REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 – HEALTH AND COMMUNITY SERVICES

THE PROVISION OF DRUG REHABILITATION SERVICES IN REGIONAL, RURAL AND REMOTE NEW SOUTH WALES

CORRECTED PROOF

At Macquarie Room, Parliament House, Sydney on Monday, 12 March 2018

The Committee met at 9:30 am

PRESENT

The Hon. Greg Donnelly (Chair)

Dr Mehreen Faruqi
The Hon. Courtney Houssos
The Hon. Shane Mallard
The Hon. Dr Peter Phelps
The Hon. Bronnie Taylor

The CHAIR: I welcome participants to the first hearing of Portfolio Committee No. 2—Health and Community Services inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales. The inquiry is examining a range of matters including the types of services available as well as the funding, cost and accessibility. The inquiry will also consider if there are any gaps or shortages in the provision of services and will specifically examine the services that are available for treating methamphetamine [ice] addiction. Before I commence I would like to acknowledge the Gadigal people, who are the traditional custodians of this land, and pay respects to elders past and present of the Eora nation and extend that respect to other Aboriginals present today or who may join us on the internet. Today is the first hearing for this inquiry. As it has a strong regional focus, the Committee will be conducting six hearings in regional areas during April, May and June.

Today we will be hearing from a range of organisations including medical and legal organisations, non-government organisations and NSW Health. Before I commence I would like to make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the Parliament's website. The transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, while members of the media may film or record Committee members or witnesses, people in the public gallery should not be the primary focus of any filming or photography. I remind media representatives that they 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 the hearing, and so I urge witnesses to be careful about any comments they may make to the media or to others after they complete their evidence, as such comments may not be protected by parliamentary privilege if another person decided to take an action for defamation. The guidelines for the broadcast of proceedings are available from the secretariat.

There may be some questions that a witness could only answer if they had more time or with certain documents at hand. In these circumstances, witnesses are advised that they can take a question on notice and provide an answer within 21 days. Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. To aid in the audibility of the hearing, I remind both Committee members and witnesses to speak into the microphones. In addition, several seats have been reserved near the loudspeaker for persons in the public gallery who have hearing difficulties. Finally, could everyone please turn their mobile phones to silent for the duration of the hearing.

LARRY PIERCE, Chief Executive Officer, Network of Alcohol and other Drugs Agencies, affirmed and examined

ROBERT STIRLING, Deputy Chief Executive Officer, Network of Alcohol and other Drugs Agencies, affirmed and examined

The CHAIR: I welcome the first witnesses from the Network of Alcohol and other Drugs Agencies. We have received your submission to the inquiry, submission No. 25. You can take your submission as being read by Committee members. I invite either or both of you to make an opening statement before we have some questions for you.

Mr PIERCE: At the outset we would like to thank you for the opportunity to appear before you today and we commend the Committee for this inquiry. The need for treatment in rural, regional and remote New South Wales, in particular, is extremely high. The capital and major urban centres across New South Wales are reasonably well resourced; not so in regional and rural New South Wales. In terms of our opening statement, we believe the best way to address that gap, as we have said in our recommendations, is for the New South Wales Government to apply the Drug and Alcohol Services Planning Model population health planning model for drug and alcohol services, which I understand, since our submission, has now been taken on board by the ministry, which approves of its use. That is a tool that would allow us not just to measure the population need but also to identify the level of service provision that is needed across low-, medium- and high-need treatment populations within the overall drug and alcohol population.

In line with this, to increase funding to drug and alcohol rehabilitation and other services providing support to people in the community based on the population health need but implemented over time so that the workforce and the infrastructures can be built up. Our third key recommendation to this Committee is to address the workforce challenges across the State, but in particular, again, in regional, rural and remote New South Wales, where it is more difficult to attract and retain staff—in frontline treatment services, in specialist clinical roles and in community engagement and support roles when people leave intensive treatment. The workforce issues are even greater in terms of the need in those areas.

Mr STIRLING: I think that covers it, but in terms of context, the Network of Alcohol and other Drugs Agencies represents the non-government sector in New South Wales. We do not represent hospital-based drug and alcohol treatment. Of the 95 members we represent across the State, about 38 are regional, rural and remote organisations.

The Hon. BRONNIE TAYLOR: What percentage was regional, rural and remote?

Mr STIRLING: Not percentage; the number is 38 services in regional, rural and remote New South Wales.

The CHAIR: That has given us an overview and some context. We have representatives on the Committee from the Opposition, the crossbench and the Government and we will share the questions. We will start with Opposition questions.

The Hon. COURTNEY HOUSSOS: Thank you for your very detailed submission, which is very useful for all of us. I begin with a question on demand. The NSW Health submission states that the most recent emergency department data indicates that, "emergency department presentations for methamphetamine may be stabilising." Is that your experience? Do you feel that the demand for rehabilitation is stabilising? I appreciate NSW Health is talking about emergency department demand, but the implication is perhaps that this issue is stabilising.

Mr STIRLING: I probably would not say that that is the experience of the non-government treatment sector. Episodes for methamphetamine have remained at a higher level—in fact, over the years in rural, regional and remote New South Wales the treatment episode for methamphetamine is almost on par with alcohol, which is a change in what we have seen over the past 10 years, where alcohol has always been the primary presentation. In terms of the number of presentations, the numbers for methamphetamine in the non-government sector have remained fairly stable.

Mr PIERCE: That is right. But in terms of the data that the health department is referring to there is a levelling trend in presentations at places like emergency departments [EDs] for methamphetamine. But the treatment population heading into treatment centres, particularly in rural and regional places, have probably been bouncing in and out of accident and emergency departments for a long time. As Mr Stirling has just said, the level of patients seeking treatment has remained pretty consistent and is on a par with alcohol, so that is a real worry.

The Hon. COURTNEY HOUSSOS: Absolutely. Thanks very much. The next question I have is around the government response. You would be aware of the Drug Package that was announced. Do you have any feedback not just on the Drug Package but also on the National Ice Action Strategy and whether that has been an effective approach or is there still demand for more services?

Mr PIERCE: What we have argued in this paper is that the State Government's Drug Package was sorely needed and much welcomed and done in consultation with the non-government organisation [NGO] sector and specialists around the State. It is a very good package. The National Ice Taskforce recommendations we are funding for treatment services has come through primary health networks [PHNs], which is the new commissioning model that the Commonwealth put in place over the last couple of years. Both of those things were done in isolation from each other. So on the ground in New South Wales there are elements of the Drug Package that are very well focused, particularly at youth, women and regional populations.

It has a number of very good initiatives in it, but unconnected to the way in which the PHNs rolled out the Commonwealth ice strategy funding, which was largely spent in metropolitan and high population centres along the coast of the country and largely for outpatient services, not really the kinds of services that you would need for people who are in the grip of a serious dependency on either ice or other drugs along with that. So they did not really fund intensive treatments. Both of those things, while welcome—and certainly we are not criticising either level of government for those initiatives—they were not planned together and they were not planned on a population health or a need level, or a geographic population need level. That is why we are arguing that point in this paper.

Mr STIRLING: One of the main points there is that whilst the National Ice Action Strategy did not actively exclude residential rehabilitation it did not prioritise beds, so it was outpatient treatment that it focused on. Similarly, with the NSW Drug Package there was not really the funding to go towards beds. Whilst I think the women's funding was to do residential rehabilitation.

Mr PIERCE: It was the only one.

Mr STIRLING: Other than that, as our submission says, there is a need to increase the number of residential rehabilitation programs in regional and remote New South Wales because of the demand and the feedback we receive from our members about the waiting list.

The Hon. COURTNEY HOUSSOS: I want to unpick the final point you made that there is a need for more residential beds. Your submission also talked about the workforce challenges for the existing places.

Mr PIERCE: Yes.

Mr STIRLING: That is right.

The Hon. COURTNEY HOUSSOS: There is a dual challenge there.

Mr STIRLING: That is absolutely right.

The Hon. COURTNEY HOUSSOS: We have received that message through a lot of submissions—that there are some beds there but there are long waiting periods or there is a need for more beds. You have also highlighted the workforce problems. Would you like to explain that a little more for the Committee?

Mr STIRLING: Part of the challenge is when you increase investment, which is obviously needed, we need to make sure that we have an appropriately skilled work force that can respond to the funding and the expansion of the treatment sector. That is why we have put in our submission that we need a slow incremental increase in funding and parallel to that have a workforce strategy to increase the skills and the drug and alcohol workforce to respond to that.

The Hon. COURTNEY HOUSSOS: Someone else's submission mentioned the fact that there used to be a certificate III in TAFE. Are you aware of how available that is across New South Wales? It is a broad question so it is okay if you are not able to answer.

Mr STIRLING: I think certificate IV would be the minimum now. In terms of where we are at the moment, we would think a certificate IV in alcohol and other drugs would be the minimum. The majority of our workforce is at that level.

Mr PIERCE: And, in fact, above that level. Our workforce profile shows that people generally have at least a certificate IV level and then tertiary level qualifications. The workforce is older and fairly well experienced—and fairly stable within the sector, which is a good thing. However, coming on from what Mr Stirling said, the issue is not so much about how much training is available, because there is stacks of it. We are pretty well serviced. I would not say "stacks", but I think we are pretty well serviced in this State for access to

certificate level and academic training and also the amount of specialist workforce initiatives that organisations like ours and others run out, particularly across the local health districts. There is plenty of training available. The issue is the capacity of organisations to hire, attract and develop staff on very low budgets. The alcohol and drug budget component of regional rural New South Wales would be the smallest component of the budget. These guys out here in the regional areas just do not have the resources to bring in staff specialists, clinical nurse consultants, psychologists and so on. That is the big problem.

Mr STIRLING: I make one final comment in relation to that. We have received feedback—and I am probably not the best person to answer questions on it—around the availability of TAFE NSW and some changes to TAFE NSW in terms of availability and subsidising of some of those courses for alcohol and other drugs.

The Hon. BRONNIE TAYLOR: It is really about bringing the education to the areas rather than expecting people to leave and be able to access that, which I know is an issue as well. Maybe we need to explore things like making sure those courses are available locally through things like the country university centre that was recently established in Goulburn and Cooma which is really changing the landscape for people, so people can stay where they are to do that. Mr Pierce, in your opening statement you said you were using a different method of assessing population, density and need. Can you take me through how you have come up with that? You said the ministry was interested in it when they saw it.

Mr PIERCE: It is the drug and alcohol services planning model. It is the same kind of population planning that the mental health sector has been doing for years and years. So, per 100,000 head of population, given the epidemiology that we know about drug and alcohol dependency and drug and alcohol need across a range of low, moderate and high need, what kind of places would you need in terms of access to detoxification services, access to pharmacological replacement services, access to residential inpatient treatment and also outpatient treatments?

It is a model that gives you the framework for planning for the number of people you can estimate, based on population numbers and then based on the epidemiology that we have, which is good epidemiology around how many people are suffering from a moderate, mild or acute drug and alcohol use and dependency problem. It has been modelled off the mental health approach that has been in this country for nearly 20 years. New South Wales led an intergovernmental process about eight or nine years ago to develop a similar model for drug and alcohol. It was developed and then processed through the intergovernmental committee on drugs, the previous governance strategy for the federal drug and alcohol strategy. It was not actively taken up by most States and Territories after that period, primarily because of the budgetary implications.

Drug and alcohol is not a well-funded program. In this State—I think the department can tell you better—it is $250 million or something like that. The mental health budget is $1.2 billion. We are a very small program and very under-funded, and it is very difficult to meet the need, which is why we talked about waiting lists and so on and so forth. A population based health model would give you the capacity to identify, in geographic locations as well, where you have the highest population need for services. If we applied that model, we would be able to say, "For Goulburn, we need 35 rehabilitation beds, 10 inpatient detox beds,"—or five or whatever.

The Hon. BRONNIE TAYLOR: Yes.

Mr PIERCE: You would be able to say that you need X. That gives you a chance to then ask, "How do we build those services up?" We are not saying that you should triple the drug and alcohol budget tomorrow, because we probably would not cope with it, anyway.

The Hon. BRONNIE TAYLOR: Would it be fair to say that you have a bit of a crossover with respect to mental health as well? I used to be a nurse and when I worked on the wards we had a particular fellow who came into detox regularly. It was a difficult situation because we would have to detox him on the ward and then get him home, but he wanted to stay in Cooma. Those things are difficult too, are they not? You cannot have everything everywhere. It is about being able to manage that.

Mr PIERCE: Correct.

The Hon. BRONNIE TAYLOR: There would be a lot of crossover with your mental health services in regard to access and use of those services by people who would require drug and alcohol services as well, I would imagine.

Mr PIERCE: One thing to get really clear is that most people who have a severe drug and alcohol dependency, and end up in inpatient treatment, in detox or in a hospital setting, have mental health issues—anxiety, depression, PTSD, particularly for women, et cetera—but they are not the "mental health population".

The Hon. BRONNIE TAYLOR: I understand what you are saying.

Mr PIERCE: They are two different things, and people go to drug and alcohol—

The Hon. BRONNIE TAYLOR: I get that, yes.

Mr PIERCE: But drug and alcohol services treat mental health. Particularly over the past decade we have made huge inroads in being able to do effective psychological and mental health support interventions for people in drug and alcohol treatment.

Mr STIRLING: We are good at responding to the people with mild and moderate mental health issues. Obviously those partnerships between mental health and drug and alcohol services are really important for those people who have acute mental health issues and those referral time plans. But just going back to the Drug and Alcohol Service Planning [DASP] model, when we said we need this, the service planning model was not in the public domain. It now is in the public domain, so we can take that on notice to provide the Committee with the service planning model that is available.

The CHAIR: That would be good.

The Hon. Dr PETER PHELPS: Thank you for your excellent submission. Given that the DASP model has now been adopted by NSW Health, is there any reason why this Committee should continue its inquiries? Presumably you do not adopt a model unless you are going to use it for the funding and provision of alcohol and other drugs [AOD] services. If that is the core component—I think you identified previously the misallocation of funds to services if you are not going to have an objective model—have the majority of problems not been solved and this Committee does not really need to continue to keep meeting?

Mr PIERCE: I do not think that is the case at all.

Mr STIRLING: I do not think it has been adopted and applied by NSW Health, as yet. They led it and approved it, but it has never been implemented.

Mr PIERCE: Take, for example, the Government's recent drugs package. While that was an excellent contribution and well-targeted—and well consulted before it was put together—it was not based on population need. It was based on what the sector thought were the most important things—not that that is wrong. Also the amount of money and the targeting of that money into those initiatives was not driven by the planning model; it was driven by some other process that people like us never get to see.

The Hon. Dr PETER PHELPS: Would it be "politically determined funding for programs"?

Mr STIRLING: I think that that is a feature of drug and alcohol services nationally, and has been for a long time. It is an emotive issue. It is driven by a lot of negative media, very frequently. Governments generally tend to respond to perceived drug crises in a media context. Things are call epidemics when, if you use the true meaning of the word "epidemic" they are not. Therefore, I think there is a tendency for the political necessity approach over and above a more rational population health model for dealing with it.

The Hon. Dr PETER PHELPS: Why is it difficult to attract and retain staff in country New South Wales?

Mr PIERCE: There are two reasons. One is that they amount of the resource within each of the non-government sector agencies providing, say, residential treatment—which we know about—is fairly limited. So they are not competitive in terms of wages and salaries.

The Hon. Dr PETER PHELPS: Compared to the Government?

Mr PIERCE: Yes, we lose people. They will do a little while in an NGO and then they will get a much better job—paying nearly half as much again—in the local health district or a primary health network [PHN]. The other reason is that we do not have a really well embedded workforce strategy to attract and assist in the retention of staff.

Mr STIRLING: There is a national alcohol and other drug workforce strategy that was developed by the Flinders University, but at the New South Wales level there has never been the next layer of that policy implemented for a New South Wales workforce strategy or plan. That is something that we are calling for in this document.

Mr PIERCE: We have never planned for the workforce. We just build it how we can.

Mr STIRLING: In terms of workforce issues in regional and remote New South Wales I do not think it is limited to drug and alcohol.

The Hon. BRONNIE TAYLOR: It certainly is not.

Mr STIRLING: I think it is an issue across all health care.

The Hon. Dr PETER PHELPS: Given that there are a large number of organisations—I think your chart shows there are 55 specialist alcohol and other drugs service deliverers, and you have identified 49 of them—in rural, remote and regional New South Wales, is there an argument that there are too many and that the atomisation of these services leads to diseconomies of scale, and that perhaps it would be better to rely on a small number, or completely leave the NGO market entirely and just have State Government financed services? My basic question is: Does the atomisation lead to inefficiency?

Mr PIERCE: I am not sure what you mean by "atomisation". Do you want to expand on that?

The Hon. Dr PETER PHELPS: Having 49 separate agencies operating in rural and regional providing essentially the same drug and alcohol service strikes me as not—

Mr STIRLING: Just for clarification on the 49, there are 38 organisation but there are 49 programs. When we collect the data it is based on a program.

Mr PIERCE: One organisation might have two drug and alcohol streams.

The Hon. Dr PETER PHELPS: Even still, 38 organisations is a lot of organisations.

Mr PIERCE: A lot of those organisations are quite small providing a limited service. There are some rehabilitation services with 10 beds. There are some that run 20 and 30 beds. There are some out-patient services that only have two staff. You do not get to see a lot of people in those settings. I will also go back to an earlier point made about the disparate population centres across regional and rural New South Wales. It is very difficult to have people within an economy-of-scale model of service when they have to go 50, 60 or 70 kilometres to where there might be a larger service.

The Hon. Dr PETER PHELPS: My point is that you can have smaller services operated by a larger organisation which does not have the same administrative requirements that 38 separate smaller individual organisations would require. I do not agree with that, but I am just trying to get your argument as to why. The argument is: Why should NSW Health not simply take over the whole lot and run it as sub-units of a broader organisational model, with the economies of scale that that would bring?

Mr PIERCE: There are two reasons. One is that the diversity of approach, and the diversity to meet specific local community need, is best done by the non-government sector, because it is community close and community managed. Secondly, government is more expensive in terms of overheads and what you are saying. So if you wanted to expand specialist drug and alcohol services as the Government runs them, into the nether regions of rural LHDs, it would cost a fortune.

Mr STIRLING: I just want to clarify one more thing. Of the 38, only 20 are residential rehabilitation services. As part of regional New South Wales we included the Central and Wollongong, which skews the data in terms of more rural and remote areas, where the numbers are a lot smaller.

Dr MEHREEN FARUQI: Thank you very much for your submission, and for coming in today. You referred to a study by the University of New South Wales drug policy modelling program, which estimates that around 200,000 to 500,000 people would be in treatment if demand were to be fully met. That is a massive number. If you are familiar with that study I just wanted to find out a bit more about the breakdown of that demand. How much is for alcohol and how much is for other drugs? Is most of it in regional and rural New South Wales or in other places? Do you have that information or any more details on those specific numbers?

Mr STIRLING: I do not have the breakdown of the specifics in terms of drug types from that study.

Dr MEHREEN FARUQI: Do you know if the study has that?

Mr STIRLING: I am not sure. The Drug and Alcohol Service Planning Model certainly did go into the different drug types. I am not sure if New Horizons did, which is the study you are referring to.

Dr MEHREEN FARUQI: That is fine. We can look at the study. I am sure it is publicly available. Based on those numbers you would think that more could be invested in preventing alcohol and other drug dependency. I would like to hear from you because your network sees so many patients. What do you think are ways of preventing dependency and addiction?

Mr PIERCE: As a first point we seriously as a nation and also as State and Territory jurisdictions have massively underfunded and ignored good prevention work. Nobody invests in it much. The political dimension we were talking about before is always focused on direct service delivery and treatment by and large.

That is not a bad thing. But the similar investments are not made in prevention. There is an evidence body for the effectiveness of some preventative measures. We know that others are not that effective. This State has a fairly robust drug and alcohol preventative focus within the high school curriculum and has had for quite some time, but we do not have a lot of good evidence about whether or not that changes behaviour when people move through from high school into late adolescence and early adulthood.

We do know there is an evidence base for some preventative activity in alcohol, for example. Not much of it is around education and classic prevention programs. It is more around taxation, availability, floor prices and those sorts of things. I really do not know how to respond other than to say we really do not have a history of good investment in preventive level activities at a number of levels—at a local community level and a community development sense, at a broader social grouping level or at a mass media level.

Dr MEHREEN FARUQI: In your experience does the criminal nature of drug use in Australia mean that people are less likely to come forward for rehabilitation or detox services?

Mr STIRLING: I would say absolutely. I think stigma and discrimination play a huge part and is a huge barrier to access to treatment in Australia, not just in New South Wales.

Mr PIERCE: We know from our work with organisations that work with people who use drugs but are not in the treatment system that it is a big issue. Coming forward, regardless of where you are in the social hierarchy, if you like, about your drug or alcohol problem is still very difficult. It is very highly stigmatised. Particularly with illicit drugs it is doubly stigmatised.

Dr MEHREEN FARUQI: You mentioned that staffing is really difficult in the city and more so in rural and regional areas and that a large number of employees are over 45 years of age. What do you think could be done to get young people into the workforce? There are very few Aboriginal and Torres Strait Islander people in the workforce as well. That is an additional challenge to staffing altogether. What can be done to improve that side of things?

Mr STIRLING: I think there is a range of things that can be done. When you look at university qualifications for psychology and social work there could be a greater emphasis on alcohol and other drugs. The feedback we receive is that they really get very minimal education around working with alcohol and other drug issues as part of university qualifications. There is an opportunity there to raise the profile of alcohol and other drugs to try to get new graduates to enter the alcohol and other drug field.

Dr MEHREEN FARUQI: How would that be done? What is the barrier to that? Why has it not been done?

Mr PIERCE: We do not have a workforce strategy, so there are not any agreed sets of strategic activities and processes within the drug and alcohol specialist field that look at attracting people into the field of drug and alcohol treatment in particular.

The Hon. COURTNEY HOUSSOS: We have received some submissions that have talked about the need for new culturally specific facilities, but there is also a question of how culturally aware the existing services are. Do you as a peak organisation provide any training or support for existing services?

Mr STIRLING: Absolutely we do, but that is limited and it is not a strategic rollout. It is really just something that we offer and organisations can opt in to that. I think there could be a more strategic approach to make it a criteria to be an alcohol and drug worker that you must undertake this cultural awareness training.

The Hon. COURTNEY HOUSSOS: Do you think, for example, if you wanted to tender for government provision and you were going to provide places to Aboriginal and Torres Strait Islander people that you would need to demonstrate that you have undertaken this training regularly?

Mr PIERCE: Absolutely.

Mr STIRLING: Absolutely. We would support that.

Mr PIERCE: We are working with the ministry at the moment on this particular issue and also in relation to the broader range of qualifications and also certification and accreditation that agencies need to have that will be embedded in the new form contracts that the ministry is going to roll out in the new financial year this year. Also we are currently doing a bit of innovative work with the Primary Health Networks through some of their funding to develop specific cultural competency training packages for non-Aboriginal community controlled drug and alcohol organisations to implement. That is a new initiative that we are on at the moment.

The Hon. COURTNEY HOUSSOS: Another relatively new initiative from the Government has been the response to the Reparations for Stolen Generations upper House inquiry. Part of that talked about the need

for a more trauma-informed workforce across the board. Have you found any of the new initiatives to be useful in the work that you are undertaking?

Mr STIRLING: I am not sure what initiatives—

The Hon. COURTNEY HOUSSOS: Have you had any contact with any of those yet?

Mr STIRLING: No. In our own workforce development we provide trauma-informed care and practice training to organisations. I think cultural responses to trauma-informed care is probably an area that we need to do a lot more work in.

Mr PIERCE: The focus on trauma-informed care from our side of things in terms of providing the workforce support initiatives that our little organisation provides has been done in partnership with the mental health sector, which has been pushing for more trauma-informed models of intervention in mental health as well.

The Hon. COURTNEY HOUSSOS: The Royal Australasian College of Physicians submission said there is obviously a need for coordination amongst alcohol and drug work with lots of different specialties. They have talked about the concern in merging mental health with alcohol and drug support and said that they should remain two separate and discrete areas. Would you like to reflect upon that?

Mr STIRLING: We would absolutely agree.

Mr PIERCE: We totally agree. As I said, the populations that approach mental health specific services and drug and alcohol services are not the same populations, while there is crossover. Secondly, we have just come out of a period of about four or five years here where drug and alcohol was subsumed under mental health in terms of executive management through the health department and it was not very productive for drug and alcohol. We got lost at the back of the bus. Mental health is always the main game. I think there are a number of reasons why you need to have separate programs that have very close program linkages for drug and alcohol and mental health. We would totally support that.

