

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

At Nowra on Thursday 5 April 2018

The Committee met at 10:45 am

PRESENT

The Hon. Greg Donnelly (Chair)

The Hon. Wes Fang

Dr Mehreen Faruqi

The Hon. Paul Green

The Hon. Courtney Houssos

Mr Scot MacDonald

The Hon. Dr Peter Phelps

The CHAIR: I welcome everybody to the second 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 aspects including the types of services available as well as funding, cost and accessibility. The inquiry will also consider whether there are any gaps or shortages in the provision of services and/or specifically the services that are available for the treatment of ice addiction.

Before I commence I acknowledge the people from the Yuin nation who are the custodians of the land. I also pay respects to elders past and present and extend that respect to any Indigenous people who may join us here today—welcome. Today is the first regional hearing for this inquiry. As it has a strong regional focus, the Committee will conduct a further five hearings in regional areas during April, May and June. Today we will be hearing from the local health district drug and alcohol service and two Aboriginal rehabilitation services.

Before we commence I will make some brief comments about the procedures for today's hearing. Today's hearing is open to the public. A 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 who may join us may film or record Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that 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, so I urge witnesses to be careful about any comments they may make to the media or to others after they complete their evidence today as such comments would not be protected by parliamentary privilege if another person decides to take an action for defamation. The guidelines for the broadcast of proceedings are available from the Committee secretariat.

There may be some questions that witnesses would be able to answer only if they had more time or certain documents to 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 the Committee members through the Committee staff. To aid the audibility of the hearing, I remind both Committee members and witnesses to speak into the microphones. In addition, several seats at the back of the gallery have been reserved near a loudspeaker or at least where people should be able to hear for those in the public gallery who may have hearing difficulties. Finally, I ask that everyone turn their mobile phones to silent for the duration of the hearing.

MARGOT MAINS, Chief Executive, Illawarra and Shoalhaven Local Health District Drug and Alcohol Service, sworn and examined

DAVID REID, Director, Drug and Alcohol Service, NSW Health, sworn and examined

The CHAIR: I welcome our first witnesses. I will invite either or both of you to make an opening statement, but I confirm that we have the submission from the New South Wales Government which is a whole-of-government response, which you would no doubt be aware of. That is marked submission No. 34. Take that as read, so there is no need to go into that submission in detail in your opening statement. Once you have completed your statement, if you are happy with this arrangement, members of the Committee will ask you questions. Is that okay?

Ms MAINS: Thank you.

The CHAIR: Ms Mains, we will commence with your opening statement.

Ms MAINS: We would like to thank you for the opportunity to appear before you today and acknowledge the important work of this Committee in seeking to improve the treatment of people in our community who struggle with alcohol and drug issues. Illawarra and Shoalhaven Local Health District has a population of just over 400,000, of which 13,000 residents identify as Aboriginal or Torres Strait Islanders. Just over 18 per cent of our population were born overseas and on average we have more than six million tourists visit this district annually. We have eight hospitals and 45 community based service sites.

As an organisation, Illawarra and Shoalhaven Local Health District has a strong commitment to addressing drug and alcohol problems both in individuals and in families. We provide a broad range of drug and alcohol services across this district. These include counselling and group work for adults and young people, outpatient and inpatient withdrawal management or detoxification, Magistrates Early Referral Into Treatment [MERIT] court diversion scheme service, the stimulant treatment program, substance use in pregnancy and parenting program, opioid substance substitution treatment services, and then our whole-of-family health team services.

Across the district drug and alcohol service in 2017, 30 per cent of our people sought help for their alcohol use, 24.7 per cent for amphetamines including meth, 20 per cent for cannabis and 8 per cent for heroin. We provide a needle and syringe program that distributes over 600 needles per year. The vast majority of people who present with drug and alcohol problems can be managed in the community whilst they undergo treatment. We believe that drug and alcohol issues can be addressed only in partnership with our community and key agencies. Those agencies include the Commonwealth and State partnerships and, of course, now importantly our primary health network. We work with our primary health network to upskill local general practitioners [GPs] around these scheduled changes to coding and the use of pharmacotherapies for the treatment of substance use. We are also very much intricately involved with other stakeholders like the Kirby Institute in the provision of hepatitis C treatments for the injecting drug population.

As a district we have piloted an innovative partnership with a non-government organisation [NGO], Watershed, which is a drug and alcohol residential rehabilitation service. We have purchased three beds in the service where clients can be detoxed in a low-risk residential care setting and will be monitored on a daily basis by our district nursing staff. This enables us to provide a seamless pathway for clients moving from public to non-government organisation services. Our service has also established one of the first needle and syringe secondary outlets in the South Coast Aboriginal Medical Services, which is an example of working under a harm reduction model that seeks to minimise the physical, social, psychological and legal harms that individuals may experience. There is of course a critical role for law enforcement around supply reduction and for community education and training focused on demand reduction. Drug and alcohol issues affect everybody and the solutions need to be made in consultation and partnership with our broader community. Thank you for the opportunity to make an opening statement.

The CHAIR: Thank you. Mr Reid, do you have anything to add to that?

Mr REID: No.

