewart House, near Manly, and kids come in from all over the State. It is a good place to go to, by the way; I am not telling you how to do your job but it was an eye opener to me. Some of those kids come in and when they sit down at the table do not know how to use a knife and fork. Some of the primary school kids have never sat at a table with a knife and fork. Nor do they have hygiene knowledge. What we try to do is go through that as specifically as we can.

The Hon. JAN BARHAM: With the family program on your website, how do you engage parents? Do you do that with children? Is it a whole family program?

Mr BACIK: That is very important to us. We have a family program that we like to run in schools. There are two things. Let me start with what we are doing now. With the help of Bupa we are running a thing called Harold's Healthy Family Challenge. We are encouraging families to get on board. It is not about drugs and alcohol, but it is about the choices you make in life. It is about setting up a little competition and your mum sponsors and your grandmother sponsors the whole family to try to do healthy things: exercise, tick, tick; eating something, tick, tick. A Big Mac is not poison. In fact, I worked in the ministry in working class housing commission suburbs in Sydney—I am talking about Dundas Valley when it used to be called "Dodge City". For some of those kids the most nutritious meal they had was what they got from a fast food restaurant. I am not for fast food, but I just make the point that we need to be very careful about making judgements about people and their situations.

At Life Education we call scones and jam,(just picking something random), “sometimes” food for kids. It is not your staple diet. So that is a very important thing to us. We are trying to get that happening with kids through the internet. We have a family program that we do after school. Schools are buried in programs. It is hard to get the schools to stay open after school hours and it is hard to get the parents. I have done a few of those. In one case in a Vietnamese-dominated community, it was just wonderful. About 100 people turned up and it was wonderful to see the children at the school communicating what was happening to the Vietnamese parents who had almost no English language. I think there is an opportunity, and certainly our vision is to do more of that. The infrastructure issue of schools wanting to be open and coming back at night and that sort of thing is challenging. So we are probably going to pursue it through the internet.

The Hon. JAN BARHAM: Much of the evidence we are hearing is about that intergenerational side of it and children learning at a young age.

Mr BACIK: Absolutely. In fact, as I just mentioned about the Vietnamese community, we are finding that the kids are actually teaching their parents. I was at a function in Tamworth the other day. Tony Windsor is a great friend and an ambassador for Life Education. He told 300 people that Healthy Harold saved his life. I do not know if I should tell this, but Tony was smoking 60 cigarettes a day—he told 300 people, so he will not mind me telling you. He tried hypnotherapy and all sorts of things. His kid came home and said, "Dad, Healthy Harold said if people smoke they can get sick and some can die." He threw his arms around Tony and said, "I don't want you to die." Tony gave up like that 20 years ago. It is a great illustration of the impact of children. We need to be careful how we do that. I do not want phone calls from angry parents about their drinking and smoking habits. But it does not work without the family. It is very important.

The Hon. JAN BARHAM: That is why I was interested to hear how you approached the idea of the whole family.

Mr BACIK: We can do more on that. In fact, if I had more funding, we could do a lot more.

CHAIR: It is a good final message.

The Hon. JAN BARHAM: We have heard concern about the effectiveness of education but it sounds like you have had peer review assessment of your program, is that right?

Mr BACIK: Nobody has done a longitudinal study. I would say, have a look at the numbers of what is happening. In terms of drug use, for example, alcohol use has not increased. The way people use alcohol is scary—the binge drinking thing. If you guys come up with an answer to that, I'll be straight into helping to implement it.

CHAIR: Well, that is the Committee we are on.

Mr BACIK: That is an issue. I have a 24-year-old son, he is on his second degree, he has a Commerce degree and he is doing Law I now. He is doing Law I, so he knows everything, right? He is now the social justice champion.

CHAIR: He is a future politician in the making.

Mr BACIK: Yes. I would not be too enthusiastic about that, Chair, because I do not think he would be coming down on your party's side.

CHAIR: He might eventually.

Mr BACIK: I think he is a bit on the pink side. So he loves what I am doing. He said, "I am so proud that you are helping kids". And then he will say, "I'm going out with the boys"—his Uni mates and St Andrews school mates—"on Saturday night". I said, "What are you doing?" He said, "Oh, we might have a few beers". He is in favour of decriminalisation, so I said, "What does that mean?" And he said, "Well, we are going to get wasted, dad". I said, "Why?" He said, "I don't know." I said, "Next time we get together, face-to-face, I am going to talk about that issue." I think we have got to start engaging these young people who are getting smashed to say, "What is the drive here?"

The Hon. JAN BARHAM: The psychology—that is what we are trying to do.

Mr BACIK: He said, "I don't know, I'm bored". I said, "Mate, get off your backside and do something." So I would love to help with that issue but we can't save the whole world. We start with the kids.

Reverend the Hon. FRED NILE: Where is your main centre now? It is not at the Wayside Chapel any more, is it?

Mr BACIK: No, the Chapel needed the space. We have established a national office in Pitt Street which is mainly administration, program development and keeping the company in good shape—marketing. The big centre is at Colyton in western Sydney, which is owned by the Health Department. The land is leased to Life Education.

Reverend the Hon. FRED NILE: You mentioned going into public schools. Are you having any problems getting access into the schools?

Mr BACIK: No, but it is getting more complicated in schools and one of the challenges is for people to see drug and health education as critically important. One school said to us, "We won't have you this year but we will have you next year because this year we are having cooking classes." Because, you know, people see cooking classes on TV. We need to be careful that we are not positioned as another outside organisation that comes in and teaches dance, culture, music—all of which are important but they are crowding into the curriculum of the schools. I am the sort of guy who will say to the principal—if I know him reasonably well—"Mate, this is life-or-death stuff. You are teaching the kids about what they might choose to do, especially in the smoking and alcohol regions, early in their lives." But, no, it is a crowded marketplace, if I can use that phrase.

Reverend the Hon. FRED NILE: That is what I was getting at, that there should be access in the curriculum for Life Education, annually.

Mr BACIK: I think the Government is on what may be a healthy drive towards letting the local schools make that decision. Having stuffed up what they used to do before I think this is a better option with the schools and we will wait and see what happens. It is up to us to market to the school that this is a critical health issue for the children to wrestle with.

Reverend the Hon. FRED NILE: But if they laid out the curriculum with optional things like cooking classes, there is no room for your program.

Mr BACIK: Yes and it is not just a crowded curriculum but it is also the outside providers. Some of those things are really good. It is great to have music people come in and teach kids about culture and stuff. They also have a Personal Development, Health and Physical Education [PDHPE] program.

The Hon. JAN BARHAM: That competes with what you are doing, basically.

Mr BACIK: What we have tried to do is to supplement and support. In our preparation and research, we go through every State's curriculum and needs in that area and trust me, they all different. It drives me mad that we probably have one person working full-time on sorting out the differences. Hopefully in a brave new world we will have one curriculum.

Reverend the Hon. FRED NILE: Are you working with parents and citizens [P & C] groups and the local schools?

Mr BACIK: We do our best to do that.

Reverend the Hon. FRED NILE: Because they may be able to get the access for you.

Mr BACIK: The access is not so much a problem but the P & Cs are not as—I will use jargon and you can make up your own minds—strategic.

CHAIR: Proactive?

Mr BACIK: Yes, not as strategic in the competency realm in this kind of issue.

Reverend the Hon. FRED NILE: You mentioned that you had 41 vans. What is the cost of a van, fully equipped, with all the instructional material, models and so on?

Mr BACIK: I can give you an insurance replacement amount because we have just had one trashed in another State by vandals. It is cheaper than it used to be but probably from scratch, $89,000 to $100,000. That is with all the new technology, air conditioning, carpet and the built-in safety factors.

Reverend the Hon. FRED NILE: So you need that funding.

CHAIR: Thank you for coming in and sharing your expertise. We value all the work that Life Education has been doing for so many years. If there are any questions that are placed on notice as a result of this inquiry you have about 21 days to answer and any of the material, I think that there was a report—

Mr BACIK: I will send one to each of you. I did not want to turn up today and look like I was selling something, which I am not. We are doing something in partnership with you and your Government and we appreciate that. I think it is absolutely vital to every family and every kid in New South Wales.

(The witness withdrew)

DAVID ANTHONY MCGRATH, Director, Mental Health and Drug and Alcohol Programs, NSW Ministry of Health, affirmed and examined:

CHAIR: Thank you for coming to this session. Would you care to make an opening statement?

Mr McGRATH: No, nothing.

CHAIR: I know you have a very lengthy and comprehensive submission.

Mr McGRATH: Nothing specific.

CHAIR: When we were talking to some of the other witnesses, they mentioned the abuse of prescription drugs and people shopping around for doctors who write out scripts for them. I know you are NSW Health, but is there a move towards getting a national approach to the monitoring of real time pharmacy dispensing of prescription drugs, so that we can start to minimise the abuse of that area of drug usage or abuse?

Mr McGRATH: Under the Council of Australian Governments [COAG] framework, there is an Intergovernmental Committee on Drugs, an officer-level group that used to support what was called the Ministerial Council on Drug Strategy, which was recently disbanded. That group has developed—under the auspices of the Standing Committee on Health—a national pharmaceutical drug misuse strategy. One of the elements of that strategy is looking at a pharmacy-monitoring program for the use of prescription drugs. It is not my area of expertise, in terms of the roll-out of that program. The Chief Pharmacist of NSW Health would be the best person to talk to with regard to the intent of that program. I can advise you that there is an element under the National Pharmaceutical Drug Misuse strategy which does look at the roll-out of prescription medicine pharmacies using real time IT infrastructure.

CHAIR: The Committee was recently in Western Australia and visited WA Health. It was interesting that, when some of us were in taxi cabs, both on our way there and on our way to the airport, we heard a lot of strategic radio messages aimed at young people, warning them about the effects of alcohol and illicit drug use on their bodies. Basically, the orientation was: It's not cool. I know that we have had a good development of messaging to young people about drug and alcohol usage. How much money has been devoted to that and how are we researching the best way to get our messages through to people, both adolescents and adults? How much research goes into that? How effective are we measuring any outcomes on how we are spending that dollar, in terms of education?

Mr McGRATH: I will break up my answer, because there are a few elements to that question. I will start with the response to young people in the first instance. The most effective piece of research that helps to stratify the market, for want of a better phrase, with young people in terms of how to target our responses was done by the Blue Moon group in Victoria. It took an approach that said: All young people are not the same. That is not rocket science. If you want to target a particular young person with a given message you need to understand their basic orientation with regard to drug use.

It stratified young people into six different groups. I will not go through all of the groups. The first group was those who, irrespective of the offer of drugs and alcohol, would be unlikely to ever take up an offer. There were two groups in that category. The next group were those who may contemplate or consider use, most likely on an experimental basis, but who would be unlikely to come up with any future problematic use. They would likely decline it and push it away, after the initial orientation. There were two groups in that category. Then there were a further two groups—probably the primary groups to consider—which were two groups that were very likely to have a positive orientation towards drugs. They were defined as the thrillseekers—those people who were looking for experiences outside the norm and at the edge of societal norms; and the reality swappers—people who had been through difficult childhood experiences, painful childhood experiences, and were using drugs as a way of overcoming those childhood experiences.

Not surprisingly, the outcome of the research was that, depending upon which group of young people you are targeting, the message needs to be different. For instance, if you make a significant reference to the dangers of, say, party drugs—amphetamines, Ecstasy, those sorts of drugs—you may, in fact, be encouraging the thrillseekers to use drugs, if you target the message towards that particular group. You need to be careful about understanding the orientation of the group you want to target the message towards, ensure that the distribution channels are targeted towards those groups and that the message matches those distribution channels

for young people. That was very helpful piece of research done in 2004-05 and it has formed the basis of much of the activity that has gone on across the country in terms of targeting young people. The second element of your question, which is the most difficult for me to answer, is the research associated with the impacts of broad population health campaigns.

The reason for that is that it is very easy for us to measure the recall of messages in the drug and alcohol space, to measure whether people have heard the message, whether they think it may have an impact on their future behaviour and whether it may have an impact on how they communicate with other people. It is difficult to measure the change in behaviour for the given individuals in receipt of that message, which is what we are all really interested in. We can look at broad population-based behaviours.

Whether that was tied to that person having heard a particular campaign is tremendously difficult to measure for a range of reasons: People get different exposure to the message, they come from a different orientation in the first instance, their drug use behaviours are all varied and you are unable to control the groups, you cannot do a randomised control trial—those things that we like in the research space. So it is a tremendously difficult thing to research. We continue to work on looking at outcomes associated with our campaigns and most of the outcomes we look at are the retention of the message and reported intention to change behaviour as a result of the message. It is difficult to measure that and follow up as to whether the actual behaviour does change.

CHAIR: Is there any effective use of social networking sites or smart phone apps; is that something that has been looked into?

Mr McGRATH: Looked into, yes. We do not currently have any specific programs that are solely on those platforms. However, all of our current programs incorporate some sort of social media component. Recently we rolled out the Know When To Say When campaign, which was a binge drinking campaign targeting young people. It included a Facebook component and a social media component at particular events. We rolled out that campaign in combination with a number of events where young people were likely to be attending and particularly young people who might be interested in behaviours at the edge of where we would like them to be.

We were able to use social media through some of the marketing throughout the event to allow young people to access the messages in a way they are comfortable with. We do not run programs purely on the social media platform. We generally start with a traditional mass media platform but we do always incorporate a social media component. It would be fair to say that government is still learning the social media skills that the smaller public relations organisations are able to achieve. I think that is a fair thing for me to say.

The Hon. DAVID CLARKE: Mr McGrath, I have been through this report and it is a comprehensive report as an overview. I complement whoever put this together. I have rarely seen anything better in stating what the situation is and what programs there are and so forth. I complement you on that. Naltrexone comes into our terms of reference. Will you comment on what the department's view is on that as a program and the position, as you understand it, as far as investigations into Naltrexone are concerned?

Mr McGRATH: Naltrexone has a number of different uses. The primary focus is looking at Naltrexone as a preventative to opioid misuse.

The Hon. DAVID CLARKE: And alcohol?

Mr McGRATH: I was going to get on to that as well. Obviously Naltrexone's primary task is as an antagonist to the opioid receptor sites. What that means is the Naltrexone binds to the receptor sites in the brain that attract the opioid molecules and therefore prevent the opioid molecules from binding and causing a reaction. It also brings on immediate withdrawal as a result because it also displaces any existing opioid molecules that are binding to the receptor sites. It is often used by ambulance officers—or Naloxone which is a variation on the same drug—when they go to overdoses.