The CHAIR: At the bottom of page 12 of your submission you talk about bed capacity and availability. First of all, could you explain exactly what bed capacity means; when we talk about beds for rehabilitation what do we mean by that for drug and alcohol rehabilitation? Secondly, what is the importance or otherwise of having the availability of beds as a key part of a comprehensive drug rehabilitation program?

Mr PIERCE: As it is noted here, the provision of a bed for a client who comes into a residential service is not only the physical bed itself; it is the number of staff they have got to manage 24/7 care, essentially. Is there the right mix and range of staff with the right skills and the right number of them to ensure that the facility is safe 24 hours a day and under appropriate supervision. That is the key point. The second point was about the—

The CHAIR: Is having beds key and, if so, why?

Mr PIERCE: It is key because most people who come into drug treatment, particularly for residential treatment, have very significant, high-need drug-dependency and associated health issues and also fairly chaotic lifestyles, so they are not stable in the community. One of the things that a residential setting is able to do is place somebody in a residential setting with a specific drug and alcohol treatment program identified for their needs that can also address the levels at which they are able to identify a key number of issues for themselves to be able to return to the community. We provide a lot of primary health care input for clients who are in drug and alcohol treatment. We do not just deal with their drug problems; we deal with their bad teeth, their abscesses, and a whole range of things.

From the bed setting, we can then do discharge planning and a continuing care type of approach where the client can move out of the residential setting back into supported, supervised or independent living, depending on their need, and are then provided with some support in the community. What it provides is a setting for a very intensive period of treatment in a bed base and the capacity to manage and support people to actually do what they need to do—get back to work or study or engage with family, get into stable living conditions and that sort of stuff. We say that residential treatment is not for everybody; it is for the high-need clients. They are the ones that clog up accident and emergency departments and are in our prisons and lock-ups at the moment. It is that group in particular. With the Drug and Alcohol Service Planning [DASP] model, we can tell what number that is roughly, and when we do, we know that we only have enough beds to meet about a quarter of the demand for those beds.

That is why we were talking about the need for the DASP earlier on. Residential treatment should be seen—and is, in fact, run—as a more holistic approach that gives people a kind of a timeout, whether it is for six

weeks, three months or longer, depending on the need, but also to address—and we can never tout this enough—their primary health needs and how they are going to integrate into the community. They leave a chaotic drug lifestyle behind before they walk in the door and then get back into some sort of stable, social living, study or work arrangement.

The Hon. BRONNIE TAYLOR: I was going to ask that question before the Hon. Greg Donnelly asked it. The six-week respite is often a respite for the families. Mr Pierce referred to it as a mediate approach, and that is because some families cannot take anymore. Mr Pierce, you said there had been no further investment or funding for an increase in beds. Do you mean beds provided only by non-government organisations [NGOs]W or does that include beds provided by NSW Health?

Mr PIERCE: We were referring to the non-government sector.

The Hon. BRONNIE TAYLOR: Where I worked at Cooma, we did not have a specialised centre, but we had a drug and alcohol worker and a room that we would reserve for people who needed that. Would that be counted as a bed?

Mr STIRLING: No.

Mr PIERCE: No, that would be in-hospital patient care.

The Hon. Dr PETER PHELPS: In the final section of your submission "Any Other Related Matters", you referred to the obvious problem you have with Commonwealth and State funding arrangements and how they do not necessarily join up. Is there an argument that either the State Government or Federal Government should exit the field and allow one particular government to manage that with associated funding so you are not simply cutting back. Presumably, it would be better for the State Government to simply allocate the money to the Federal Government or the Federal Government to allocate money to the State Government and then have that one administrative disbursement to organisations based on the sort model you mentioned earlier.

Mr PIERCE: Both of those options are canvassed quite well in the Drug Policy Modelling Program New Horizons report for the Commonwealth to consider either dispersing all of the money to the States and allowing the States to manage the funding disbursements for specialist drug and alcohol services, or for them to have a joint role, where the Commonwealth provides leadership in certain areas and funding in certain areas. That obviously does not get us out of the woods with respect to the jurisdictional problems that this country has with a federated system.

The Hon. Dr PETER PHELPS: It tidies it up, does it not?

Mr PIERCE: I do not have enough expertise to answer that question; other people do. We have always seen the Commonwealth having a very important leadership role and being a funder of drug and alcohol treatment services that the State should be funding. That is being partly addressed, as I understand it, through its process of commissioning drug and alcohol services through primary healthcare networks and the Commonwealth itself ceasing to manage direct contracts with NGOs across the country.

The Hon. BRONNIE TAYLOR: They should all talk to each other.

Mr PIERCE: They should.

Mr STIRLING: Agreed.

The CHAIR: We have run out of time. Gentlemen, thank you very much for coming in. Being provided with an opportunity to question you directly and have you elucidate a number of points in your submission has been valuable. We asked one question on notice. Indeed, after reading *Hansard* some of the Committee members might have additional questions. The Committee has resolved that answers to questions taken on notice be returned in 21 days. Hopefully that will be acceptable. The secretariat will contact you about the questions taken on notice.

(The witnesses withdrew)

ADRIAN DUNLOP, Fellow of the Australasian Chapter of Addiction Medicine Committee, Royal Australasian College of Physicians, affirmed and examined

The CHAIR: I welcome Professor Adrian Dunlop.

Professor DUNLOP: I clarify that I am seconded to the alcohol and drug branch in the Ministry of Health and am the director of drug and alcohol services for Hunter New England Health, but I am not representing either of those organisations today. I am representing the Royal Australasian College of Physicians.

The Hon. Dr PETER PHELPS: He is wearing his university stethoscope; rather than his government stethoscope.

Professor DUNLOP: That is right.

The CHAIR: This inquiry has received the submission of the Royal Australasian College of Physicians, which is marked as submission No. 10. Take that as read. Professor Dunlop, before we begin with questions, would you like to make an opening statement? You do not need to repeat in detail anything that is covered in your submission, but an opening statement would set a good frame for questioning.

Professor DUNLOP: I am very happy to do that. The Royal Australasian College of Physicians [RACP] welcomes the opportunity to appear and give evidence before the Committee today. The RACP is the largest specialist medical college in Australia. It trains, educates and advocates on behalf of approximately 23,000 physicians and trainee specialists across Australia and New Zealand, and represents physicians from over 30 different specialties, including addiction medicine and public health medicine. Today I speak on behalf of the RACP as a foundation Fellow of the Australasian Chapter of Addiction Medicine. As an addiction medicine specialist, I witness firsthand the significant harms caused by drug-use and alcohol-use disorders today in regional and rural New South Wales.

The severe shortage of drug and alcohol treatment services and an appropriate specialist workforce around Australia, together with chronic underfunding, are the critical issues that have been repeatedly identified by the Royal Australasian College of Physicians [RACP] and the Chapter of Addiction Medicine as a matter requiring urgent attention. People with substance use disorders are bearing the brunt of inadequate access to a limited range of health services and face long waiting times in the public sector. This problem is even more pronounced in regional, rural and remote areas of Australia. The RACP urges the New South Wales Government to provide more funding to increase access to evidence-based drug treatment services to meet the needs of drug users and their communities across this State. When I say treatment, I mean the full range of drug and alcohol treatment services, not only residential rehabilitation services.

We strongly recommend the New South Wales Government use a planning tool, such as the drug and alcohol services planning tool, to make effective long-term service planning decisions. This would allow a more accurate estimate of demand for drug and alcohol services, assist in ensuring appropriate access and address unmet demand. We also urge the drug and alcohol treatment services to work together closely with other mainstream health services, including acute care, primary health services and social welfare services due to the significant comorbidities associated with substance use disorders.

To underpin the delivery of drug and alcohol evidence-based treatment services in regional, rural and remote New South Wales, the RACP believes that all treatment services should, at a minimum, reflect an understanding that drug and alcohol use is complex and varied, and there is a need for a wide range of interventions to place harm minimisation at the centre; recognise the importance of multidisciplinary clinical care; undertake ongoing monitoring independent evaluations; consider the wide range of social determinants of health; be aware of the significant over-representation of Aboriginal people who experience substance related harms and their over-involvement in the criminal justice system; be tailored to local needs and be culturally safe and accessible, both in terms of cost and location to individual patients; and be led by medically qualified health professionals and specialist physicians. In conclusion, treatment is effective and cost-effective—for example, for every dollar spent, nine dollars is saved. Fewer than half the people who need treatment can currently access it and this is even worse in rural New South Wales.

The CHAIR: That is a very comprehensive and succinct opening statement, and we like those very much. We would like to share the questions around as we have representatives on this Committee from Opposition, Government and crossbench.

The Hon. COURTNEY HOUSSOS: Thank you for joining us, and for your submission, which was very informative. I want to pose a question to you based on the NSW Health submission, which said that the

most recent New South Wales emergency department data indicates that emergency department presentations for methamphetamine may be stabilising. Does that echo your experience or the experience of your colleagues?

Professor DUNLOP: Yes and no. Yes, in that speaking with colleagues across the State they report some stabilisation in numbers but, of course, there is local regional variation. The Calvary Mater Newcastle hospital, which is in our district, is one where there does not appear to be any recent decrease, and I am also aware of other hospitals like St Vincent's Hospital. There are hospitals where there are very frequent presentations—St Vincent's Hospital and Royal Prince Alfred Hospital being examples, and hospitals in rural New South Wales such as the Calvary Mater Newcastle.

The Hon. COURTNEY HOUSSOS: That is just talking about emergency department presentations; that is not necessarily reflective of the need for rehabilitation services more generally.

Professor DUNLOP: That is right.

The Hon. COURTNEY HOUSSOS: Do you see that demand stabilising or is it continuing to grow?

Professor DUNLOP: It is difficult to estimate. There has been a good evaluation funded by NSW Health conducted by the University of New South Wales and the University of Technology a couple of years ago that estimated that one in three emergency department presentations have a patient with a current drug and alcohol problem. It did not try to attribute causality to that presentation, but it is likely to be a leading factor in people presenting to emergency departments. One in three people in our emergency departments has a current drug and alcohol problem. Our health system is not set up to respond in that way and it does not respond adequately. Indeed, it was a very difficult and significant undertaking to try to measure that accurately. It was measured at eight hospitals across New South Wales. It is a common problem, but measuring the individual variation from time to time is not so easy. NSW Health does have a reasonably accurate tool to measure that and it would be worth asking the Chief Health Officer this afternoon.

The Hon. COURTNEY HOUSSOS: The NSW Health submission also talked about a need for a minimum qualification for alcohol and drug specialist workers, as seen in other jurisdictions such as the Australian Capital Territory and Victoria. Do you support that?

Professor DUNLOP: I think that is probably a better matter for the non-government organisation [NGO] field to decide on. There certainly is a need for a wide range of different professionals, including people with lived experience. There would need to be an adjustment period if people with lived experience were required to undertake a qualification such as in Victoria, where it is a certificate IV. It is possible to do, but it would need resourcing and time, so I think it would be a matter best for the NGO sector to comment on.

The Hon. COURTNEY HOUSSOS: One final question on cultural awareness: Do you provide or are you aware of the college providing cultural awareness training specifically for alcohol and drug workers?

Professor DUNLOP: No, I am not aware of that.

The Hon. COURTNEY HOUSSOS: What sort of cultural awareness training does the college provide generally for physicians?

Professor DUNLOP: I would have to take that as a question on notice.

Dr MEHREEN FARUQI: Your submission notes that there is quite a big shortage of addiction medicine specialists across Australia, particularly in New South Wales. Is this a new phenomenon or has that always been the case?

Professor DUNLOP: Addiction medicine is a relatively new speciality. The Chapter of Addiction Medicine was formed in around about 2000. The College of Physicians had its first recognition of specialists in 2002. It is still young but we are not growing at the rate that we need to—for example, I would expect that, not long after I retire, at our current rate we will become extinct. It was formed due to a recognition that at that time the College of Psychiatrists was not placing adequate attention on the need to train addiction psychiatrists. Fortunately, that has reversed since then and there are addiction psychiatrists coming through, and that is a good thing, but still with addiction medicine we really struggle to get anything like the number of specialists coming through that we need to replace the current workforce.

Dr MEHREEN FARUQI: In an ideal world, how many positions are there in New South Wales, for example, that need to be filled with that speciality?

Professor DUNLOP: It is hard to give you an accurate answer because, when you have an area of workforce shortage, you cope with having unfilled positions. If we had more candidates, we could create more positions and change funding around and maybe fund some medical positions where we fund other positions at

the moment. It is hard to give you an accurate answer on that. For example, there are approximately 180 current specialists across the country and around about one-third of those in New South Wales, but every district could employ more if there were more available and, of course, if they had the resources to employ them.

Dr MEHREEN FARUQI: How many of that one-third would be in rural, regional, remote New South Wales compared to here?

Professor DUNLOP: Very few—I can probably think of them by name with more than the fingers on one hand, but not more than the fingers on two hands—so it is very, very difficult. Many rural areas operate on a fly-in fly-out system. Of course, that is important but it is not ideal. It is difficult, as you know, to get doctors, including specialists, into rural New South Wales. Again, I am not here on behalf of Hunter New England Health, but we have an effective model where the metropolitan side maintains contact with the rural side. For example, next month when one of our long-term specialists will retire in Tamworth, I will take on the load of flying to Moree on a regular basis to do that, but in other parts of New South Wales that would be very hard to fill. The needs of people in central Sydney are still quite great, so they do not have time for their specialists to be flying to other parts of the State. There is a system that operates currently, and it does the best with the resources that it can, but it struggles to meet the demands and certainly rural communities are very affected by that.

Dr MEHREEN FARUQI: The submission from Lives Lived Well Lyndon, a service provider in regional New South Wales, notes that the current study pathways are not always relevant to the clinical reality of drug and alcohol work in the real world. It is suggesting some improved training. Do you have any comments on that?

Professor DUNLOP: Improved training to whom?

Dr MEHREEN FARUQI: It is talking about academic study pathways and saying that they are not always relevant to what happens on the ground. People have the academic background but it does not match up with the reality of drugs and alcohol on the ground and somehow that gap needs to be met.

Professor DUNLOP: I can comment best on addiction medicine training, because I am a supervisor as part of the College of Physicians where I train trainees and I do not have concerns about that training pathway, other than we do not have enough trainees. It is probably more difficult for me to comment on other pathways; I certainly have some familiarity with the psychology pathway. The challenge, of course, is to have the public sector—public health services—providing appropriate training places for psychologists. That is a challenge, and there are certainly gaps. With nursing, the struggle is to attract nurses to work in this area. We have an ageing workforce across New South Wales; a number of staff have worked as nurses for many years, but we are not getting the number of young people coming through that we need. It is probably best for me not to comment on other parts of the workforce.

Dr MEHREEN FARUQI: The lack of an accreditation scheme, or even any oversight of private service providers in this area, really concerns me and has been raised in a number of submissions. Are there any other areas of medicine that have such little oversight? Would you support an accreditation scheme?

Professor DUNLOP: As I said earlier, the answer about accreditation is best met by the non-government organisation [NGO] sector. There are some services where I think it is very important that people with lived experience work; clients identify them as being peers and they are important workers. Any process that requires accreditation ideally should not exclude that workforce. Having said that, I come from a field where training is very important and having adequate supervision and continuing professional development are important. I would think a number of submissions would have said our patients are becoming more and more complex. There is more use of multiple substances and currently there are more mental health problems—maybe because of more awareness. There are more intergenerational chronic cycles of deprivation and social problems. That means people present as more complex patients, and monitoring that requires skills not just experience. I will leave my answer there.

Dr MEHREEN FARUQI: In your submission you make a very good point that drugs cannot be eradicated from society and there is the need to have broader policies focused on harm prevention and minimisation. Do you see the decriminalisation of drug use as a harm-minimisation policy? Could the current nature of the criminal aspect of drug use be preventing people from seeking help?

Professor DUNLOP: You would also see in the submission that we note that the overwhelming majority of funding in Australia is spent on policing and interdiction. Unfortunately, there is little evidence that there is an effect from those interventions. I am not for a moment suggesting that they should not occur, but there is very little evidence of their effectiveness. There is robust evidence of the effectiveness of different sorts of drug and alcohol treatment programs, but there is a much smaller allocation of funding to those areas. The College suggested, as an attachment, the submission to the Victorian Parliament, and in that you will note a

consideration to reduce the emphasis on the criminal response to drug problems in our society and a greater consideration of harm reduction and the health problems of patients, and that is the broad concept of not just medical health but mental health and, importantly, social health and connection to communities and families.

If those are taken into consideration, options like the model that is being used in Portugal, which is depenalisation and not decriminalisation, is an important one. The evidence from Portugal continues to emerge, but it does not show a marked upsurge in drug use or problems related to drug use—in fact, in comparison to neighbouring countries, such as France and Italy, Portugal's situation has deteriorated much less than other countries. It certainly is a model that would be important for us to consider in how we continue to evolve our drug policy.

The Hon. Dr PETER PHELPS: I am glad you brought up the Portugal model, because you have pre-emptively answered one of my questions. On page 5 of your submission you say that the merging of drug and alcohol services with mental health services may have a negative impact on drug and alcohol clients. Could you expand on that? Are you saying people are being dissuaded from seeking out services because they will be thought of as having some sort of mental illness? What is the specific nature of the problem?

Professor DUNLOP: I note that you asked the Network of Alcohol and other Drugs Agencies [NADA] a similar question. I agree with a part of their response that, if you look at the patients that typically attend drug treatment services compared to the patients that present at mental health services, there is an overlap of conditions but there are also quite different conditions. For example, the majority of the people who attend intensive public mental health services have diagnoses like schizophrenia or very severe depression. There is an increased prevalence of substance use, but that is different in the population that is going to drug and alcohol services. Their mental health services are much more commonly anxiety disorders, depression but not of the same intensity, post-traumatic stress or other trauma-related disorders.

Those traumas typically are not treated as a high-prevalence problem by public mental health services; they are sometimes in the private sector. They are slightly different population centres, and saying that putting the two together is going to make them more efficient or better is an argument that has been used in the past. Unfortunately, it did not seem to reflect the reality of the situation. I note that two public health services—South Eastern Sydney and the Central Coast local health districts [LHDs]—did have mergers of their drug and alcohol and mental health services but subsequently decided to de-merge, because it was not working for them and it was not working for their patients. We could use lots of examples of putting a large health services with resources but also many, many demands—and I think every member of the Committee would be aware of the enormous mental health demands that we have in our society—with another area that is much smaller in terms of population prevalence but with common problems and much smaller resources, you do not necessarily get an enhancement of services. In fact, drug and alcohol issues can be neglected when there are merged services.

It is not to say there are not some good mental health and drug and alcohol services—there certainly are and I note the mental health service at the Calvary Mater Newcastle of Hunter New England Health is a great example of a service that sees both populations—but overall we do not support the merging of drug and alcohol and mental health services because of the needs of their patients and the fact that there are different specialties that are responsible for the patients. In fact, there is a need for drug and alcohol services to work with a wide range of services including obstetrics and gynaecology, emergency department, infectious diseases, general medicine, general surgery, orthopaedics—the many health system that our patients appear in, not to mention all of the social and welfare services.

The Hon. Dr PETER PHELPS: On the harm minimisation aspect, is it not the case that one of the things that comes out of the Portugal model is the idea that depenalisation leads to no real increase because people who want the drugs can get them?

Professor DUNLOP: There are many things to come from the Portuguese system. One of the most interesting thing is the fact that if a person is apprehended by the police with substances and possibly with substance abuse problems, their next visit is not to a court, so to appear before a magistrate or a judge; it is to a tribunal where there are two people usually with a health background and one person with a social work background or a member of the community. They make decisions to try to match the needs of the individual—and there might be a wide range of individuals from a young person trying cannabis for the first time to a person who has had a severe alcohol problem for many years—to the appropriate response.

The Hon. Dr PETER PHELPS: But there is still a compulsory aspect to it—

Professor DUNLOP: Appearing.

The Hon. Dr PETER PHELPS: —and that is you are being diverted from the legal system but you are not being diverted from the consequences; you are being diverted into a treatment program in the first

instance, rather than in the first instance going through the legal system and eventually getting to some sort of treatment program, if you are lucky and the resources and people are available.

Professor DUNLOP: That is correct.

Dr MEHREEN FARUQI: In your view is the tribunal a better system than the drug court system that we have in New South Wales?

Professor DUNLOP: The drug court system is for an entirely different population. The Portugal model is for a population with significant but non-violent criminal problems, not individuals caught up in the legal system where there is an opportunity to have a custodial sentence. The NSW Drug Court model is a very expensive program; it is one of the most expensive sorts of drug treatment that we have—probably the second most expensive. It certainly has a benefit for the patient, but this is an entirely different way of looking at how our health and legal systems should respond to drug problems.

The Hon. Dr PETER PHELPS: Presumably, self-regulation of individual addictions is an important and effective tool in minimisation of the social consequences of drug addiction. Would that include not so much tobacco but nicotine that is accrued from tobacco? Would vaping be a useful harm-minimisation tool for introduction into New South Wales?

Professor DUNLOP: From a New South Wales perspective, there are potential benefits of vaporised nicotine products. There are certainly populations that do not respond to public health interventions or to current nicotine tobacco cessation programs like nicotine replacement therapy or varenicline or bupropion medications. This is a public health conundrum. For the benefit of the population the public health perspective is: "Do not introduce vaporised nicotine products because maybe we will see an increase in nicotine use." Maybe they are not entirely safe but maybe that will then turn into a switch to tobacco products and we might see a future generation increasing their smoking. But from the needs of the individual patients and the sorts of patients I see, vaporised nicotine products certainly hold promise. There are a number of research projects with which I'm currently engaged to try to better understand their role and their effectiveness.

The Hon. BRONNIE TAYLOR: Thank you very much for your time, Professor Dunlop. You are obviously an extremely busy person and we appreciate your time. On-the-ground rural and regional services are our focus. You mentioned that the specialist in Tamworth is leaving, so now you are going to fly up to Moree, and I commend you for that—that is fantastic. You also said we need to empower and educate our workforces. The best way when you are a rural practitioner—as I was—is when someone flies in and you get to spend a day in a clinic with them. The amount of stuff you learn is often better than any three-month course a person might undertake—it is fantastic to have that synergy between the specialist and the person on the ground in the rural or regional area. Is that the model we need to be looking at, even though there are not enough of you? No matter what we do, we are never going to get a drug and alcohol specialist in Cooma, because we simply do not have the population base. Do we need to make that better? We could ensure a close relationship with specialists from major treatment centres who do fly in and fly out so that if I have a problem with one of my patients on the ground and I am the community worker, I can ring Profession Dunlop and say, "I need some help. Do we use strategy A, B or C here and can you send me the authority to do that?"

Professor DUNLOP: I agree with you in that rural communities are very used to being very adaptive and look at a wide range of ways to try to sort out the problems for their local community, because they do not have an option. They are often far more flexible than bigger centres or Sydney central, for example. However, the problem we have at the moment is there is not an adequate critical mass of specialists in central Sydney or even in Western Sydney to have the resources to have greater connectivity to all of our rural health districts. Speaking to rural specialists across the State there is an enormous demand—there is an enormous demand everywhere for people's time.

The Hon. BRONNIE TAYLOR: We need more.

Professor DUNLOP: If we could increase the critical mass then we might be able to increase the access in the sort of model you have just suggested.

The Hon. COURTNEY HOUSSOS: In your submission you noted that it is not specifically within the scope of our inquiry but you made some comments about the availability of drug treatment services within prisons or upon people's release from prisons. Within the NSW Health submission they referred to their Connections Program. Do you have any insights or feedback you would like to provide on that? I think it is directly relevant to our considerations.

Professor DUNLOP: The Connections Program is a very effective program that tried to link up prisoners with an intensive case management type service so upon release to the community, they are linked in

to the sorts of health and welfare services they need. The problem is degree—that we do not have enough of those connections workers, with the enormous flow through of prisoners in and out of prisons in our State on a regular basis, to do the work that they need to do. So inevitably people come in and out of jail multiple times.

The Hon. COURTNEY HOUSSOS: Another submission—I cannot remember which one—talked about how this used to be done a lot more effectively in the past and those connections were made. Is that your experience as well?

Professor DUNLOP: Yes. And part of the problem, as I sure the Committee is aware, is that there has been very considerable growth in the number of prison beds in New South Wales and the number of incarcerated people, so there is a greater volume of people coming in and out of prison without the commensurate increase in health services to the prisoners.

The Hon. COURTNEY HOUSSOS: Obviously I am not asking you in your official capacity in Hunter New England Health, but one of the other submissions noted that that is an area that has a very high Aboriginal population within its health service—I think it was 10 per cent.