The CHAIR: The members of the Committee present today are the Hon. Wes Fang representing The Nationals; Mr Scot MacDonald and the Hon. Dr Peter Phelps from the Liberal Party; I am Greg Donnelly, the Chair, from the Labor Party; the Hon. Paul Green is from the Christian Democratic Party; the Hon. Courtney Houssos is from the Labor Party; and Dr Mehreen Faruqi is from The Greens, so there is a broad cross-section of representatives from the Parliament here today. We will start with questions from the Hon. Paul Green.

The Hon. PAUL GREEN: Ms Mains, you mentioned in your opening statement the three beds. Could you provide a snapshot of how many people are on the waiting list? First of all, to be fair, is there a waiting list for those three beds and, if so, how big is the waiting list?

The Hon. Dr PETER PHELPS: I would like to add an addendum to that question. Given that Watershed is not appearing before the Committee today, will you give more details about Watershed and what it does?

Mr REID: Can I just clarify whether they are not appearing? I understood that they were.

The CHAIR: They were. They are a late scratching.

Mr REID: Watershed is a non-government residential rehabilitation service that is situated in Berkeley, which is in this district. It has a State remit so it sees people both locally and from across the State. In our district we have what we regard as a very innovative model to address the issue of withdrawal management or detox for those people who cannot withdraw at home because their home life is unstable. They are able to go into a residential rehabilitation like Watershed where there is a bed available. We manage the entry into that bed. So they come to our service, they see our doctors and nurses, they get assessed as being suitable and they go into Watershed for what is usually about a 10-day detox program. Our nurses will then go in every day and monitor them and so provide the sorts of expertise that a non-government rehabilitation service generally would not be able to afford to provide.

At the end of that 10 days a number of things could happen. In some circumstances people will stay on and do a rehab program in the facility that they are in, and that is for about another month or six weeks, depending on the program. They may come back to our service as an outpatient and be followed up by our service or they may be discharged home. In regard to waiting lists, generally there is about a five to seven day waiting list. We manage those. It often depends on the complexity of the detoxification. Sometimes that detox may be less than 10 days and sometimes it might be more. So it really is an individual assessment but generally there is not a long waiting list to get into that service.

The Hon. PAUL GREEN: Watershed was going to give evidence today. I am led to believe that Watershed had an annex either here or at Wollongong?

Mr REID: I believe they are just in Wollongong, yes. They have an outpatient facility.

The Hon. PAUL GREEN: Here?

Mr REID: No, in another part of Wollongong in the Illawarra. So they have an outpatient service but their residential service and their outpatient service are both based in the Illawarra.

The Hon. PAUL GREEN: If people from the Shoalhaven want to enter those services they have to go to Wollongong?

Mr REID: They have to go up there. Again we have a public drug and alcohol service in Nowra and we are the gateway for those beds.

The Hon. PAUL GREEN: Will you provide the Committee with a snapshot of how many detox beds are available in Nowra for drug addiction or addictions of that kind?

Mr REID: I guess the important thing to say is how we manage detox. Could I just explain it?

The Hon. PAUL GREEN: I hear what you are saying but my question is: How many beds are available for detox in the Shoalhaven area? I am happy for you to go through other processes but I have other questions about distance and affordability, and whether parents and families are able to access that care.

Mr REID: I understand. Let me put it into context for you and answer your question. That model of detox does not mean that everybody has to go into an inpatient setting or into a residential setting. We provide a very comprehensive outpatient withdrawal management service which provides for the bulk of our clients. Most of our clients would be seen in an outpatient service. Certainly in the Shoalhaven, here in Nowra, we provide an outpatient service with doctors, nurses, daily support, medication and all the things that go with that. There is a strong withdrawal management detox focus here in Nowra.

The way that detox works in our model is that we have an outpatient service and we have residential beds that I have just mentioned in Watershed for those people that are low risk. In other words, if you have a medical complication in your withdrawal, going into a residential rehabilitation is not the option for you. If you fit that model where you have a low risk but you have a bad home life, you can go into that model. If you have medical complications then we put you into hospital. Basically, in answering your question, there is an

opportunity for people who meet the criteria to be detoxed in the local hospital but currently no residential beds provide a detox facility for low risk people in this area. It is an hour up the road.

The Hon. PAUL GREEN: Given that the Shoalhaven has no services to deal with acute detox issues, you say that people go to the local hospital. Are you able to provide the Committee with statistics over the past few years of how many beds were occupied by people undergoing acute detox in our local hospital?

Ms MAINS: We have the figures with us about the admissions to Shoalhaven District Hospital and Wollongong for methamphetamine use per 1,000 general admissions, but we would have to take that on notice to provide the rest.

The Hon. PAUL GREEN: It would be helpful to the Committee if you could break down those statistics. This Committee is conducting regional hearings; it is not focusing on Newcastle, Sydney or Wollongong. The Committee wants to know what is available in regional, rural and remote areas. How accessible are those services and what can be done to provide better drug rehabilitation services. It is good to focus on Sydney but we want to know what the Shoalhaven needs.

Mr REID: It is important to stress that the population of people who need to go into a public hospital to detox is a small group. As I have said—and we will find those figures for you—I do not think it will be a large number. In reality most people can either be detoxed at home or they need to go to a low-risk residential setting. The question then is: Where is the residential setting where that will be provided.