As you rightly point out it has been shown to have positive properties with regard to anti-craving responses in people who are addicted to alcohol. It reduces the central nervous system stimulation associated with the craving. Some of the discomfort that comes with an individual having a craving is that their entire central nervous system becomes highly agitated which leads them to feel a compulsion towards the particular behaviour that will resolve that, which is to drink. Naltrexone has been shown to reduce that particular central

nervous system stimulation and therefore reduce the impact of the craving. There was a study done back in 2003-04, the National Evaluation of Pharmacotherapies for Opioid Dependence, which is considered to be the seminal study looking at the variety of particular interventions for treating opioid dependence. That particular study found that Naltrexone as a treatment or opioid dependence had a place for a particular cohort

The Hon. DAVID CLARKE: Did that study involve implants?

Mr McGRATH: No, at that stage implants were not a primary mechanism as a distribution method for providing Naltrexone. It was generally done through a mechanism that was called rapid opioid detox, which involved mild sedation and then administration of Naltrexone in quantities to trigger a withdrawal. The sedation was for the purpose of comforting the patient during the rapid opioid detox.

The Hon. DAVID CLARKE: Do you have any results of studies of Naltrexone implants?

Mr McGRATH: Certainly not in New South Wales. There have been no clinical trials run in New South Wales with regard to Naltrexone implants. I understand the Commonwealth is looking at some trials with regards to Naltrexone implants. Generally most of the clinical trials run for new medications or medications that are moving into a new realm or purpose are run through the Therapeutic Goods Administration and the National Health and Medical Research Council [NHMRC]. There have been no clinical trials run in New South Wales for Naltrexone implants.

The Hon. DAVID CLARKE: Why do you think there have been very few trials in New South Wales and around the world to do with Naltrexone?

Mr McGRATH: I am not sure I can answer that.

The Hon. DAVID CLARKE: Is it because most of the trials are financed by pharmaceutical companies and this is a product with no big profits, therefore they have no interest in being involved in trials; could that be a possible scenario?

Mr McGRATH: I would be speculating if I tried to answer that question. I do not have any evidence to provide to a Committee of this stature. In New South Wales we fund very limited clinical trials. The majority of clinical trial funding goes through the Commonwealth. It would be rare for us, given the Commonwealth has constitutional responsibility for research, to invest money at that level given our focus is generally on service delivery. Your suggestion may have merit but I have no evidence to support it.

The Hon. DAVID CLARKE: If it is a treatment that Dr O'Neil and his clinic suggest has this outstanding result, it would be something that the department would be interested in, would it not?

Mr McGRATH: We would be interested in anything that demonstrates positive outcomes for patients in this space. If I was going to make an opening statement, which I declined, I would say that the most important thing to think about in the drug and alcohol space is that the cohort is not homogenous. It is a diverse cohort. As you see from our submission we work hard on targeting the different niches of the cohort and providing a particular response to each niche to get the outcome. There is a particular niche that may benefit from this particular form of treatment and properly researched we would be interested.

The Hon. DAVID CLARKE: Have you sought any information from Dr O'Neil's clinic?

Mr McGRATH: I have met with Dr O'Neil recently here at Parliament House. From our point of view it is difficult to implement something that the Therapeutic Goods Administration has not approved as a medication for that particular purpose. As far as I am aware the Commonwealth is looking at undertaking the appropriate research to allow the Therapeutic Goods Administration to make a determination. Once the Therapeutic Goods Administration makes that determination we would be interested in looking at how to turn that into a treatment program—if the Therapeutic Goods Administration has a positive affirmation, I should not presume that.

The Hon. JENNIFER GARDINER: Following on from the resourcing of opioid treatment programs: You say in the submission that the New South Wales Government has invested additional funding towards the provision of non-government community-based services for people wishing to cease opioid use. Can you give us an indication as to when that funding was made available and how much was it?

Mr McGRATH: I can. The election commitment was for $2.5 million per annum on an ongoing basis. The funds rolled out at the beginning of this calendar year, around January or February—to give you a specific date I would need to refer to the files at the ministry—but around the start of the calendar year, the program provides $2.3 million in this calendar year, from recollection, and next calendar year $3 million recurrent. We anticipate that from the next financial year onwards it will be $3 million recurrent per annum.

The Hon. SHAOQUETT MOSELMANE: In your submission on page six you talk about New South Wales Government's key priorities for the next 10 years and in particular the NSW State Plan 2011. My question to you is: What funding is there to back the New South Wales plan for the delivery of drug and alcohol treatment programs? You say there is a wide-ranging program and you mention the drug and alcohol program and treatment services: What funding is there and is it sufficient to back the 10-year plan?

Mr McGRATH: The overall budget for the drug and alcohol program in New South Wales this financial year is approximately $161 million. Again I would need to refer back to the files at the ministry to get you a precise figure.

The Hon. SHAOQUETT MOSELMANE: For how many years?

Mr McGRATH: That is this year's annual budget. Next year it will be in excess of that. The quantum I will not be able to tell you until after the State budget next week but it is $161 million this financial year. The preceding financial year it was about $153 million and the year before that it was roughly $145 million. I would like to check if you want a precise figure but they are fairly accurate. In terms of being able to assess the new funding that has come in recently the previous question with regard to the additional funding for the non-government sector was one set of additional funding that came in this year. There was additional funding of $3 million to expand the opioid treatment program across New South Wales as a result of increased demand for people in the opioid treatment program space. It was an attempt to alleviate some of those demand pressures.

We have rolled out a number of campaigns such as "Know When To Say When" and "What are you doing to yourself?" in the alcohol space. We have rolled out targeted campaigns around the use of illicit drugs, what we call the Club Drugs Campaign, focussing on people that use amphetamines and ecstasy, the stimulant drugs that are particularly problematic. The concept of adequacy it is a difficult question to answer. There is currently a national project underway which is a drug and alcohol clinical care and prevention model. It is sponsored by the Intergovernmental Committee on Drugs funded via the cost-shared funding regime under that particular committee. New South Wales was the successful bidder to run that project. It is run out of my office.

The intention of that project is to work with clinicians across the country, including non-government organisation shareholders, to identify the relevant treatment resourcing required to meet the needs of the community and to use that as a template for resource planning into the future. That project is not yet complete but it is not far from completion. It will allow evidence-based methodology for assessing what the appropriate resourcing is for each of those niches I described before. The complexity in the drug and alcohol space is that there are a lot of good ideas for certain niches that do not necessarily apply to other niches. You need to separate out the population epidemiology to apportion the resourcing appropriately to each one of those groups to get the outcomes that are helpful.

The Hon. SHAOQUETT MOSELMANE: We have heard that significant funding has gone into the mental health area at a great cost to drug and alcohol funding when alcohol is the biggest current day issue. How do you counter those challenges when you have significant resources in one area and you know, in actual fact, that there is a huge need in another area, such as drug and alcohol, and you are not able to get the required funding?

Mr McGRATH: I should start off by saying that both programs are quarantined for their specific purposes so there is no cross-subsidisation from one program to the other. They are both quarantined budgets for their own special program purposes and they are rolled out that way from the Ministry. They are rolled out under separate program codes and those program codes are monitored and reported on via our annual reporting processes.

With regards to the scale of the budgets, to a certain extent there are a couple of defining parameters for determining why the mental health budget might be larger than the drug and alcohol budget. Number one, obviously the population prevalence of mental health is much higher, which is a relevant consideration. The

second consideration is that there is a much stronger inpatient component to treatment in the mental health space on the basis of safety and risk. Particularly at the higher acuity end of the spectrum there is a requirement for much more secure facilities, which you do not necessarily have in the drug and alcohol space. There is an attendant cost with that, which is disproportionate to what happens in drug and alcohol. Much more of what happens in the drug and alcohol space occurs through the community sector, the non-governmental sector and operates on an ambulatory basis, which comes with a lower cost structure than the mental health program, notwithstanding the fact that we would like to shift a lot of our attentiveness in the mental health program into the community space, and that is part of the Government's stated intention.

It is very difficult to make a fair comparison across the two programs. What I would say is that project I described in drug and alcohol occurring on a national basis, working with clinicians to identify appropriate resourcing is also occurring in the mental health space to provide the same rational evidence base paradigm for making determinations around resource allocation. New South Wales was the successful jurisdiction in getting that contract, and it is about 12 months behind the drug and alcohol program because it is so much more complicated and requires so much more consultation on the basis of the size of the program. That is about the fairest way I can answer that question with regards to a comparison. I understand that the individual stakeholders in both programs like to make the comparison. It is a common thing to do.

The Hon. SHAOQUETT MOSELMANE: My last question relates to the question that was asked by the Hon. David Clarke in relation to naltrexone. At what level is the naltrexone research at the moment and has it convinced your department that there is a need to take the research a step further and, therefore, allocate the required funding?

Mr McGRATH: There are a couple of questions. The Hon. David Clarke is correct that there is not a tremendous amount of research globally with regards to this particular form of intervention. I guess the second stage in that thought process is the Ministry would not roll out anything without the Therapeutic Goods Administration's approval for the use for that particular purpose. That is the second thought process. The third one is probably something that is outside of my portfolio responsibilities so I should answer in a guarded way. What the Government determines to invest in in terms of clinical research trials really is a matter for government policy. I would not step outside of that government policy with regards to my particular program.

As I have said previously, we do not tend to invest a tremendous amount in clinical trials in New South Wales as a result of the Commonwealth having a very large budget for that particular purpose. Generally they try to align their budget expenditure with the Therapeutic Goods Administration's priorities, and it is sensible for them to do so. The Therapeutic Goods Administration has a particular set of authorities about how they want to approve particular medications, and it is sensible for them to roll out their clinical trial research program alongside that.

The Hon. SHAOQUETT MOSELMANE: If we were to recommend that a naltrexone implant study or research take place in New South Wales, do we need the support of the Federal Government?

Mr McGRATH: No, not necessarily. There just needs to be an identified source of funds within the State's budget for that purpose. My comment is about my consistency with government policy with regard to clinical research trials. I would not step outside of that.

The Hon. HELEN WESTWOOD: Thank you, Mr McGrath, for being with us today and for your submission. If I could go back to the question that the Hon. Shaoquett Moselmane asked regarding funding, some of the evidence that we have had from a number of groups—non-governmental organisations and advocates as well as government-funded organisations—have talked about the lack of growth in drug and alcohol funding. It seems to be a perception in the sector that funding for drug and alcohol treatment—programs, research and support—has not kept up with the growth and that it is a public health problem today. We have had some advocates argue that there needs to be a separate stream of funding for it, not within, not for D and A to be seen as part of the mental health stream of funding, and, for that matter, clinical service to a degree. It is hard as a public servant, but do you have a view on that? Secondly, are there other models in other jurisdictions in respect of the Government addressing the issue of providing funding for D and A services that you think we could look to?

Mr McGRATH: I will do my best to answer the question. The first thing, and I need to reinforce something I said earlier, is that the two programs have separate program codes and they are both quarantined for their specific purposes, so there is no cross-subsidisation between mental health and drug and alcohol. The

second answer would be that my experience in the Ministry is that the drug and alcohol programs growth would be consistent with or perhaps even superior to the general program growth across the health system, so I do not think it would be inadequately comparative to other growth in the health system. The third comment I would make is that there has been a tremendous amount of Commonwealth investment in the mental health space probably over the past five or six years and clearly mental health has been a nationwide priority, both for the State Government and for the Commonwealth Government since 2005, so mental health probably has had a disproportionate growth relative to the rest of the health system. As a result, the drug and alcohol stakeholder base has seen that growth and compared themselves alongside that particular growth. It would be my guess that is probably the reason for the perceptions.

With regards to other models, the majority of jurisdictions around the country have merged the portfolio areas from a policy perspective, which means they have shared portfolio responsibilities within their ministries. Western Australia did have a separate drug and alcohol office, but it has recently announced it will incorporate that into the Mental Health Commission, which is an interesting model, and I am sure it will cause some interesting views among the drug and alcohol staff in Western Australia. In the main, most of the policy parameters have a certain similarity to them: the way the programs are constructed, the way the funds are rolled out as special program protective funds, the way the relationships with the clinicians operate are similar.

Having said that, there are many other programs in the health sphere that have the same principles and parameters and, alongside the two programs, you could allow a number of other special program areas in the health system that would not fit poorly because they have the same protected structures, the same contract arrangements, the same performance arrangements, the same stakeholder management arrangements, the same governance arrangements. It is not necessary to say that mental health and drug and alcohol pairing is the only pairing that you could have. Given the way that the public service has been structured around the country over the past three or four years, pairings are a logical consequence of that outcome.

The Hon. HELEN WESTWOOD: Your comment about the Western Australia office is interesting because we visited there a bit over a week ago.

Mr McGRATH: The announcement is very recent.

The Hon. HELEN WESTWOOD: I certainly was impressed with what they have been able to achieve as a standalone agency. It has given them a degree of autonomy within the health bureaucracy that we do not have here. No doubt we will watch those developments. The other area related to funding is that of workforce capability and, within that picture of addiction, medicine and treatment of addiction, whether you think that the workforce has kept pace with the skills and expertise that is needed in that field?

Mr McGRATH: It is an interesting question. The only fair answer I could say to start off with is that obviously the pace of development within a given workforce varies from workforce participant to workforce participant, so it is not uniform. If you look at it across the board, clearly addiction medicine specialty is a nascent specialty. It has not been around for very long and, as a result, it is on a steep curve in terms of the exercise of additional competencies and the exercise of additional interventions that are available to that particular workforce. The fact that there is finally a particular specialty in drug and alcohol has generally been positive for the drug and alcohol workforce overall. That has created a degree of stature within the health system, which is helpful. Unfortunately, those sorts of medical politics are important to creating a critical mass in the health system. That is a positive.

There are substantial opportunities, particularly for the non-government sector, to take on additional responsibilities in the drug and alcohol space. They have often been confined to a particular paradigm of treatment, which is the residential rehabilitation paradigm. There are many other paradigms for which I think they have the capacity to organise themselves and to organise an appropriate clinical governance for them to undertake, but that would require that workforce to look at additional competencies. I basically construct the drug and alcohol program into three boxes and within those three boxes this is a gross oversimplification, but you have got the assessment and treatment planning component, the actual provision of treatment and then the psychosocial support that comes with it. If you look at the middle box, there are lots of subcomponents to these broad headings, but there are four broad headings of withdrawal management, substitution treatment, residential rehabilitation and then outpatient or ambulatory care. At the moment, of those four the non-government sector has largely positioned themselves around residential rehabilitation. I see no reason why they could not provide services across the other three components. It is just a matter of the necessary upskilling in their workforce to be

able take on some of the more complicated medical components of withdrawal management or substitution treatment.

Reverend the Hon. FRED NILE: Thank you for your detailed submission and your presence today.

Mr McGRATH: My pleasure.

Reverend the Hon. FRED NILE: One of the issues we are looking at in our inquiry is the consideration of mandatory treatment. On page 17 of your submission you have a great deal to say. You say it is important to distinguish between mandatory treatment and coercive treatment. Often the two words are used interchangeably. Will you clarify that for the sake of the evidence today?