Professor DUNLOP: Yes.

The Hon. COURTNEY HOUSSOS: Do you have any anecdotal feedback you can provide us about effective ways that they have recruited staff or reasons why that number of staff is so high?

Professor DUNLOP: Sure. Again I clarify I am not talking in my Hunter New England Health capacity. There are multiple ways to try to better respond to the needs of Aboriginal people. In that district, frequently it is above 10 per cent. At times it is at 20 per cent or sometimes more, depending on which particular community it is. Hunter New England drug and alcohol is very effective in having a very proactive Aboriginal recruitment strategy for its workforce and has 11 per cent of its 160-odd staff Aboriginal identified clinicians. Having said that, that is still a small drop in the ocean in terms of what we need to do. It has a program of encouraging professionalisation in that workforce, so encouraging certificates, degrees or further qualifications and very proactively supporting its workers in doing that. It has an Aboriginal identified manager to try to look at the cultural needs of those staff.

But there is still work to be done. It would be great to have more Aboriginal doctors. It would be great to have an Aboriginal drug and alcohol specialist. It would be great to have more Aboriginal psychologists and more Aboriginal nurses—across all of the different professions that work in this area—so we could see better responses. The other critical issue is, of course, working with the Aboriginal community controlled health sector. Again, some of the challenges just come back to resources. There is great work that could be done with Awabakal, with Biripi, with Pius, with Tamworth Aboriginal Medical Service [TAMS], with Armajun community controlled health services, but it is a matter of how much work we have to do and the workforce we have to provide the assistance to them that they need.

The Hon. COURTNEY HOUSSOS: You talked about the need to professionalise within the service. Is there the ability to locally train those workers?

Professor DUNLOP: Fortunately there are good models in New South Wales. The Aboriginal Health College in Sydney has a great residential program where people spend time out of their own communities and come down and do study here. That is at Long Bay. That is a great service. The University of Sydney has a number of programs that have been very effective at different degrees of trying to encourage professionalisation of the workforce. But there are other universities too that do this. Fortunately there are good examples of different ways of trying to meet the needs of that individual. Sometimes people cannot move out of their communities for study—they need to be home for family and other needs.

The CHAIR: Page 3 of your submission states:

> While there are many reasons why people choose to try or take drugs—some highlighted above—it should be understood that repeated drug or alcohol use leads to changes to the brain that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs.

For the benefit of the Committee could you describe in lay terms that change in the brain? There is an engineer and another doctor on the Committee, but I am not a medical doctor.

Professor DUNLOP: I would like to situate this way of trying to understand it within a broader context, because I think that makes more sense. There are multiple ways of trying to understand substance use. A moral perspective is one. People could say, "It is immoral to take drugs," or, "It is not to do with my culture or my faith." There is a legal perspective. You could say, "This is legal; this is illegal." So we are particularly interested in biomedical but also social ways of trying to understand drug use, because no single model explains all behaviours or all incidences. There is the social context, the cultural context, the intergenerational context—

if you grow up in a family where smoking is very common, you are very likely to be a smoker, not just on genetic risks but also on social risks.

If you live in a community where there are many smokers, many drinkers or many drug users, you are more likely to notice drug use. So that needs to be taken into context too. In terms of the brain changes and the neurological or neuro-biological model of substance use, I will give you an example about repeated exposure to a substance. If you drink alcohol regularly, your brain adapts to the presence of alcohol and that amount of alcohol has less of an effect. So if you have two drinks of beer on a daily basis, after a while two drinks does not feel like two, it feels like one drink. That is the phenomenon of tolerance. There is another phenomenon. If you drink very heavily and regularly your brain gets very used to functioning under the presence of that drug—not as optimally as it otherwise might, but it does get used to it—and if you stop you get withdrawal. That is another brain change.

All of these changes are thought to come through a central area called the dopamine reward pathway. The best way of trying to describe that is to think of something that you really like: chocolate, flowers or walking along a path and seeing a nice sunset. When I mention those things your brains will light up with a dopamine reward pathway and you will think, "That would be nice." This sort of response, because of the intensity of the effects of a substance on the brain, is far stronger than the sorts of suggestions that I just gave you. So this reward pathway is overworked in conditions of addiction.

The CHAIR: Sorry to interrupt. That particularly applies, as a general proposition, to alcohol and drugs?

Professor DUNLOP: And tobacco, amphetamines, cannabis and other drugs too. There is another important and linked pathway that is best thought of as the brakes on your behaviour. There are parts of your brain that tell you to say no. Imagine that you are in a car and it is a wet afternoon. If you are driving along and you see the light turn amber up ahead, your foot goes onto the brake, not onto the accelerator, because you think you are in a dangerous environment and you should not proceed. In substance use, this pathway to say no becomes interfered with, and it takes a lot more energy from the brain to say no to something that would appear to be obvious. This in part, not totally, helps us understand why people cannot say no; why they cannot just decide that they should stop. It explains why a pregnant mother, for example—I work in a drugs and pregnancy clinic every week—cannot work out that she should stop drinking, taking methamphetamine or some other substance.

The CHAIR: When you talk about the energy to stop, are you essentially talking about willpower? That is a general term but my question is: Does saying no involve a conscious decision to act in a particular way?

Professor DUNLOP: Yes, but it is not just conscious willpower. Some of the thinking about a lot of the actions are subconscious. They operate on a primal level. In fact, that part of the brain that I was talking about before often operates on a more primal level of the brain. Things happen without our necessarily thinking of them or being aware of them. That is one of the cognitive responses to substance use: to try to make people more aware of unconscious decisions that they are making.

The Hon. BRONNIE TAYLOR: Professor, I ask my next question very respectfully. Is there not some responsibility in terms of the college and the medical profession to push the fact that this is a speciality where we are really lacking? We saw it in palliative care decades ago. We still do not have enough specialists, but we had none and there was a real push. My question is, Do you feel that the medical profession has a responsibility to push this because it is a specialty that is in great demand and is growing, so that we have more of you?

Professor DUNLOP: I agree that the profession, not just the Royal Australasian College of Physicians but the Royal Australian College of General Practitioners and psychiatry as well and all parts of specialist medical colleges have an obligation to be aware of the range of health problems. Sadly, drug and alcohol problems have, for many years, been neglected and thought of as a social problem or somebody else's problem—"not my problem"—by specialist practitioners.

The Hon. BRONNIE TAYLOR: Is that the Government's role?

Professor DUNLOP: I will give you a recent example. About 10 years ago the State recognised the importance of stimulating more specialists. It created a small fellowship system where, each year, one health service would be awarded one new training position. It did not cost hundreds of thousands of dollars This was not a specialist position; it was a training position. Out of that, over the years we were able to have a new specialist in northern New South Wales and a specialist paediatrician who is also a specialist in drugs and alcohol. Unfortunately, several years ago, after revisions in how NSW Health funds things and what it considers

important, that training scheme was abolished. So we did not see the same increase in numbers of new specialists, people attracted to the field who were not otherwise attracted to the field. Fortunately there has been some reconsideration of that now. Again, it is probably best to speak to the Chief Health Officer about that this afternoon. There are small things that the Government can do that are not incredibly expensive but do stimulate interest in the field.

The Hon. BRONNIE TAYLOR: Perhaps we could look at that.

Professor DUNLOP: Clearly, working together to respond is part of how we ought to respond.

Dr MEHREEN FARUQI: One of the terms of reference of the inquiry is about investigating the impacts of mandatory detoxification programs. Not many submissions have addressed that issue. One of the submissions said that it did not support compulsory treatment. With your experience, what is your view on that?

Professor DUNLOP: There is a very limited role for mandatory treatment. The key reason is that we have inadequate evidence that mandatory treatment changes the course of somebody's dependence. There are many anecdotes, but anecdotes form a small level of evidence. There is an evaluation of the involuntary treatment system that exists in New South Wales now that has a very small number of beds—there are 12 beds for the State—and that might give us some more information about the role of mandatory treatment.

At the same time, fortunately, there has been an increase in other alternatives to mandatory treatment in New South Wales—ways to try to more proactively find patients who might present to an emergency department once every week or once every fortnight with a substance-related problem, an alcohol problem or another drug problem. We know they exist, they are out there in the community, but the amount of work required to get somebody into an involuntary bed is very considerable. Even then, there is no doubt that there are problems with the Drug and Alcohol Treatment Act.

For example, if I decide today that a patient ought to go for involuntary treatment under that Act there might not be a bed, so the Act cannot be invoked. In the meantime it is not clear what happens to the patient, whose responsibility that patient is, and how we should best respond to that. Changes to the Act need to occur. Getting back to the question, involuntary treatment is very expensive, and it may be that less expensive forms of treatment produce just as good an outcome. That is why it is important to evaluate not only involuntary treatment but also these other forms of trying to more assertively engage patients who have severe problems and see if we can connect them with treatment systems.

Dr MEHREEN FARUQI: Did you say that there is not much evidence to suggest that forcing someone to take this treatment actually works?

Professor DUNLOP: Exactly. I guess there are also potential concerns that the Act could be used inappropriately.

The Hon. Dr PETER PHELPS: In relation to finding the workforce for it, surely that relies particularly on universities. Presumably at the current time—I do not know; I am just asking—there is no mandatory requirement for psychology students or medical students to go through a compulsory course component involving drug and alcohol addiction and treatments?

Professor DUNLOP: I am not aware of any mandatory requirement. To my knowledge, universities that have undergraduate or postgraduate medical degrees in New South Wales do, and there was a curriculum—

The Hon. Dr PETER PHELPS: They have the option?

Professor DUNLOP: They have a set of learning objectives that they can choose to use, but the amount of training is small. For example, at Newcastle University, which I am connected to, there is about 20 hours of teaching across the course.

The Hon. Dr PETER PHELPS: A six-year course.

Professor DUNLOP: Yes. So it is not enormous, especially when you consider—

The Hon. Dr PETER PHELPS: "Not enormous" is a generous understatement.

Professor DUNLOP: It is minimal.

The Hon. Dr PETER PHELPS: Is that something that governments should be requiring universities to look at as a constituent part of their courses, considering that the most likely people to be frontline are psychologists and medical practitioners?

Professor DUNLOP: It would be great if we could have more graduating medical practitioners, psychologists, nurses and all of the professions that work with this population have a better understanding at an

undergraduate level but also more opportunities for exposure to it early in their career. That is training positions, training posts, et cetera, so they can get exposure to drug and alcohol problems.

The Hon. Dr PETER PHELPS: If it is tangential to what being a real doctor, nurse or psychologist is about they will just say, "I won't bother about that." If it is treated a little more seriously people will think, "This is something that I should be looking at as a future career."

Professor DUNLOP: Correct.

The CHAIR: Thank you very much. You took one question on notice. Perhaps after reading *Hansard* some members might have additional questions. The Committee has resolved that answers to questions taken on notice be returned within 21 days. Would you be able to consider the questions in that time?

Professor DUNLOP: Of course.

The CHAIR: The secretariat will contact you about those questions. Thank you again for coming along.

(The witness withdrew)

(Short adjournment)

MARTIN DALITZ, Solicitor in Charge, Drug Court, Legal Aid NSW, affirmed and examined

JENNY LOVRIC, Program Manager, Cooperative Legal Service Delivery Program and Regional Outreach Clinic Program, Legal Aid NSW, affirmed and examined

The CHAIR: The secretariat has received the Legal Aid NSW submission and processed it as No. 27. You can take the submission as read but I will invite you to make an opening statement to set the scene. There is no need to go through in detail what has been covered in the submission. We will then open it up for questions from the Committee members.

Ms LOVRIC: Thank you for the opportunity to give evidence before the inquiry today. It is a very important inquiry for our clients and for us that interface with them. We are here mainly to talk about the cohort of drug users that get themselves caught up in the criminal justice system. We talk about these users sometimes as our frequent flyers. They are rarely single drug users. They may be using many drugs. They are also using alcohol and often painkillers as well. The vast majority of this cohort of drug and alcohol users have other accompanying and complex issues. They often have psychosocial issues, often mental health issues, often trauma and abuse and often intergenerational trauma and abuse. They have disabilities. They may have cognitive impairment, insecure and unsafe housing and homelessness, low educational attainment, and financial hardship. They often are subject to relationship breakdown and family violence, sometimes informed by their drug and alcohol use. It is precisely those issues combined with alcohol and drug use that brings our clients into contact with the criminal justice system.

In regional, rural and remote areas these issues are exacerbated by: high rates of drug-related crime; the relative lack of accessible, on the ground and culturally appropriate services; low recruitment and retention of staff in health and social support settings; lack of transport options for our clients to get to those rehabilitation centres that exist; and lower socio-economic status generally, which may include low employment, low or no literacy and little access to technology, which challenges things like telehealth. Not addressing these issues and, significantly, not addressing the trauma issues leads to self-medication, with ice and alcohol obviously very much at the forefront at the moment. The relative lack of treatment options or the waiting list to get into treatment options leads to offending and sometimes reoffending.

We agree with many of the submissions that there is not a one-size-fits-all option to look at. There are many forms of drug treatment and other submissions set those out quite well. Getting an addict to an addiction-free state brings benefits not only to that individual but also to the family, the community and the economy more generally. It eases the burden on Health in the criminal justice system and enables engagement in education and employment. It is difficult to know what is going on across the State but we do know from our work across regional and remote New South Wales that access to drug and rehabilitation centres is difficult, it is chaotic and it is hard for our clients to navigate their way through the system. Residential rehab is certainly expensive but the alternatives, which are prison and multiple presentations at emergency, are more expensive in the long run.

Mr DALITZ: I am a criminal defence lawyer working for Legal Aid at the Drug Court. I assume that you are familiar with the Drug Court procedures and I will not take time up by going through that, but most importantly there are three drug courts across specific areas in New South Wales and they have the capacity to cater for 280 participants. It is slightly under 280 just now. Of those 280 participants about an average of 40 per cent across the courts utilise rehabilitation facilities to do their programs. They are either living in or are involved in supportive accommodation through a rehabilitation facility.

I can speak to the issues of the Drug Court interaction with the rehabilitation facilities and in particular the way it flows both ways. In other words, it is a mutually beneficial arrangement. The Drug Court needs the rehabilitation facility—obviously, 40 per cent of our people are in rehabs—but the rehabs need the drug court as well. It cuts both ways.

The Drug Court obviously needs our people to be in stable accommodation and have a stable source of treatment for their needs and the rehabs obviously need a steady flow of customers and something to do with people who are in a rehab facility but misbehave in some way—for example, by using drugs or otherwise do not comply. The rehab centres generally have to put them back out on the street and say, "Sorry, we cannot help you any more". But with the Drug Court as backup, the Drug Court calls the person back in—perhaps with the assistance of police or perhaps without—and the person goes into custody for a period of time. They are then able to refocus their mind, so to speak, with the aid of the motivation provided by the Drug Court sentencing that is hanging over the head. They are then released back into the rehab, which will take them back, with a renewed sense of focus.

These are the issues that I can help—if I can help. I am aware that there have been campaigns in the communities of Dubbo, Wagga Wagga, the Illawarra and Wollongong area and, more recently, the Central Coast to expand the Drug Court process to those areas. I am disappointed to see that Scot MacDonald is not here today. I understood that he was going to be here—he was on the list of members of the Committee. Mr MacDonald is apparently involved in the Central Coast campaign. I know that Professor Adrian Dunlop said in his submission to the inquiry that it is an expensive process, and obviously it is. But the report from 2008, the Don Weatherburn report that is referred to in our submission, makes it very clear that, in monetary terms, it is cheaper to keep people in the Drug Court than it is to keep them in jail, and Drug Court participants are people who would be in jail if not for the fact that they are in the Drug Court program. It is expensive, but to expand it to those areas is clearly beneficial. However, without the rehab it is not going to happen. It cannot happen with 40 per cent of our people being in rehabs. I am happy to answer any questions.

The Hon. COURTNEY HOUSSOS: I thank you both for your submission and for joining us today. It is informative for the Committee to consider the legal aspects of drug rehabilitation services and the way that they are intrinsically linked. In your submission, you noted that the Bureau of Crime Statistics and Research [BOCSAR] has noted an increase in police-recorded incidents of the possession and use of amphetamines in New South Wales in each quarter since June 2010. The submission from NSW Health seemed to indicate that presentations to emergency departments are starting to stabilise. Is that your experience?

Ms LOVRIC: We can only speak to the data we have through BOCSAR because we do not work in the health space. But we are hearing anecdotally that there is no decrease in the amount of drug use. I suspect that the statistics on hospital presentations only partially represent the issue of people with drug and alcohol presentations, for reasons mentioned earlier. Some people will not present to emergency departments because of shame and stigma and will not seek services. It is certainly my experience in travelling across New South Wales that crystal methamphetamine—or "ice"—is a key issue. Putting aside the media issues and hot air around this, I think there is an issue. In most regional and remote communities I will hear that people are still very much affected by methamphetamine use and it is not uncommon to go to a small community and there be funeral every week.

The Hon. COURTNEY HOUSSOS: I am not sure whether that was in your submission or someone else's.

Ms LOVRIC: I think it might have been in someone else's, but it is absolutely an issue.

The Hon. COURTNEY HOUSSOS: It is very compelling evidence for us to hear. I note that in your submission you talk about the Drug Court and the Magistrates Early Referral Into Treatment [MERIT] program. Another key support in the legal system is the provision of mental health nurses at local courts. However, there are some significant gaps around the State. Can you speak to the important role that mental health nurses play and to whether you have done any mapping of where they are available?

Ms LOVRIC: I can speak a little bit to that, but, once again, it is going to be anecdotal. I am happy to take some questions on notice on this issue. MERIT is available in some courts but is not available in many courts and is certainly not available in courts where we know there are high amounts of drug use. Justice health nurses are certainly a limited resource. We are unclear on what basis that particular resource is allocated to courts, but there are some significant gaps, which I suppose goes to the issue of the comorbidity of issues. Yes, there is certainly an issue with drug use and mental health—there is a correlation, but it is not necessarily a causation issue. But we do see some significant gaps, particularly in areas where we know there are high levels of mental health issues and high drug use issues.

The Hon. COURTNEY HOUSSOS: Mr Dalitz, you mentioned the expansion of the Drug Court to Dubbo, Wagga Wagga, the Central Coast and the Illawarra. Has your organisation identified a particular area or areas where the expansion of the Drug Court would be most useful?

Mr DALITZ: I do not think the organisation has identified a particular area. We respond to people who are in those areas who contact us to ask, "When are you coming?" Obviously, Dubbo is such a hotspot of issues, and it is particularly prominent in that regard. The Central Coast is also prominent because there is this awkward gap between Sydney and the Hunter. It seems illogical that there is this gap there and it seems awkward that people living just south of Lake Macquarie have no Drug Court to go to. That is an issue for across Sydney as well. In answer to your question, the reality is that all those places have issues that could be addressed with the assistance of the Drug Court.

The Hon. COURTNEY HOUSSOS: And, as you said, it depends on the support services that exist within the community around that.

Mr DALITZ: Without those support services, it cannot happen.

Ms LOVRIC: It is a condition precedent to have a Drug Court to have some well-funded, sustainable services to support the Drug Court and the good work it does.

Mr DALITZ: There are approximately a dozen rehab facilities in New South Wales, primarily in Sydney but also in regional New South Wales, the North Coast and the Central Coast. Those services are utilised by drug courts in Sydney, the Hunter and Parramatta—they are all utilising those facilities. I work primarily in Parramatta, but also in Sydney and the Hunter. All of those drug courts are sending clients to Adele House in Coffs Harbour, AAGANA in Macksville and the Glen Centre on the Central Coast. All of the rehabs are being used and are bulging at the seams with Drug Court participants. It was suggested that we could open a Drug Court in Dubbo and send the people who need rehab to Adele House—that is not going to happen; it is full.

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

The Hon. COURTNEY HOUSSOS: I have one final question that crosses over to the previous inquiry of reparations and the Stolen Generations. Your organisation, again, made a very useful submission to that. You talk about in this particular submission to this inquiry that a 12-week program is unlikely to be a complete answer, that there are much broader issues around mental health and trauma that need to be addressed. Has your organisation seen any of the responses from that particular inquiry? Have you had any interactions with those yet?

Ms LOVRIC: Yes, we certainly have. We understand there were 20 to 24 recommendations made out of that inquiry; only some of them have been implemented at this point. Certainly, the reparations scheme has started. Regrettably, we are seeing many clients being refused access to that scheme because of a cut-off date of 1969 for removals. It does go to that issue about trauma and trauma-informed services. Our clients need to be approached in a different way to come into these kinds of reparations. The payment that people are getting, the recognition payment, is one thing but it is those support services that will actually see that client properly repaired in many ways—and those services certainly are not available in regional New South Wales.

The Hon. COURTNEY HOUSSOS: There were obviously a lot of broader recommendations, more than just the specific payment, and they were what I was interested in—whether you are starting to see any interaction with those yet?

Ms LOVRIC: I am not aware of the implementation of many of those recommendations at this point and we certainly are agitating for that to happen.

The Hon. Dr PETER PHELPS: In your submission you say you are in favour of compulsory drug treatment but opposed to mandatory detoxification. What is the difference?

Mr DALITZ: I can speak about the Compulsory Drug Treatment Centre Correctional [CDTCC] unit at Parklea. You are probably aware of the aspects of eligibility to become a CDTCC participant, and it is a compulsory drug treatment program. It is for the people at the very top end of the range in that you have got to have a jail sentence with between 18 months and six years still to serve. For people in that category, you are talking about really recidivist offenders invariably, with a significant drug problem which is causing them to reoffend. For those people, my experience anecdotally is that they are hard cases. We get the history when they come through the Drug Court to be admitted to the CDTCC, they have spent most of their life in jail, almost invariably. They get out of jail for a few weeks and they go back in again. The connections system that Professor Dunlop was talking about has not worked for them one way or another.

If you can get them on the CDTCC program for 18 months—12 months of which can be in the community or partially in the community—and they stay out of trouble, it is a miracle. It is a great achievement; it is progress. If that is the gauge of success then the CDTCC is working. So, from Legal Aid's point of view, we certainly support that.

The Hon. Dr PETER PHELPS: Why should that not be expanded to earlier, non-hard cases?

Mr DALITZ: I am not a doctor; I am not a treater. I am a lawyer. But I would have thought that the more appropriate response was to people at that early stage of their criminal career that does not involve a mandatory imposition of that kind of treatment.

Ms LOVRIC: There is no evidence really to suggest that mandatory referrals are actually going to work in that case. There is some thinking—and, once again, I am speaking as a lawyer, not as a professional—that that point of people's readiness to participate in drug rehabilitation conflicts with that mandatory referral aspect; whereas with the other program, people are actually already incarcerated, already sentenced and there is great incentive to participate and succeed. And certainly the results are very pleasing.

The Hon. Dr PETER PHELPS: In relation to the 2008 Weatherburn study, it showed pretty good results. But 2008 essentially predates methamphetamines, so basically you are looking at cannabinoids and opioids in that cohort at that time. Is there any statistical analysis that has been done since that time, as that is now 10 years ago?

Ms LOVRIC: Are we talking about MERIT?

The Hon. Dr PETER PHELPS: Essentially, recidivism rates for people who go through these diversionary programs or through the Drug Court for recidivism. That is 10 years old and the prevalence of methamphetamine use has substantially increased between 2008 and 2018. Is there a substantial reduction in recidivism because of these alternate pathways?

Mr DALITZ: I am not aware of any study since the Weatherburn report; as far as I know, there has not been one. I have been working for Drug Court for 10 years, so my experience crosses that period and certainly it is wall-to-wall methamphetamine or ice use now. Obviously, there was methamphetamine before but ice is now the drug of choice for 99 per cent of the Drug Court participants. Personally, I do not think that I have seen a change in the recidivism rate or the compliance rate. It is all treatable using appropriate techniques—some people respond and some people do not. We have got an unusual cohort in as much as it is a non-violent part of the drug using and offending community that find its way to the Drug Court. I guess it is not necessarily representative. But to the extent that there is a continuum through there—so it is the same cohort as it has been all the way through— I do not believe there has been any significant change as far as recidivism and compliance is concerned.

The Hon. Dr PETER PHELPS: From your experience, what would be the cost of a hit—I do not know the appropriate term—of ice in rural and regional community?

Mr DALITZ: I do not know, and I do not know if Ms Lovric knows the actual cost. But certainly it is regarded as being as cheap as chips.

The Hon. Dr PETER PHELPS: Are we talking $100?

Mr DALITZ: No.

The Hon. Dr PETER PHELPS: Fifty dollars?

Mr DALITZ: Less.

The Hon. Dr PETER PHELPS: Twenty dollars? Twenty-five dollars?