The Hon. PAUL GREEN: The Committee is aware that many regional centres in New South Wales are facing an ice epidemic. What happens when there is an acute ice epidemic and the police pick up people who are off their faces after using that drug? How does the system deal with those people?

Mr REID: At the moment they would probably be taken to the public hospital and be assessed. Again we have figures that in the past year about three people in 1,000 general admissions—just to give you a sense of the ratio of people—would have presented to Shoalhaven District Hospital with an acute methamphetamine toxicity. Those people would then be assessed by staff. Generally they would be given some sort of symptomatic medication, depending on whether or not they were psychotic. If they were psychotic obviously they would be treated in the normal way that patients would be treated when they go into hospital in psychosis. We have what we call a consultation liaison service which involves nurses going into the hospital to assess and monitor those people and link them back into services. Some of them may be referred into a detox service like Watershed and some of them would be managed at home, depending on their acute symptoms. If somebody is in psychosis they would be very unwell and they would be managed in the hospital.

The Hon. PAUL GREEN: I am referring to acute psychotic episodes for people on ice. It has been shown throughout the regions that those patients or clients need a swag of people around them—two to five policemen and probably a few nurses. What sorts of resources are needed for acute psychotic episodes in a local hospital, given that regional hospitals are already understaffed and struggling and that those areas are normally underpoliced?

Mr REID: They are huge. It is often a terrible situation when somebody comes in with acute psychosis. It takes up a large amount of resources. It takes up police resources and it takes up hospital staff resources. You will not get any argument from us that this is not something that is a scourge on our community. We see these things, and frontline emergency department [ED] staff do see these things. From our perspective we would not use the term "epidemic". I think we need to look at the statistics around ice use and methamphetamine use, and see that it is a serious problem in our community. I agree that there are probably pockets around New South Wales and the rest of the country where it is a far greater problem for the community. It is really impacting the social fabric of those communities. It takes up a lot of resources. In those instances where they turn up it requires a number of staff and a number of police officers.

The Hon. PAUL GREEN: That is what I want to finish on, if I can.

Ms MAINS: I have often been down to ED at those times. The intensity of the resourcing depends on how the person has presented and where they are at. That can be truly significant and have a very significant impact on emergency departments.

The Hon. PAUL GREEN: That is fair enough. Every case is individual, but when it is acutely psychotic—

Ms MAINS: It is intense.

The Hon. PAUL GREEN: —the worst of what we see in an ice situation, that demands a lot of resources. My question is: Should we be looking at presenting, in regional and rural areas, a different scenario—

that the local hospital just does not have the resources, all the time, to cope with that? Should we be resourcing regional and remote areas differently to deal with that, rather than using the hospital and the police in every situation? Is there another way to do that, rather than draining an already strained system across regional areas?

Mr REID: I have to say that I have not given that much thought. I could not answer that.

Ms MAINS: We would need to take that away.

The Hon. COURTNEY HOUSSOS: Thank you for your opening statements and for appearing this morning. I wanted to come back to some of the things that you said in your opening statement. You have eight public hospitals and 45 community health centres. Across that entire network you have three public beds for detoxification—is that correct?

Ms MAINS: That is what I was referring to when I spoke about the partnership arrangement we have. We also do see a number of people in our hospitals. Mr Reid referred to it recently. We have three admissions per thousand at Wollongong and 2.2 admissions per thousand at Shoalhaven. So we also see a number of these people within our own hospitals.

The Hon. COURTNEY HOUSSOS: Do you have dedicated bed for those, or is it on an as-need basis?

Mr REID: No, we do not. I think you would understand that it is very difficult to have a dedicated bed in a public hospital. With the demand in public hospitals these days you cannot have a bed sitting there like that. I will just labour the point about how withdrawal management works. It is a continuum. Person A may be able to be managed at home. Person B may need to go somewhere else—a residential unit. Person C may need to go into a hospital. All of those are available and are provided.

The Hon. COURTNEY HOUSSOS: But in regard to the actual beds for the person who needs residential detoxification there are just the three beds in Wollongong and across the Illawarra-Shoalhaven?

Mr REID: No, the three beds are in a non-government residential rehabilitation. That is for low-risk people. If somebody needs to go into hospital then they are admitted into hospital.

The Hon. COURTNEY HOUSSOS: I think your words were, "There is a very low proportion of the population who have such high medical risk that they need to go into a public hospital for detoxification."

Mr REID: Correct.

The Hon. COURTNEY HOUSSOS: If someone is going into residential detoxification—not a public hospital—there are only those three public beds that are available across your network.

Ms MAINS: Nowra also has an Aboriginal men's residential rehabilitation service at Oolong House—

The Hon. COURTNEY HOUSSOS: Yes, we are hearing from them later.

Ms MAINS: —which will present later about their views around women and children residential services and the need for that in this area. That is something that they will be talking to.

Mr REID: Yes. And to answer your question, there are the three beds.

The Hon. COURTNEY HOUSSOS: Okay.