Mr McGRATH: The merit program is the simplest example of a coerced program where somebody presents before a magistrate. Prior to pleading, they are offered the opportunity to enter into a treatment program if they meet the entry criteria and the magistrate feels it will be beneficial for them in terms of treatment. While there is no requirement for them to go into that treatment program, there is an implied contract that if they enter the treatment program and they do well, their court proceedings might be more positive. Similarly, the adult drug court program and the compulsory drug treatment correctional centre program have similar elements.

On the surface, the voluntary people have to choose to participate; there is a negative consequence if they do not participate. I would describe those as coerced programs. If you think of the involuntary treatment units, or the Drug and Alcohol Treatment Act—another example is the Mental Health Act, for that matter—they involve schedules by medical practitioners which lead to somebody being treated involuntarily against their will without consent. The difference is that coercion is consent on the part of the participant with a negative consequence if they do not consent, and mandatory treatment is the State taking responsibility for the person's consent and providing treatment against their will. That is the best example I think I can give, if that is clear.

Reverend the Hon. FRED NILE: You say in your submission that there is a very limited evidence base in Australia for mandatory treatment. Is mandatory treatment operating as distinct from the coercive treatment that is connected with the person having committed an offence? What happens to people who are drug addicts but have not committed an offence, other than using drugs?

Mr McGRATH: You have hit the nail on the head. The primary reason that there is limited evidence is that there are limited options for mandatory treatment. The primary option since 1912 was the Inebriates Act, which operated to place people who had a dependence or inebriation with regards to drugs or alcohol into a mental health facility for extended periods of time, but the treatment they received was limited because mental health facilities often were not the best place to treat somebody with a drug and alcohol problem. They were often there for much longer than was necessary to treat their problem and their treatment plan was actually prepared by the presiding judicial officer, generally the magistrate so it was not an effective regime for actually undertaking intervention with somebody with a drug and alcohol problem and it was poorly researched over time.

Following the Alcohol Summit in 2003—and I am sure this is contained in the submission—there was a similar inquiry to this one with regards to the Inebriates Act and its benefits or limitations and that inquiry made a recommendation of a new form of mandatory treatment, which is the Drug and Alcohol Treatment Act. The three benefits of that particular Act over the Inebriates Act are the corollaries of the three I mentioned a minute ago, which are the treatment of plans are done by a medical officer so it is done by somebody who understands the addiction sphere—

Reverend the Hon. FRED NILE: That is the 2007 one?

Mr McGRATH: That is correct. So instead of the magistrate making the treatment plan, the treatment plan is done by somebody who is actually trained for that purpose. The length of the order is generally from two to four weeks, which is appropriate for getting an inpatient intervention withdrawal underway and then followed up with appropriate community and psychosocial supports and the third benefit is the treatment is provided in a drug and alcohol unit with staff who are trained to provide drug and alcohol interventions rather than in an acute inpatient unit for mental health.

They are three significant improvements on the Inebriates Act. We obviously undertook an evaluation of that for the purposes of the trial and that is obviously a piece of research available that looks at the benefits of

mandatory treatment but that would be the primary piece of research in New South Wales. There are not a lot of mandatory treatment paradigms around the world. Coerced treatment is generally preferred in most cases and I think it would be fair to say that given the nature of drug and alcohol interventions and the importance of participation of the individual in most cases, there is generally a view that maintaining mandatory treatment just for the people at the tip of the pyramid who are clearly unable to consent to treatment in an appropriate way or who are clearly at risk of serious health consequences is probably the best place to limit it to.

If you start to bring that down to those people who still have the capacity to make determinations about their decision-making and they are participating without any voluntary component to what they do within the program, you have a tendency not to get as positive an outcome, and that is seen in drug and alcohol treatment at all levels where people are coerced by family members, for instance, into programs; they tend to generally do poorer in treatment or if they are coerced by an employer they tend to do poorer in treatment than those people who voluntarily enter into the program.

Reverend the Hon. FRED NILE: Have you conducted any consideration of the mandatory drug program in Sweden?

Mr McGRATH: I am obviously familiar with it and I think that underpinned the compulsory drug treatment correctional centre that is in operation through Corrective Services. I anticipate you will be seeking evidence from Corrective Services on those programs. It is probably best that they comment on the programs and their benefits but clearly that was the genesis of that program and the more recent trial announced by the current Government.

Reverend the Hon. FRED NILE: It is my understanding that the Swedish one is not connected with committing an offence except using drugs. I note you say there have been a number of evaluations undertaken of the involuntary drug and alcohol treatment trial and you say that the system of care is effective and efficient. Do you have any plans to expand that or does it require any changes to legislation to assist the department or people operating in that area? Is the legislation effective as it presently exists?

Mr McGRATH: A couple of changes; subsequent to the trial now that we have gone statewide, which we did last year and also fortunately the Attorney General's Department repealed the Inebriates Act shortly afterwards so this is the primary piece of legislation now for this particular cohort. We have two units open, one in the Northern Sydney Local Health District and one out at Bloomfield Hospital in Orange, which are providing services to this particular patient cohort. I guess the first thing we will need to watch is demand. I made reference to three particular deficits of the Inebriates Act which led to it being used infrequently and I suspect that part of that was that magistrates did not find it an effective intervention anyway and therefore perhaps chose to use it less than they might have.

We have built in enough capacity to exceed recent Inebriates Act referrals by threefold so hopefully we have enough capacity but we will need to observe that. The second thing we would like to look at—and we are due to do a review of this particular legislation at the end of this calendar year—is the appropriateness and applicability of community treatment orders which are used within the mental health program for the purposes of providing treatment in the community on an involuntary basis. There could be benefits in doing something similar with regards to the Drug and Alcohol Treatment Act but we would like to look at that clearly through an appropriate judicial review process.

The third thing is to ensure that there are appropriate community follow-ups for people who participate in the program. We have built that into this current model and we would like to evaluate how well they are taken up. With any drug and alcohol program the inpatient component is generally just an engagement with treatment. The most important component is once they are discharged, how they engage at the community level and how they continue to achieve success or not once they are in the community because that is where most of the challenges for them are going to be. Most of their triggers and pressures to use are going to be in that community environment.

The Hon. JAN BARHAM: We actually went to the Bloomfield centre last week. I want to ask you about the funding model, the DACCP, and I understand it is June that it is due to be finished?

Mr McGRATH: Yes.

The Hon. JAN BARHAM: Will that provide a tool for you to use and then that will inform government budget setting and the like or is there something in that that will change the way health services are delivered?

Mr McGRATH: I guess the first answer to that question is my job is to put it up to the Standing Committee on Health and those determinations will be made at levels senior to me but the intention clearly is to provide a framework for making decisions about resource allocation. We have brought together people from across the drug and alcohol spectrum to get agreement on the right care packages to be provided to different people against their epidemiology.

We took an arbitrary population of 100,000 people for the purposes of identifying the epidemiology and using all the available research stratified them into the market niches for each of the different groups and then looked at the suite of things that they should get in order to get the appropriate outcomes that we would like. That allowed us to aggregate across all those packages the resource inputs that would be necessary to achieve those outcomes. Clearly it is a tool that is a point-in-time tool and it needs to be reviewed probably every two to five years because there will be new treatment interventions that come up. We acknowledge that. We acknowledge that there will be improvements in research; we hope there will be improvements in research.

The Hon. JAN BARHAM: I am particularly interested in rural and regional needs and the fact that distance and transport opportunities are often not considered in terms of availability of services. I am hoping this model can in some way, compared to a distribution formula, factor in real circumstances, needs and access?

Mr McGRATH: It looks at the necessary resources available; it does not look at how a given chief executive might organise those resources. It does not seek to tell them how to organise resources in a given location or indeed in the primary care space. One of the real strengths of doing a national model, which I must admit I advocated for relatively passionately, is that the interface between the Commonwealth's responsibilities and the State's responsibilities in drug and alcohol and in mental health is pretty intertwined.

Unless there is effective treatment at the primary care level and access at the primary care level to a patient cohort—primary care often are a little bit reticent to get involved with; they are a little bit more difficult than other parts of the patient cohorts they might deal with—particularly in rural areas books are full and often there is a need for general practitioners to ration their available services and often people with drug and alcohol problems end up on the outside of that as a result of being more difficult patients to treat. So it is important that that interface is dealt with.

The Hon. JAN BARHAM: You mentioned earlier about additional funding for opiate treatment programs. Your submission, which is a great submission, refers to 19,000 people currently being in treatment?

Mr McGRATH: That is correct.

The Hon. JAN BARHAM: But the need is probably more like about 35,000?

Mr McGRATH: The number of people who use opiates is about 35,000. It is estimated that the number of heroin-dependent people is about 35,000. Whether you would want the entire populace of that 35,000 or it is reasonable that the entire populace of that 35,000 would be seeking methadone treatment or buprenorphine treatment per se would be up for debate. Some will be going into withdrawal management paradigms, some will be going into outpatient treatment, some might indeed be looking at rapid opiate detoxification.

The Hon. JAN BARHAM: I think we have heard that there has been a stagnation of the opportunities in that program, and again particularly in rural and regional areas where availability for dosing is difficult sometimes and problems associated with going to a doctor or finding a doctor or pharmacist. I will probably put a question on notice to ask about the historical trending of that.

Mr McGRATH: Sure.

The Hon. JAN BARHAM: Is that fairly constant?

Mr McGRATH: I can give you a bit of an answer but it will be in general terms and you can take from that what you wish. Obviously from the Drug Summit in 1999 there was a substantial expansion of the

methadone program. The treatment base at that time was around about 12,500 and obviously that was the funded treatment base. There was an expansion in the program by the Drug Summit program to about 16,200 funded using the existing treatment methodologies at the time, so that was in the absence of suboxone and in the absence of buprenorphine. They are the two newer medications which can be provided in two ways. They can be provided on a broader takeaway basis because they have got higher safety profiles. Suboxone cannot be injected because it precipitates a withdrawal regime so it is safer from that perspective and it reduces the risk of diversion.

The reason for making all these points is that obviously that funded base of 16,200 grew as a result of some of these new medications and the capacity to drive more people through the program. It was clear, though, 12 to 18 months ago that we had reached the point where demand was exceeding the available supply and that was the reason for the additional investment that came in last year's budget. We will of course continue to monitor demand. At the moment there were a couple of hotspots where that demand was particularly noticeable—the Hunter-New England was one that got a fair bit of media coverage and would not be a surprise to anybody on the Committee and we are not getting reports from Hunter-New England at the moment that demand is exceeding supply. We are pretty much down to the sort of treatment throughputs that we would expect, but we will monitor it closely because clearly prison release is a big issue and many people come onto OTP in prison; they begin their treatment in prison and it is important to make sure that they move into the treatment flow throughs appropriately.

The Hon. JAN BARHAM: Another issue that has come up in terms of emergency departments is that there is not clear data collection on presentations related to drug and alcohol issues. I am from Byron Bay and we have known for a long time the pressures on an emergency department when there is a clustering from night time or whatever. We have heard that there is not clear data collection on that. My concern is where it then impacts on the availability of services to general users.

Mr McGRATH: There are a number of answers to that question. The first one is historically there has been a heavy reliance on point in time studies. There has been quite a range of point in time studies done in emergency departments around the impact of drug and alcohol on presentations in emergency departments. Those studies demonstrate that between 15 and 25 per cent of all presentations have some factors associated with drug and alcohol use but that does not mean dependence. That may mean Byron Bay or particularly St Vincent's make this claim frequently that many of their trauma presentations have as an underlying precipitating factor a drug or alcohol misuse.

However, the recorded presentation might be an orthopaedic injury or a laceration as a result of a fight or a car accident, so that is what gets recorded in the system rather than the drug and alcohol problem per se. The second thing I would say is that we have rolled out a trial over the last five years of consultation with liaison staff in a number of emergency departments after hours. We have historically had consultation liaison staff in hospital emergency departments Monday to Friday during business hours. That has been the historical model.

The Hon. JAN BARHAM: Isn't that the issue; that it is not at the time of need?

Mr McGRATH: No, indeed, and that was the reason for rolling out trials in about six hospitals where we provide consultation liaison staff Thursday, Friday, Saturday nights up until 1.00 a.m. and on Sundays to facilitate discharge, screening and referral appropriately. The National Drug and Alcohol Research Centre [NDARC] is running a longitudinal study for us on the evaluation effectiveness of that particular model.

The Hon. JAN BARHAM: When is it due?

Mr McGRATH: I would need to check the files.

The Hon. JAN BARHAM: I will put a question on notice.

CHAIR: Alcohol is such a cost socially, physically and mentally on society and on governments. It is a huge problem. We have done so well with the reduction of tobacco intake. What do you believe this inquiry should focus on given that alcohol misuse and availability is such a huge issue? When was the last alcohol summit or task force that brought together governments on a national basis? My personal view is we have to attack it nationally as well as having a commitment from the State Government. What are your views on what governments should do to get the scourge of alcohol usage down?

Mr McGRATH: That is a broad question which necessitates a broad answer. There was an alcohol summit in New South Wales in 2003 but you are quite right, it focused only on the State's responsibilities. There was an attempt at a national binge drinking strategy in 2008 auspiced under the Ministerial Council on Drug Strategy and led by the Commonwealth Government, which led to a national binge drinking strategy, but I have to say the implementation of that has been less than ideal in meeting the initial stated objectives. There is a lot of research in the drug and alcohol space around those things that create the greatest benefit to the community in terms of reduced alcohol-related harms. I am sorry to say the majority of them are not in the demand reduction side of things, which is my area, but in the supply reduction side.

The four key things are, firstly, reduction in liquor outlet density. The greater the number of liquor outlets in a given area and the more densely populated, the greater the likelihood of alcohol-related harms. Reductions in trading hours tend to lead to reductions in alcohol-related harm. Increases in taxation, particularly on the quantity of alcohol relative to the quantity of tax applied tend to reduce alcohol-related harm. Much of the harm caused in the alcohol space is by cask wine or cheaper wines, which have a much lower level of tax. There are a whole lot of other issues that come with tackling that particular problem, but there is significant research, particularly that undertaken by Dr Robin Room, looking at the improvements in alcohol-related harms as taxation is increased. The fourth one, which is no surprise, is random breath testing. RBT tends to reduce significantly driving accidents associated with alcohol. Those things are all very important.