Ms LOVRIC: We would have to take that on notice and consult our clients.

The Hon. Dr PETER PHELPS: Effectively, you could get two hits of ice for the cost of a slab of beer in a rural and regional community and, despite all the policing measures that are put in place, there appears to be no lack of supply in those areas. Would that be correct?

Mr DALITZ: I think so, yes.

The Hon. Dr PETER PHELPS: Is there an argument, which was made by Professor Dunlop, for a move to a Portugal-style model of at least decriminalisation of recreational drug use with appropriate treatment programs following on from that?

Ms LOVRIC: I think from a harm minimisation approach and also from a cost-benefit approach clearly diverting people away from the criminal justice system, the health system and prison is absolutely something worth exploring.

The Hon. Dr PETER PHELPS: The Portuguese have a compulsory aspect to it, and that is you are diverted away from the criminal system towards mandatory treatment. You appear to be opposed to mandatory treatment for, if you like, first-instance appearances, but you support mandatory treatment for people who, to be frank, are probably beyond the ability to fully restructure their lives away from that culture.

Ms LOVRIC: I am not sure whether that is actually a completely straightforward characterisation of our users. Let us just put that in context. Our users come from the full spectrum—there are first-time users who may, unluckily, get caught and we have some people who are serial reoffenders. So I think that is unfair. In

terms of looking at things like the Portugal model, it is news to me; I have only just heard about it. I think we need to do some research and see whether that kind of model is something that could be adaptable to the Australian environment. I think it is unclear at this point. Just in relation to the financial cost of a hit of ice, I was recently up in Moree and an acting superintendent of police there said he actually wished back to the days of heroin compared to ice. At least with heroin use the offenders would often just get tired and fall asleep. Ice has a completely different impact on the users and the families and the community. I think what he was bemoaning was the easy accessibility of ice and that pervasive impact on people's lives.

The Hon. Dr PETER PHELPS: That is a function of what we have done—we have gradually increased the taxation on alcohol to the point where it is now cheaper so if one wants to get whacked one goes out and gets a hit of ice, rather than buy a slab of beer. People are product substituting away from a legal, regulated and taxed product to an illegal but still prevalent product that has no safeguards or tax and, for users of it, a material disincentive to seek treatment because of its very illegality. Is that not the material effect of public health campaigns against alcohol?

Ms LOVRIC: You seem to be speaking to a legalisation of drugs.

The Hon. Dr PETER PHELPS: The transcript should note that Mr Dalitz should "no".

Ms LOVRIC: I will take that as a comment.

Mr DALITZ: I said "totally". I totally agree with what you are saying.

Dr MEHREEN FARUQI: I would like to know about the Magistrates Early Referral into Treatment [MERIT] program. What is your view on that program? Should it be expanded to other areas? How does the cost of the program compare to the Drug Court? They are two different things but is one a substitute for the other?

Mr DALITZ: The MERIT program is short-term treatment whereby a person gets referred by a magistrate to treatment. A few weeks later that person comes back. Then, if everything is okay, they get another referral and a report. The magistrate takes all that into consideration in sentencing.

Dr MEHREEN FARUQI: What are the conditions of that referral? Who can be referred to the MERIT program?

Mr DALITZ: The solicitor might make a request but the magistrate makes a referral. It is called the Magistrates Early Referral into Treatment program.

Dr MEHREEN FARUQI: Why do you think it has not been rolled out in really high need areas?

Ms LOVRIC: That is a really great question. We would actually like to know the answer.

Dr MEHREEN FARUQI: What are the barriers?

Ms LOVRIC: The number of limited courts. I understand that it is a resourcing issue. It has been under review and redesign. We have just recently heard that the redesign has been abandoned. So we are unclear where it is going at the moment. MERIT is a great program and magistrates love using it. Magistrates in courts where MERIT does not exist are often bemoaning its absence. It is short and sharp. What works with MERIT as well as with the Drug Court is the judicial supervision that accompanies those programs. It seems to have a civilising effect on service providers because of the oversight and the monitoring, and it is good for our clients as well. MERIT is in places—it is the same answer about rehab—there are just not enough facilities.

The Hon. Dr PETER PHELPS: Are you saying that the judicial oversight effectively puts in place key performance indicators which have to be met that otherwise would not be met by those providers?

Ms LOVRIC: No, I am not saying that.

The Hon. Dr PETER PHELPS: What are you saying about the judicial supervision that makes it particularly effective?

Ms LOVRIC: It encourages our clients to re-attend and to comply.

The Hon. Dr PETER PHELPS: It is a compliance.

Ms LOVRIC: It is a compliance.

Dr MEHREEN FARUQI: How many courts have the program?

Ms LOVRIC: I do not have that information. I will have to take that question on notice.

Dr MEHREEN FARUQI: Could you also take the locations of those courts on notice?

Ms LOVRIC: Absolutely. Certainly we have been lobbying to have MERIT rolled out across New South Wales, especially to regions with have high rates of drug and alcohol use. We would like to see MERIT expanded to include alcohol. MERIT is also like the Drug Court, there is limited criteria for entry, so indictable offences—I think I am right in that, am I not?

Mr DALITZ: Yes, it is a magistrates court.

Ms LOVRIC: Indictable offences will not be able to access MERIT and young people under 18 will not be able to access MERIT. It is a less intensive piece of compliance in terms of its case management approach. It may or may not involve referrals to a residential or outpatient rehab centre; it may just involve a drug and alcohol counsellor in terms of getting people on the straight and narrow.

Mr DALITZ: Practically speaking, MERIT clients are on bail. They need to be on bail in order to do MERIT—that is how the process works. The Drug Court, in contrast, is for people who are almost invariably in custody. They have to go into custody in order to start the Drug Court program for the detox process. It is for people significantly further down the path so to speak. The Drug Court is for people significantly further down the path. It is a minimum 12-month program at the Drug Court so it is far more comprehensive. Just in relation to the judicial supervision aspect of it, with MERIT I think they come back twice, perhaps three times, before the magistrate over a 12-week period or whatever it is. In contrast, in the Drug Court they start by seeing the judge twice a week at Parramatta. It is a very high level of juridical supervision. If a participant does put a foot wrong he is pretty soon going to have to come and face the magistrate and risk losing his place in the community. The Drug Court is a far more intense process.

Dr MEHREEN FARUQI: In your submission you call for the reintroduction of a fully funded Youth, Drug and Alcohol Court in New South Wales, with a legislative basis. You used the word "reintroduction". Has there been a previous court like that and can you tell the Committee why it was abandoned?

Mr DALITZ: There was a Youth Drug and Alcohol Court up until about three years ago, when it was closed quite suddenly. A fairly small number of participants were involved in it and it worked in a very, very difficult area. Today we have spoken about motivation and people being at the right stage in their development to decide so to seek to put drugs behind them—I think the youth are particularly disadvantaged in that regard—and it was a very difficult jurisdiction. Perhaps its results reflected that. I am not exactly sure the reason why it was disbanded but it certainly was quite sudden, as I said, three or four years ago.

Dr MEHREEN FARUQI: In your view was that successful?

Mr DALITZ: In terms of numbers?

Dr MEHREEN FARUQI: Yes.

Mr DALITZ: I could not tell you in terms of numbers of successful outcomes and that type of thing, but in terms of the clear need to treat people in that situation as opposed to just go to jail, it is very beneficial to do so as early as possible. That is anecdotal.

Ms LOVRIC: My understanding is it was extensive. It was actually deemed and I think it was evaluated to be very successful, but it was also very expensive. In the same way we have a Youth Koori Court. We are also seeing some very good results in that, although the evaluation is yet to be publicly released.

Dr MEHREEN FARUQI: On page 10 of the submission from Yfoundations it states:

> The criteria for entry into rehabilitation varies with each service, but two conditions were raised as problematic by almost all youth homelessness services interviewed: the requirement to be engaged with the justice system, and the need to undergo detox before entering.

That implies that people have to have a run-in with the law before being accepted for rehabilitation. In your experience is this engagement with the justice system a requirement for many services?

Mr DALITZ: From the Drug Court point of view I do not know. The rehab facilities that we use take people not from the criminal justice system as well, but you really need to speak to their rehab providers. I could not tell you.

Ms LOVRIC: My speculation is they have put in that limitation because there are so many people who actually would want to access rehabilitation services. It is actually just a self-limiting criteria. There are many barriers and detox is certainly a very clear barrier. I suspect it was just, "Let's try and pick people who are at the most risk." It does not speak to a preventative, early intervention approach, which is ideal. It is just a matter of, "How can we limit the dollars that we have to spend?" That would be my suspicion.

Dr MEHREEN FARUQI: My last question is about the criminal aspect of drug use. Do you think because of the criminal nature of drug use in New South Wales and nationally people are less likely to seek treatment because of the stigma?

Ms LOVRIC: I cannot speak to that scientifically. Certainly, I do hear in some of the remote communities that I work with that people are very stigmatised and families are very stigmatised about drug use and seeking treatment. You have to put that hand-in-hand with the difficulty for people to access treatment. If you are in Bourke, you are not going to be able to access a treatment centre but you are going to have to go to Orange. That is difficult; it would mean owning up to family, leaving your family, travelling, getting somewhere—all of which is a big deal. For people with no public transport options and no driver's licence, that is a significant hurdle. I suspect that it is often a complex issues, which mean that people would find it difficult to step up, reach out and get access to appropriate treatment.

The CHAIR: I take you to page 17 of your submission, where you say:

> The requirement to detoxify before entering a rehabilitation facility is sometimes a barrier. Detoxification is a precondition for rehabilitation and it is essential that both of these services are available. Legal Aid NSW understands that public hospitals do not provide detoxification facilities.

In regard to detoxification as a pre-entry condition, typically how long does detoxification from a pretty hard-core addiction, like ice addiction, take? Is it several months of treatment?

Ms LOVRIC: My understanding—and I am not an expert in this area—is that detox can take between five and 10 days sometimes, and that it depends on the nature of the detox facility. There are a number of forms of detoxification—it could be at home, it could be supervised, it could be at a centre that has detoxification. It is indeed true that it is a prerequisite for most places to have detoxification before entry into a rehab centre. The wait lists for rehab centres are up to three months and sometimes longer, and that is a significant hurdle. If someone is lucky enough to find themselves a detox centre, they still may have a wait period before they can get into rehab, and we do hear stories about people relapsing in the meantime.

The Hon. Dr PETER PHELPS: I think your argument about mandatory detoxification is that there are already not enough places for people who enter it voluntarily and to impose mandatory on top of that simply exacerbates a problem.

Ms LOVRIC: Absolutely.

The CHAIR: Who runs detoxification programs and where are details of these programs to be found?

Ms LOVRIC: That is a really good question. Trying to navigate what is available at any given point is really problematic. I have been in a location in remote New South Wales where a solicitor would say, "I would like to have an online register to know when beds are available and where," so that they can make appropriate representations to the court in terms of referrals to treatment. That is a problem; it is chaotic. We heard evidence about the link between Commonwealth and State and NGOs. Local health districts might run their own lists of what is available, but that may not suit our clients who travel around different areas. As far as we understand, there is no one source to find out what is available. Conversations with Don Weatherburn from the Bureau of Crime Statistics and Research suggested that we need an audit of what is available, so that people can know what is going on. It is very difficult to find out what is available.

The CHAIR: From what you said it is true that I cannot go to a single website or government agency to establish the detoxification programs currently operating in New South Wales and what is available. There is no single point of accessing the information.

Ms LOVRIC: That is my understanding. I understand that people are so desperate that some might keep their own directories, which are fairly informal. I have a couple in my folder and from looking at those I know that some of the services no longer operate. It is a little random; they are subject to—

The CHAIR: Surely it is very random? I find it surprising that there is no ability to find this information in one spot.

Ms LOVRIC: No, there is no ability to do that. You can imagine how frustrating it is for us, as lawyers, trying to find diversions. But imagine how much more frustrating it is families and people who are looking for these services. It is almost impossible. Some of those resources may be online. In some of our communities people do not have access to the internet, so they are not going to find those services in any case.

Mr DALITZ: The Drug Court has a requirement, before a person can commence on the Drug Court program, that they spend time—and this is across the three courts—at the Metropolitan Remand and Reception Centre [MRRC] detox facility; a minimum of two weeks before they are released on the Drug Court program.

All Drug Court participants from the courts are funnelled through MRRC detox, where they are detoxed. That is an appropriate and required issue to be addressed before a person can transition from jail to the community. The detox is regarded as a clean zone within MRRC, because just because you are in jail does not mean you are not using drugs. The detox facility is regarded as being clean and people are released from the Drug Court program with a minimum of two weeks spent in the detox unit.

The Hon. Dr PETER PHELPS: I take you to the study of Tamsin and David at the end of your report. The thing that strikes me about the study is the physical displacement from the milieu within which they were previously operating. In David's case, he is removed from his milieu to a farm and, as I read it, cannot leave the farm for quite a few months, whereas Tamsin finds herself back in the same community, presumably mixing with the same people she was mixing with while she was using. Does that indicate that physical removal from their environment is more likely to lead to a successful outcome?

Ms LOVRIC: I know where you are going with this question. Once again, it is not a one-size-fits-all answer. Some people may benefit from being away from family and community, but for other people having the close support of family is what is going to get them over the line in terms of success and outcomes.

The Hon. Dr PETER PHELPS: It is interesting that the two examples you chose are clearly differentiated by physical displacement of that person and substitution of work. They had busy hands and were not in a position to access drugs; they were not in the same milieu, which allowed them to have drugs.

Ms LOVRIC: Absolutely, but once again there is some good evidence that says that people are really good at rehab as long as they are in rehab. The test is when someone leaves a rehabilitation facility and their transition into community. We need to look at the combination of what is right for particular communities.

The Hon. Dr PETER PHELPS: Where do you go when you leave rehab? If you go back to your old house in your old neighbourhood with your old flatmates, all of whom are doing crystal meth, how successful is rehabilitation likely to be?

Mr DALITZ: You leave the rehab with skills that you have learnt there and actual strategies. You also leave with the skill of accessing ongoing help. It is the case that you are not going to succeed unless you have picked up some skills on the way. Obviously, in at least some cases, it is true that they to pick up those skills and progress as a result and do not return to that community despite its attractions.

Ms LOVRIC: There are some ways of coming at this; the connection to family and community, particularly with Aboriginal communities, is very important and there could be some other ways of coming at it. We understand in some prisons they are trying to facilitate regular family audio visual link [AVL] visits so that people can at least feel supported. We think it is important that there is some way of facilitating that connection to community and families, so that people are encouraged and supported to help people to succeed.

The Hon. Dr PETER PHELPS: Provided that those people are interested in maintaining that person's abstinence from drug use in the future, and their old friends are not simply saying, "Wait till you get out and back to party days." Is that correct?

Ms LOVRIC: That would be right.

Mr DALITZ: Yes.

The Hon. COURTNEY HOUSSOS: Obviously, a change in physical circumstances is sometimes valuable but equally, if you have family commitments such as children, your removable from that environment could be problematic, not to mention if the person is Aboriginal or Torres Strait Islander, when the removal from that kinship group can be detrimental, as opposed to being a positive experience.

Ms LOVRIC: Absolutely.

The Hon. COURTNEY HOUSSOS: You talked about the abolition of the Youth Drug and Alcohol Court in 2012, which Dr Faruqi also spoke about. Since then there has been the emergence of the Youth Koori Court pilot, which you talk about in your submission. Obviously the two are not interchangeable; they cater for two separate populations that need to be accommodated within the justice system. Could you provide any feedback for us on either of those?

Ms LOVRIC: We spoke about the Youth Koori Court, and I understand that is, as I said, undergoing an evaluation. We can take it on notice to provide you with a copy of that evaluation, should it be available. I am not quite sure of the question.

The Hon. COURTNEY HOUSSOS: There is still a need for a youth drug and alcohol court even though there is a Youth Koori Court in operation.

Ms LOVRIC: They are very different purposes, yes. The reason why the youth drug court was abandoned is unclear.

The Hon. COURTNEY HOUSSOS: My advice is it was budget cuts.

Ms LOVRIC: I would say it is probably everything to do with budget cuts.

The Hon. BRONNIE TAYLOR: Professor Dunlop, who was here before, talked about—and I do not know anything about it so I am asking you as lawyers—the Act in terms of when someone had to be compulsorily told to detox. I suppose it is like a schedule 8 in a more general health sense in terms of the Mental Health Act, but he said that you cannot invoke the Act for someone who absolutely needs detox if there is no bed available. So then the question is what happens to the person? You can take that on notice. I was just thinking back and thinking that is something we really need to look at in terms of a legislative change as well. You are the experts, you are the lawyers.

Ms LOVRIC: We will take that on notice.

The CHAIR: Thank you both very much, it has been very informative for us to have the ability to ask you some questions directly and build on the content of your submission. In regard to questions on notice, there may be one or two and I think you may have accepted a couple yourself, the Committee secretariat has resolved a turnaround time of 21 days for answers to those. The secretariat will liaise with you directly in regard to the content of those questions, and we look forward to receiving the answers. Once again, thank you both very much and thank you for the great work you do in the community.

(The witnesses withdrew)

MICHAEL HIGGINS, Regional Community Engagement Manager, Aboriginal Legal Service NSW/ACT, affirmed and examined

ALAN BENNETT, Chief Executive Officer, Orana Haven Drug and Alcohol Rehabilitation Centre, NSW Aboriginal Residential Healing and Drug and Alcohol Network, sworn and examined

STEPHEN BLUNDEN, Acting Chief Executive Officer, Aboriginal Health and Medical Research Council of NSW, affirmed and examined

The CHAIR: We have received submissions from both the organisations. Submission No. 24 is from the Aboriginal Health and Medical Research Council of NSW and the NSW Aboriginal Residential Healing and Drug and Alcohol Network. Submission No. 33 is from the Aboriginal Legal Service NSW/ACT. We have received both of those submissions and you can take them as read by the Committee members. We invite you to make an opening statement, if you wish, and then we will share the questioning around the table.

Mr BENNETT: Yes I have a statement. We are here to represent the residential rehab services within New South Wales primarily because of the work we do—the complex issues that are a result of drug and alcohol use, the situations where we have struggles with funding and also the complex nature of the work we do; other than drug and alcohol, there are social, economic, employment, education and mental health-related issues. We would like to cover all those and address those. We are primarily funded for drug and alcohol, however it is not only drug and alcohol that we deal with; it is a very complex issue that we cover, but the problem is trying to highlight the importance of our role and how important it is for rehabs to be there for Aboriginal people as we are aware that some of our residents come from communities where there is a large problem with drugs and alcohol within the community, and in trying to address those issues with the individuals and also with the family members. We are here to present our case and the reason why it is important to have residential rehab centres for Aboriginal people in New South Wales.

The CHAIR: Mr Blunden or Mr Higgins, do you want to add to what has been said there?

Mr BLUNDEN: Yes, thank you. First and foremost, I would like to pay my respects to the elders both past and present and make you aware that the Aboriginal Health and Medical Research Council has 47 members throughout New South Wales, and the substance abuse rehab services are part of that membership. Our main aim is to advocate and support the need for those services and, in particular, our community out there on the ground. That is why I am here today with Mr Bennett, so we can hopefully get the message across. I have a few notes here but they are maybe a little bit lengthy. I could probably leave these for your consideration.

The CHAIR: It may come out in the questioning, but towards the end you can add them in if you feel it has not been adequately covered. Mr Higgins, is there anything you would like to add?

Mr HIGGINS: Yes, I do have a statement. I would like to begin by acknowledging that we are today meeting on the land of the Gadigal people of the Eora nation and I would like to pay my respects to their elders, both past and present. On behalf of the Aboriginal Legal Service, I would like to thank you for the opportunity to give further evidence to this parliamentary inquiry today. I am confident that our submission adds additional weight to an Aboriginal voice and perspective on what is required to address issues relating to the provision of drug rehabilitation services.

Briefly, the Aboriginal Legal Service is the peak legal service provider to Aboriginal adults, young people and children throughout New South Wales and also the Australian Capital Territory. We provide direct court representation, advice and community legal education in the areas of care and protection, criminal and family law. Our submission is based on community feedback as well as feedback from those who work in supporting families, which we gathered during a series of statewide forums last year as well as an online survey. Our survey results conclusively indicated there is insufficient rehabilitation service to meet demand. There is strong support for Aboriginal-specific rehabilitation services, strong support for increased focus on painkiller medications and their addictive impacts, strong support for Aboriginal-specific services that focus on particular genders, and strong support for services that focus on young people.

The clear majority of feedback told us how the increasing prevalence of ice is particularly devastating for those who live in regional, rural and remote New South Wales. This is leading to alarming Aboriginal incarceration rates and much wide social impacts. Ice is an insidious drug that is tearing apart families and ruining young lives. Of course it is not just Aboriginal communities that are being affected, so it needs a whole-of-community approach to resolve. Methamphetamine addiction remains a high priority for treatment providers but our feedback has identified accessibility challenges which are preventing Aboriginal people from

accessing crucial rehabilitation services, especially at times when they require it the most and are likely to be at their most vulnerable.

Without appropriate, timely rehab and adequate diversionary programs, Aboriginal people proactively seeking treatment end up engaged with the criminal justice system whilst their families suffer. We know that diverting particularly young people from the criminal justice system is economically and socially beneficial. It is 18 per cent cheaper to refer to youth justice conferencing rather than undertaking formal Children's Court proceedings. It is a shared desire of all New South Wales citizens to see investment in communities that provide environments for families to be nurtured and supported to raise strong, resilient and healthy children and young people. For Aboriginal people particularly this desire is achieved when communities are strong and confident in their identity and cultural practices.

Without a preservation approach to at-risk families, we continue to see more and more Aboriginal children entering out-of-home care with far too many exiting with their own unaddressed trauma. Far too many of these children then engage with or engage further with the juvenile justice system and, if not supported, will escalate in an alarmingly quick manner to the adult prison system. Removal of our young people and our men from our communities negatively impacts on social and familial structures. Aboriginal women, many of whom are mothers, now comprise 30 per cent of the New South Wales prison population, while the overrepresentation of Aboriginal children in out-of-home care in New South Wales continues to rise at unprecedented rates—almost 10.8 times the rate of non-Aboriginal children.

In order to support a preventative and early intervention approach, appropriate resources and attention is required to address the social and emotional wellbeing factors that impact on drug addiction, such as mental health, including intergenerational trauma, poverty, housing, isolation, lack of employment and education, among others. In order to break the cycle we must urgently improve access to treatment and support for Aboriginal people with addictions for their sake and for the wellbeing of their families. The focus must always be on prevention and rehabilitation rather than custodial sentencing. By working together, we can develop holistic community-led models of drug rehabilitation services for Aboriginal people in regional and remote communities.

The CHAIR: Thank you, Mr Higgins and Mr Bennett. We will move on to questions.

The Hon. COURTNEY HOUSSOS: I particularly want to thank the Aboriginal Legal Service, not just for their very comprehensive submission but also for the way they set out that information. I have to confess I do not have a lot of questions for you because there is so much detail in the submission.

Mr HIGGINS: That is fine. Great.

The Hon. COURTNEY HOUSSOS: One thing you have highlighted is the incredible demand for services and the lack of specialised services for young Aboriginal and Torres Strait Islander people and also for women in rural, remote and regional New South Wales. Do you have a view about whether they should be residential places or whether outpatient programs would be more valuable?

Mr HIGGINS: No, I do not have a particular view on that. That might be a better question for my colleagues to answer.

Mr BENNETT: I come from a very remote area of New South Wales. I have clients who come in to our service from very remote areas. They have difficulty accessing outreach services. Outreach services come in for a day and then they are gone for two or three weeks. Unfortunately—

The CHAIR: Do you mind telling us where that is?

Mr BENNETT: Out at the Wilcannia area, even Bourke, Goodooga, Weilmoringle, even Broken Hill, they have difficulties accessing the services at times, because, unfortunately, drug and alcohol goes 24/7 when you have addiction. Outreach services only go for certain periods of time. That is the problem. At times with our clients that come through our service, there is also a problem with their partners. Sometimes their partners have addiction. Because we only deal with males, there is no help for the females. We work with one side. At times they cannot access the outreach services available, especially when they need them. From what I can gather, the only time some of them do access it is through other services is when parole is involved, where it is forced on them. Unfortunately at times parole has the power to be able to access those services and bring them into line with them.

The Hon. COURTNEY HOUSSOS: Mr Bennett, I note that we have received other submissions that talked about how effective your particular facility is. I want to place that on the record and thank you for the valuable work that you do. I also thank you, Mr Blunden, for your submission from the Aboriginal Health and Medical Research Council. It was very informative as well. It states:

It is recommended that there is a specific standard for residential rehabilitation services that is designed for small services and accreditation is funded appropriately.