Mr REID: However, I think it is probably fair to say that, in my experience as a clinician over the years, communities generally would like to see a detox close to where they are. There is a desire to have a local detox, where people do not have to travel. Keep in mind that most people we see are outpatients. When you look at how many beds you need—and that they need to be occupied 24 hours a day, seven days a week—you see that that generally works pretty well.

The Hon. COURTNEY HOUSSOS: My next question is: How do you get onto that waiting list? You said that there is a five- to seven-day wait. How do you get onto that list?

Mr REID: People are assessed at our service. When you come into our service you have a comprehensive assessment. You see a doctor and a nurse. If you are suitable you will be referred to the Watershed beds. Essentially, we manage that list. People are triaged depending on particular issues. It is done by us, basically; we organise who gets there and who does not.

The Hon. COURTNEY HOUSSOS: How many people are on that list, as of 11 o'clock this morning? I am happy for you to take that on notice.

Mr REID: There may be two people.

The Hon. COURTNEY HOUSSOS: So it is a relatively small number.

Mr REID: It is very small. As I said, within five to seven days of being assessed and getting in, that is probably the time it takes for people to get their affairs in order and to organise payment and look at the options for the residential rehab.

The Hon. COURTNEY HOUSSOS: Sorry, when you say "organise payment" do you mean that these are not public beds?

Mr REID: Sorry, I will clarify that. There is no payment for coming into those, but if they are going to stay and do a rehab following, then they are required to have their benefit—I cannot tell you for sure but I think it is a sickness benefit or some sort of benefit through Centrelink—sorted. I should clarify. I am not sure we would call these beds public beds; they are beds in an NGO, but we purchase them.

The Hon. COURTNEY HOUSSOS: I appreciate that you said that this is an innovative solution. You have purchased those beds and provided the nursing staff that come in, which is additional to what may perhaps be in other residential facilities. Is this something that was pioneered within your particular health service? Do you know if that is occurring within any other local area health services?

Mr REID: I do not believe it has. I think the answer is that, yes, it was something that we pioneered. That has partly come about because we have had a close relationship with the NGOs. For many years we have often sat on various committees together and did planning together. So this was something that came out of that.

The Hon. COURTNEY HOUSSOS: I have one final question. The public component of those beds is just for the 10 days of detoxification or whatever period.

Mr REID: Correct.

Ms MAINS: Correct.

The Hon. COURTNEY HOUSSOS: If you want to stay on and do a residential rehabilitation—spend a longer period—is that a separate waiting list?

Mr REID: For the rehab service?

The Hon. COURTNEY HOUSSOS: Or is it one?

Mr REID: No, it is a separate waiting list.

Ms MAINS: Separate.

Mr REID: The beds are physical beds. So when you finish your 10 days you get out of that bed and, depending on whether the rehab has bed availability, you can stay if that is what has been decided.

The Hon. COURTNEY HOUSSOS: In your experience—because we are not going to hear from Watershed this afternoon—is there usually a bed available within the rehab service if someone is exiting the detoxification bed?

Mr REID: I believe that to be the case, although I would put a caveat on that—it really depends on the particular circumstances of the people who are there at the time. There can be a wait to get into a residential bed. There can be a wait, sometimes, of up to four weeks. Generally, I believe the program runs for four weeks as a residential program but there are circumstances where people are there longer. I cannot answer that exactly; it is not really a question that we can answer.

The Hon. COURTNEY HOUSSOS: But you concede that there can be a significant wait between detoxification and being able to access rehabilitation services.

Mr REID: There could be a wait; yes.

Dr MEHREEN FARUQI: Thank you for coming in this morning to provide evidence. I will start with a broad question, given that you have so much experience in this area in providing these services. What do you think are the three biggest challenges faced in this area, with regard to the provision of drug rehabilitation services? What would you need to overcome those challenges?

Mr REID: I think the ones that come to mind, when we are thinking about an area like the Shoalhaven especially, are around workforce. We have been very fortunate to have been funded for some very important and critical programs in this area. I mentioned the Stimulant Treatment Program, which was the New South Wales Government's response to the methamphetamine issue; we were one of four districts around the State who were funded for one. We have also been funded for a Whole Family Team, which is a program that we run in conjunction with Family and Community Services, looking at at-risk families. I guess it is a challenge at times

to be able to recruit experienced drug and alcohol clinicians, and by that I mean nurses, psychologists and, especially at times, specialist doctors.

Drug and alcohol medicine, in about the year 2000 the field of addiction medicine came under the College of General Practitioners; so addiction medicine is now a sub-specialty of the College of General Practitioners. It is a very small workforce in New South Wales and Australia, so finding properly qualified specialists to be able to come down and work down here is a real challenge. Employing Aboriginal staff is also a challenge in our area. Shoalhaven does have a higher than proportional Aboriginal population than other parts of New South Wales and we really would see the benefit of being able to see Aboriginal nurses—an Aboriginal base, I guess, for clients who come into the service and can see a psychologist or a nurse or a doctor. So that is an issue.

I guess the third thing I would say is that I think methamphetamine is a challenge and we do not shy away from the fact that alcohol is still the major issue that we see. Cannabis used to be the second, and probably heroin and then amphetamines. I think we now see that alcohol is the major problem, but amphetamines is fast approaching it in terms of an issue.