There has been a big debate about alcohol advertising. New South Wales has taken to the Ministerial Council on Drug Strategy a number of times a desire for the Commonwealth to get more involved in better controls on alcohol advertising. The sorts of exemplars I have used in the other inquiry on tackling alcohol use in young people are that the product most likely to be shown on a billboard 250 metres from a school is an alcohol product. Alcohol products are permitted to be advertised in M- and MA-rated movies despite the fact the audience is likely to be under the age of 18. Those sorts of things can be tackled and they are the sorts of things that impact on people beginning to use alcohol earlier. I use a parallel from the tobacco space: there is significant evidence that if you stop somebody from smoking before they turn 18 they are very unlikely to begin smoking after they turn 18. I think you can look at similar parallels with alcohol. Preventing people from misusing alcohol under the age of 18 means they are very likely to have a relatively safe alcohol use history from that point onwards. That is probably the best answer I can give.

The Hon. DAVID CLARKE: The Hon. Fred Nile asked a question about the Swedish program and I think you said it was something for Corrective Services to look at. I would like you to have a look at it and provide a response as to your department's evaluation of the Swedish approach to drugs.

Mr McGRATH: I am happy to take that question on notice.

The Hon. DAVID CLARKE: If you could give us a response I would be very grateful.

The Hon. JENNIFER GARDINER: Going back to the drug and alcohol consultation liaison services, you mentioned the evaluation program that is taking place. Depending on the outcome of that program is it envisaged it will be rolled out to other emergency departments throughout the State?

Mr McGRATH: Obviously I would be providing advice to Government on the outcomes of the program and that would be a decision for the Government in terms of government policy. Clearly if the benefits are there in 25 per cent—let us unpack the average of what most of the point-in-time studies suggest, which is 20 per cent of people coming through emergency departments have some drug and alcohol-related problem and the majority of those are coming in on the big drinking nights of Thursday, Friday and Saturday. There are clearly opportunities to get better screening and referral of people into treatment that might produce downstream benefits in terms of lower presentations at a later date. What the Government chooses to fund is obviously a matter for government policy.

The Hon. JENNIFER GARDINER: With respect to the issue of growth in pharmaceutical drug misuse you have mentioned in your submission a number of areas that NSW Health is working on to try to reduce that incidence. One of the problems is inappropriate prescribing by doctors. What is NSW Health doing to try to address that particular problem? Is it just a State responsibility or is the Commonwealth involved as well?

Mr McGRATH: Clearly it is not just a State responsibility and that was the reason for the National Pharmaceutical Drug Misuse Strategy noting that there were not just requirements for partnerships across State and Commonwealth divides but also between health and law enforcement agencies in order to be tackle this because of the diversion components that were prevalent, particularly with regard to OxyContin, which is one of the most diverted drugs in the market at the moment. We work with pain management prescribers within the State system to assist them in firstly being aware of the problem of diversion of pain medications and then work with them on the variety of interventions that are available for people with pain-related problems, particularly chronic pain-related problems, and the interface with addiction. I have to say that they are not the primary source of the problem. The primary source of the problem generally is general practice and those people prescribing in a primary care setting.

I need to temper some of those remarks by saying that OxyContin clearly is an improved medication over the preceding medication and it is unsurprising there has been some growth in its use given it has a 24-hour action compared to the shorter acting Endone. I am singling out that particular medication because it is the primary growth of licit drug diversion. Notwithstanding that, there has clearly been growth in the primary care sector in general practice in providing that medication to people who perhaps otherwise might not have needed it. Clearly the controls over the use of that medication and supervision of its use can do with some improvement and the Commonwealth has taken responsibility for improving clinical guidelines and prescribing guidelines with regard to those medications in primary practice.

The Hon. JENNIFER GARDINER: The new Drug Court at the Downing Street centre was up and running as of February, was it not?

Mr McGRATH: We provide the treatment services for the Drug Court. Obviously the Attorney General's department provides the infrastructure and oversight of the project.

The Hon. JENNIFER GARDINER: Are there any plans to roll out any services beyond the existing ones at Parramatta and Downing Street?

Mr McGRATH: That question is best addressed to the Attorney General's department. Certainly if there were we would be supportive in terms of providing the appropriate treatment interventions for the participants. The submission we made provides some details and some of the evaluations of that program that have been undertaken both here and overseas. I think Don Weatherburn has done some good work on the benefits of that program. Clearly it is a program with some significant merit.

The Hon. JENNIFER GARDINER: You mentioned earlier the Inebriates Act and there are discussions underway with a view to repealing the Act. I presume there are discussions with stakeholders in that regard? Is there any time line for such a repeal?

Mr McGRATH: I believe it may have been repealed. I may be wrong.

The Hon. JENNIFER GARDINER: I think you might be right.

The Hon. JAN BARHAM: I think it is by the end of this year.

CHAIR: With regard to alcohol and pregnancy, I am aware of education about foetal alcohol syndrome for certain members of the community where it has been proved to be a problem in the past. It came as a surprise to some members of the Committee when we were in Western Australia to learn that some of the illicit drugs that are used have a depressive effect on the breathing reflexes of neonates and adverse effects on the foetus. Is your unit providing any education on this for pregnant women or young women likely to become pregnant who are taking drugs?

Mr McGRATH: There are clear guidelines provided to medical practitioners in terms of interventions with people who are working towards becoming pregnant, particularly with regards to alcohol use, and there are standard guidelines provided to any general practitioner who is operating with a patient who is likely to become pregnant shortly. With regard to illicit drugs, it is a tricky question because our message generally is we would prefer they did not use drugs at all whether they are intending to get pregnant or not. It is a very nuanced message to talk about when it may be safe or not safe to use drugs. With illicit drugs we would not tend to focus heavily on pregnancy per se other than talking about all the negative consequences of illicit drugs.

Clearly, there are some complexities around mothers who become pregnant subsequent to or during heroin use. We have quite a sophisticated and complicated program for managing the pregnancy to term such that the babies are safely delivered. Obviously we have the difficulty of ensuring we can withdraw the infant from the effects of the medication that the mother has been taking. That is a very important program for ensuring the safety of the child. It is very complex because you do not really want a pregnant woman to be going into heroin withdrawal, particularly in mid-term. We do a lot of work to ensure the safety of the child with those people who may have abused heroin during the term of their pregnancy. I am not sure if I have captured the drug you were looking for.

CHAIR: You have. Certainly that was interesting. Is your unit aware of any research that has been done with a possible link between an increase in sudden infant death syndrome [SIDS] and drug use within the young female population? It was anecdotal but I asked a group of young women whether they were aware of it and they just looked at each other. These were 18 to 22-year-olds. They looked at me and said, "What are you talking about?" It seems to me young women may not be planning to fall pregnant but it may occur and they may be participating in recreational drug use not knowing that there may be an effect if they fall pregnant. Is there any information on linkage between drug use in young women and an increase in SIDS?

Mr McGRATH: Nothing that I am aware of. It does not mean that it does not exist. I am happy to take that as a question on notice and get the team to have a look at what is available.

The Hon. JAN BARHAM: Chair, were you not concerned about the connection between methadone and SIDS?

CHAIR: And methadone treatment as well. We heard from Dr George O'Neil that there could be a link with methadone treatment.

The Hon. JAN BARHAM: They claimed there was some research that demonstrated that.

Mr McGRATH: I am not sure if you are alluding to methadone provision to a child by somebody who is on the program.

CHAIR: No, methadone usage by a woman who is in an age group where she could become pregnant. There is research. We were given a paper by Dr O'Neil on methadone usage and an increase in SIDS. Could you get some information from your unit as to whether this is an issue you are looking into?

Mr McGRATH: I will take it as a question on notice and provide you with what advice I can.

The Hon. HELEN WESTWOOD: Could I ask you about the detoxification beds? We were given some evidence from a number of witnesses to date that were critical of how few detoxification beds were available in New South Wales. They also expressed concern that there were not enough youth-specific detoxification beds and also detoxification beds that were identified for people of different ethical or cultural backgrounds. Has that been an issue within the Ministry that you have been aware of or whether you are looking at addressing that?

Mr McGRATH: I will start by saying that the purpose of Drug and Alcohol Clinical Care and Prevention is to define resource needs into given strata. I will park that over to the side, because I have said that before. The bed occupancy rates for our detoxification beds across the State would not suggest that demand exceeds supply. If there is excessive demand, it is not showing up in our bed occupancy rates. That would be my first answer. My second answer would be to construct the questions slightly differently. Withdrawal management, in the main, for the majority of drugs, can be handled effectively on an ambulatory basis, and relatively safely. There is a proportion of people for whom inpatient admission is required and any general hospital bed in the State is available for anybody who is likely to have a life-threatening withdrawal, alcohol being the predominant case because of the possibility of DTs and seizures, et cetera.

There is historically built in to the withdrawal management component a residential component, a hotel component, provided by Health, which has the benefit of engaging people in the treatment pathway. It is more of a psychosocial benefit than a medical benefit per se. Frequently when you are having these conversations it is often about that hotel respite component and the social, psychosocial engagement component that the debate begins. You brought up three populations. I will start with the general population. I have no evidence to suggest we have a shortage in detoxification beds for the general population. With regards to young people, there are

two points. One is they tend to have much lower levels of dependence than older people because of the neuro-adaptation, and changes in brain chemistry have not occurred at the same rate. Therefore, the requirement for inpatient admission is much lower than it would be for the adult population. Frequently the benefits of treating them in a community setting, surrounding by their personal support infrastructure, is better than putting them in an environment where you have a range of individuals in the same set of circumstances. The therapeutic benefits are not necessarily the same as you would get for the adult population, because they are more socially isolated.

The third group, the core group, is a difficult one because clearly providing treatments—they are not one group, obviously, there are many groups there and the capacity to create inpatient programs for all the different groups is relatively limited. Generally we like to work with the Drug and Alcohol Multicultural Education Centre—

The Hon. HELEN WESTWOOD: Yes, they were here this morning.

Mr McGRATH: We have a very solid relationship with them. They participate in our corporate governance structures and are able to assist us in tapping into the community groups that allow our existing treatment structures to provide appropriate services to different core subgroups. There are some core subgroups that are tremendously tricky, just on the basis of their small incidence or prevalence in the population. Often the number of support groups for some of those smaller populations is limited.

The Hon. HELEN WESTWOOD: We have certainly had that evidence from a number of groups about the shortage of detoxification beds.

The Hon. JAN BARHAM: The waiting times.

The Hon. HELEN WESTWOOD: Yes, the waiting times. They have indicated to us they have not been able to get people who need it as part of their treatment to detox and get them into bed. We need to follow that up with those people.

Mr McGRATH: I will make a dangerous, off the cuff remark. Obviously these circumstances are tremendously traumatic for support individuals, carers, spouses, parents, and often they are looking for a respite component as part of the treatment pathway for a given individual. Frequently, admission to a detox unit provides that respite and often for them, even if it may not be the best treatment pathway for the individual, the individual is not 100 per cent ready to engage or willing to engage, or even 10 per cent willing to engage in a program, and they are then coerced and they feel that pressure more acutely and frequently feel their access to detoxification as they wish it to be. I accept that as a reality.

The Hon. HELEN WESTWOOD: On the issue of the sobering up centres in New South Wales and the Government'0s legislation that is to be established, what sort of input has the Ministry had into developing the guidelines and the standards for those centres?

Mr McGRATH: We have had a limited involvement in the non-mandatory centre. We have assisted the Department of Family and Community Services in providing them with the sort of frameworks we use for treatment inventions for the treatment of its rollouts to the sorts of organisations to be selected to provide those services. I will park that one off to the side. We provided them with advice, is about the most I can offer in the non-mandatory ones. With the mandatory ones, we will be providing the health services in the mandatory centre in the Sydney Central area. That will be run through the Justice and Forensic Mental Health Network.

We have a significant amount of experience in providing services to police cells and other correctional institutions for people who might have health-related problems. The important thing from my point of view is to ensure a presentation that might have been attributed as an alcohol-related behavioural disturbance that is not an alcohol-related behavioural disturbance is picked up as quickly as possible and the individual referred to an emergency department or the correct place as quickly as possible. There are many things such as hypoxia or dementia or other brain injury or brain bleeds that can present as alcohol-related problems. If someone might have had a drink and they have some contextual factors that might suggest alcohol when in fact there is another health concern, that needs to be picked up quickly.

The Hon. HELEN WESTWOOD: Are those guidelines available publicly at this stage?

Mr McGRATH: They are still being developed. Justice Health would rely on its normal clinical paradigms for providing treatment in those environments. We are not intending to develop a brand-new set for that purpose. But clearly they will be looking at giving clear directions to the staff inside the sobering up centre around the assessment that should be undertaken, the right sorts of things that need to be checked off as part of the assessment checklist, and so on. There would be no need to develop a new set of clinical guidelines per se, because the presentation is similar to when someone gets brought to the cells for other purposes.

The Hon. HELEN WESTWOOD: Do those guidelines include staff ratios, those nursing staff and medically qualified staff? I do not know whether you are looking at an addiction specialist or emergency doctors or simply general practitioners?

Mr McGRATH: Justice Health has provided us with the necessary budget to undertake the services of the centre. That is based on the usual operating practices. I cannot answer for you what that staffing profile is off the top of my head, but I would be happy to take it on notice and provide you with the staffing profile if that is helpful.

The Hon. HELEN WESTWOOD: Could you take that on notice and provide it?

Mr McGRATH: Yes, happy to.

The Hon. HELEN WESTWOOD: That would be great. Thank you very much for that. Further on the issue of specific multicultural program treatments; I am wondering whether the Ministry has identified particular barriers—and I made the same point this morning; the multicultural community in New South Wales includes both cultural and religious groups and there are barriers to some treatment programs—from a policy perspective and is able to look at a range of programs that are culturally appropriate to a range of cultural, ethnic and religious groups?

Mr McGRATH: It is a difficult question. We will work with the Drug and Alcohol Multicultural Education Centre for quite a while around the source of priorities that it will suggest for the Government to intervene with. I have to say, the measure formally would be to look at our utilisation rates through our minimum data set through the various communities, relative to their prevalence in the population. It is fair to say that those communities are underrepresented in the treatment population. Some of that might be around biology and cultural practices with regard to drug and alcohol misuse—so in certain populations where alcohol use or illicit drug use is particularly stigmatised or ostracised and is likely to be less represented. But it is clear that they are underrepresented in the treatment population across the board. If I were to point out the thing that is the greatest difficulty that we have been working with the Drug and Alcohol Multicultural Education Centre on, it is getting access to timely interpreter services.

When I say interpreter services, not just people who can speak two languages but people who understand the health language. Health language is specialised and the sorts of things we are looking at are nuanced. I am trained in psychology and if I talk to somebody whose first language is English, that takes a number of efforts to nuance out the message that someone is trying to send you with regard to what is happening to them psychologically. If you add a layer of another person and another language and another set of cultural paradigms, it becomes incredibly complicated. Clearly, we are not doing that as well as we could. I cannot give you another answer except to say we have not come up with a method of getting that communication such that people feel comfortable coming into our services.