That is obviously recognition that we do not want to be increasing the regulatory burden on small residential services. We have also received submissions saying that there is a lack of cultural awareness for Aboriginal people. That is often when they are forced to travel to major centres to utilise those rehabilitation services. With that in mind, would you support a provision that requires a service, in order to receive government funding to run rehabilitation support, to demonstrate their cultural awareness training or provisions?

Mr BENNETT: Yes. The issue of culturally appropriate services is a difficult one. What is culturally appropriate? There is one thing, when the guys come in. I am an Aboriginal guy and proud of it. That is like asking me how can I present a service that helps Chinese people—I would not have a clue where to start, because I do not understand their culture. Really it is that relationship and that kinship, how they feel about us, how we talk to each other. You just have to understand us, how we relate to each other, how we welcome each other, how we make each other feel comfortable and relaxed. That is the whole thing about my service—when the guys walk in, they feel so relaxed. They feel like they are part of the family and our community, and that is what counts. You cannot invent that.

The Hon. COURTNEY HOUSSOS: You can provide some training though. If particular providers want to provide rehabilitation support for Aboriginal people then they need to demonstrate that they have done some kind of training of their workers. Obviously it is innate in someone like you, but if they are going to be providing that—and obviously our entire workforce cannot consist of Aboriginal people, as much as we would like it to—then there is a need for them to demonstrate it.

Mr BENNETT: Yes, you can train but it is the level of how you communicate to each other. You can do all the training you want, but that is just born into us. You can do a level of training, but it is just breaking that barrier down to be able to get in close with that individual. They feel trusted, they trust you and they feel like "I relate to you, I know where you have come from. I know who you are: You are one of mine." And unfortunately this is Aboriginal; how we are.

Mr BLUNDEN: If I could add to that.

The Hon. COURTNEY HOUSSOS: Thank you.

Mr BLUNDEN: It falls on the call of Aboriginal community control. An Aboriginal person naturally is going to feel more at home with his own mob looking after him. Whether we like it or not, there is still a lot of closet racism out there. You can make another person feel that they are culturally competent but our mob are pretty good at body language, reading, and they can tell a false face. So, basically, I am not quite sure whether I am getting that across clear enough, but there are problems there. Even in terms of the Aboriginal medical services [AMSs] and providing cultural awareness training to general practitioners, there is an online course which I suppose the Federal Government has introduced for GPs and that is ringing somebody up and they are talking to you over the telephone. To be quite honest with you, I do not think that is successful at all. You need to be working at the grassroots with the community. That is just responding to that question.

Mr HIGGINS: I support that. Training is one thing, but in terms of being able to understand your users, training is one form of being able to do that I think. It is not just a one-off thing; it has to be ongoing, it has to be built into the service model as well. But we also need to ensure that the environment is a welcoming environment as well—it is culturally supportive, it is culturally safe. Part of that is about training, but also it is about your policies and your procedures and the types of people you employ who have life experience, not just cultural experience but life experience, who can relate to the people coming through the service. They can build that rapport and the people using that service can have some faith that people helping them have some legitimacy, I guess.

The Hon. Dr PETER PHELPS: To what extent within your programs do you use people who formerly were addicted to drugs as counsellors or support people for residents in your organisation?

Mr BENNETT: I would prefer to have all my staff with that lived experience. Myself, I come from lived experience.

The Hon. Dr PETER PHELPS: I do not want to pick on the Hon. Courtney Houssos, but I have a great fear that one of the recommendations which the Committee may make will be the need to have some sort of credentials—a cert IV or something similar. I want to know whether the actual practitioners regard that as a necessary requirement for effective counsellors within drug treatment facilities?

Mr BENNETT: I find with the guys who I work with doing groups, they will tell us straight out, "I prefer to talk to you because you have been there." I have been in the service when we have had doctors come

in that have never lived it, different ones using harm minimisation. Our guys walk out of the group. They do not want to talk to them because they are coming from a book; they are not a lived experience. And it leaves me: What can I say? Also, they pick it up. They can read you; as Mr Blunden said, body language, they read you. If you have not lived it and they have picked it up, they will close you out. Unfortunately, they will not let you in there.

The Hon. Dr PETER PHELPS: You make an interesting statement about methamphetamine use. You say that 80 per cent of your clients overall have identified methamphetamine as their primary drug of concern. But you also say:

> It is unusual for clients who are only using ice to seek treatment at residential rehabilitation.

Mr BENNETT: Poly substance abuse.

The Hon. Dr PETER PHELPS: Are you saying that people who only use ice still have a level of functionality within a community which the poly drug users do not have? Or is it simply the case that the ice users do not recognise that they have a problem which needs treating?

Mr BENNETT: They are just not ready at that time to seek treatment. At times, they are forced to do it. They are forced to do an assessment, unfortunately. Their parole officer is on their back: "You need to do assessment, you need to get into a rehabilitation centre." They will go through the motions, but there is primarily a high rate of poly substance use—more than one drug. Why they use is that with ice they can be up for two, three weeks without sleep and they will either get cannabis, OxyContin or heroin to bring them down. Because if they do not come down properly they can crash and end up with drug psychosis in a mental institution and may never come back. What we say, what we refer to, is "You don't get a return ticket." You go through the door and you never come back; you are there but your mental health state is never going to be the same. That is why they use poly substance. We do find that alcohol and cannabis are common together.

The Hon. Dr PETER PHELPS: Most of these institutions seem to have 15 to 20 people seeking treatment. Is that what you view as an optimal size, or is that simply the most you can handle given the funding limitations?

Mr BENNETT: Funding limitations.

The Hon. Dr PETER PHELPS: These could be bigger single facilities but for funding limitations?

Mr BENNETT: Yes. There is a lot more involved. That is the thing when we have residents come in. They are very complex. We get funding for drug and alcohol, we do not get funding for transportations and also the other elements. Because we do a lot of transports to and from medical appointments, psychiatrists, psychologists. We do a full health check when they do come in, and then you have got referrals. And also because of our isolation we may have to take a client to specialist appointments that may take a full day's travel. Just to Dubbo and back from where we are situated you are looking at a 3½ to four hours drive one way. And that is not all. It all does come into the fact. It is the other costs as well. As we know, everything is going up but unfortunately our funding does not go up. But we understand that. We just have to try to work with what we have.

Mr BLUNDEN: The other side of your question, in regard to credentials, most of our service basically want to be strong and understand about providing the right message to the client—that is why they develop individual programs for those types of workers to deliver. But as to accreditation, organisations vary from the International Organisation for Standardization [ISO], the different other levels of accreditation. We want to ensure that the message we do give the clients will keep them safe. But it is a challenge, particularly when some services employ people who have had that type of lifestyle because there is no money there to employ somebody. I think Mr Bennet may want to touch on that.

Mr BENNETT: We do not do it—I do not do it—for the money. I do it because I want to do it and I want to make a difference because I lived that life and it is a tough life. That is how a lot of us feel. If we did it for the money, we would not be there; we would be in the mainstream getting more money. It is also working to try to make a difference to our people. It is the passion and knowing that it can be done and being a role model; that is the biggest thing. I am quite open and so are the workers who experience it. We are open with our clients to let them know where we come from and where we have been, and the tools we actually know when there is something not right. You just know how to read. You walk in, you see somebody, you know they are not travelling too well, yet you know there is something not right and you can read it. Until you live it, you cannot read it.

Dr MEHREEN FARUQI: Good afternoon and thank you so much for your submissions and for coming in today to give evidence to the Committee. We have seen in a lot of submissions—we have had a

discussion, as well this morning—about the lack of staff to fill positions that are required in many rehabilitation services. It is even more acute in regional and rural areas. And it is only 7 per cent, I think, of Aboriginal people who are involved in the staffing. I would like to know from you how we could change that. What are the barriers, and how could we get more Aboriginal people working in these facilities?

Mr BENNETT: I suppose there are a few things we could do there. We have trouble giving training. Some leave courses due to finances—it is not worth the time—and, unfortunately, the support network. Burnout is a problem and the stress that comes with the role, especially if you are working multiple jobs or trying to cover staff shortages. It is very demanding. Speaking for myself, I have not had a holiday for four years. I have been working as a chief executive officer and in management positions in drug and alcohol positions in between because we have been short of staff. If I did not care I would not be there doing it.

Dr MEHREEN FARUQI: So you need more support, more training and more funding.

Mr BENNETT: Yes, more funding, to encourage staff and give them the training and support available. The lack of resources are unbelievable. We cannot buy vehicles. The best vehicle I have has 277,000 kilometres on it; that is our transport vehicle.

Dr MEHREEN FARUQI: I think in one of the submissions there was also the issue of ownership of property where rehabilitation services are provided. Do you think the Government should play a much bigger role in helping you to acquire permanent properties?

Mr BENNETT: It would be a step in the right direction. It would give it that certainty and ownership. That would go a long way. When you own something you work towards advancing it and improving it because you know it is going to be there, and that it will be there for the next generation—unlike if it is on borrowed terms. People seem to take more care of things that they own.+

Dr MEHREEN FARUQI: We also had a discussion this morning about drug courts, and there are community campaigns going on about expanding those services to rural and regional areas, as well. I would just like to know from you whether, in your experience, the drug court model has been useful for Aboriginal people as well. It goes, I guess, to some of the cultural sensitivity training that we were talking about earlier. Do you think that people like judges within those courts have that training, and has it had a positive impact?

Mr BENNETT: I have had very little to do with the drug court. Fortunately I was at a meeting last week when I was provided with some information. The model that they presented looked pretty good. To me it is the before care and the drug court working towards it, and also the after support. It is also an opportunity for our residential rehabilitation service to gain a little bit more funding, which we are always chasing. It would go a long way, to be honest with you. With respect to how the model is set out, once they finish with the services they go back and have police support, as well. That is a big element that we are trying to focus on and work on. I think it is a big plus.

Dr MEHREEN FARUQI: You have mentioned the cultural issue of moving off country to undergo rehabilitation. I would like you to expand a little bit more on that, and what problems it creates if it does—

Mr BENNETT: When the guys come to our service we know that we live in a remote part of New South Wales but we are all linked to each other. For example, if you come into our service I would ask your name and say, "How're you going?" We would introduce ourselves and your surname would ring a bell. I would say, "Are you from there?" "No, I'm from there." That would break the ice. We may even realise that we are related—that kinship brings us closer. They feel comfortable and relaxed that they are in a environment where they feel welcome and where they belong.

It is hard to describe until you feel it but you must welcome the guys, make them feel comfortable, and gain their respect. There are different ways of communicating. Once you gain that respect, that is when the work begins. If they do not trust you, you will never get the respect. The trust comes from who they can link you to and who they relate to. If you are one of the brothers or sisters they feel more comfortable. Unfortunately, that is just the nature of the beast. A lot of times Aboriginal people have been discriminated against. That defines the lack of trust. Sorry, I don't mean to be rude but people think, "If I let this white person come in what will happen? I have been burnt before." They just put up a protection shield.

Dr MEHREEN FARUQI: Yes; that is fair enough. The Aboriginal Legal Service [ALS] submission talks about prisoners on remand not being able to access rehabilitation services. Could you explain that a little bit more—and what impact that has?

Mr HIGGINS: It relates to their classification—some of the things they are allowed to do when they are on bail or on release, or even when they are in a correctional facility waiting a sentence. There are certain classifications that allow them to do extracurricular activities until they are sentenced. A lot of them are sitting

there waiting for a sentence and not being able to participate in a program that could assist them post release. That is part of the challenge.

I will make another point about the drug court. The jurisdictions in which it operates are limited. The ALS's perspective is that it works very well because it takes a case management approach rather than identifying an issue and then sending that individual off—out into the wilderness hoping for the best. The drug court takes an intensive case management model approach. We are seeing, in the jurisdictions where it operates—mainly here in metropolitan Sydney and Toronto—that it is working well. We would support the expansion to regional and rural locations particularly.

Dr MEHREEN FARUQI: There is also an issue raised in your submission about competing for funds, especially with large service providers who have the capacity to prepare large tenders, which smaller service providers like you do not. What is your recommendation to address this? Should there be a separate pool of funding for smaller facilities, or how would it best be delivered?

Mr BENNETT: Yes, separate funding for specific Aboriginal identified organisations. We just cannot compete against the Salvation Army, which has units just working on tenders. Mission Australia has units working just on tenders. We are just individuals trying to do all the work—trying to run the organisation, do this, put submissions in, put reports in, and put model reports in to funders in order to keep what funding there is available. It is endless. We just do not have the staff or the funding to set up those units that the big organisations have, unfortunately.

Dr MEHREEN FARUQI: I know that this inquiry is focused on treatment and rehabilitation, and the lack of it in rural and regional areas, but I would like your view on harm minimisation in prevention, so that we do not have people ending up in treatment. What do you think are the different ways of minimising harm—reducing the harm of drugs? We often talk about decriminalisation as a harm minimisation technique. Maybe if the use of drugs was decriminalised it would also help people going into rehabilitation, because it would not be stigmatised. I just wanted your overview on that.

Mr BLUNDEN: I will give an example. I was the chief executive officer of Durri Aboriginal Medical Service at Kempsey for about 26 years. Back in the 1980s, we introduced six units of health education in the school system. One unit was about making children aware of substance abuse. I would have a health worker show a video on the ill-effects of substance abuse. One showed a stainless steel bowl with some white foam from an esky in it. Petrol is poured on it and it dissolves. The worker would tell the kids that when they sniff petrol or glue their brain dissolves like that. It would terrify the kids and put them on top of that fence, if you know what I mean. A young teenage alcoholic would also come from Bennelong's Haven Family Rehabilitation Centre and provide a personal testimony to the class about what he had done to his mum and dad, brothers, sisters, and friends. He would tell them that it is not part of our culture. He would say he had been in Bennelong for six months and he was sober, and hopefully that he was straightening out his life.

You can see the problem in some families. A father fronted me in the street in Kempsey one day. He said, "Steve, what's this program you're running in the schools?" I said told him it was an early intervention program to make the kids aware and to educate them so they can make an informed decision about their life. I asked him why he asked. He said, "I went home the other night with a slab on my shoulder and a couple of mates in tow. We went out the back of my place and had a charge. My son comes to the top of the stairs and says, 'Dad, that's gunna kill you.'" The son started lecturing the father. I thought that was great; it was wonderful. He thought I was going to apologise, but no way. I said, "That's great. We're getting the message across to the children." Hopefully they becoming fence sitters will make an informed decision about what way they will go. I am proud of that.

As a health group around this country, we need to partner with education to ensure these programs are operating in schools as well. My current Aboriginal health service at Casino and I are going into schools with general practitioners, health workers, nurses, audiometrists, and dental therapists to do health assessments with parental consent. We are sending the referrals home to the parents and it is up to them to take their children to the appropriate appointment.

I have been involved in this for 10 years and I have had only one male drug and alcohol worker. The idea of that worker doing the job without burning out is a massive problem. There is not enough funding to provide the service. Substance abuse centres can work really well with Aboriginal medical services using referral pathways. That is what I am doing with the schools; we can refer the child back in and the parent can have a yarn with the doctors. We can develop it to suit our children.

The Hon. BRONNIE TAYLOR: We are rolling out a few school nurse programs across rural and regional New South Wales. They will not do health checks like you do with your teams; they will follow up

after the teams have done their work. They are looking at a substantial number in Western New South Wales. A nurse has also been placed in Young in southern New South Wales. I am excited about that because the programs are fantastic. The issue they talked about in Tasmania—and this is why they implemented the program—was that people would run a program but no-one followed up after eight weeks. When kids were confronted with a situation, there was a nurse at the school they trusted and they could speak to that person, who could follow up. I recommend that you watch that. Hopefully that will play out in western and southern New South Wales.

On the last page of your submission you talk about families. Often we talk about the individual and the available rehabilitation services, but it is the often the families that are crying out for residential care because they cannot handle it any more. I would like you to elaborate on that issue. If we are going to discharge people, it is not only their care that is important. We must also care for their families so that they can help them to continue their rehabilitation. How do you see that? Do we need more of that and are we doing it well enough?

Mr BLUNDEN: We mentioned Bennelong's Haven Family Rehabilitation Centre. It is probably the only Aboriginal rehabilitation centre that takes in the whole family—mum, dad and the children. Due to unforeseen circumstances, the Bennelong centre near Kempsey has gone into voluntary liquidation. Alan Bennett might talk a little about the rest of New South Wales and family rehabilitation. There is a massive need for the family to go on that healing journey together. When I was with the Federal Government, I worked out of Cairns and operated in all the remote communities on Cape York. I shared this story with my colleagues here this morning. There is a place called Pormpuraaw, which is west of the Gulf of Carpentaria. We developed a drug and alcohol program in the community at a cattle station called Barrs Yard.

We would take a family or two out there and set them up in humpies, and there was a main building with washing and cooking amenities. For three months the children would be out in the community and they would be educated over the radio. There was the mum, the dad, all the children, the uncles and aunties, and probably the grandparents if they were still alive. They would provide support about the ill-effects of substance abuse. While they were there, back in town the local council would go through their property and fix it up; perhaps giving it a paint job. When the family returned home after three months, they would have a fresh start. All the family members would be in tow offering peer support back in the community.

Too often in our communities there are a number of different groups putting peer pressure on others to join in with their drinking or substance abuse. The program was seen as inclusive of the entire family and they could heal together. Not enough of that is happening. I would like to see more of that. We must resource ideas like that, and that is where we fall down.

Mr BENNETT: We have to support the family unit because they are the main drivers trying to encourage the individual to get help and treatment. They want them to get better.

The Hon. BRONNIE TAYLOR: They are also suffering the consequences of the addiction.

Mr BENNETT: They are suffering the stress and the worries. They are living the life without taking the substance themselves. Unfortunately in the family unit there might be a husband and a wife both with addictions and they do not want to split. One might go into a centre but their might not be a place for the other one. It is like trying to solve 100 per cent of the problem but working only on 50 per cent of it. You are leaving the opposite one out. When the individual goes back they are going back as a different person. If the other one does not understand why you are different they will feel uncomfortable. If they understand they can work together. Sometimes through the drug and alcohol life they have lived so long it becomes complicated and difficult and they need relearn how to communicate and live together.

The Hon. BRONNIE TAYLOR: Abnormal becomes normal.

Mr BENNETT: Yes, and communication is a big thing. There are children involved and what do the children see? What monkey see monkey do.

The Hon. Dr PETER PHELPS: Legal Aid mentioned the Magistrates Early Referral into Treatment [MERIT] program, which appears to be only available east of the sandstone curtain—like so many other things. Is it the view of ALS that it would be advantageous to roll that out to magistrate courts in western New South Wales, particularly far western New South Wales? If it were to happen, would there be services available to effectively implement it or would it require additional funding?

Mr HIGGINS: Firstly, yes, I think there would very much be support for the expansion of the MERIT program but, again, MERIT is very much based on a wraparound support service system that has to be there as well. You must make sure that the support structure and those resources are there wherever you want to put the

program, but certainly the model itself is very reputable. We would certainly support an expansion of it but an appropriate expansion.

Mr BENNETT: I do like the idea of MERIT. However, we have difficulties with it because with our program structure after 60 days our guys get a five-day leave. They leave on a Monday and come back Friday. The purpose behind that is to go back into the environment—as long as it is safe and approved by parole or approved by the court—just to practise what they have learnt. It is just to review what is going on, if they are travelling all right, if they are coping all right and what areas they need to work on and come back and identify those. Unfortunately, with MERIT they do not allow that. For example, in the last six months I had two MERIT guys. One guy worked up to his five days leave and then MERIT said that he was not taking it. He gave up hope. He just did not care anymore. He just did not care. He was looking forward to the five days leave to go back and link up with his daughter and that but, unfortunately, MERIT overruled it.

The Hon. Dr PETER PHELPS: Presumably the argument you would make would be that rehabilitation treatment is better if it is done on country. But then how do you get out of the same milieu of people that you were with that may have got you into the problem in the first place? What strategies do you have to say that localised treatment is more effective while, at the same time, if you are still hanging around with your mates the problem is going to recur in all likelihood?

Mr BENNETT: That is what we teach them through the group meetings. That is also where the family support network is very, very important. The guys might be a little bit weak at saying no but their wives will not stand back. They will tell the guys to go and jump, in other words. That is that important network where we need to learn and hopefully work with the family as a support network. We do work with the guys and educate them on how to deal with this. Also after 30 days in our program we allow them to do shopping trips. Staff are with them but we have not got them on a leash. As long as we are within a safe reach it just gives them a bit of a feel as to how they need to respond.

It is unfortunate that where I come from, Brewarrina, drug dealers know who we are, know our residents and they are waiting in town to pick on them like vultures—and they will do it. That is where our local workers know what is going on because you have lived it, you know it and you get to know who the drug dealers are and you keep an eye on them and keep them safe. It is just about learning about the guys and understanding that this is what can happen and all that. Also that family support network that can keep them safe and help them is so important. It is progress. There is that five days leave to see how they are going. They need that system in place. We really focus on it in our groups.

The Hon. Dr PETER PHELPS: In your view does that limited release and limited re-immersion back in the community work better than a straight 12-week exclusionary program and then going back into the community?

Mr BENNETT: That way if they get 12 weeks and they go out and they are not travelling too well what do they do? They fall over. If you give them that five days and work with them and keep in communication with them they get a taste. I have had guys ring me up and say, "I need to come back," after three days. They come back, they are right. As long as they understand the purpose of that leave and their family understands it and also their other support networks it seems to work all right. The whole idea is just so they can come back and say, "Right, I'm not travelling too well on this. I need to work on this area. I need to work on that area." Then we can work on it. That guy might realise he needs to stay for six months instead of just three months.

Dr MEHREEN FARUQI: The Committee is also looking at the impacts of mandatory detoxification programs. I would appreciate your view on that and if you think they are effective.

Mr BENNETT: You can force a horse to water but you cannot force them to drink, unfortunately. I have lived it. I was not ready to do anything about it until I was ready. It got to the point. It is hard to describe. They are going to go in and if you force them in there they will go through the thing just to keep everybody happy but as soon as they set foot back out they are back into it. What is the cost of the resources? Then you have individuals who are motivated and want to get into treatment but cannot get that detox bed because it is taken up by someone who is forced to go in there. We talk about all these resources. Do we throw it away or could we use that resource that is not going to work in another area?

Mr HIGGINS: I think whether it is mandated or not, it comes back to the model itself in terms of what is it actually teaching the individual about behavioural changes, understanding their triggers and understanding where they can seek out that additional support. Part of it also, as we have heard, is about taking the family along on that recovery journey. What does that look like in a clinical setting, a rehab setting and an

outreach setting? We need to understand the importance of valuing the family in terms of recovery and involvement in that after-care support.

The CHAIR: Mr Blunden, you brought some documentation along with you. Would now be an opportune time? Is there anything in there you particularly wanted to draw to our attention, or is it for us to take away and study?

Mr BLUNDEN: I would just like to table this documentation for evidence for your consideration. It was only provided to me at about 9.30. I would also like to table my notes as some evidence as well. Whilst I am speaking, the social determinants of health is an all-of-government responsibility. Not any one government department, be it the Department of Health, is going to fix the problems that we face. We talked about early intervention and the family healing. Ultimately, we need to take care of the issues that our people are living with. There is not much we can do about racism. If people have had one bad experience with an Aboriginal they will probably go the rest of their life saying that Aboriginal people are no good and they will pass that on to their families. We have major barriers there. But as to social determinants of health, once we can get our people on a level playing field, if you like, only then can we stand up proud with other Australians to move forward.

Our people are currently entrenched in poverty and racism. On the North Coast of New South Wales and I believe in other parts of New South Wales you cannot buy a job for any of our people. We need to become educated, more so than other people, to really compete to get a job. I will give you one example: In Kempsey one day, my reception staff said, "Boss, look, there's a bloke down here; he's going to punch us out." I was doing up a proposal, so I walked down the stairs and down this long corridor. I was pretty cranky. I was probably about 26 then. This bloke seen me coming and he started crying. He said, "Mate, I don't want to cause any trouble. All I want is my teeth fixed up so I can apply for this job. If I can smile, maybe I'll get the opportunity of getting employed." Naturally, it knocked the wind out of my sails and I said to my girls, "Fix his teeth up." About three months after that, I was driving in Kempsey, come up to a stop sign and I just looked up; this bloke was there, smiling at me. So him and his family are right now. He has a job and they can move forward and live a little bit better than how he used to live in the past, because he did not have a job.