The CHAIR: Sorry to interrupt. When you say it is fast approaching, are you suggesting it is going to move up towards alcohol or skip the next two after alcohol?

Mr REID: It is now alcohol and methamphetamine. About 30 per cent of people we see is alcohol and about 24.5 per cent of people that we see have methamphetamine. There is about 20 per cent cannabis and about 8 per cent heroin, and the rest of it is sort of prescribed opioid drugs. That is a challenge, I think, to us in working in this area. Whilst those numbers are not huge there are a lot of social dislocation issues that happen around methamphetamine in the community and it is an issue of a concern.

Dr MEHREEN FARUQI: Going back to the staffing issue, there are a number of issues. In regional areas it is hard to find staff. I think what you said was that there are just not enough staff properly qualified with the qualifications that you need. What can be done at that end to change things?

Mr REID: That is a very interesting question because we have worked with universities in the past; we certainly take students from universities. We have medical students from Wollongong university who rotate through our services; we have students from other universities. I think that has been the most powerful issue in terms of having an influence on whether people stay in a field—they get exposed to working within drug and alcohol. We have a transition to practice nursing position, which is essentially a position that a new graduate will come into for six months, and we have been able to recruit a number of those following their exposure with us.

I do not feel like drug and alcohol is one of those areas that young people sitting around a sandpit think that they will do when they get older. But it is one of those areas that once you get exposed to it and work in it, it can be very satisfying and very rewarding. We find that the bulk of our staff have been here for a long time; they are very dedicated to the field.

Dr MEHREEN FARUQI: What percentage of your staff identify as Aboriginal or Torres Strait Islander people?

Mr REID: 2.5 per cent.

Dr MEHREEN FARUQI: And how many would that translate into?

Mr REID: That means two. We have a drug and alcohol worker in the Illawarra and one in the Shoalhaven, whose positions are essentially to provide a bridge between the local communities and our public health services. We have had more staff in the past but that is the way it is at the moment.

Dr MEHREEN FARUQI: Ms Mains, you mentioned minimisation in your opening statement. In your experience, do you think that the criminalised nature of drug use in Australia means that people do not come forward and are less likely to come forward for rehab in detox services?

Ms MAINS: I am going to ask Mr Reid, who works with this every day, to respond to that. He is the person who understands this in much more depth.

Mr REID: I think there are issues around people's willingness to come forward. We certainly strive to provide a confidential and non-judgemental sort of service. We have clients who come to us via the court system—the Magistrates Early Referral Into Treatment [MERIT] program is a court diversion system. But I think there is generally a reluctance by some people to come forward and to present themselves to the service. I think the challenge for us is to provide a service that is very open and non-judgemental.

Ms MAINS: And I think that is the experience we have generally with health professionals, in declaring their own issues it is about creating a supportive environment to do it rather than feeling it is going to hamper them in any way, and appropriate supports around that.

Dr MEHREEN FARUQI: In regard to funding, what funding packages do the services that you are dealing with receive and is that enough? Is more funding required to improve services?

Mr REID: We have a really broad range of services that we provide in the Illawarra/Shoalhaven, and Ms Mains alluded to some of those earlier on. I do stress the point that drug and alcohol treatment really needs to be seen as a range of options and that residential is really just one part of the services that we provide around counselling and around specialist services towards young people and stimulant users and so forth—people on methadone programs or opioid treatment programs, as we call them. We have all of those sorts of services available down here; we have access to residential rehabilitation beds. So I believe we have the capacity and the tools to be able to do the jobs that we need to do.

The Hon. Dr PETER PHELPS: My first question to Ms Mains relates to what you said in your opening statement. Is there any evidence that legal enforcement leads to demand reduction in New South Wales?

Ms MAINS: I could not answer that directly.

Mr REID: Legal enforcements?

The Hon. Dr PETER PHELPS: Yes, legal enforcement of anti-drug laws leads to demand reduction.

Mr REID: I am not aware of that.

The Hon. Dr PETER PHELPS: In fact, it is probably arguable that it would only lead to substitution of one product for another.

Mr REID: I do not think you could say that around smoking, around nicotine. I have been working in this field for 20 years and the sort of work we were doing earlier on around changing nicotine laws and some research that has just come out this week showed that the Illawarra has the second-lowest smoking rates in New South Wales. I think there has been a lot of very important work done looking at that. I guess drink-driving laws are probably another example of that in terms of people's capacity to get in a car and drive.

The Hon. Dr PETER PHELPS: Going back to your earlier statements about detoxification, is there any evidence that detoxification without rehabilitation leads to abstinence amongst users later?

Mr REID: I do not have evidence for that at hand. I think there is evidence to say that any exposure to treatment services is a positive thing in the sense that being engaged in treatment services with drug use tends to be a process that happens, so it may not be your first or second attempt but the more exposure you have to treatment, the better outcomes you have.

The Hon. Dr PETER PHELPS: But if the only exposure you are having is to the, if you like, physical detoxification process without the life skills, without the ability to deal with the circumstances that led you to not merely use but abuse in the first place seems to be an exercise in futility, does it not?

Mr REID: I would not disagree. We certainly would not be encouraging that. Most people that would go into detox, following the detox they would then be engaged with counselling services, group services, if they are in an outpatient service. We certainly would not see detox as an end in itself.