The Hon. JAN BARHAM: I want to go back to the issue of foetal alcohol syndrome. Studies have been done in Western Australia. How much work has been done in New South Wales in relation to, particularly, the Aboriginal community?

Mr McGRATH: I will just go back to the genesis of some of the Western Australian work. Again there was an intergovernmental committee on drugs. This was brought up as a national issue and a national project was undertaken by a group of expert clinicians across the country, including some from New South Wales. There was a consortium of three jurisdictions, of which New South Wales was one, which developed the foetal alcohol syndrome monograph, which mapped the problem and mapped the action pathways on a national basis to begin to address our concerns about foetal alcohol spectrum disorder. Clearly, prevention is the number one priority in this regard and getting appropriate warnings, both through general practice and on alcohol labels to warn about the dangers of drinking while pregnant or intending to become pregnant. The screening methodologies that have been promoted through the monograph and picked up by Western Australia are the

screening methodologies we are looking at here to improve people's capacity to identify foetal alcohol spectrum disorder in the treatment population.

The thing that concerns me a little bit is, the experts universally, not just in Australia but across the world, do not have a specified set of treatment interventions that differ from the general treatment interventions to assist with this particular group to improve the outcomes for the individual patients identified with this disorder, which is often a dangerous thing to do, to tell somebody they have a problem but there is nothing we can do about it that is different. So, I am concerned to make sure that when we—

The Hon. Jan Barham: Are you saying it can really only work as a preventative strategy?

Mr McGRATH: No, I am saying the preventative strategy is number one, where you want to start, but if we are going to roll out the new screening tools to our clinical population I need to give them a menu or a toolbox to operate with when they screen and find somebody has a problem and it is not just a matter of applying a label. It is a matter then of applying a differing treatment methodology. A conversation I have had with a number of experts in this space.

The Hon. JAN BARHAM: Does it have its own value in some of the research that is defining the number of people who have been psychologically and personally damaged by not being recognised as having the syndrome and thought to be stupid or slow learners, and all those things, and it creates another psychosocial opportunity by having that definition of what it is?

Mr McGRATH: Certainly getting an idea of the prevalence is important from the perspective of the individual and also from the perspective of governments the purposes of identifying what the correct regulatory approach is. Any regulation in the alcohol space is complicated and needs to be well thought through. Clearly there might be an argument for some regulation with regards to alcohol and pregnancy but that needs to be treaded through in a very sensitive and careful way.

The Hon. JAN BARHAM: The issue of young people and whether there are enough residential places for them, my understanding from some of my reading and particularly from people I know who have young children, the value of the residential is to get them away from the cultural context that they live in and operate in that entices them. I know Victoria has some really good facilities, but New South Wales seems to be lacking in those youth-oriented ones?

Mr McGRATH: I go back to some of my similar answers: There comes a certain point in time where they have to be discharged from an inpatient facility if, indeed, they are in one. Most of the merits of intensive programs with young people can equally be achieved in the day program space. You have got to manage the skills training within the environment of the triggers or stimulus to use, and while those changes are important—and I do not mitigate the importance of this—but frequently it is the carers, the parents—

The Hon. JAN BARHAM: Who can often also have a problem.

Mr McGRATH: Indeed. But also they are looking for a bit of respite often from the difficulty of the young person.

The Hon. JAN BARHAM: That is nice.

Mr McGRATH: No, I understand the importance of it; I am not minimising the importance of it. But in terms of the best treatment outcomes for the individual, they are often best provided in a setting where they are exposed to the triggers associated with the drug and alcohol use in the first instance and done through a day program.

Reverend the Hon. FRED NILE: Just a general question. With the Needle and Syringe Program, do you have figures on the total number of needles that are distributed in New South Wales?

Mr McGRATH: I suspect you are getting frustrated with some of my answers to questions like this. It is not my portfolio area, unfortunately. Aids and Infectious Diseases runs the Needle and Syringe Program—Dr Jo Mitchell. She would have those figures, absolutely, but unfortunately I do not have them.

CHAIR: We can put it in writing to NSW Health.

Mr McGRATH: I will seek the answer from the relevant part of the Ministry for you.

Reverend the Hon. FRED NILE: You would not have the budget amount?

Mr McGRATH: Again, it is not my area. But I will seek the answer for you from the relevant part of the Ministry.

Reverend the Hon. FRED NILE: But with the programs that you are involved in, has anyone conducted an evaluation of the Needle and Syringe Program?

Mr McGRATH: Almost certainly. But, again, I would have to seek advice from Jo.

Reverend the Hon. FRED NILE: Not by the health department?

Mr McGRATH: Not my branch. But, none the less, I would be certain that an evaluation has been undertaken. But I would not be in a great position to give you the contents of those evaluations or any details. I would probably give you poor advice.

Reverend the Hon. FRED NILE: Apparently there is a vending machine now in Redfern. That is not related to anything that you do?

Mr McGRATH: It is not my portfolio. Again, it is Aids and Infectious Diseases.

CHAIR: Thank you, Mr McGrath, you gave us valuable insights. I remind all members that they can place further questions in writing. Mr McGrath, you have got 21 days to respond to any questions in writing. Thank you so much for coming in today.

(The witness withdrew)

(Luncheon adjournment)

CARLA UNICOMB, Member and Volunteer, Family Drug Support, sworn and examined:

TONY TRIMINGHAM, OAM, Founder and Chief Executive Officer, Family Drug Support, and

JUDY SMITH, Member and Volunteer, Family Drug Support, affirmed and examined:

CHAIR: If you wish to make an opening statement to the Committee you may do so now.

Mr TRIMINGHAM: I guess the three of us would like to take up that offer. Thank you, members of this Committee, for the privilege of giving evidence. We really do appreciate that. The three of us sitting in front of you share a very sad commonality in that we have all lost sons to drugs. Our organisation receives 28,000 telephone calls a year from families seeking support. Not all of them lose their children and family members of course, but we certainly see a number who do. We have 2,000 members and 140 volunteers.

From the start I would like to say that our organisation does not support, condone or promote drug use. The reality for us is that that would be the last thing we would want to do. We do, however, accept the sad reality that many people in our community use drugs, a lot of them without serious negative consequences, but, unfortunately, some with very severe consequences. We support evidence and we support a wide range of treatments. It would also be true that all family members, in my experience, would like their loved ones to be drug free. That would be their ultimate hope and goal. But, of course, when you have dealt with this issue for a period of time it is obvious that that is not always going to happen in the short term. One of our concerns is that 95 per cent of drug users do not actively seek treatment at any given time. We believe that those people and their families deserve services and support. We want to operate from that reality.

We know that this is an inquiry about treatment, but we also believe that, in the broad range of treatment, ancillary services such as ours should be supported. We support the families who support the drug users. Whilst we are not directly involved in treatment ourselves, we think we provide a very important service to the community. We have been funded by New South Wales government since the year 2000, but we have never been funded adequately. Despite many attempts with both Governments since that time, we are still not funded adequately. Of course, that is a great concern to us. I will wrap up by saying all family members want their loved ones to be safe. That is why we support the philosophy of harm minimisation as well as other treatment services, because many people do eventually make their decision to give up drugs completely, but it can take many years and many attempts for a lot of those people. Thank you.

Ms UNICOMB: I am a registered nurse, but I appear today in my capacity as a member of Family Drug Support and the mother of James Unicomb. On 7 September 2005 my son James had a naltrexone implant inserted into his abdomen. He only had a very brief assessment by a medical practitioner and a psychologist, and we were told that the implant would last up to 24 weeks. I asked the psychologist who owned the clinic if there was a possibility of undertaking blood naltrexone levels and he said no, because it was very expensive and it would take some time and that is why the implants would be replaced after 12 weeks. So, in my mind, I still thought it would be effective for 24 weeks.

When a naltrexone implant wears off you are at high risk of overdose. At the 12 week mark James used heroin and died. On autopsy there was no naltrexone detected in his blood. We tried very hard for many years to get someone to look into that, because we did not want it to happen to anyone else. Finally last August there was a coronial inquiry. The coroner found that James was given incorrect information about the life of the implant, that he probably was not suitable for the implant as he did not really want to have ongoing counselling, and that a long-term methadone program would have been more appropriate for James's addiction.

The medical and nursing staffing at the clinic where the insert was made was extremely inadequate. The assessment process, the staff training, treatment protocols and post insertion follow-up information about possible alternative treatments were completely inadequate. At the moment I do not think naltrexone implants, the way they are at the moment, is an option for people undergoing drug addiction, but I do not rule it out completely. I think if naltrexone implants were to be used that there needs to be proper research done as to the effectiveness of the implant, the Therapeutic Goods Administration needs to improve the implant for its use, and we need to have health professionals with extensive experience in this field and people who can properly assess these individuals. These should be medical tests, especially blood tests, taken on a regular basis to see that the implant is still effective and there should be counselling support and follow-up services available for the person.

I think high-risk individuals, such as people with severe substance dependence, need treatment to be delivered with the same if not greater protocols and safeguards as individuals receiving treatment for other illnesses such as diabetes or asthma. I also do not consider that the imposition of any form of mandatory treatment on persons with severe substance dependence is an effective solution for their issue. I think individuals with substance abuse should at least be given the option of different treatment options. I consider that individuals with severe substance dependence are entitled to be given the opportunity, after consultation with trained health professionals in this field, to choose the treatment option that best suits their needs.

Ms SMITH: Thank you for the opportunity of speaking before this Committee today. My name is Judy Smith and I live in Katoomba, Blue Mountains. My son and my only child, Daniel, died in January last year from an accidental heroin overdose. He died alone in my car early one Sunday morning in a quiet residential street in Blackheath, but across the road from a well-known drug dealer. He was 28. Daniel's battle with heroin lasted nine years and for most of that time he was living at home with us. It was a terrifying time, but somewhere along the way we learned not to be afraid. We embraced harm minimisation, because we had to, in order to keep him as healthy and as safe as possible. I also do not condone drugs, but when I finally faced the reality of heroin addiction I made a conscious decision to stand by my son, always with the focus that one day he would get through it and he would be well enough to lead an independent, peaceful and contented life.

Daniel did not grow up in an abusive or dysfunctional home. His early years were very happy and balanced. He was private school educated, including extensive drug education. He was intelligent. He had a university degree. But, he suffered from anxiety and low self-esteem. He had a strong social conscience and was constantly worried about his place in the world. Daniel was on the methadone treatment program for eight years, which enabled him to remain stable, to function and to have employment. Prior to his death he had completed a rehabilitation program, reduced his methadone and successfully transferred to buprenorphine. His drug use had almost stopped. He was looking good and he was talking positively about the future. He did not have a criminal record and he never contracted hepatitis C. He was his own worst enemy. Unfortunately, his death appears to have been caused by a combination not just of heroin but also of alcohol. Thank you.

CHAIR: I know it is hard to tell these personal stories and journeys. We appreciate that you have taken the time to come in and share that with us. Because we have limited time, I will go to the recommendations in your submission. One recommendation is to expand existing opioid replacement treatments such as methadone and/or buprenorphine especially in areas where waiting lists for treatment are particularly high, for example the Hunter area. We have heard about long waiting lists in certain regional areas. Why do you place this emphasis on the Hunter area? Do you have some information?

Mr TRIMINGHAM: Yes. We take phone calls from all around Australia on our support line, but we have had particularly sad stories about the Hunter and the absolute long waiting list that people experience there. It is not just the Hunter though. We have heard of people living in small country towns where the local prescriber may have a full book. In those cases the family has had to move to another area in order to get methadone treatment, or do without. That is intolerable in the modern era when we should have these services available to anyone who needs them anywhere they need them.

CHAIR: Your recommendations state, "Improved access to and integration with mental health services for AOD [alcohol and drug] clients", Improving focus on targeted AOD clients most at risk – GLPTI, Indigenous, and prisoners", and "Expanded access to naloxone …". We will leave naloxone for a minute. But by improving focus and expanded access, are you talking about increasing the funding, or is there any other targeted approach that you are implying?

Mr TRIMINGHAM: Sadly, I do not think there is any way we can expand any service without funding. I think that is an imperative. But I think we do need more treatment services of all kinds, both residential, rehabilitation, pharmacotherapies and I guess, as I said earlier, the ancillary services, such as Family Drug Support, to ensure that people not just directly are having treatment, but those around them are supported as well; so, everything. But I think, yes, of course it comes down to funding. Our great concern is that we have heard, particularly in New South Wales and Queensland, that budgets are tight and funding cuts are happening across the board. We are very, very concerned that one of the first targeted areas would be drug and alcohol issues because of community perception and the negative attitude that a lot of people have towards these issues.

CHAIR: Do you think that is changing? Do you believe that the community is understanding more because people like Ms Unicomb, Ms Smith and you? Everyone can tell you anecdotally they have had someone in their family circle affected by alcohol and/or drugs.

Mr TRIMINGHAM: I think that there has been a small move to a more tolerant attitude across the board. I have particularly seen that in government circles, and I welcome that. When we started, families were not mentioned but they are now part of most governments' drug policies. But I still think that if I go to a school or a university and talk, I can talk to a maximum of 200 people. When Alan Jones opens his mouth, he speaks to hundreds of thousands. When those people have attitudes that are so anti drug treatment and opposed to progressive measures to counter the drugs problem, they get far more attention than we do. Unfortunately I think it is very, very slow going.

CHAIR: Your recommendations also state, "Expanded access to naloxone in order to reduce the increasing numbers of accidental opiate overdose deaths in Australia". Currently naloxone is administered by paramedics and by accident and emergency professionals. Who did you have in mind expanding it to? It is a very powerful drug.

Mr TRIMINGHAM: But there is no damage or harm that can come from it. This is a very, very strong opinion of both myself and many of our members. In fact, our members were involved with the Kirkton Road Centre and the National Drug and Alcohol Research Centre [NDARC] in a survey. Our members fully supported being trained to use it. In states in America, particularly in Chicago and in Europe, naloxone is available over the counter. I know the medical profession in general is not in favour of giving up control of this in Australia, and this is where I am at loggerheads with them. Even good friends of mine, like Dr Alex Wodak whom I respect, does not believe in the distribution of naloxone. We do. We feel that it should be available to family and friends of all drug users because we know it would save lives. It is something that can be administered quite easily with basic training. If it just saves one or two lives a year, that is one or two people who do not have to go through what we have gone through.

CHAIR: Pharmacologically, though, when you are talking evidence-based findings—some of you have mentioned evidence based—at the end of the day we have an evidence based pharmaceutical benefits scheme, an evidence based emergency medicine resuscitation protocol and evidence based every section.

Mr TRIMINGHAM: Absolutely.

CHAIR: At the end of the day, whether it is naloxone given more openly or naltrexone implants, you would say that you have to follow an evidence-based protocol.