In terms of the social determinants of health, your Committee needs to understand that we need to put that across the broad Government front, not just with the Department of Health or any other individual agency. We need to move forward as a State and take it on, full on, and walk hand-in-hand with our people. Only then will early intervention work, because our people are on a level playing field. I just thought I needed to mention that.

The CHAIR: They were very fine words. On that note, we will conclude this session. On behalf of the Committee, I thank you gentlemen for coming along. Having firsthand experience of the ups and downs of life and also from seeing others experience the same thing has enabled you all to bring valuable testimony to this hearing. Your attendance today has provided us with the opportunity to ask you questions and for you to reflect on solid details that we can use in our deliberations. Thank you so much for coming along and thank you for the great work you do in your communities.

(The witnesses withdrew)

(Luncheon adjournment)

LUKE BUTCHER, Area Manager, Mission Australia, sworn and examined

GABRIELLA HOLMES, Program Manager, Triple Care Farm and David Martin Place, Mission Australia, sworn and examined

GERARD BYRNE, Operations Manager, Recovery Services, The Salvation Army, sworn and examined

GAVIN WATTS, Manager, Dooralong Transformation Centre, The Salvation Army, sworn and examined

LYNNE MAGOR-BLATCH, Executive Officer, Australasian Therapeutic Communities Association, appearing on behalf of We Help Ourselves, sworn and examined

The CHAIR: Thank you for providing submissions from your respective organisations: submission No. 6 from We Help Ourselves [WHOS]; submission No. 15 from Mission Australia; submission No. 17 from the Salvation Army. They have been read, so when making your opening statements there is no need to go through the detail contained within the submissions. Would you like to make an opening statement?

Ms HOLMES: I have worked at Triple Care Farm for the last 17 years. We opened a new detox last August. What we know is where you meet people with complex needs with the appropriate resources change is possible and sustained over time. When the sector is invested in appropriately, people are able to make change and step out of addiction.

Mr BYRNE: The Salvation Army has a long history in New South Wales and, indeed, Australia for providing drug and alcohol services, commencing in 1904 in Sydney on a farm at Collaroy. Since then we have continually developed our services to be more responsive to the needs of people who fall foul of their drug and alcohol use. In relation to the residential rehabilitation services for people in rural and remote areas of New South Wales, there is a need there, there is a gap. There are a lot of social and logistical barriers and disadvantage for people living in regional and remote communities in New South Wales in accessing treatment.

Dr MAGOR-BLATCH: I would like to take a slightly different tack, if I could. WHOS, of course, has been around for a long time. It was established in 1972, interestingly enough, in a country location; it started off in Goulburn. People come to WHOS—and other programs as well, of course, but I am talking about WHOS—with a whole range of personal and substance use problems. One of the things I want to say is that substance use is not an event; it is a process that happens over time. Recovery is in the same context; it happens over time. So I want to put that in that context because what we need to do is really view this as a social, family and community context.

I live in a country town; I live in Yass, and I work there as a clinical and forensic psychologist. I work with a number of people with drug and alcohol problems who come in to see me. I need to get them referred as often as possible into a residential program. The reason for that is not because I am a terrible psychologist—in fact, I think I am not too bad. I have had a long history working in the sector. But the point about it is that 10 Medicare sessions a year is not going to cut it with people who have complex needs. So it is really important that we look at what is the context for people coming into treatment.

As an example, I have recently worked with somebody who works in the public service. He was doing his honours year at university. But he got caught up in ice use, and he got caught up in it in the context of a lot of the work that he was doing and the strain and stresses that he was under. He had a hugely supportive family, but in the context of his drug use he has now had a number of psychotic episodes, he has had mental health problems. He has been in and out of mental health institutions as well as drug and alcohol. You could say that I am pretty well-connected, so I managed to get him into a program—in fact, into WHOS—in a relatively short period of time. But even with all of those connections, he was sitting on a waiting list for other programs for over three months.

That is the problem. We know treatment works but it needs to be available, it needs to be accessible to people. Whilst there is always the possibility—and this is often a good thing—for people to move out of the context of their own geographic location, what we need then is ways in which to support them back into the community. Because families, community, social connectedness is one of the things that is actually going to succeed and help people to succeed in this area.

The CHAIR: Thank you, Dr Magor-Blatch, I appreciate that. We will now proceed to questions.

The Hon. COURTNEY HOUSSOS: Thank you very much for your time this afternoon and for your detailed submissions. I will begin where you ended, Dr Major-Blatch. I will ask you first of all about the question of demand. I have posed this question to almost everybody who has come in this morning. NSW Health has provided us with a submission that emergency departments admissions—and I realise that is

not the way you interface with people with alcohol and drug related problems—are stabilising when it comes to methamphetamine use. Is it your experience that the demand for rehabilitation services is stabilising or is it continuing to increase? I would invite each of you to provide a brief answer.

Dr MAGOR-BLATCH: I would say that it goes in stages. Yes, in some ways it might be stabilising but the demand is still high. Certainly the services that we all work with take people who have complex needs. It is not just about drugs. People who come to our services have trauma histories and a whole range of issues that need to be addressed. It is not just about stopping drugs.

Mr BYRNE: We have seen a marked shift in the number of people who present to our services in relation to the use of methamphetamine or ice. For decades alcohol was the most commonly reported drug of use. These days it sits a distant second to methamphetamine use. We have gone from about 55 per cent of all our treatments provided to people who identified alcohol as their main drug of problem to in the Central Coast service, which Major Gavin manages, it is 50 per cent of presentations and at our Surry Hills facility it is 55 per cent of presentations. Alcohol has dropped down to 32 per cent and 28 per cent respectively; there has been a shift in the number of people. The other thing is that there are not less people having an alcohol problem, there are more people with methamphetamine problems coming into treatment and there is still also that broader unmet demand in relation to people with an alcohol-related problem.

The Hon. COURTNEY HOUSSOS: It is that the people with methamphetamine issues are more severe or are requiring more immediate treatment?

Mr BYRNE: Yes, that is correct. There have been better referral pathways for those in relation to various strategies that have been put in place in regards to funding at both the State and Federal levels.

Ms HOLMES: For the Triple Care Farm, at a minimum we have 35 young people waiting to come in to treatment at any one time. We have stopped advertising our service. Where we had a national ad run for our service, we had 7,000 inquiries for service in one month. We no longer go out and publicly advertise what we do because whenever we do that we are inundated with unmet need. In 2014 the primary drug of concern became methamphetamine and it continues to be, with most of the young people we are seeing using five or more substances—91 per cent having a co-accrued mental illness and 73 per cent having attempted to take their life in the 12 months prior to entering treatment.

The Hon. BRONNIE TAYLOR: That was just the most amazing statistic—91 per cent of your inpatients have a mental health illness but they presented to you for drug and alcohol?

Ms HOLMES: That is correct. Of those young people, 50 per cent have a psychotic illness that they have been diagnosed.

The Hon. BRONNIE TAYLOR: Of the 91 per cent?

Ms HOLMES: Of the 91 per cent. It is an exceptionally complex group of people who are accessing treatment and care through non-government organisation services. What we see are some dramatic outcomes. The other part of that was that 73 per cent had attempted to take their life in the 12 months prior to entering treatment. Young people who access our services needed to have a support network that knew we were there, because we can no longer advertise. We cannot meet the demand. Our assessment and intake officer has upwards of 30 phone calls in a week inquiring for service for young people. We work with 16- to 24-year-olds and we know there is an unmet need for young people to access. We recently started a detox service for the same age group. But we know there is a demand for services for people who are under the age of 16 as well. I regularly get inquiries for service for 13-year-olds which we are not able to meet. Luke would be able to talk to that more because of his experience with that younger age group.

The CHAIR: Just to be clear, are these phone calls emanating from within New South Wales or from around Australia?

Ms HOLMES: The majority are from within New South Wales. Triple Care Farm does take referrals for young people interstate. We have had some inquiries from Queensland and the Australia Capital Territory. We have had a young person participate in a program from Norfolk Island. But the services are not there to meet the demand for young people who want to step out of addiction. The average time somebody sits on our waiting list—you can strike the lotto and be in in a week, but that very rarely happens. Generally speaking, it is at least three months from when a young person makes that inquiry, or their support network does, to them entering the program.

The Hon. COURTNEY HOUSSOS: We have the submissions but all of your submissions have covered something similar along these lines, which is there has been some highly publicised Federal and State responses to drug and alcohol support but this has not resulted in new residential beds.

Ms HOLMES: No.

The Hon. COURTNEY HOUSSOS: That is a key requirement for methamphetamine rehabilitation support. I do not need to quote but I would ask for a short elaboration on that.

Ms HOLMES: I am sure everybody can speak to this but both federally and from a State government perspective there have been funding responses. But because it is divvied up between large PHN areas, the cost of residential rehab and providing a bed for a placement for somebody, it just has not been able to contribute to that at all because of the funding structure and the way that has been set up. There might be some things coming through with the new New South Wales Alcohol And Other Drug package but so far it has not really resulted in any increased beds. That is because beds require additional support. The other thing that underlines that is the sector has had funding instability for a long time. There have been lots of reviews for the drug and alcohol sector which have resulted in Commonwealth and New South Wales contracts being at three years and most often 12 months for the last five years. It is really hard for a sector to be able to respond to the complex needs whilst at the same time managing funding instability, which makes the recruitment of the workforce very, very difficult.

The Hon. SHAYNE MALLARD: Could I add to that and ask a related question?

The CHAIR: Yes.

The Hon. SHAYNE MALLARD: Page 3 of the WHOS submission talks about the ice task force:

> The Federal Government has gone to services that are more appropriate for people with mild to medium dependency issues.

On the tail of that, has Federal money gone to areas where it is easier for them to get results? What is the reason for it going to those areas and not targeting the more chronic problem?

Dr MAGOR-BLATCH: One of the issues that has come up strongly is around the PHNs. One of the things that we are all going to be saying is that our services bring in people from a wide geographic area and the problem is that when you focus funding in just one small area it is likely that what will happen is that that particular PHN says "We don't need 100 beds here" or "We don't need this many services in this particular area". What then happens is that the services are restricted and in actual fact what has happened with the funding at the moment, going through that kind of the process, is that residential beds in fact have not been funded. There is this idea that residential beds are more expensive and the WHOS submission outlines the costing. Actually that is not the case because what happens within a residential program is that the people within that program, and that includes residents, are doing a lot of the work themselves. That is the process that is happening. It is not to say that you do not have lots of trained staff and so on. In terms of how the funding is distributed, they are important things to be taken into consideration. I am not sure if I have answered the particular area in the submission that you were asking.

The Hon. SHAYNE MALLARD: It sounded to me that you were suggesting the geographic focusing of the funding, the model. We heard earlier today that it is not population based.

Mr BYRNE: It is a geographic and a service type focus, which excluded residential. That funding that came out of the ice task force and went to the primary health networks was targeted not at the people that were on the ads on television that generated all the concern but at users down the softer end of the drug-use continuum. Those people at the harder end of the drug-use continuum access our types of services. Our types of services were never given an opportunity to access that money for enhancement. In fact, part of the NGO drug and alcohol service sector that is groaning under the greatest unmet demand—that is, residential treatment—got very little expansion money.

Mr BUTCHER: Just to follow on from that point, I think it is important to acknowledge in New South Wales particularly the Department of Juvenile Justice fund to residential drug and alcohol services was in New South Wales—one in Dubbo and one in Coffs Harbour for 13-year-olds to 18-year-olds. I was reflecting with Ms Holmes this morning that the philosophical approach from a justice agency funding a service largely to provide health care and health-orientated services is kind of an interesting dynamic.

The CHAIR: Would you like to elaborate on that? What do you mean by "interesting dynamic"?

The Hon. Dr PETER PHELPS: Why would Justice be doing something which Health should be doing? I think that is the point you are making.

Mr BUTCHER: Yes. The two residential Juvenile Justice funded services work exclusively with Juvenile Justice referred young people. If I look at my service experience I find that 85 per cent of the young people accessing our program come via a custodial sentence—either on remand or on completion of a control order. The types of services that we offer in that program are geared not only towards drug and alcohol

rehabilitation but also that broader offender rehabilitation space. It is a very different approach. They are both highly effective services. Look at Ms Holmes' service which is philanthropically funded and the other two youth residential services in New South Wales are funded out of the Department of Justice. Perhaps there is an argument around health approaches there as well.

The Hon. SHAYNE MALLARD: Is Justice Health funding that?

Mr BUTCHER: No, Juvenile Justice.

The Hon. COURTNEY HOUSSOS: One thing that has come through other submissions has been the need for specialised and culturally aware specific residences but also the need for cultural awareness within the provision of rehabilitation services. Can you explain quickly what sorts of cultural awareness practices you have in place and whether you would be opposed to the idea of government funding being contingent upon them?

Ms HOLMES: Part of what most drug and alcohol services do is sit under some healthcare standards. We have accreditation through the Australian Council on Healthcare Standards. A big part of that is looking at how you work with young people that come from lots of different culturally diverse backgrounds. About 15 per cent of young people we see identify as being Aboriginal and Torres Strait Islander. A similar amount identify as being from culturally and linguistically diverse backgrounds.

We approach that in a number of different ways. We provide support and training for staff regularly to make sure that we are understanding the different cultural backgrounds that young people are presenting from. We have a look at where our stats are, where young people are referring, so that where we might be getting lots of referrals from a new cultural area we are getting skilled and equipped to be able to respond in that way. Then we also do that by individual planning with the young person—getting to know them, getting to know where they are up to, and what they are wanting to have happen for them to feel culturally safe and connected to move forward. We might have an understanding about a culture but that is different for that young person. It is about both having that holistic look at staff training but also looking at the individual within that.

Mr BUTCHER: On an organisation-wide perspective, Mission Australia has a reconciliation action plan that sets minimum targets for the engagement and employment of Aboriginal people within our services. It is important across all our services that Aboriginal people are involved at the front level all the way through the organisation management structure and governance structures to ensure that the services we are offering are culturally relevant, reflective and appropriate. Our reconciliation action plan is a guiding document that makes sure we are accountable in that space.

Dr MEHREEN FARUQI: The Royal Australasian College of Physicians expressed concerns related to the increasing merging of drug and alcohol services with mental health services. They understand that these are interlinked but that the target groups are significantly different and require different treatment approaches. I would just like to hear your view on that, given that you mentioned that 91 per cent of the people that present to you with a drug dependency also have issues with mental health.

Ms HOLMES: Are you asking how we change our treatment approach because of that?

Dr MEHREEN FARUQI: Yes. They are increasingly concerned that these services are being merged. That is a concern for them.

Ms HOLMES: We have had a focus on being able to address a young person's holistic needs. That has always been the service approach that we have had. For the past at least10 years that co-occurrence of a drug and alcohol issue and a mental health issue has been very high—upwards of 75 per cent. We approach the young person as a whole. We have medical staff as a part of our team as well as connections with our mental health services. The difficulty in providing drug and alcohol services is when a mental health need becomes acute and it might be difficult to access emergency care. That is the most complicated factor for us in providing a service, but they have gone hand in hand for a very long time.

Mr BYRNE: In calendar year 2017 we did 1,450 admissions to our services in New South Wales. Seventy per cent of those people either came with a historical mental health diagnosis or were diagnosed when they were in our care—seven out of 10 people. If we do not concurrently treat both the treatment outcomes are going to be greatly reduced in both areas in regard to a person's mental health wellbeing and in regard to the drug and alcohol situation.

Mr WATTS: Certainly that is the case on the front line at Dooralong Transformation Centre. We too have trained psychologists onsite, a medical team onsite. I would agree that it goes hand in hand and that is what we are seeing on the front line.

Dr MAGOR-BLATCH: If I can just also add to that. I think one of the things that is really important to understand is that a lot of mental health problems are also in the context of particular drug use. Both Garth Popple and I were part of the team that was looking at drug and alcohol clinical care planning, which the New South Wales Government had set up over a long period. One of the things that we looked at was what particular physical health and mental health problems are associated with particular substance use. You would expect people coming into treatment with alcohol problems to have a lot more physical health problems.

What we have seen, particularly in the context of methamphetamine use, is a rise in mental health problems and psychosis. What that has meant of course is that therefore staffing has to change—not only the numbers of staff that you have on board but also the training of those staff in order to be able to deal with those problems. I think, once upon a time, we expected that people would come in with issues of depression, anxiety and so on. But we are seeing the pointy end of mental health problems. We are seeing bipolar disorder, we are seeing schizophrenia and we are seeing other problems that require really complex needs people coming into treatment. Therefore, the whole person has to be treated. The WHOS approach, along with other therapeutic communities is that it is a holistic approach to treating the person.

Dr MEHREEN FARUQI: How difficult is it to get the staff that you need for that holistic treatment? We have seen in submissions that it is really difficult to staff these services.

Dr MAGOR-BLATCH: In particular areas it is harder than others, for instance. There is a lack of psychiatry services, particularly in country and rural remote areas. That is something that is a problem. I am sure that Dooralong will talk about that a bit more as well. But the WHOS approach has been to employ clinical staff, psychologists, nursing staff and so on, as part of the staffing structure and to set up arrangements with visiting medical doctors and other professionals to come in—psychiatry and so on—because those needs are something that emerge often during the person's treatment. When you assess them you may not know what is going to emerge as the treatment continues.

Dr MEHREEN FARUQI: This question is specifically for you, Dr Magor-Blatch. In your submission I think you mentioned that you were the only service licensed to dispense pharmacotherapy treatment in Australia. Could you explain what this treatment is and why you are the only licensed service?

Dr MAGOR-BLATCH: It has been an interesting process for WHOS over a period. There are other programs now that take in people who are on opioid substitution therapies, or OST. WHOS now has the licence and the ability to dispense the opioid treatment therapies onsite rather than taking people offsite. The WHOS Rozelle site is a campus that has four different programs as part of it. It has a men's program and a women's program and it has people who are coming in and who are reducing off their opioid substitution therapies and working towards abstinence. It has another program which is a stabilisation program.

People come into that and they continue to be provided with their opioid substitution—methadone, buprenorphine, suboxone and so on—but they would be stabilised off other substances that they might be taking; for example, alcohol, a range of benzodiazepines and so on. It has been an interesting process because I think what people have tended to think about is that the medical model and the rehabilitation model do not mix. In actual fact they mix very well. Many of our services—I know that the Salvation Army is in this same situation—are taking people now who are on opioid substitution therapies but moving off them towards abstinence.

Dr MEHREEN FARUQI: We were talking earlier about the needs of the Aboriginal community. We heard this morning from NARHDAN, the NSW Aboriginal Residential Rehabilitation Healing Drug and Alcohol Network, as well as the Aboriginal Health and Medical Research Council of NSW. For them, being a very small service, it is very hard to compete with bigger organisations like you for funding. I understand that only one bucket of funding is available and it requires a lot of effort and tenders to go about getting that funding. I would like your view on how you could work more with them or how we could have an equitable sharing of funds.

Mr BYRNE: I think it is hard for every organisation to compete for the funding, particularly when the tenders are so prescriptive in what will be provided and where. From our perspective, the Commonwealth money that came down through the primary health networks certainly did not meet any of the priorities we had from a service delivery perspective in relation to the pressures on our services. Although we did secure some funding, that was for services out in the community. The services that have been funded by the primary health networks have created a greater stream of people wanting to access secondary services such as ours, or Mission Australia, or WHOS. Whilst we have created this environment where there is now a stream of people seeking treatment, there is no treatment to provide it. The issue around supporting other organisations, we look for partnerships and we look for ways in which we can work with other organisations. The NGO sector is

collaborative; it does want to work together. We see the value as a sector of supporting each other to do that; however, often the prescriptive nature of submissions, or tender specifications, precludes a lot of that happening.

Dr MEHREEN FARUQI: Would you like to see that prescriptive nature change or what would be your recommendation?

Mr BYRNE: Yes, certainly we would like to see that change. Service mapping based on demand rather than a geographical breakdown has more of a place in relation to what is put out to tender.

The Hon. Dr PETER PHELPS: That is a very nice segue into my next question. Just quickly from your three organisations, would you like to see NSW Health moved to the drug and alcohol service planning model, the DASP model, for the provision of funding for services?

Ms HOLMES: I think the funding for the drug and alcohol sector is something that has not had anybody look at it with a consistent long-term view ever. While we talk about making it a more equitable sector, the $75 million drug and alcohol package that was announced last year is the only new funding for the sector in almost the 17 years I have worked in the sector. We had the drug and alcohol package that was rolled out from the Commonwealth, which was the Non-government Organisation Treatment Grants Program (NGOTGP), and the Substance Misuse Service Delivery Grants program, which have now come together. This was under review as to whether or not it would continue and is on, I think, a two-year contract at the moment. So it is a very small pool. When you are looking at treatment beds it is also a very small pool. Everybody has just been looking at whether or not they could cut it and it has just hobbled along as best it could. It is a bit of a house of cards when it comes to funding stability, so it really is a sector that requires longevity to be able to plan a service response, to be able to plan a workforce and to be able to then have a stable sector to respond to these complex needs. I am not quite sure whether I answered your question.

The Hon. Dr PETER PHELPS: Yes.

Mr BYRNE: I agree that that would be good. As Ms Holmes was saying, the issue around funding is a house of cards process that we are all in. For arguments sake, the service that Major Gavin manages from their grant from the Commonwealth provides us with an enhanced capacity to provide services to people with complex mental health conditions, so we are able to access telepsychiatry simply because our street address is 50 metres outside the exclusion boundary. Our two psychiatrists are actually in Brisbane—that is how inventive you need to get to provide your services. Should we lose that funding when it goes across to the PHN in June 2019 we will be stopping that service. As an organisation we do not have the capacity to be able to provide that from our own finances. That will remove complex mental health treatment and support from 40 people who access that service. It funds that service out of 40 beds. With regard to our male program up there, we get about $450,000 through Hunter Health and we provide 78 beds for that.

The Hon. BRONNIE TAYLOR: Is that $450,000 per annum?

Mr BYRNE: Yes, we provide 78 beds for that. The standard benchmark bed rate in New South Wales is $85 for new funding, but there has been no real increase in the bed capacity within the NGO sector since the Drug Summit in 1999 and the funds that stemmed from that.

The Hon. Dr PETER PHELPS: One of the things that NADA brought up in its submission was the fact that it has geographically been misallocated on the basis of political judgement as to where problems are. What the sector really needs and is looking for is an objective standard—something like the drug and alcohol service planning model can provide, which is to say, "We may have misallocated in Western Sydney and we need to go across the sandstone curtain", or alternatively, "We need to go to the North Coast"—something which moves beyond simple spur of the moment political judgement towards a more objective standard of needs and potential needs in the future.

Mr BYRNE: There certainly is a heavy concentration of places east of the Great Dividing Range—the sandstone curtain. I do not think it is a case of building residential treatment services in lots of communities. It needs to be much more strategic. We have issues. We are a big State. If you are in Cobar and you need to access a service that places an impost on you and there is a disincentive for people to access drug and alcohol treatment. There is a dislocation from community and from family. The stressors that places on family in relation to maintaining relationships, particularly for parents and children, is one of the drivers that stops people in rural and remote areas from accessing treatment.

The Hon. BRONNIE TAYLOR: So what do you do?

Mr BYRNE: I think there needs to be some strategic mapping, which is what you are talking about, so I am supporting what you say. We look at key areas that sit on major transport routes where satellite towns and regions within rural and remote areas of New South Wales can more readily get access.

The Hon. BRONNIE TAYLOR: A hub and spoke model.

Mr BYRNE: Yes.

Dr MAGOR-BLATCH: I will pick up on that point. I eluded before to the drug and alcohol clinical care planning model, commonly known as DA-CCP, which was based on MH-CCP here in New South Wales, the mental health clinical care planning.

The Hon. Dr PETER PHELPS: That is right, because it morphs into this.

Ms HOLMES: It does.

Dr MAGOR-BLATCH: That is right. I sat on that for two to three years doing a lot of planning. Our brief was if you were dropped into a community of 100,000 people, what sorts of services would they need over a period of one year? We had to map that out right down to the last dollar basically to establish what sort of treatment they would need. It would be good if that model was now picked up and put into place.

The Hon. Dr PETER PHELPS: The other thing which these smaller agencies have raised—and I would like you to discuss this as well—is that the level of paperwork, the administrative rigmarole required for funding allocation is too great for them, and that the big organisations have it easier because they have specialised staff who can do tender applications. The second thing which the smaller agencies have raised is short-termism; in other words, one year, two years. First, they are administratively time consuming for what you get and, secondly, there is no real result possible—no objective evaluation. First, paperwork, because of government requirements and, secondly, what do you consider to be the minimum time that a funding grant can or should be given so that reasonable results can be adduced from that program?

Ms HOLMES: I would advocate very strongly for a minimum five-year contract.