The Hon. Dr PETER PHELPS: That leads to my next question, which is: Your preference for outpatient as opposed to residential rehabilitation services. For the outpatients, they simply return to the previous environment, whether it is bad and abusive relationships in their own family or a milieu within their community which accepts excessive use of drugs as a standard part of life. How is an outpatient service supposed to handle that effectively when the person, if you like, even if they see them once a day, for the remaining 23½ hours of the day they are in the same milieu that led them to drug abuse in the first place.

Mr REID: One part of the assessment process is to determine whether or not being an outpatient is going to have a chance of being successful. If somebody is from a very difficult background then sometimes there may be short-term residential required. It may be that somebody needs to look at other options of where they will stay during that period. But the same thing applies to leaving a residential after one month—generally you are still going to have to go back into the community. The idea is to provide people with the tools that they need to be able to address the issues in their life that have been leading to substance use. We know that is not a short-term problem; we know that is something that needs to continue. We know that the more supports you put

around people in the community the better the outcomes are, and that is really what our services aim to do. We certainly would not see that just putting somebody through a detox is an end in itself.

The Hon. Dr PETER PHELPS: You mentioned that the district as part of the harm minimisation program 600 needles per year—

Ms MAINS: It is 600,000.

The Hon. Dr PETER PHELPS: I thought 600 needles per year would tend to indicate there is not much of a problem that needs addressing. Thanks.

Mr SCOT MacDONALD: I have a question on the Magistrates Early Referral Into Treatment. Around 40 per cent do not complete. What is the pattern there? Who does not complete? Why do they not complete? Are there barriers?

Mr REID: Again that is a very interesting question. We have worked very hard on trying to improve completion rates in our Magistrates Early Referral Into Treatment program. You need to accept the fact that this is not necessarily a voluntary program. People are coming to the court, appearing before the court and then in some ways given a "choice"—in inverted commas. I guess a lot of people that come do not come with an attitude that that is what they really want to do. Part of our role is to work on motivating people around that process. The program is a 120-week program. We have improved our figures up to the mid to high 60s.

Mr SCOT MacDONALD: It is 62 or something.

Mr REID: That is right—62. That is the way it is across New South Wales at the moment, but there is work to be done to try to improve that.

Mr SCOT MacDONALD: The dividend is there, is it not? Reoffending is almost three times more likely to occur for non-completers.

Ms MAINS: That is correct.

Mr REID: It is correct.

Mr SCOT MacDONALD: That is a pretty big social dividend.

Mr REID: It is a very useful program.

Mr SCOT MacDONALD: Do the magistrates uniformly support it?

Mr REID: Certainly the magistrates down here do. In fact they are very supportive. If for any reason—because of illness or something—they are not able to provide the same level of service, we usually hear from the magistrates around that.

Mr SCOT MacDONALD: You see no barriers from government resourcing or area health resourcing—it is there.

Mr REID: Yes, it is there, as far as we know.

The CHAIR: Ms Mains, in your opening statement you provided an overview of the variety of drug and alcohol services provided in the Illawarra. If one takes the period of the 2016-17 financial year as a snapshot, can one get a complete picture of the meaning of what you have described in specific terms? In other words, with the local health district for that period—2016-17—can one create a document which provides a snapshot of what all of that means in terms of services delivered?

Mr REID: I could answer that.

The CHAIR: I am trying to grasp if you stand back and look at the fatality, bearing in mind the point you made with respect to the beds—that is an important component but only a part component of the overall services provided—what does the whole picture actually look like in terms of delivery of services?

Mr REID: If I use the expression "occasions of service", which basically means an activity that we would provide for a person, an individual might have half a dozen or 10 occasions of service. In 2017 we performed 50,600 occasions of service.

The CHAIR: Is this for the 2016-17 financial year?

Mr REID: This is the calendar year of 2017.

The CHAIR: What was that number again?

Mr REID: From 50,217 occasions of service.

The CHAIR: That is an individual—

Mr REID: That is about the amount of activity that we are providing as a service, if you take a step back and say that this is all the activity that the whole service provides.

The Hon. Dr PETER PHELPS: Among how many unique individuals?

Mr REID: That is a good question.

The Hon. Dr PETER PHELPS: You can take it on notice if you want to.

Mr REID: It is about 3,500, I think, but I—

The CHAIR: Could you take that on notice?

Mr REID: Yes. We see about 180 people across the district for opioid treatment, which is methadone heroin substitution programs. But all of that information is available in terms of a breakdown of what we see.

The CHAIR: In the Government's submission, which, as I said, is submission 34—I am not quite sure if you have in front of you or close to hand—on pages 3 and 4 it is not referring to actual deaths in table 1 but it has the various types of drug and alcohol categories. Does your data set break it down by the actual addiction?

Mr REID: It does. So, for example, in 2017, 29.9 per cent of people that we saw were for alcohol as their primary drug, 24.7 per cent were seen for methamphetamine as their primary drug—keeping in mind that a lot of people are poly drug using, so they are using a number of substances. So it is about 30 per cent for alcohol, almost 25 per cent for methamphetamine, 20 per cent for cannabis and about 8 per cent for heroin. The rest of it is really pharmacotherapies like Oxycontin or Fentanyl—all those sorts of drugs that people may get dependent on. Alcohol is still number one across the district but methamphetamine is now about 25 per cent.