Mr TRIMINGHAM: Absolutely, and we should not introduce it wholesale. We should have clinical trials. I notice it is actually happening in the Australian Capital Territory and I believe it is on the counter for New South Wales, and I hope it proceeds. But, yes, of course there should be trials, but in my view it is something that we definitely should be trialling because I believe the evidence will be strong when we do it because it has been proven overseas.

The Hon. JENNIFER GARDINER: I thank all three of you for your submission and also for those harrowing stories that you have been brave enough to tell us about. You have a list of recommendations. Could I ask each of you to state the number one thing that you would like to see this inquiry recommend, if you had your druthers?

Ms UNICOMB: I think what I would like to see, as I said before, is that people with an addiction problem be given a treatment option, that it should not be forced onto them, because there is no one-size-fits-all. Everybody is different.

The Hon. JENNIFER GARDINER: Flexibility, and a range of options?

Ms UNICOMB: Yes.

The Hon. JENNIFER GARDINER: Mr Trimingham?

Mr TRIMINGHAM: Yes, I broadly concur with that. I think all treatments should be supported as long as they are evidence based, but I believe we can do more and should do more. But within all treatments

should be the recognition that dependence is a long-term thing; that is it not simply a question of getting people into any form of treatment immediately; that with alcohol, it takes many, many years for people to recover, if ever; that with heroin, one-third of people die of overdosing, one-third of people never recover and of the one-third who do on average take 15 years and 15 attempts.

Ms SMITH: The one thing that became very obvious to me during our struggle was that it is very easy to detox from heroin. I feel that I would like to see more funding or more detail thrown at the psychological implications of long-term drug use. You know, simply going to a drug and alcohol counsellor once a fortnight—and I can only speak from my situation—was not enough during the bad times. It really needed to be daily, and yet we did not have the resources or the facilities in the Blue Mountains to allow that to happen. Counsellors often were not located there. They had to travel there and they were there only for certain days. It is not just a physical problem. It is certainly a highly emotional and psychological issue.

The Hon. JENNIFER GARDINER: Having counselling available on such a constant basis, how would that work in many parts of the State where, as you point out, counsellors simply are not physically located in some places in any great numbers?

Ms SMITH: How would it work?

The Hon. JENNIFER GARDINER: Is there some option maybe for some telephone counselling to back up the weekly visits person to person, for example?

Ms SMITH: That is a possibility, but obviously the ideal is having face-to-face counselling; yes, maybe having someone on the end of the phone, but ideally it would be perhaps having someone more available at the community centre; rather than one or two days a week, maybe having someone everyday. Often they were so booked out, my son could not get in to see anyone.

The Hon. JENNIFER GARDINER: Even when there was someone that he was seeing, he could not get access to them because they were simply too busy.

Ms SMITH: Yes, or often they were just there for certain hours. They were only there for two or three hours a day. I just found with it, you know, he often did not have access when he really needed to talk to someone and, you know, having the people that had the proper qualifications to be able to handle these very complex drug and alcohol issues.

The Hon. JENNIFER GARDINER: Sure. Thank you.

The Hon. SHAOQUETT MOSELMANE: I thank you all for coming in, particularly having heard your harrowing stories. I certainly appreciate the part of the inquiry that tells us on a personal basis what happens when people unfortunately are caught up with drugs and alcohol. Ms Unicomb, in terms of your son, the first 12 weeks on this naltrexone implant, how was he doing for that 12 weeks?

Ms UNICOMB: For approximately six weeks, he did well.

The Hon. SHAOQUETT MOSELMANE: Right.

Ms UNICOMB: After that, I could see signs he was going downhill. I am a nurse. I could not quite put my finger on it. I thought he was using some drugs; I was not sure what. He started associating with the same people and he himself told me that he then went back to the clinic and told me that the implant had been faulty and he was getting a new one. That fact has since been denied, but that is what he told. I am not sure how long the implant lasts for, and that is my concern.

The Hon. SHAOQUETT MOSELMANE: You thought it was for 24 weeks.

Ms UNICOMB: Yes. I was told for up to 24 weeks. In my mind, I felt at peace. I thought, "I can sleep at night because he's got an implant. He's not going to overdose." Then that was not the case. I think that is why at the moment, the way they are, they are high risk.

The Hon. SHAOQUETT MOSELMANE: Was there communication between your son and the surgery or the doctors when complications or issues started in six weeks time?

Ms UNICOMB: No.

The Hon. SHAOQUETT MOSELMANE: There was no follow-up from either side.

Ms UNICOMB: No. There was supposed to be the implant and follow-up counselling. My son said right there and then when he got the implant inserted, "I don't really want counselling. I will go to NA meetings instead." That is why I think he probably was not a suitable candidate. I think you need to be really ready to give up the drugs before you have an implant, but they still went ahead and inserted it.

The Hon. SHAOQUETT MOSELMANE: At that time, was there any briefing as to the amount of counselling he would get throughout the process?

Ms UNICOMB: Yes. I went with him and I spoke to the psychologist who offered counselling. James said, "No. I'll keep going to the NA meetings." That was it. There was no more follow-up with the clinic until his death.

The Hon. SHAOQUETT MOSELMANE: You stated categorically that there should be no mandatory treatment.

Ms UNICOMB: Yes.

The Hon. SHAOQUETT MOSELMANE: No-one should be forced, or the implant should not be imposed on anyone.

Ms UNICOMB: That is right.

The Hon. SHAOQUETT MOSELMANE: We have noticed from recent evidence that people sometimes who are under significant effect from drugs or alcohol sometimes have difficulty making decisions. An implant in those circumstances may help that person come to a situation where they can then make a decision whether to proceed or continue. Mr Trimingham, you are shaking your head. Can you respond and tell us why not? That is one of the issues, I think, that this inquiry is looking at.

Mr TRIMINGHAM: Yes. Heroin dependence—which is what naltrexone implants are broadly used for, even though George O'Neill claims he can cure everything including smoking—is not just a physical problem. I think this is the point Carla is making. There is a place for naltrexone and there is certainly probably a place for naltrexone implants after proper clinical trials and approval, but it only addresses the physical elements of dependence. As Judy and Carla both said, there is more to dependence than physical. It is a psychological and emotional issue, which is why assessment of how people are is so important. When people are well and truly psychologically and emotionally ready, I believe naltrexone will work. But I believe it has been absolutely ruined by the people who are practising now, in the way they are doing it. I think that is the sad thing.

I might add that for something like 15 years now, putting have been putting implants in people under an emergency clinical trial, which just seems bizarre. For 15 years, something that is supposedly only to be used as an emergency and as a trial is still existing as regular treatment for many people. One of the sad things that I see, of course, is that a lot of these practitioners prey on that desire of families to have their children drug-free. They get to both the drug user and the family when they are vulnerable and sell them the idea of drug-free, and we see the negative consequences. I know of at least five deaths of people on naltrexone and lots of other negatives too.

Ms UNICOMB: Could I just add something there? When James had his autopsy, the medical examiner was not even looking for a naltrexone implant. We asked him to have a look, so I wonder how many other deaths there have been of people with naltrexone implants where the medical examiner has not even looked for the implant. The other thing is that naltrexone only works on heroin. If a person is not ready to live a drug-free life, then naltrexone might stop them using heroin but then they go on using other drugs.

The Hon. HELEN WESTWOOD: Thank you for coming in today and also for your submission. Was James' death one of those that the Coroner inquired into dealing with that clinic?

Ms UNICOMB: Yes.

The Hon. HELEN WESTWOOD: A number of witnesses have given evidence about the broad issue of funding for drug and alcohol services and treatment in the wider sense of the word. People have been critical that funding has not grown in the same way as, for example, mental health. Certainly some witnesses think that it should not just be seen within the parameters of mental health; it should be seen as an area of medical practice separate to mental health. Could you comment on that?

Mr TRIMINGHAM: Yes. On the issue of combining mental health and drug treatment, I am in broad agreement because for a long time people fell between the cracks and you could not get one if you had both of them. That has been an improvement. However, as it has developed and the way governments have gone, drug and alcohol is now the poor relation in the partnership. I believe that mental health gets a much better public profile than it did many years ago; drug and alcohol still lags behind. FDS struggles for funding. We started as a group of parents in 1997 and we were self-funded for three years. In fact, my business funded the organisation.

After the Drug Summit, which was a turning point in many ways, we received our first lot of recurring funding, but it was $100,000 for a service that cost $350,000. We were only able to survive through donations from people who we helped. Since then our funding has gone up to $185,000 recurring in New South Wales. We are a national service, but 70 per cent of our clientele is New South Wales based. Victoria has a service called Family Drug Help, which receives $750,000 a year and has done for the past 10 years. We are still on $185,000. We get 28,000 calls; they get 3,000. We provide more than a telephone service. I have given each of you an envelope with details of what we do.

We know only too well the limitations of funding. I do not want to make out that we only have the $185,000. Every year since 2000 we have topped up with about an extra $120,000. So we are now receiving about $300,000 but our business plan is still for $500,000. The business plan that the Government commissioned two years ago is still sitting on a shelf and we still have not been given approval. So we live a hand-to-mouth existence year after year. It is just intolerable. We are providing support that these families get from nobody else. This is just my experience but I am sure it is mirrored by many other services. At the same time I believe that we should be accountable. We have been fully accredited since 2000 and we know that there is waste. I am sure there is waste in drug and alcohol services. I think all services should be accountable, but certainly family support is one that should not be left out of the equation. Thank you for giving me the opportunity to get on my soapbox.

Reverend the Hon. FRED NILE: Thank you for coming in and sharing your very sad stories of losing your three sons. I do not know how I would have survived if I had lost one of my three sons. Your experience is part of the reason—one of the main reasons I suppose—I am involved in fighting the whole issue of drugs. You probably think I am not fighting it in the right direction.

Mr TRIMINGHAM: I think we shared similar opinions about alcohol when were at the Alcohol Summit

Reverend the Hon. FRED NILE: That is right, and with tobacco as well.

Mr TRIMINGHAM: Yes. But maybe on drugs we divert.

Reverend the Hon. FRED NILE: I campaign against all drugs, legal and illegal, to help young people in our society. We have to try to evaluate the conflicting information we receive. Ms Unicomb, I note that you said you had no objection to a proper trial of Naltrexone by the TGA?

Ms UNICOMB: Yes.

Reverend the Hon. FRED NILE: In view of your experience where, obviously, it was misused.

Ms UNICOMB: Yes.

Reverend the Hon. FRED NILE: And contributed to the tragic death of your son.

Ms UNICOMB: Yes.

Reverend the Hon. FRED NILE: But, Mr Trimingham, in your submission you said that you are opposed to it as well because of the high rate of mortality. What is the evidence of the high rate of mortality through using Naltrexone? Has anyone actually died from Naltrexone?

Mr TRIMINGHAM: I think the Coroner's inquiry suggested that they had.

Reverend the Hon. FRED NILE: From Naltrexone or from an overdose following the Naltrexone treatment?

Mr TRIMINGHAM: To be pedantic, I do not think anybody has ever died from an overdose of Naltrexone, no.

Reverend the Hon. FRED NILE: That is the point I wanted to make.

Mr TRIMINGHAM: I think that the treatment and the way it is administered definitely has produced mortality and I think there are many recorded deaths. I am not a researcher. I am not an academic. But I have read many research papers about mortality and I understand you have submissions from NDARC and other organisations to that effect. Nobody dies from Naloxone and that, and Naltrexone is similar to Naloxone in its effect; it is an antagonist. Certainly, people have died because they have gone on Naltrexone treatment, whether it has been rapid detox or implants. I am not opposed to Naltrexone either, let me make that clear. I think Naltrexone has been very well used in helping with alcohol dependence and I believe it would have good use with opiates if the assessment, the follow-up and the after care is well provided. I might add that that will also apply to all treatments, not just Naltrexone. I think we can certainly improve our methadone services in the same way.

Reverend the Hon. FRED NILE: That is exactly what we were told at the Fresh Start clinic as to the requirements for the use of Naltrexone; that is the policy of that clinic. Obviously, another clinic was operating. I assume that the one you referred to was in Sydney?

Ms UNICOMB: Yes.

Reverend the Hon. FRED NILE: That has since been closed down.

Ms UNICOMB: No. I heard it is still operating.

Mr TRIMINGHAM: The psychologist has been deregistered but the business continues.

The Hon. HELEN WESTWOOD: He gave evidence to us at the first hearing.

Reverend the Hon. FRED NILE: Obviously, that clinic deserved the criticism for the way it was functioning?

Ms UNICOMB: Yes.

Reverend the Hon. FRED NILE: And probably did contribute to your son's death.

Ms UNICOMB: Yes.

Reverend the Hon. FRED NILE: As far as we know, Naltrexone is supposed to take away the desire for drugs for up to six months, not a few weeks.

Mr TRIMINGHAM: If I could make a comment, Reverend Nile. What puzzled me about this inquiry was that I understood it to be a broad look at all treatments for drug problems, yet we seemed to have narrowed it down to talking about Naltrexone, which is really quite a small part of the whole treatment regime for dealing with drug and alcohol issues. I guess I am just puzzled by that as someone who has been involved for 17 years now. Why the focus on Naltrexone? Why are we not more broadly speaking about much bigger treatment options that probably are far more effective?

Reverend the Hon. FRED NILE: We are looking at all treatment options. There seems to be a ban on Naltrexone to even be considered.

Mr TRIMINGHAM: Only because it has not yet been properly trialled and evaluated.

Reverend the Hon. FRED NILE: That is why we are trying to open the door to another opportunity if it may save some drug addicts. If it may save, as you say, one life, it should be investigated.

Mr TRIMINGHAM: You could say the same about heroin prescription, which I believe would be a very good option to trial. We almost did it 17 years ago.

Reverend the Hon. FRED NILE: I notice you are very strongly opposed or critical of Naltrexone in your submission, but you are quite happy to supply heroin to addicts. I find that pretty inconsistent.

Mr TRIMINGHAM: Where is the inconsistency?

Reverend the Hon. FRED NILE: Heroin is a harmful drug. That is the whole reason we are trying to ban it and stop it.

Mr TRIMINGHAM: Heroin dependence is a terrible affliction. Its three major damages are overdose deaths, blood-borne diseases and crime. Where countries actually have prescription heroin or the like, those three causes are eliminated. It does not mean that heroin dependence is not a terrible thing to live with. It is. There are more impacts than those three, but heroin prescription is evaluated, has been trialled and has been successful in many places. Naltrexone does not have a good record in effectiveness to this point. So I do not see that as inconsistent. I can see the moral objection to providing a drug of dependence. I can see that and I can understand that that is where you come from. I have always understood you and understood people in your position on that. I have no problem with your view. I differ from it, but I understand it.