Dr MAGOR-BLATCH: And I would agree with that.

Ms HOLMES: With that contract having a possible extension of three years should your key performance indicators be met at the standard required for that contract. That enables a service to be able to have appropriate staffing in place, to look at practice, to have a quality plan in place and to do things like accreditation. I acknowledge there is an administrative burden on organisations, but as an organisation you do need to be able to demonstrate and meet your ability to work with complex people. When we go through a tender process, I was writing that. Mission Australia does have support staff that do that, but they then also rely on those people running programs to write those tenders. From that perspective it is a similar situation to those smaller organisations. But the larger organisations then have the capacity to respond to those complex needs and all the support networks you need to be able to do that in order to respond to clinical and critical incidents, and to be able to have a workforce development. There are swings and roundabouts for small and large organisations. I acknowledge that difficulty within a small organisation, but the seemingly bigger ones have those difficulties as well.

The Hon. Dr PETER PHELPS: A two-year contract on a small organisation will make it even less attractive for someone to enter deals, is it not?

Ms HOLMES: Yes, whereas five years with an option of a three-year extension enables you to step out of that administrative burden significantly.

Mr BYRNE: Within our submission we raise that as well, because it is an illusion that large non-government organisations [NGO] can drive all of these resources into things, particularly for the Salvation Army where we have got this reluctance to use consultants because of the expense and the diversion of funds that have been generously donated to us by corporate and public Australia, and also from government funds employing consultants to write tenders. We do them in and of ourselves and with our services. That then takes people's time. They are done in the evenings and they are done on weekends. In our submission I have eluded to the fact that they are onerous and I eluded to the repetitive nature of them. Government in other areas has preferred provider starters. Why can we not move to that within the NGO where, if you are an organisation, every three years or whatever the term could be we could put up our goods and chattels to say that we are a reputable organisation. Why do we need to keep going through that again, whether we are a small two-person service somewhere or a larger NGO such as the Salvation Army?

Dr MAGOR-BLATCH: The thing that that brings up of course is the fact that we keep losing good staff for that reason. Because there is no certainty, workforce development is a huge issue for WHOS, for other programs as well and the ATCA, the Australasian Therapeutic Communities Association, to which the WHOS belongs. It is concentrating very much on workforce development at the moment. We train up good staff, fantastic staff, but because they have got no security of tenure they move, usually to the government sector.

The Hon. Dr PETER PHELPS: You mean NSW Health snaffles them?

Dr MAGOR-BLATCH: Absolutely.

The Hon. BRONNIE TAYLOR: That is a constant theme across NGOs in every area. You have not got some overriding organisation that gives you some type of rating so therefore you do not have to keep reapplying. I think there are people working on that because it is too onerous for you. But this has been a long-term problem, has it not?

Mr BYRNE: Yes, it has.

Mr BUTCHER: The issue with short contracts such as your one-year or two-year contracts, particularly in rural New South Wales, is that it might take you six, eight or 12 months to be able to fully staff a project to get the skilled, qualified and experienced staff you need to deliver the contract. So you have already burnt through that time and you are up for another tender process when you have just found your feet.

The Hon. COURTNEY HOUSSOS: Mr Butcher, I would like you to finish that point because I think it is an excellent one and one that has come up in a number of inquiries before—the challenge of finding staff in a short period of tenure. If you have a one-year contract by the time you recruit staff you barely have time to deliver the services let alone start thinking about re-recruiting. Then they will move on to a new position because they obviously will want continuous work and you cannot guarantee them that. It is such a challenge.

Mr BUTCHER: Particularly developing a clinical workforce in rural communities, we are forced by default to look at new graduate positions primarily—so your new graduate psychologists, graduate social workers and graduate nurses—and try to find an experienced clinical supervisor to be able to support people to develop the skills, capability and capacity in a fairly quick manner. Longer-term contracts would also be a more attractive process to get a more skilled workforce in rural locations.

The Hon. COURTNEY HOUSSOS: Did you want to provide any other reflections?

Mr BYRNE: I support those comments.

Mr WATTS: We are seeing that on the frontline at Dooralong Transformation Centre. Trying to find the right sort of staff is difficult all the time. We are talking about the graduates or the nurse straight out of university.

The Hon. COURTNEY HOUSSOS: In regional areas, if you want your staff to undertake additional training, do you find that easy or difficult to access?

Ms HOLMES: I think the most difficult aspect for us is not identifying the training; it is doing the travel to get there.

The Hon. COURTNEY HOUSSOS: Can you give us some examples of that?

Ms HOLMES: If a staff member wants to attend training we are in reasonable distance to be able to travel to Sydney, but then you have to have the flights or the travel and the accommodation.

The Hon. BRONNIE TAYLOR: And replace them.

Ms HOLMES: And replace them for the day, that is right. Providing learning and development opportunities is very expensive, whereas for metro services you do not have to worry about accommodation and transport for people to be able to attend that basic learning and development training. So it is quite a challenge for services.

Mr BUTCHER: A fortnight ago I had a staff member from Dareton, located in far south-western New South Wales, travel to Dubbo to do some motivational interview training—a basic kind of training—and he was on the road for a day to get there, a day training and a day to get home. So that is three days out where he had not seen anyone—three days wages and travel. We are looking at things such as videoconferencing but the learning you get by being in a room with someone is much more important.

The Hon. COURTNEY HOUSSOS: And the social interaction surrounding that.

Mr BUTCHER: Exactly.

The Hon. COURTNEY HOUSSOS: There are obviously no regional opportunities for that kind of staff development?

Ms HOLMES: Some regional training does come around but it is about timing as well. You might have somebody who started new that needs to do that training really quickly to be equipped to do their role. But for staff who have been on for a while you might be able to wait until that training comes to a regional centre.

Mr BYRNE: There are limited opportunities in relation to training. We have services up in Queensland as well and one of the things that Queensland Health did was fund the training and the trainers to go out to all of the regional areas. They did not stop at the eastern seaboard; it was out to Mount Isa, Cloncurry and small towns where there are services. They take the training to the people which, at the end of the day, is much more economical than providing subsidies to non-government organisations [NGOs] to fly people down to Brisbane, or across to Cairns or Townsville.

The Hon. BRONNIE TAYLOR: You also get the specialists coming out to the communities, do you not? It is easy to run a course, or whatever, but if you have a specialised drug and alcohol person who comes in and actually is there on the ground that they can use, it is just a phenomenal learning opportunity but we have to bring it to them. We cannot just expect everyone to leave.

Dr MAGOR-BLATCH: One of the things that We Help Ourselves [WHO] did a couple of weeks ago was actually host some training. Ironically, both Mr Byrne and I were the trainers.

The CHAIR: Top-shelf training.

Dr MAGOR-BLATCH: But it was a WHO's. There were 34 people involved in that training and they came from not just Sydney but from a fairly wide area. One of the things that happens, then of course—it was three days training; a block of three days and there will be another block of three days in about four weeks time—all their staff have to be replaced while they are away on the training. There is accommodation and a whole range of things that the organisations have to think about. Here is one: Victoria is funding 100 new beds down in Victoria, funded by the Victorian Government, and they have funded 100 places in this particular training for Victorian staff. I go down there next week to roll out the training down there. It is that kind of proactive support that really would be necessary for other governments to look at as well because it is vital for staff—particularly because the sector has changed. We have new issues to be thinking about, new problems associated with people's mental and physical health, and so training is absolutely important.

The CHAIR: Can I ask you about particular challenges with respect to providing assistance to Indigenous Australians with addiction issues? Can I have either reflections from your own organisations or general observations that you know with your level of expertise? I am just trying to open this up.

Ms HOLMES: One of the biggest challenges I see for young people is when they move off country to participate in rehabilitation. We are based in the Southern Highlands of New South Wales. If a young person wants to participate in our program, they are moving off country and so they are losing connection with their community and their local elders. They can be really disconnecting for that young person. If they are able to participate in treatment that is in their local area, we will always recommend that they do that, but often there is not that opportunity for them to stay connected.

Dr MAGOR-BLATCH: That is right.

Ms HOLMES: We try to connect them with the local elders in our area as soon as we are able to, to see if we can connect them with mob and country here as a visitor. But that is really difficult for young people.

Mr BUTCHER: About 85 per cent of the young people that access our 13 to 18 year old residential we have in Dubbo identify as Aboriginal primarily because of the catchment area being western New South Wales, which is basically Bathurst out to Broken Hill up to Lightning Ridge and down to the Murray River. The critical thing in our service model have been making sure that we have a range of Aboriginal staff in the unit. We have Aboriginal residential support workers, we have Aboriginal program staff and a trainee Aboriginal clinician as well to match the needs of the young people against the needs of our staff. Also, about 60 per cent to 70 per cent of young people coming to our service have a primary caregiver or parent that uses substances regularly at home.

The CHAIR: What percentage was that?

Mr BUTCHER: Sixty to 70.

The CHAIR: Gosh.

Mr BUTCHER: So it is really important that when we take someone out of that environment and put them in a residential environment with a predictable routine—all those kinds of basic needs being met—that there is a parallel servicing of the family back at home as well to make sure that those conversations around re-entry are being had. If we could support mum or dad to work on their drug or alcohol issue while the young person is working on theirs, then there is likely to be a more sustained outcome long term.

The Hon. BRONNIE TAYLOR: They have a chance when they go home then, have they not?

Mr BUTCHER: Yes.

The Hon. BRONNIE TAYLOR: No matter what you do in the treatment facility, if you send someone back to the same environment it is pretty tough, I imagine.

Mr BUTCHER: We had a young man that went home—this is about 12 months ago—and we were talking to mum about him getting ready to come home. She had gone to the bottlo and bought a couple of cartons and said, "Oh, well he's not going to have pot, but we'll just have some beer." Well, how about we kind of do a bit more work around that, whereas it was kind of, "Well, he's gone away. He's been 'fixed'. He's done his treatment. He's okay. He's ready to come back and he won't start that process again." Really embedding family work in our service models, particularly for Aboriginal people, has been absolutely critical.

Mr WATTS: From the Dooralong perspective, I would agree with what my colleagues have said. We work very closely with Yarran, which is the Aboriginal healthcare service on the Central Coast. We have a good relationship with them and with the Aboriginal area health service's drug unit. We work with them. We also have some of our support workers and our caseworkers identify as Aboriginal Indigenous workers. That gives a good working relationship and a good understanding there so that when they work and when they go home, hopefully, we can work through those issues as well.

Dr MEHREEN FARUQI: I am more interested in the 13 to 18 year age group as well. Is the lack of services similarly desperate as in other age groups? Do we really lack services for that age group at the moment?

Mr BUTCHER: Particularly for 13 to 16 year olds. There are no detox beds accessible in New South Wales for that cohort. Of course the 13 to 16 year olds generally will not have the level of dependence and withdrawal syndrome as the older year range, but you have those psychosocial factors at home where mum might be using, dad might be using and brothers might be using, et cetera, which makes home-based detox not necessarily the best option for those young people.

One of the solutions we are looking at is we have partnered with two local health districts [LHDs]—the Western in the Far West LHDs and Deakin University—to look at: Is there a way that we can upskill local doctors to admit local young people to smaller regional hospitals? They are operating off activity-based funding anyway, so it is about using the resources in these communities that are already there. You negate the issue of taking young people off country. You are accessing people into primary health care, into hospital-based treatment, and then you are having a predetermined treatment pathway into residential care. It is exceptionally challenging to get young people under 16 detoxed. It is a very spasmodic. It is up to the discretion of the doctor on the day.

Mr BYRNE: Recently NSW Health let tenders for the provision of detox to young people and residential treatment to young people. I think the sector is still waiting on the outcome of that. As part of that process we made an inquiry in relation to tendering. We have a property up at Morisset which is good to go. You just have to hang your clothes up in the wardrobe and you are ready to go. It can be up to our 26-bed facility. The development approval is in place for that to be a residential drug and alcohol service. Our service model involves both the detox and the residential treatment because I think the two need to go hand in hand.

Kudos to Mission Australia for their impetus in getting David Martin Place operating alongside Triple Care Farm—fantastic. We were looking at that. When we asked frequently asked questions around the model, they said we could only be funded for one of them and if our service model involved both, then we had to provide both treatment services for the one funding pool, which made it not happen because it just was not sustainable. We could have made it work—and this is not sour grapes, by the way, because we made the decision not to go ahead with the tender based on that—but had we been able to tender for both service types as a combined service model for both funding opportunities, then we would have progressed the tender. What happens after that is whatever happens.

Dr MEHREEN FARUQI: This is the prescriptive nature you were talking about.

Mr BYRNE: A hundred per cent, yes. It stops. Someone else probably tenders up and gets the funds—terrific. I mean that sincerely. However, when you look at the prescriptive nature and when you look at what the service would have been able to provide, was our model more efficient, more effective, than the one that fitted the tender specifications? Maybe not, but the tender panel did not get an opportunity to have a look.

The Hon. Dr PETER PHELPS: Please take this question on notice: Do you have any statistics in relation to either complete abstinence, or at least substantially reduced use two, three or even five years after completion of treatment? It is foreseeable that someone has reduced use and is still a fully functioning individual. I know that the Salvation Army has figures, but I am not sure for how long after treatment; is it immediately after treatment or some time into the future? Mick Palmer, former Commissioner of the Australian

Federal Police, has a very strong view, which he enunciated after being commissioner, that we should stop treating misuse of recreational drugs as a justice problem and start treating it as a health problem—in other words, effective decriminalisation or at least depenalisation of those drugs and a subsequent change in resourcing away from the justice system to the health system. Could I get your views on that proposal?

Ms HOLMES: I can answer both of those questions. What we see six months later is a 70 per cent reduction in substance use. We see young people move out of both severe and moderate use to abstinence. We do have 30 per cent of young people that are still using at a low level, but for many of those young people that might be drinking or some low-level substance use.

The Hon. Dr PETER PHELPS: So 70 per cent abstinence and 30 per cent reduction?

Ms HOLMES: Yes, it is a pretty phenomenal outcome. We follow up young people for six months; that is our after-care program. After that, young people move on with their lives and we do not have the resources to follow up.

The Hon. BRONNIE TAYLOR: When you say you follow them up, if you are in the Southern Highlands and you are treating someone from Cooma, do you phone them or do you refer them? What do you do as a follow-up?

Ms HOLMES: We have two after-care support workers that cover different areas. If somebody lives as far afield as Cooma and we are not able to travel to them, what we will do is set up support networks in that area for that young person and we will connect with them by phone and by social media to make sure that they are still continuing with that support network. For young people in the Australian Capital Territory [ACT], say, we will go and visit them there. We go as far afield as to the Blue Mountains and Newcastle to visit people regularly. Mission Australia in 2014 completed a social return on investment study to look at the long-term outcomes for investing in the sector. It is referenced in our submission, and for every dollar invested, we found that five years later $2.91 was returned. We saw a significant reduction in substance use, we saw increases in education, in housing, in health and wellbeing and in aspiration. Young people went from having no hope to having hope for the future. It is really hard in the service sector to have long-term follow-up outcomes, because we have fairly minimal resources to follow up young people we are not currently working with. We have had an opportunity to look at where those young people were five years down the track and what the investment was worth.

The Hon. BRONNIE TAYLOR: We need to do a study on that.

Mr BYRNE: It is an expensive exercise to follow up people. In particular we are not really a club that people want to put their hand up for having been involved with once they move on in life, which is understandable. We get similar outcomes, and I have put some of them into our submission in relation to alcohol and other drug users. That is at a three-month mark or a 12-month mark with that cohort now, for admissions from 2014 through to 2017.

The Hon. Dr PETER PHELPS: That is the 12-month mark in your statistics.

Mr BYRNE: Yes. The thing about the outcome is, as an example, the average length of time for substance use for people in our treatments is 17¼ years. We are dealing with very experienced users, people who have been on the road for a while. There are people in that cohort who have been there for two or three years or even a year, and some that have been there for 30 or 40 years. When you look at an average of 17¼ years—

The Hon. BRONNIE TAYLOR: It is massive.

Mr BYRNE: It is, yes, and with that comes a whole range of social and personal issues that happen in relation to that. Two of the biggest factors that influence any positive treatment outcome—and it does not matter what we are able to do with the person when we have them in treatment—if these two things not in place then their capacity to maintain change afterwards is hugely diminished. The two things are an address and a job; without those two things quality of life begins to deteriorate. It is not somewhere to live that is out the back of the boondocks somewhere; it has to be not one of the band 3 or 4 socio-economic communities, not that I am denigrating them. I am saying that people need to be in thriving communities if they are going to thrive. The employment issue for people is such that we have people who are long-term unemployed. If you have on average 17 years as a drug-use career, you have most likely been unemployed for a long period of time, as most of our people have been.

Under the Federal Government's employment structure people are streamed into 1, 2, 3 and 4, with streams 3 and 4 being the most difficult. Ours are 3, mostly 4, and that makes them a really unattractive option for job network providers. That diminishes their capacity then to access appropriate accommodation—and I do

not mean transitional housing; I mean a home, where they can say, "This is where I live. I'm moving away from that life and I have my new address. This is my new community. There is my job network provider. I'm in training and I've got a job or I'm going for that job." Quality of life has a huge impact, and we are powerless over that.

Dr MAGOR-BLATCH: I agree with everything that has been said, but I want to pick up on something about this particular client group, going back to Dr Faruqi's earlier question. I used to work in drug and alcohol policy and I felt like we were sentencing young people to continue their use until they became adults because there were very few programs available for them. When you consider WHO's stats and other people's stats, most people will say they started using at around 12 years of age. There is often a significant period of time before they get into treatment. I did my PhD looking at follow-up for people who had methamphetamine use and I followed them over a period of time. I compared outcomes for them and found it is not just about stopping drug use; it is about quality of life. It is about all of the things that Mr Byrne was talking about in terms of employment, stopping crime and a whole range of things.

For the first program I ever worked in, we followed people up for five years. The reality is—and it is the case if you think about your own life—could you say that what you get in a particular treatment makes it justifiable to say the outcome five years down the track has to depend on that treatment? Lots of life changes happen along the way, and that is a fact. We are already dealing with a chaotic group, when we talk about family connectedness or social connectedness. These are major issues, but the reality is we will tell you that some of the families are so disintegrated before people come in. Families are the source of the problem, often, in terms of people being unable to go back into the family because of the problems associated with the family, including the fact that it may be the family that introduced them to drugs in the first place and they are continuing to use. All of those things are vitally important in terms of the social fabric and what happens to people as they come through treatment. If they move out of their community to come into a treatment setting, the geographic move might not be necessarily bad, but we need to work with the community to help people to re-enter and reintegrate back into some social system. That is a major issue in terms of people's recovery.

The CHAIR: Your comments have been very insightful. You all have a depth of experience and you have given us useful information. Thank you for your submissions and sharing your insights and experiences with us. The Committee has resolved that answers to questions taken on notice or sent to you should be received within 21 days. Is that okay with you?

Mr BYRNE: Yes.

(The witnesses withdrew)

(Short adjournment)

ROBERT GORDON BATEY, Clinical Professor of Medicine, University of Sydney, sworn and examined

KERRY CHANT, Chief Health Officer, Deputy Secretary, Population and Public Health, NSW Health, affirmed and examined

MICHELLE CRETIKOS, Director, Population Health Clinical Quality and Safety, Centre for Population Health, NSW Ministry of Health, affirmed and examined

DANIEL MADEDDU, Director, Alcohol and Other Drugs, Centre for Population Health, NSW Ministry of Health, affirmed and examined

The CHAIR: Thank you for coming along this afternoon. The Committee has received the New South Wales Government submission, submission No. 34 to this inquiry. We have members of the Opposition, the Government and the crossbench here this afternoon. In a moment we will provide them all with an opportunity to ask questions, but before that would any of you like to make an opening statement? Information covered in the submission does not need to be covered again in any detail.

Dr CHANT: I will speak for a few moments, if that is okay. First, I thank the Committee for the opportunity to give evidence today. I will just indicate the backgrounds of the people who are presenting today, which will help guide members. Professor Batey is the Clinical Professor of Medicine at the University of Sydney and professorial fellow in medicine at Flinders University at Alice Springs Hospital. He will be able to speak as a longstanding clinician in the system. Dr Michelle Cretikos is Director of Population Health Clinical Quality and Safety within the NSW Ministry of Health, within the drug and alcohol program. Dr Madeddu is Director of Alcohol and Other Drugs in the Centre for Population Health.

NSW Health provided a significant contribution to the whole-of-government submission, but for the purposes today we will only be able to speak in relation to NSW Health and may have to take on notice any issues that relate to other government agencies. There is a key message that reducing alcohol and other drugs harms requires very much a community response. A whole-community response includes services and initiatives and opportunities beyond health care, such as access to housing, training and employment opportunities as well as other initiatives that reduce the supply of alcohol and other drugs. There is no silver bullet in relation to managing the harms associated with alcohol and other drugs. There is a high demand for alcohol and other drugs services. It is also important to remember that addiction is a chronic and relapsing condition; so people need a range of services to meet their varied needs and they need ongoing care and support.

The majority of people who need treatment for substance use are best served by treatment in the community, and counselling and opioid treatment are the key evidence-based treatment options provided. Excessive consumption of alcohol remains a major cause of health and social harm, and illicit drug use is stable, but the substances used continue to change from time to time. The evidence is that general community use of methamphetamine in New South Wales has declined since 2010, although the harms have increased significantly from 2010 and have stabilised since 2016, with evidence of a decline in some indicators. I would like to draw the Committee's attention to the fact that we will be releasing updated data on methamphetamine use.

There was recently a roundtable on 1 March with a number of stakeholders from community as well as academics to look at all of the relevant data sources. We are aiming to get that report finalised with the input from that 1 March meeting in the next couple of weeks and we would be very keen to share that with the Committee. Also we will be releasing the latest drug and alcohol consumption data, which will then update the data that has been provided in the report.

New South Wales has a comprehensive response to alcohol and other drugs. As the New South Wales Government submission outlines, there is a broad range of service providers across primary care, local health districts, Aboriginal medical services, non-government organisations and other government agencies that have important roles to play. I am aware of the high demand and unmet need for alcohol and other drug services, particularly in regional, rural and remote New South Wales, and draw attention to the elements covered in the submission where we have enhanced some services in a number of rural and regional sites in recent years. We continue to look at innovative approaches to support rural, regional and remote communities in relation to alcohol and drug services. I will leave it at that point.

The CHAIR: Is that the general opening statement?

Dr CHANT: That is the general opening statement.

The CHAIR: Thank you very much. We will commence our questioning.

The Hon. COURTNEY HOUSSOS: We have received a lot of submissions and evidence today to show that the recent Drug Package announced by the Government did not provide any additional residential beds and did not particularly provide for Aboriginal people, which were two of the key areas of unmet demand received by this Committee. What is your response to that?

Dr CHANT: The drug and alcohol package that was announced had a focus on young people, mothers and also particularly vulnerable groups. We are happy to provide the details of the funding, where that funding went to, and the stage of rollout of those various programs. I would be happy to throw to Mr Daniel Madeddu to talk about the extent particularly in terms of the residential rehabilitation services and which services have been funded.

Mr MADEDDU: Because there was a specific component of that which was about building additional capacity in residential rehabilitation services. There was $8 million put into residential rehabilitation services for women and children in particular, so that has gone in there. There was also a very big—

The Hon. COURTNEY HOUSSOS: Can I stop you there and ask how many additional beds that funding resulted in?

Mr MADEDDU: That funding was specifically for additional people rather than additional beds. There is a whole complexity, I suppose, that probably Professor Batey would be better to speak to than me, but it is the outcome we are after rather than just occupying a particular bed for a certain period. So the Drug Package $8 million announcement was to add capacity for 1,000 extra women.

The Hon. Dr PETER PHELPS: Hold on—can I just follow that up? If there is already overcapacity or excessive demand in the existing structure for residential beds, what you are essentially saying is you have done an $8 million substitution of women going into the beds, but there is no additional capacity for beds, so all you are doing is moving men out.

Dr CHANT: No, that is not correct. We can provide a breakdown of the additional money that has gone to each of the services, which will have translated into additional beds. I think what Mr Madeddu was saying was we are more interested in the outcomes associated with the investment in the residential rehabilitation in terms of how many additional women are treated and how many are supported to a positive outcome from that. We are very much wanting to work with the Network of Alcohol and Other Drugs Agencies [NAODA] to ensure that we have outcomes measures in drug and alcohol so that we can be assured that the residential rehabilitation component, when combined with other components, leads to successful outcomes for patients. We will be able to provide the Committee with the investments that we have and the new services that have come on line associated with that investment.