The CHAIR: With respect to alcohol, we are doing an inquiry into—perhaps naively on my part—drugs, but of course the submissions that come in talk about alcohol and drugs. Every time we receive a submission it talks about alcohol and other drugs. It is the complete gamut; it is not just alcohol on one side and drugs on the other. Looking at alcohol specifically, with respect to what you have described in the programs available in the Illawarra, is there anything specifically for alcohol or is alcohol treated as part of "alcohol or other drugs" and dealt with under that umbrella?

Mr REID: Essentially we look at substances. The first thing we do when somebody comes in is a comprehensive assessment to see what substances they are using. For example, throughout my working life we have had people who are addicted to caffeine. They literally drink two litres of Coca-Cola, for example. People have problems with substances. As a result of that we do an assessment. We work with the individual really on where their substance use is. If alcohol is the substance we have a range of interventions now. We have some very good pharmacotherapy, some drugs, that we can give people to stop cravings, to help with blocking receptors around alcohol in the brain. There is a range of different interventions that we provide. I stress that that assessment process is really critical because that is the first point of a treatment pathway that may end in a residential rehabilitation, in a hospital or in a short-term counselling stint.

The CHAIR: You may need to take this question on notice because of the time. With respect to the efficacy of the drug and alcohol treatment programs in the Shoalhaven and the Illawarra, how are the outcomes assessed? There are the contacts that you have described that can be reduced because sometimes it is the same person coming back. How do you assess the efficacy and success of programs for those who are entering and leaving the program?

Mr REID: It is a little more complex in our field than it would be for other parts of Health. For example, if an orthopaedic surgeon fixes a patient's leg and he or she can walk again that is a good outcome. It is complex in drug and alcohol because addiction is a relapsing problem. However, we are very fixated on the issue that we need to have better outcome studies. The New South Wales Ministry at the moment is working with clinicians around an outcome tool. We need to be able to look not only at reducing someone's level of addiction but also at their level of social engagement—being able to get employment, their social interaction and those sorts of issues.

There are various tools around that people are using at the moment but I think the ministry is looking at a consistent tool across the district to be able to provide some tangible evidence of improvement as a result of treatment. If you ask clinicians I think they will say anecdotally that they know that people are improved because they see them getting back on with their lives. We know that methadone has had a lot of research around improvement and the capacity of people to go back to work. They are far less likely to be involved in crime to try to get money for heroin. There is a lot of research around those sorts of things. But I think in regard to counselling services we need to get that sort of outcome tool up and running.

The CHAIR: The evidence that you provided was very usual and will contribute to our inquiry. Thank you very much for attending. There will be some questions on notice that will be forwarded to you with a 21-day turnaround. The secretariat will liaise with you.

(The witnesses withdrew)

TANYA BLOXSOME, Acting Chief Executive Officer, Oolong Aboriginal Corporation, sworn and examined

IVERN ARDLER, former Chief Executive Officer, Oolong Aboriginal Corporation, sworn and examined

FAYE WORNER, Chief Executive Officer, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, affirmed and examined

LISA WELLINGTON, Senior Program and Client Service Manager, Waminda—South Coast Women's Health and Welfare Aboriginal Corporation, affirmed and examined

The CHAIR: Do you want to make an opening statement?

Ms BLOXSOME: Oolong House is officially known as the Oolong Aboriginal Corporation and most commonly known as Oolong House. Oolong House is a men's only residential rehabilitation service that covers statewide. We are the only Indigenous rehabilitation service from the South Coast down to the Victorian border. We conduct cultural programs in our organisation, cognitive behaviour therapy [CBT] groups and we have lots of traditional and culturally appropriate ways to help our clients. We have been established since 1981 in Nowra on the South Coast.

We recently—last year—won two business awards for this local area, for the work we do in the community. We have the only rehab, that I know of, that has participated in providing 10 years worth of data in conjunction with the Wollongong University. I have a copy of that here, for you to take with you. That started in 2008 and has run up until the present. We have a lot of evidence based information around drugs and alcohol and, particularly, the increase of ice, especially in our local area.

The CHAIR: Just pause there. There is a piece of research that has been done in conjunction with the university. Has that been done with the medical faculty at the university?

Ms BLOXSOME: The research section of the Wollongong University.

The CHAIR: Okay.

Ms BLOXSOME: That is obviously done independently.

The CHAIR: Is there a report there?

Ms BLOXSOME: Yes, there is a report that I would like you to keep. It is the only concrete piece of evidence that I know of that is in existence with regard to residential rehabilitation for such a long period of time.

The CHAIR: Will you be able to tender that report when you have finished referring to it?

Ms BLOXSOME: Certainly. We would love to do that.

The CHAIR: Are you able to give us a bit of an overview of what the report demonstrates?

Ms BLOXSOME: Certainly. Back in 2008, when we first started—

The CHAIR: Sorry, I have done the wrong thing. I am cutting into your opening statement and asking questions. I should let you finish your statement.