The Hon. JAN BARHAM: Thank you all for coming along. I am sorry for your loss, but what you have done today is broaden the way we are thinking about this issue: the extension to family and the ripple effect of how many people it impacts on and how many people need support. Judy made the point about counselling in remote areas. I am from the regions. Do you support the idea that training be given to family, friends and those nearest and dearest to provide that support and for government to realise the broadness of that support? A public servant or an NGO will not always be provided, but at least there should be recognition of those who loved someone in this pattern of behaviour.

Ms SMITH: To provide training counselling?

The Hon. JAN BARHAM: Not strictly counselling, but an understanding of how to support someone, as you do?

Ms SMITH: Of course I would encourage that. Through finding Family Drug Support and doing the training courses with them, which were the only things that were available to me at the time, I went on to become a volunteer counsellor and I used to man the volunteer phone lines and listen to other people's stories. Through all that experience I learnt to deal with my son's problems and, in effect, I became his counsellor. He used to come to me and we would talk about all sorts of things as I gained his trust and confidence over the years. But I would encourage any further training that would have been available. You can never learn enough.

The Hon. JAN BARHAM: Carla, did you want to say something?

Ms UNICOMB: Yes. I think it would be good for the families to have some training. But as for the families counselling their son, it becomes very hard because you are already very emotionally involved and that is where something like Family Drug Support comes in to support the families. Often you are at a loss; you just really do not know what to do.

The Hon. JAN BARHAM: I am aware of the good work that is provided. The point you make in one of your recommendations relates to cost for those who use methadone. Can you expand more on the review of the dispensing fees and how that might affect people trying to be in an opiate maintenance program?

Mr TRIMINGHAM: I guess the price of methadone is either very cheap or very expensive, depending on the means of the person accessing the service. For some people it would be regarded as a very cheap alternative to heroin. It is certainly cheaper than heroin off the street. But to some people whose means

are minimal, it is too much. Therefore, they resort to crime and other activities, prostitution and dealing, to support any habit they might have. We believe methadone is not a particularly costly alternative and to provide it free of charge across the board to my mind would be money well spent.

The Hon. JAN BARHAM: Through your service have you come across any trends or degree of poly drug use, prescription misuse and combination with alcohol, any of those sorts of things?

Mr TRIMINGHAM: Yes, certainly. We have talked a lot about heroin today and we are all affected directly by heroin, which is probably why, but yes we do. Our service picks up very quickly on drug trends. We recognised the heroin shortage within two months. In our first year of operation heroin was 49 per cent of the calls we took and last year it was nine per cent. There has been a dramatic reduction in the use of heroin. As that reduced we have seen alcohol related issues rise from four per cent to 24 per cent. We have seen the stimulant drugs increase, all of them, particularly speed and ice or crystal methamphetamine. When we started the combination was about nine per cent and it is now 20 per cent of calls.

The one constant is cannabis, it seems to operate around the 25 per cent mark across the board. A lot of people use cannabis without problems but we see the problematic side of it and that is the calls we get. By the time people come to Family Drug Support it is not recreational, it is usually traumatic and out of control. The latest trend is the use of prescription opiates amongst older people who have initially gone on to them through legitimate pain relief but have become hooked and now we are seeing a large number of older members of the population dealing with legal opiates.

The Hon. JAN BARHAM: Do they come to you seeking help?

Mr TRIMINGHAM: The families do. It is more children in their cases.

The Hon. JAN BARHAM: There is a role reversal?

Mr TRIMINGHAM: Yes.

CHAIR: On behalf of the Committee and inquiry I thank you for taking the time to come in and speak to the Committee this afternoon. I remind members if they have questions for the witnesses to put them in writing. You will have 21 days from the receipt of the questions to reply. The secretariat will be in contact with you if there are any such questions from members. Thank you for coming in today.

Mr TRIMINGHAM: We really do regard it as a privilege. In all your deliberations do not forget the families because that is what we are about.

(The witnesses withdrew)

BRENDAN THOMAS, Assistant Director General, Crime Prevention and Community Programs, Department of Attorney General and Justice, and

ANNE MARIE MARTIN, Assistant Commissioner, Offender Management and Policy, Corrective Services NSW, sworn and examined:

CHAIR: There is an opportunity to place any opening statements on the record. Do you want to make an opening statement?

Dr MARTIN: No.

Mr THOMAS: No, thank you.

CHAIR: The brief is comprehensive. The Committee members spent the weekend going through it. On page five of your submission you outline the services: Getting SMART Program, Sober Driver Program, Intensive Alcohol and Drug Treatment Program, Ngara Nura Alcohol and Drug Therapeutic Program and the Compulsory Drug Treatment Correctional Centre. What sort of measurement is there of successful outcomes from those programs? Is there fine-tuning based on any evaluation of outcomes?

Dr MARTIN: Generally how we evaluate the programs is by looking the re-uptake of abusing substances or reoffending. There are a few general indicators around participation rates, completion rates, reoffending rates and psychometric assessment pre and post change as well. Within the briefing that you have been given you will see that some programs such as the sober driving type complainant over the last few years have had reductions of 40 to 50 per cent. Others such as the Getting SMART program have only had around a 15 per cent reduction. There are some programs where there have not been formal evaluations as yet but all of the programs are based on what is seen in the psychological area as best practice principles.

The three main principles the programs are based on are: Having the right intensity, targeting the right areas relating to risk of reoffending and also ensuring the programs address any response issues such as the people engaged in those programs can understand the program, that it works to their learning styles and it overcomes any barriers in that way. In terms of the question concerning developing what we do and looking at that into the future: Yes, we are. It is one of the tasks I have been given. I have only been with Corrective Services NSW for the last three months and one of the tasks I have been asked to do is look at the offender management and policy division both from a staffing point of view and the scope of programs into the future. I have made it quite clear that we need to look at internal and external partnerships for the ongoing monitoring and evaluation of what we do, not only in terms of monitoring the effectiveness but increasing transparency around what we do—which is needed.

CHAIR: I notice in reading the report that when it got to waiting list periods—you are honest—it seems to be a common theme that there is no waiting period for access to individually run intervention programs or the assessment phase and group delivered programs tend to be run when there are enough young people to form a group. Waiting periods are not measured or reported on; is that my simplistic interpretation of reading the report?

Dr MARTIN: It is not a simplistic interpretation. Programs targeting substance abuse can be delivered anywhere in a person's sentence. There is no reason why, if somebody is able to engage in one of these programs, they should not be offered the opportunity at some point in time. With programs targeting other areas such as violence, sex offenders or domestic violence there is a much bigger discrepancy between the number of specialist staff that can be involved in delivering that and who needs to go into those programs. That is a group that we are constantly monitoring and push but in the substance abuse area all of our service and programs officer positions across Corrective Services NSW can get involved in those programs. There are a large number of staff that can support and push it through and we have a fairly high turnover in those programs both in custody and in the community. We do not, as you have noted, monitor the waiting list for those groups.

CHAIR: Is there any plan or need to do that into the future, let us say for budgeting purposes?

Dr MARTIN: My understanding is that everybody that needs one of those programs can be offered an opportunity to participate in one of those programs, so monitoring might have limited effect in that way.

CHAIR: With a change in patterns of drug usage that we have been hearing about from the previous witnesses and also the link between mental health issues and illicit drug intake—I am not saying one necessarily goes with the other, sometimes one can lead to the other and vice versa—in terms of training the personnel within corrective services have you changed training programs to take that into account? I know emergency medicine departments can often be very violent, there can be a lot of aggression and so NSW Health has to train personnel to deal with it. What are we seeing in Corrective Services NSW?

Dr MARTIN: I will answer it from a Corrective Services point of view. What we have been seeing is greater partnerships with Justice and Forensic Mental Health in the training of staff, particularly in units where we have inmates that are fairly difficult to manage. We have a number of crisis units and safe management cells in different areas where we work closely. Justice health are involved in the training of staff in those areas. I think even within the last six months there are some positive developments in terms of partnerships with justice health. We have a lot of committees with them in terms of clinical governance and working with different inmates and offenders. That is moving forward. We have different personality disorder units, so there is a whole range of different set-ups happening moving towards an approach where we have, at some sites, a mental health screening unit having separate step-down step-up units. There are satellite services across the State which might not have as many justice health staff directly involved but our staff will be up-skilled and trained to provide appropriate support in those areas.

Mr THOMAS: My area of the department deals with programs at court level and in that sense we rely very heavily on the Justice and Forensic Mental Health Network for the provision of the treatment services. There is not so much a need to up-skill staff but we have over a number of years provided training to solicitors and others in the criminal justice process so they can better understand the drug using patterns of their clients and that has been beneficial.

CHAIR: Looking at trends in corrective services over the last 10, 15, 20 years, are issues with management of alcohol and drug offenders taking up a larger proportion of the budget, are there more people presenting with those issues or are they being better diagnosed or a bit of both? Is there anything positive that we can point to in order to show we are managing better even though presentations might be on the increase?

Mr THOMAS: There are a number of mainstay activities that the justice system has had for a little while to deal with that, particularly prior to people coming into the correctional environment: The drug court and the MERIT program have both shown a strong reduction in reoffending rates for people who do go through those programs. The drug court has been evaluated two or three times and economically assessed at least twice and each time it shows a strong reduction in reoffending of approximately 37 per cent. The MERIT program is a pre-plea program at court and has shown a consistent 12 per cent reduction in reoffending. The number of people coming through the system needing that kind of treatment seems to be relatively stable. The numbers are not dropping but for those people who successfully complete those programs the rate at which they are continuing to offend is dropping.

CHAIR: It is dropping?

Mr THOMAS: Both of those programs have been successful in reoffending assessments

Dr MARTIN: I would also say despite the changes in the population we have some good programs and good staff in Corrective Services NSW that are doing a great job in terms of how they engage and work with the people we supervise. There is no reason to say that there are specific problems with the programs that are delivered, they do match the best practice principles. The challenge that we do have is that when people come under our supervision there might be substance and alcohol related issues but that is associated with some other offence whether it be violence, driving related offences or break and enters. The challenge in trying to breakdown the specific costs associated with that particular group is often quite murky and actually quite a challenge for us because of those other offending behaviours or presentation that goes along with it as well.

The Hon. JENNIFER GARDINER: Dr Martin, you said that you have only been at Corrective Services for three months?

Dr MARTIN: Yes.

The Hon. JENNIFER GARDINER: Could you tell us a bit about your role as Assistant Commissioner, Offender Management and Policy, and how much of that role is dedicated to drug and alcohol or do you have other responsibilities as well?

Dr MARTIN: I do have other responsibilities. I look after the cost centres, the ones around sentence planning so our classification and sentence management area, Corrective Services Industries, Prison Industries, which is quite a large area within Corrective Services and offender services and programs; there are around 173 services and programs officers staff. Then there are psychologists and there are also some program facilitator roles, around 40 program facilitator roles. I look after them within the actual program-type stream. I also have another much smaller area that is around the restorative justice area which looks at some conferencing and also support to victims of crime.

The Hon. JENNIFER GARDINER: What is the purpose of the review that you mentioned? You mentioned looking at staffing and effectiveness of programs and transparency. What triggered the review and when is that expected to be completed?

Dr MARTIN: A number of reviews have happened here over the last year or so. One of them had a strong outcome around Let the Leaders Lead initiative, pushing things down to the appropriate level wherever possible. The executive team has been almost halved really by the beginning of the year in terms of moving things forward under a new structure. Community Corrections has looked at a new supervision model, a new staffing arrangement where the level of supervision is now modelled against both risk of reoffending and the consequences of reoffending, so halved.

Now with me coming on board from February, I have been tasked to look at how things are running at the moment and how we might be able to have a more consistent, efficient service delivery model both in custody and in the community. When I talk about education, I am talking about psychological, education and support type services as well as improved case management and the whole gamut around the staff that I am responsible for really. Over the years a number of things have happened. I need to make a bit more equitable service delivery across the whole State and perhaps narrow down the scope of programs being provided so that everyone potentially has access to those programs.

The Hon. HELEN WESTWOOD: Thank you, Mr Thomas and Dr Martin, for joining us today and for your very detailed submission; I am still wading through most of the detail. I am particularly interested in whether you have been able to measure the efficacy of some of the programs. In the evidence we have received to date it does seem as though that can be quite difficult. I guess that is my first question: Do you feel there is currently a program that you can be confident measures its efficacy?

Mr THOMAS: The most obvious one that has been assessed most often and most vigorously is the Drug Court. What is slightly different for us to other treatment providers is that people come to us because they have committed a criminal offence or they have been convicted of committing a criminal offence. So our first port of measurement is: Have they committed another offence? It could be that we provide effective drug treatment and they still continue to offend; it could be that we are not effective in the drug treatment but they cease offending. Often our first port of call in terms of assessments is whether or not people are continuing in offending behaviour and, secondly, particularly if that intervention is effective in reducing offending behaviour, to try to look at what is happening. As I have mentioned, the Drug Court has been evaluated at least twice independently by the Bureau of Crime Statistics and Research. It has also been evaluated by the Centre for Economic Health and Research at the University of Sydney.

There are a number of other international studies of Drug Courts around the world looking at similar kinds of things. Those evaluations are quite independent and are published irrespective of what the results are. So we are quite confident that the effect it shows it is having is the real effect that it is having, particularly on crime. I should say the MERIT program has also been strongly evaluated for its health benefits as well as its offending benefits and it is showing long-term health benefits. We often find that people who are getting into these things, particularly MERIT, the first time that they get into some type of coordinated drug treatment is after a criminal conviction, which is a bit of a challenge for the program but also I suppose one of its more positive points.

The Hon. HELEN WESTWOOD: I am not sure I interpreted correctly an earlier answer you gave. We heard earlier about the need for a range of treatment options for people with addiction, whatever the addiction, and some flexibility within the programs. Is it possible to provide a range of flexibility within the

environment of Corrective Services with all the limitations and parameters you have? Did you say that you were trying to narrow down your programs so that when people are released they can continue with treatment should they require it?

Dr MARTIN: Yes, you can individualise any intensive program to an individual. Often what we call it is offence mapping but what it really is about is analysing how a person has come to commit an offence. So in this case it is: what is the role that substance abuse played in that? What were the triggers to using? For some people it might be to escape, for some people it might be to heighten positive affective-type emotion; whatever it might be, but for that particular individual you can then target those needs within a group setting. That can still happen in a range of programs quite easily. It is about making sure that the facilitators are tapped into the actual needs of each person they are working with, so that is fine.

At the moment we have got several different programs targeting multiple different areas and really it is hard to maintain them across all of the sites so in terms of reducing the scope, that means we can really up skill and reinforce certain skills in our staff and we can ensure that every site delivers that program across the State, which is great. We can ensure all the programs are targeted towards those who are the highest risk of reoffending or cause the greatest harm and we are going to get the best outcome in that group rather than the other groups, so I think it is a real positive way of going.