The Hon. COURTNEY HOUSSOS: That would be very useful. Thank you very much. The other evidence we received this morning was that the Federal Government announced a $300 million national ice package but again this did not go into residential beds. Apparently this was because it was diverted to the primary health networks [PHNs] instead of into the local health districts [LHDs]. Do you have any comments to make as to the coordination of that money?

Dr CHANT: In my opening statement I indicated the fact that it is a complex service system for drug and alcohol. As would the community, we share the view that we need to make sure we work cooperatively with all of the service partners or all the funding partners to design a service system for the best outcomes for the patient. I would be very open to working collaboratively with the Commonwealth on planning. We have mechanisms to engage with the primary healthcare networks and we are encouraging our local health districts to work with their primary healthcare networks in mapping areas where there may be gaps in services and opportunities to work collaboratively.

The Hon. COURTNEY HOUSSOS: What are those mechanisms for the two to interact?

Dr CHANT: A number of our local health districts would have regular engagement with the primary healthcare networks. Often there is cross-representation on various committees—they would interact. I can give you some written examples of how that might work in various local health districts. Obviously it varies by primary health network and local health district, but many have close working relationships. I do not know if there is any experience from Hunter that Professor Batey might like to give.

Professor BATEY: In Hunter New England we had committees which merged the two. I moved out of primary clinical work in Newcastle at the time LHDs and PHNs were becoming much more the active healthcare delivery services. But there were those committees that existed in earlier days as well, pulling together the various groups who have responsibility for drug and alcohol. There is always the problem that each separate group feels they need more resources. Often when you are working in those sorts of committees you are

sometimes felt to be offloading work to other bodies who are not getting as much money as you are in the primary NSW Health system. But working well you can improve services dramatically.

Dr CHANT: And at a peak level we have engaged the primary health network peak organisations and had a number of forums with the primary health networks. The position is that we see primary health care as a key part of the service delivery system and would look forward to any opportunity to better plan and coordinate services across it. We are very committed to integrated care, and that needs a seamless transfer of patients across the primary care system through to our specialist and tertiary care system.

The Hon. COURTNEY HOUSSOS: The problem is that there was $300 million. It was a large amount of money that was designed to be addressing what was seen to be a severe ice problem—people severely affected by ice—and yet this did not actually address it. We have heard in the written submissions and the verbal evidence today that that money did not go into residential beds; it did not go into supporting the severe cases; it may have provided some outpatient services; it may have helped some people with mild to moderate addictions to ice; but it did not help the people on the very severe end and it did not provide new residential beds, which is the most appropriate setting to be supporting these people.

Dr CHANT: We can provide advice on what commitment we have provided to grow residential rehab. I suppose it is important at this point to also highlight, as I think you have in your question, that there are a variety of services mixes that are suited. Occasionally patients will need the residential rehab component but the evidence base supports a broad range of other initiatives as well. Certainly some of the most severe may benefit from residential rehab. I would be happy, out of session, to find what I can find out about the Commonwealth investment, but there certainly has been strong engagement locally to understand what the opportunities for that investment are and work collaboratively.

The CHAIR: I appreciate that not everything is to do with beds but I am trying to comprehend the availability of beds for rehabilitation purposes in New South Wales. Where can one go to establish that number so we can see what beds are available for rehabilitation for people with a drug addiction in New South Wales? Is there a database that we can interrogate or ask to have interrogated for us to give us that information?

Dr CHANT: As I said, we fund a range of non-government organisations to provide residential rehabilitation services. We could go to them to look at how many patients have been treated and what is their length of stay and provide that information to the Committee. We have also heard how we can better make those visible and what services are available at any point in time. We have provided some funding to the Network of Alcohol and Other Drugs Agencies [NADA] for clinical coordination and we would be happy to explore whether a greater clinical coordination role could be provided to make it more visible to people wanting to access residential rehabilitation where there might be beds available.

The CHAIR: Today a couple of witnesses alluded to the challenges they face when they have a person in need—that has been well established by looking at the person's condition—but they struggle to find out where a bed may be available. Because there is no central depository of information to which they could go to establish what beds might be available around the State there is a sense of frustration. That comment has been made by more than one or two witnesses thus far.

Dr CHANT: I say in response that I think that is an issue. We would be happy to take that back and look at how we can make that more transparent to people in navigating the system. As I said, we have provided some additional funding for NADA to provide a bit more clinical coordination—not with this specific function in mind—but we could look at whether NADA or one of our other services that we fund on a statewide basis could take up this role and establish what information technology systems we would need to support that. I think it is a very reasonable suggestion that we explore that as a matter of urgency.

The Hon. Dr PETER PHELPS: Thank you for coming along and for your submission. Both NADA and Dr Magor-Blatch raised the National Drug and Alcohol Clinical Care and Prevention Project Modelling Tool, now renamed the Drug and Alcohol Service Planning [DASP] model, and expressed some degree of dismay that it was not being used by NSW Health for fund allocations for various alcohol and other drug programs. Why has NSW Health, which was involved in the development of that, not taken up that model?

Dr CHANT: NSW Health has been funding drug and alcohol within the way we fund other services. Each year the local health districts develop gap analysis of services. They are funded for increased activity year in and year out, and we also support them with data around the need or growing need for drug and alcohol services within that. That is the framework we are using. As I mentioned also, there are a number of different service providers. I think as you have referenced before there is all the way from general practice through to psychologists, through to our services, through to non-government, including Aboriginal community controlled. It is important that there is local service planning to make sure we are leveraging off the available services.

Local health districts are best placed to understand what on-the-ground services need to be put in place. That is the approach we are taking at the moment. We obviously have reference to the principles outlined in that planning document but we are aligning the drug and alcohol purchasing within that framework. In regard to the drug package funding that was released, that was informed by data. For instance, the enhancements were allocated based on demonstrated clinical need. I understand clinical need is high overall, but we did identify and target those areas that particularly came up on a variety of indicators, such as admissions or prevalence data to which we had access to inform the location and allocation of those new additional enhancements.

The Hon. Dr PETER PHELPS: What is the specific problem with the Drug and Alcohol Service Planning model which does not allow it to be used? Are you saying it is too broadbrush or that it does not cater for localised issues? One of the things that NADA also says is:

> … funding decisions in this program area are largely politically determined based on community concern, and to a lesser extent growth funds within the health portfolio.

I am sure they do not mean the Minister says, "I want money spent here and money spent there." But I suspect what they are saying is that noisy community concerns filtering up through the local health areas attract a greater degree of attention than would an objective standard created by the DASP model.

Dr CHANT: I will choose an example outside drug and alcohol just to clarify what we mean in terms of outcomes. I take the example that at the moment we want to achieve the elimination of hepatitis C. We have access now to very good drugs which have a much reduced side effect profile. We are committed to eliminating hepatitis C by about 2026. In order to do that we know what the estimated prevalence of that is in the community and so we have modelled that with the Kirby Institute based in New South Wales and set targets for each of our local health districts. We are agnostic about how those districts reach those targets. They can reach those targets by working effectively with general practice. They can provide nurse-led models. They can enable their Aboriginal medical service. They can work with Justice. They can work and achieve those targets in many ways. We provide the data back to those districts. It allows a degree of flexibility in the service model that is fit for purpose for that local health district.

While we are respectful of the work that has been done on the service model, it perhaps just does not allow that degree of flexibility locally and acknowledging the service providers that are local and how you would tailor your considerations locally. For instance, we know a number of our rural districts are doing fantastic in that and we are sharing some of the innovative models of care that have been developed. We are very committed to the outcomes and we are doing a lot of work also to better understand the outcomes for our alcohol and drug treatment. I think this is where we need to continue to invest. Our submission also identifies that we have funded a significant research component, because that was also part of the drug package in the Alcohol and Other Drugs Early Intervention Innovation Fund. The long and the short of it is we would prefer to see our purchasing to be driven by an understanding of outcomes. We think planning needs to be done locally, taking into account the services that are there and then local districts identifying where there may be gaps in those services.

The Hon. Dr PETER PHELPS: Is drug addiction a legal problem or a medical problem?

Dr CHANT: Drug addiction causes significant harms for individuals, families and communities. We in Health have always taken a harm minimisation approach, but the harms are real, as I said, for individuals, families and the community at large.

The Hon. Dr PETER PHELPS: Today the Committee received evidence that Juvenile Justice runs two facilities without any input from Health. It strikes me as strange that what should be a Health issue is in fact being cross-subsidised by Justice.

Dr CHANT: I am aware of the test services from the submission, and I am happy to follow up concerning those services.

The Hon. Dr PETER PHELPS: You said that where prohibition is impossible—and I think we agree that prohibition is impossible in effective health outcomes—harm reduction or harm minimisation is a key component in delivering healthier communities. That is the reason we have a drug injecting room. While we would prefer people not to inject opioids, you can minimise the risk to them and to the community more generally by providing facilities for harm reduction. Is that a fair assessment of NSW Health's approach?

Dr CHANT: NSW Health supports the value of the medically supervised injecting centre [MSIC].

The Hon. Dr PETER PHELPS: Is nicotine a drug of addiction?

Dr CHANT: Nicotine is an addictive agent. It is addictive; that is why it is so hard for people to give up smoking.

The Hon. Dr PETER PHELPS: In fact, roughly 40 per cent of the Indigenous population of New South Wales smoke, and 57 per cent of children find themselves in households where tobacco is used. Would that be correct?

Dr CHANT: Tragically, 41 per cent of pregnant Aboriginal women smoke. Smoking is one of the major causes of disparity in health status between Aboriginal and non-Aboriginal people. NSW Health is passionate about reducing smoking in pregnancy and smoking in Aboriginal communities. We are rolling out significant programs to support that. It is pleasing to see that there has been some decline in Aboriginal smoking—

The Hon. Dr PETER PHELPS: Yes.

Dr CHANT: But the disparity is—

The Hon. Dr PETER PHELPS: It is almost double.

Dr CHANT: In many cases it is many more times than that.

The Hon. Dr PETER PHELPS: Given that, why does the New South Wales Government continue to persist with its opposition to vaping of nicotine liquids as an effective antismoking measure?

Dr CHANT: This issue is that vaping has not been shown to be an aid to quitting. The evidence is equivocal at this stage. We remain open to that evidence. I think you were commenting about the current legislation. The purpose of that legislation is not to ban the use of nicotine-containing e-cigarettes. The purpose of that is simply to align the fact that you cannot smoke e-cigarettes in those places where you cannot use a traditional cigarette. The harms associated with e-cigarettes is an area where we are still learning. The harms are not equivalent or the same as tobacco, but I do not know that anyone can give a definitive level of what the harms are and how they would compare overall with tobacco.

The Hon. Dr PETER PHELPS: The Royal Australasian College of Physicians seems able to do so.

The CHAIR: I have been pretty generous with respect to your line of questioning, but you are starting to stray.

The Hon. Dr PETER PHELPS: I suggest that tobacco kills more people in New South Wales than any other drug.

The CHAIR: I think you know the point I am making.

Dr CHANT: We have done very well as a country. We have very low rates of childhood smoking. The other point is that there is a legal pathway that e-cigarettes can go through with the Therapeutic Goods Administration [TGA], as did Nicorette and other quit aids. We would very much encourage them to do that.

The Hon. Dr PETER PHELPS: Provided you can find a GP in country New South Wales who is prepared to bulk bill. Otherwise, the $25 gap—

Dr CHANT: The issue I am referring to is that the companies can put up to register the product as a quit aid. The route for that is going through the Therapeutic Goods Administration.

The Hon. Dr PETER PHELPS: Which the TGA has rejected.

The CHAIR: Sorry to cut you off, but I think we have explored that pretty thoroughly.

Dr MEHREEN FARUQI: Dr Phelps has asked some of my questions so I will move on. I want to dwell a little on the harm minimisation approach. You said that NSW Health's approach is about harm minimisation. I just wonder whether NSW Health has looked at, or assessed, approaches such as pill testing or decriminalisation of personal use as harm minimisation approaches. What has been the outcome of that investigation, if there has been one?

Dr CHANT: From time to time we obviously keep abreast of the international evidence in relation to pill testing. At this point in time I would have to refer to the latest briefing I have on it. It is probably better to provide that to you. From my recollection—this is a very dangerous thing to do—I am not sure that there was clear-cut evidence for the effectiveness of it. Clearly, evidence is generated all the time and we keep a very open mind and look out for emerging evidence.

Dr MEHREEN FARUQI: There was a bit of a discussion through Dr Phelps's questions about the Drug and Alcohol Service Planning, and why NSW Health is not using it. I am still unclear about the reason so I just want to clarify. Is it because that approach does not allow for the flexibility and the localisation aspect that you were talking about? Has any other State trialled that approach or looked at that approach?

Dr CHANT: It is for that reason. Also, there are particular opportunities that come from time to time. For instance, when the Commonwealth decides to fund psychology, I then fund chronic disease plans. Then the way in which your model of care might need to adjust to a sustainable funding model is different. So we need some flexibility depending on what arrangements are in place for funding services, what primary care is focusing on and what is accepted within primary care. Sometimes we can change what primary care is capable of managing—through perhaps telemedicine support or mentoring, or through better training and education. So the static determination of a particular prescriptive workforce's numbers has to be continually reflected on. It is a good starting point but then as the environment—the funding environment or the workforce environment—or technology changes, as there are new ways to deliver services, or as the evidence changes, we need to embrace and move with those changes.

Dr MEHREEN FARUQI: Do you know how many private rehabilitation or detox operators there are in New South Wales?

Dr CHANT: We could attempt to answer that question if the Committee would find that useful.

Dr MEHREEN FARUQI: Yes, sure. I am just concerned that there does not seem to be any accreditation requirement for service providers for rehabilitation and detox, other than the ones who receive government funding. How does NSW Health know that what it is doing is best practice if you do not even know how many there are, for instance?

Professor BATEY: It is a very important question, but I am not in a position to answer all of it. Certainly a lot of the public service is linked to the private detox units because they are available and they provide services, and one is aware of the qualifications of those who are running these services. There is not one in New South Wales in which you would say that there are no professionally trained people there. It is an area where I think there could be more work done. We need to find the data.

Dr MEHREEN FARUQI: If you could take that on notice that would be really great.

Dr CHANT: Certainly.

Dr MEHREEN FARUQI: Also, the Royal Australian and New Zealand College of Psychiatrists notes that in New South Wales there are very few designated detox units in the public system, in either rural or metropolitan areas, and that most have been closed down, resulting in detox management mainly taking place in medical wards. Could you provide some comment on that, if that is the case. Why has that happened?

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

Dr CHANT: Would you also like to comment on the fact that detoxification can probably happen in a variety of settings?

Professor BATEY: Not having public beds means that people are more often realising that home detoxification for the majority of patients is safe, effective and cheaper.

Dr MEHREEN FARUQI: In reference to funding, the Committee has heard from a number of non-government organisations, both big and small, and also from those that specifically provide services for Aboriginal people. The smaller organisations raised the issue of it being very onerous to prepare tenders for funding. The big organisations have also suggested that the way the applications are framed is very prescriptive. They would like the funding providers to look at that. The Aboriginal services even suggested that there should probably be a separate pool of funding for smaller Aboriginal services. I would like your view on that.

Dr CHANT: NSW Health provides funding to the Aboriginal Health and Medical Research Council of NSW. We have been in discussions with the council, but part of the core funding we provide is what we would call "capacity building" in the sector. NSW Health and also the Commonwealth have moved to a contestable process. The peak would be well positioned to support its service members with that. We are always happy to provide epidemiological data or any other assistance we can about the prevalence or use of admission data to support any of the submissions, both at a State or Commonwealth level, or even to other government agencies. That is where the expertise of a peak—which could have critical masses of people who could support submissions—could be a very useful initiative.

Dr MEHREEN FARUQI: Were Aboriginal people identified as a priority population in 2016-17 or 2017-18 funding?

Dr CHANT: Aboriginal people are a priority population for many things because of the disparity or the higher prevalence of burden of disease. It is pleasing to note that about 15 per cent of the activity in the drug and alcohol services we run is attributed to Aboriginal people. Aboriginal people are a priority population in our plans. In terms of the specific initiatives and the $75 million package—

Mr MADEDDU: The answer is yes. For each of those funding streams Aboriginal people were a priority population.

Dr MEHREEN FARUQI: Then why do you think the NSW Aboriginal Residential Rehabilitation Healing Drug and Alcohol Network [NARHDAN] and the Aboriginal Health and Medical Research Council have stated in their submission that the funding that has been released to the non-government organisation sector in 2016-17 had little or no impact on Aboriginal residential rehabilitation services or Aboriginal communities in New South Wales?

Mr MADEDDU: Part of the dynamic is that the funding is being rolled out right here and right now. Those services are being funded now; the ink is literally still wet on the contracts. They are all going into service during this financial year.

Dr MEHREEN FARUQI: So 2016-17 funding is now being—

Mr MADEDDU: Yes.

Dr MEHREEN FARUQI: Why the delay?

Mr MADEDDU: There is no delay because $75 million is a lot of money to get out the door. When you are accountable for public funds and services being provided to incredibly vulnerable members of the population, you want to ensure it is targeted well.

Dr MEHREEN FARUQI: It is also urgent—

Dr CHANT: To reframe that, there has been some sequential rollout of the money every year. The first rollout programs dealt with substance use in pregnancy, and a number of innovation research projects have been funded. We can provide a list and a time frame for the money rolled out. It is sequential. NSW Health does fund Aboriginal community controlled organisations, and we see them as an important component of the service system. We provide core funding, but a large proportion of the money that goes to the primary care sector is sourced from the Commonwealth Government.

The Hon. COURTNEY HOUSSOS: I refer to the question of demand. The Committee has received a number of submissions and evidence this morning about the increasing rate of methamphetamine use and abuse in rural, remote and regional New South Wales. Page 2 of the New South Wales Government submission states that the rate of methamphetamine use has declined significantly in the past 12 months. On page 5, it talks about the stabilisation of rates of presentation at emergency departments. This morning the Committee heard that 99 per cent of the people who appear in the Drug Court are there as a result of methamphetamine abuse, that more than 50 per cent of the residential care providers were dealing with methamphetamine abuse, and that four funerals a week were being held in some parts of the State because of methamphetamine abuse. Is it the New South Wales Government's position that methamphetamine abuse is declining or is stabilised?

Dr CHANT: To put this in context, we regularly review all our data. For drugs and alcohol you need to look at multiple sources of data. We had a methamphetamine panel on 1 March. We drew together academics, consumers—NSW Users and AIDS Association [NUAA] and the Aboriginal Health & Medical Research Council [AH&MRC] were there—and other government agencies such as the Department of Justice and the NSW Police. They brought together all the different data sources, including our population health survey and national survey data. We now have a report and, as I indicated in my opening statement, we are happy to make that available to the Committee. We are reflecting on some minor feedback from the 1 March meeting. Dr Cretikos can talk to the conclusions from that meeting.

Dr CRETIKOS: It is important to understand that when we talk about overall community use we are talking about a decline in the overall population according to the national survey that has specific information about New South Wales use. However, there is most likely a small group of people who are using. The position as a whole has declined according to the national surveys that have specific information about New South Wales use, but there is most likely a small group of people who are using methamphetamines in more risky ways. That means injecting, using it in a higher purity crystal form, and using it more frequently.

We have seen an increase in the harms associated with methamphetamine use since about 2010 in New South Wales. That is very clear in our data. Since 2010 until 2016, there has been a rapid increase in the harms associated with methamphetamine use. We believe that is now stabilising; in fact, across four of our indicators we have seen a reduction since a peak in about 2016. We now have data until 2017 showing that.

The Hon. COURTNEY HOUSSOS: The Bureau of Crime Statistics and Research [BOCSAR] has said that there has been an increase in police-reported incidents of possession and use in each quarter since June 2010.

Dr CRETIKOS: I will refer to the BOCSAR report.

The Hon. COURTNEY HOUSSOS: I am referring to the submission from Legal Aid NSW.

Dr CRETIKOS: For the period 2016-17 for New South Wales, there was a reduction from 2015-16 in arrests for possession and use of methamphetamines. For arrests for dealing or trafficking methamphetamines, there was a reduction from 2015-16 to 2016-17.

The Hon. Dr PETER PHELPS: It is true to say that that is the first year and that for 2014-15, 2013-14, 2012-13, 2011-12, 2010-11 and 2009-10, there has been a consistent upward trend for methamphetamine use in this State. This was simply the first year. It may be a long-term decline or it may be a blip in the trend upwards.

Dr CHANT: That is right, and we are always very cautious about that. However, as I said, we routinely look at all of the data sources and pull together a report. I am happy to make this available to the Committee. We simply need to incorporate a few comments from the group to finalise this report. We will make it available to the Committee, and we will put it on our website.

The Hon. COURTNEY HOUSSOS: You noted in your submission that there is a review into involuntary treatment and evaluation. When are you expecting that to be completed?

Mr MADEDDU: It is due in another two years.

The Hon. COURTNEY HOUSSOS: That is well outside our reporting period.

Dr CHANT: To explain, we need to have sufficient numbers through it and to follow them up for a significant period to understand what is happening. It is good that we have that in place.

The CHAIR: I think most of us hope to be around in two years.

Dr MEHREEN FARUQI: Not me!

The Hon. BRONNIE TAYLOR: Ms Faruqi is off to the Senate.

The Hon. COURTNEY HOUSSOS: You indicated that the Hunter New England Local Health District has more than 10 per cent of its staff identifying as Aboriginal. You can answer this question on notice. What programs and other things are in place for that to be such a high number?

Dr CHANT: We will answer that on notice.

The Hon. COURTNEY HOUSSOS: Is there any planning for the expansion of the Magistrates Early Referral Into Treatment [MERIT] program, which I understand is not a NSW Health program?

Dr CHANT: MERIT is a NSW Health program. It is a shared program. It intersects with the Justice portfolio but we provide the treatment aspects to it. I can provide an update to you on our considerations in relation to MERIT. We are very positive about that program.

The Hon. COURTNEY HOUSSOS: Are there any requirements for cultural awareness in current government tenders, particularly if facilities will be providing services for Aboriginal and Torres Strait Islander people?

Mr MADEDDU: Yes. Part of the criteria has been to demonstrate an organisation's cultural capacity or its cultural competency and to do it at an organisational level as well as the policy and procedures level.

The Hon. COURTNEY HOUSSOS: The Royal Australasian College of Physicians said that they do not want to see the merging of mental health and alcohol and drug services as has happened but that the two can play an important role in supporting each other. Have you done any mapping of mental health nurses and where they are attached to local courts? Is that your responsibility?

Dr CHANT: As I said, we would be happy to take that on notice. Clearly, we are interested in the outcomes of the patients. Whilst administrative accountability from drug and alcohol has been split within the

ministry, we understand and recognise that there needs to be close collaboration and the models of care often need to have both participating. We also think that many psychiatrists are dual trained or have had drug and alcohol training, so we think that it is very important for us to consider that. We are happy to take that on notice.

The Hon. COURTNEY HOUSSOS: I have been told that it is a very valuable service but it is not provided everywhere. I would be interested to know where it is being provided and anywhere that you are planning on rolling it out as well. Thank you.

The Hon. Dr PETER PHELPS: We heard earlier evidence from Legal Aid about the price of methamphetamine. Basically, you can get two hits of meth for the cost of a slab. Have you done any research as to product substitution by people who have moved away from alcohol because of dissuasively high taxes that have increased the cost of alcohol? Or has there been a consistency of alcohol abuse through this period? Are you aware of any research in that regard?

Dr CHANT: We monitor alcohol use and I am happy again to provide the updated data for 2017 on what our Population Health Survey is saying about that. We also manage alcohol admissions. I am not familiar with any research but we are happy to reach out to our academic partners.

The Hon. Dr PETER PHELPS: My concern is that an unintended consequence of increasing the tax on alcohol as a dissuasive measure against its use has been product substitution into alternative areas of readily available drugs, in which case methamphetamine, being the most readily available, has taken up the slack.

Dr CRETIKOS: I think the national survey that has the New South Wales component which shows the significant reduction from 2010 to 2013 to 2016 in general community use of methamphetamine would probably argue that a switch from alcohol to methamphetamine is not a broad community impact.

Mr MADEDDU: Alcohol rates have remained stable roughly during that time.

Dr CRETIKOS: We can provide the updated data.

Mr MADEDDU: We understand that rather than switching one for another people tend to use both.

The CHAIR: Thank you for making your time available. I know you are all busy. Your evidence has been helpful and insightful. Some questions have been taken on notice and some additional questions might arise from your evidence. The Committee has determined that there be a 21-day turnaround time for answers to those questions. The secretariat will liaise with you about that.

(The witnesses withdrew)

(The Committee adjourned at 4.03 p.m.)