The Hon. HELEN WESTWOOD: What about culturally appropriate programs? That is something that has come up with organisations that provide to culturally and linguistically diverse communities. Clearly our jails have a population that is ethnically and religiously diverse. Are you able to deliver culturally appropriate programs?

Dr MARTIN: Yes. It is about understanding the actual values of whom you are working with and who are the right facilitators to deliver that. Of the research I have seen, say, if I look at the Australian Indigenous populations and only having Australian Indigenous facilitators deliver a specific cultural program, the research is a little bit mixed in terms of whether Australian Indigenous population benefits from being completely solely delivered on their own or whether it should be mixed. There are also challenges in the facilitators because of the relationship-type issues.

Then when we start to look at other cultural groups, whether it is to do with translation, language, values or spiritual beliefs, it adds another element to it, but wherever possible we try to have staff understand who they are working with and then tap into it, whether that is interpreters or other links in the community, to see whether this is going to work because the programs do not rely necessarily on reading and writing skills. They are supposed to all work from the individual's own belief system in a social way. They are fairly inclusive from that angle but that said, you sometimes get people who have clear language barriers. They would not be able to go into a group-based program like the ones we have circulated here. They would need to have more of an individual approach because it would be just too hard, the language plus the whole interactional issues that go along with it. Did you want to add anything?

Mr THOMAS: I was going to say we have seen some challenges over the years with the delivery of some programs. Again MERIT was a good example where we looked at the participation rate of Aboriginal people in that program. The big group in the justice system is the Aboriginal population; there is quite a significant number of people. When we looked at the number of people being referred to that program, it was a round about 18 per cent of the court population so it was relatively high. About 16 per cent of people going to a criminal court are Aboriginals so from that point of view it looked quite good, but when we looked at the participation rates and the completion rates, they just kind of dropped quite significantly so people were being referred to the program at a reasonably high rate but were dropping out of it at a faster rate than anybody else.

It pointed to a couple of things which were difficult to draw firm conclusions around but one was that people saw it as a diversion so they were just using it as a point of diversion rather than as a point of treatment but also that people were trying to send Aboriginal offenders with a drug problem to specifically Aboriginal-run programs which, at that point in time in particular had a very heavy focus on residential rehabilitation and there were only a small number, so you had a situation of people being sent to places that were far from their homes in places where they were away from their immediate family, which on the surface looked like they might have been providing a culturally appropriate treatment but when it came down to it for many people was providing treatment that was quite alienating and people were dropping out of it. The exact answer for that specific culturally appropriate treatment—I do not know that we have a clear and firm answer for that yet, but, as Dr

Martin said, just making the automatic assumption that you send an Aboriginal person automatically to an Aboriginal-run program is not necessarily always the best answer.

The Hon. HELEN WESTWOOD: You monitor the health of people who have been in prisons as they come in. There is a perception out there that drugs are readily available within our Corrective Services facilities throughout Australia; rightly or wrongly there is a perception about that, and the people can come out of prison with blood-borne diseases they acquired while they were incarcerated. Do you monitor prisoners' health and do you check whether people are hepatitis C positive and HIV positive or negative when they come into prison and then do you check their status again on their release and, if so, what are the figures showing?

Dr MARTIN: I cannot comment on the figures off the top of my head but we work in partnership with Justice Health around the reception assessments, which include medical assessment that looks at the needs and within that it will be identified if a person already has hepatitis or some other illness or disease of some kind. Then depending on that, that indicates what the plan is while they are in custody. Then there might be some other interaction that exposes them to a risk of some kind and when that occurs, again another assessment will occur at the appropriate time to see if a person has contracted some sort of disease, so it is in partnership. I apologise, I do not know the figures off the top of my head both in terms of reception and on release but there are a number of precautions that take place in terms of what we ask inmates to do, both in terms of the day-to-day recreation—using gym equipment for example and also cleaning-type activities of both their cell and common areas. Also the staff have to engage in a similar sort of behaviour when they are working in that environment.

The Hon. HELEN WESTWOOD: So, you test for Hepatitis C and HIV on entry to prison and if there is an incident you test again, and you test again on release?

Dr MARTIN: Yes. I should make it clear, the testing at the beginning may not always be blood testing. It will depend on the medical records that we have had come through and what the person says. Justice Health will make a determination about the level of assessment that has to happen. It is not routine that we give a blood test to everyone who is admitted to prison.

The Hon. HELEN WESTWOOD: Equally, it is not routine that you give a blood test to everyone on release?

Dr MARTIN: No.

The Hon. HELEN WESTWOOD: But you do have figures on the testing that is done?

Dr MARTIN: Yes. It would be in conjunction with Justice Health. Where Justice Health provides the medical staff, we would have to go through them and also similarly through some of their privacy issues to get some data, but whatever they do is recorded.

The Hon. HELEN WESTWOOD: Could you provide that data to the Committee?

Dr MARTIN: I can ask for that data through Justice Health. I am happy to do that.

The Hon. HELEN WESTWOOD: If you could take that on notice, that would be really helpful. I am wondering, too, if you have prisoners who are on the methadone program, upon release one of the issues we have heard about is the unaffordability of some pharmacological treatments. I wonder whether some prisoners on release have affordable access to methadone for a reasonable time upon their release, if they have been on the methadone program while incarcerated?

Dr MARTIN: When you say affordable access, are you saying is it subsidised in some way?

The Hon. HELEN WESTWOOD: Yes.

Dr MARTIN: Substitution programs are commonly set out while a person is in prison and it is recognised that on release that can be an at-risk period. People being released are given support to ensure that even those who might have had a reduced substitution-type program or replacement-type program, that that is offered to them both prior to release and following release, and that is monitored again through the health system after their release. That is something that is quite strong from our risk management perspective. It creates

some challenges for people who are in the prison system for a long period and some different thoughts about what we should be doing to try to even wean people off substitution-type or replacement-type programs. But the health model is fairly strong and clear around that risk upon release and there is quite a lot of support in that space.

Reverend the Hon. FRED NILE: Thank you very much for coming in. Your submission is impressive. I am wondering how we can get all the Corrective Services programs implemented throughout the whole of New South Wales, not just the people in prison—the Getting Smart Program, Save a Driver Program, the Intensive Alcohol and Drug Treatment Program and the compulsory Drug Correctional Centre Program. You provide in your submission the evaluation of each of the programs, which, again, is very impressive, particularly the one that interests me because we have been investigating whether compulsory drug treatment programs could work. In your submission you state:

> Data to date show that 80% complete stage 1 therapeutic programs (8-9 months); and 39% of those commencing the program have after a 2-3 year period achieved 'gold standard' graduation to end of sentence or Parole in the community. During this period they have improved all health measures, have had extended periods of time being and living in the Community with a cessation of drug use and offending …

As I said, I compliment you on that program. Would you like to comment on any other issues from your point of view?

Dr MARTIN: On the compulsory Drug Correctional Centre Program, the comment I will make is that unlike any other program which is a program itself, the whole centre is a program. The staff are heavily involved in training of that engagement, viewing lapses as something to take responsibility for and the consequences for. Many programs are embedded in it. It is sort of like what some people might call a therapeutic type community. But what you see through people who go through that program is that when they have some sort of lapse of some kind they will quite often be telling a prison officer well before the test is done what has happened, and there will be a change in regime and consequence for it. It is a different way of being within a correctional centre.

Obviously, the intensive drug and alcohol treatment program at John Morony is in its very new stages and the Compulsory Drug Treatment Centre has been operating for a little while now. It will be interesting to see how much we can replicate the benefits of the Compulsory Drug Treatment Centre within a much larger scale of a prison-type setting. I would say it is a unique program, the Compulsory Drug Treatment Centre and it has been strongly influenced by the initial staff that were involved in really driving and working that through and it is a credit to those who have been involved.

Reverend the Hon. FRED NILE: Have you been able to observe the responses of the prisoners themselves? What is their reaction? Obviously it is working. What is their personal attitude?

Dr MARTIN: I have been in there and have spoken to people in the Compulsory Drug Treatment Centre. They speak really positively about the level of support they get and see it as a real opportunity, that is what they say.

Reverend the Hon. FRED NILE: There is no atmosphere of rebellion against the treatment or not cooperating with the treatment?

Dr MARTIN: No, because most people who are receiving the service there know they are on a pretty good thing, being there as opposed to being somewhere else, and it is very different to any other jail or set up, so to lose that— it is a privilege to be there. They might not recognise that initially, but after a little while they switch on that it is a good place to be.

Reverend the Hon. FRED NILE: So they then cooperate with the program?

Dr MARTIN: Definitely.

Reverend the Hon. FRED NILE: It is similar to what happened in Sweden. I note you have evaluated the Drug Court as well, and this is evaluating against the two groups—those who are in the program and those who are not. You state in your submission after being through the program and being released from prison they are:

37% less likely to be convicted of an offence
65% less likely to be convicted of an offence against a person
35% less likely to be convicted of a property offence
58% less likely to be convicted of a drug offence

That is a pretty impressive result for the Drug Court. I imagine there would be plans to expand that, or are there any proposals to improve it or does it need any further legislative support?

Mr THOMAS: It has expanded to the Hunter and more recently to the rest of Sydney. As Dr Martin said with the Compulsory Drug Treatment Centre, people who are in the Drug Court know the consequences if they do not perform well in the court. It is giving them the opportunity to turn their lives around and they know that if they are not going to be on the Drug Court they are most likely going to be serving a prison term. There is a very strong incentive for people to do quite well while they are on the program. But one of the strings of the program is a very holistic approach to managing the offenders who are on it and it engages directly with them and often with their families and their spouses and children and other significant people in their lives to try to work with them or to try to turn their lives around.

It is a very strong team-based approach to working with offenders. It is very strongly overseen by that sort of carrot and stick approach. There is a benefit to participate in the Drug Court but there are very clear and swiftly applied sanctions for people who do not perform well. So, you often find people taking that opportunity with both hands. Again they speak very positively, and often their families are speaking positively, of their experiences while they are on the Drug Court. Often they are establishing long-term personal connections with judicial officers and probation officers and other people involved in the criminal justice process which you normally do not see in the regular court system.

The Hon. JAN BARHAM: I will follow on from there because of the point I want to make. I think these programs are working well and congratulations for that. But the success of the Drug Court, like Reverend the Hon. Fred Nile, I am interested in whether they have application for other areas. I am from the North Coast. There is a significant issue a long way away. With Grafton closing and some of the issues there, a Drug Court would seem to be suitable. The MERIT program went well there. Are those things up for consideration, the success of these things that are proven to be working? Is this a new model of rolling out how we deal with these issues?

Mr THOMAS: From the point of view of interactions with the courts, there are no immediate plans to expand the Drug Court outside the areas that it has been expanded to at the moment. It has been expanded twice in the last two years. The MERIT program is pretty strongly established in most rural areas that have a significant drug problem, and it is working quite well. We do not know of a shortage of the services being provided by the MERIT program to people who need it in those areas.

The Hon. JAN BARHAM: I was not saying that. I was just saying how well that is done, but the Drug Court is a roll-out that should flow on.

Mr THOMAS: I suppose the next element of flying on to court-based treatment is meeting people's needs more broadly than just the drugs. MERIT does provide a broader case-management function for people, but often people who have heavy drugs problems have a whole range of other problems. Resolving the drug problem is one element to trying to get them back on track, but often they need other types of support in immediate housing, counselling and other things—assistance with family law and other debt-related matters. We have been trialling an alternative program called Credit in Tamworth and Burwood for a few years. It seems to be working well. We are still waiting for the final reoffending evaluation on that, but there are certainly plans to expand that to the North Coast and to other parts of Sydney.

The idea of that is to take the idea of MERIT, that is getting people flexibly into drug treatment but at the same time to provide a whole range of other treatment for them, throughout the whole range of services in case management around a person. So, you are working with them to try to resolve a range of different problems, including drug additions and mental health-related problems. We have been testing that in the two sites that it has been operating. It has been working quite well. The Bureau of Crime Statistics and Research did a survey of offenders who participated in that program, and 95 per cent of them said it had changed their life in a positive way. We are just waiting on the final reoffending assessments of that.

The Hon. JAN BARHAM: My next question was going to be about housing. I was interested in comments you made before about post-program. How closely do you work with government and non-

government agencies to maintain the wrap-round services that are needed for someone to move through that progress, for that to have been of real benefit, and to keep going on with a change of life program? Is this a whole of government focus? Are we truly seeing that level of integration?

Dr MARTIN: I think we are doing some things. I think we can do some more things. I think the linkages with Health are pretty strong, and that is fine. I think Corrections has some good links with some large non-government organisations that help with the community-based supervision, and potentially some of those non-government organisations can link in further to provide support long after the order has expired. Housing is a really big challenge and the priority of housing for offenders creates some conflict, particularly when there is competition for housing, say, by victims of crime, and where does that all fit within the big scheme of things.

The Hon. JAN BARHAM: Is it right there are only 20 participants within that accord you have with the Department of Housing?

Dr MARTIN: I believe so, for that particular one.

The Hon. JAN BARHAM: Is that subject to an evaluation, to see if it expands?

Dr MARTIN: Yes. I think Housing is one of the biggest challenges I am seeing, in developing partnerships and how do we move forward. That said, Corrective Services is looking at what we are doing around reintegration, the funds that we are putting into the reintegration sort of space and can we do that differently. At this point in time, because different briefings are before our Minister, I cannot give a lot of details around that. It needs to be given some guidance about the ways forward, but within that there are different models around both accommodation and support services that we are considering. I think that is an exciting space, because I think we can do some things a bit differently and provide a different level of support.

The Hon. JAN BARHAM: The evaluations so far certainly give confidence to the fact that doing things differently works. You are getting the outcomes. I am interested in housing and the related issues of bail and the early intervention model to prevent kids from going to jail and getting caught up in the criminal justice system. Providing housing before they re-offend and re-engage with the criminal justice system seems to be a core support system. There is a lot of work to be done, but it adds weight to those things.

Mr THOMAS: Our Juvenile Justice area does fund specific crisis accommodation for young offenders in need of housing.

The Hon. JAN BARHAM: Not enough.

Mr THOMAS: Some of the feedback we get from staff at court is there is a challenge in getting housing exactly when you need it. When you have a person before you who needs a house right now, getting it right now is often a challenge. There seems to be a shortfall in the market for the provision of crisis accommodation for those people aged between 18 and 25. There seems to be a bit of a shortfall there. As Dr Martin said, it is one of the more challenging areas of getting that access to service. Not just getting it, but getting it at the point in time when you need it is a challenge.

CHAIR: On behalf of the Committee, I thank you both for coming in today and giving us a very comprehensive submission. If anyone has questions in writing they will be forwarded to you by the secretariat. You will have 21 days to respond. We thank you for your expertise and input.

(The witnesses withdrew)

The Committee adjourned 3.32 p.m.