Ms BLOXSOME: Thank you. As Aboriginal people we take a lot of pride in working with Aboriginal men. There is a lot of stuff out there for women—a lot of help and that—but there is a not a great deal for men. We take a lot of pride in that. Our staff are very dedicated to delivering a program. Research has been done by the University of Sydney on positive outcomes of programs. Oolong House is the only rehabilitation service—not just Indigenous—within United States of America, Canada, Australia and New Zealand that has evidence based, peer reviewed documents produced. And that has been done here, on the South Coast—in the Shoalhaven, New South Wales. Our city here in the Shoalhaven needs to be very proud of the work that is done in this local area for Indigenous people.

The CHAIR: Mr Ardler, would you like to make a contribution to the opening statements, given your experience?

Mr ARDLER: First of all, with respect to the research, the evidence is gathered at the initial assessment. That information is then researched by the university. It gives us statistical information in relation to the percentage increases in alcohol or drug use. It is broken down, and it is very good information. To help you, because you are looking at research and analysis as well, the only evidence that was ever done in Shoalhaven

that I am aware of was by Tim Royal, who investigated the emergency beds at Shoalhaven Hospital, and did a report on the Indigenous intake in relation to that. That was it—that is all I know of.

I had run Oolong for 10 years. I had given presentations on what we call our "ice report" to the task force that was conducted in Queensland Health for the Commonwealth. My only involvement in that was giving them information, because the Commonwealth had no quantitative research or data at all, in the whole country. So I thought I did a good thing by sharing our local information to help the task force tackle this problem nationally—which was mainly coming from Tasmania. You probably all know about that now. That report is now available for you. It gives you information in relation to the Shoalhaven.

The other important factor in all of this is that the Hon. Paul Green mentioned his concern about detox. There is no detox in this area. Watershed is supported because it is a level 1 detox, and they have taken some of our clients from time to time, before they came into rehabilitation. We use the three Aboriginal medical services in our region to help transport clients to detox in Bathurst and the Gorman Unit in St Vincent's Hospital in Sydney, which would gladly share with you information about the number of Indigenous people who are getting into rehabs—whether it is the Glen Centre in Newcastle, Watershed or Kedesh House in Wollongong, Triple Care Farm in Wollongong and Oolong House in Nowra. I wanted to share that with you. There was a service an Indigenous service in Bega—Wandarma—which I have found out is now closed. That was working closely with us to refer clients from down there to detox and then into Oolong House. The average client intake is a year, and the waiting list is regularly 40.

The CHAIR: Sorry, what?

Mr ARDLER: Forty people waiting, all the time. We have a ratio—we take 70 per cent Commonwealth—Indigenous people—and 30 per cent non-Indigenous. Even though we are the only rehab around we have decided to cater for everybody in terms of men over 18.

The CHAIR: Thank you both very much.

Ms WORNER: Firstly, I would like to table a document for your information. It is something that we have done in conjunction, as well. It is the most recent application that we made to attempt to get an Aboriginal women's and children's rehab in the area, through NSW Health. I guess there are three documents within that one document. There is the submission that we put in, which was unsuccessful. There is also a business plan that came from a feasibility study that was done many years ago. I think it was produced in 2011, but we have been lobbying for a facility of this kind for many, many years in this area. So there is a feasibility study and business plan attached to that. There is also a rapid review, which was done quite recently by the primary health network here—COORDINARE.

The recommendation was that, they did not have it within their means—they are federally funded—to fund a rehab but could see the need. What they have done—Lisa will talk about it a little bit later—is to fund a drug and alcohol brokerage service. Oolong is working in partnership with us as well as the other National Aboriginal Community Controlled Health Organisations [NACCHOs] in the area. That has just started, so we would like the opportunity to share what that looks like. You have those three documents there. Those should be, hopefully, quite illuminating.

First, I would like to acknowledge Uncle Ivern. He is an elder from our community, and incredibly passionate about drug and alcohol services in our area. I would just like to acknowledge that here today, and also thank Tanya, because the work that they are doing in Oolong is ground breaking. There is no other service doing what they are doing in terms of being culturally appropriate and working with Aboriginal people—men in particular—with drug and alcohol rehab services. Waminda—similar to Oolong—has been around for a long time. We have been around for 35 years in the Shoalhaven. We are an Aboriginal Community Controlled Health Organisation. We are a service for women and Aboriginal families. We now operate a service from Wollongong. We work with Coomaditchie in Wollongong, all the way down to Eden. It is a 400-kilometre footprint—quite a large area—and we also go inland.

Waminda has come from a need, identified by significant women elders, 35 years ago, to have a safe space for Aboriginal women in particular. Over the last 11 years we have grown from a service that had about six staff to now having over 100 staff. Seventy-five per cent of those staff are Aboriginal. It is a significant organisation, now, given the fact that we have 75 Aboriginal staff and their families—and the ripple effect of that along the South Coast. We are particularly proud of that, and I think the staff have worked very hard in this area to gain that ground. We operate services from very early soft entry points right through to crisis intervention and accommodation services. Really we are a wraparound service. We are the only service of its kind in New South Wales—there is one service similar but not the same in the Northern Territory. So it is quite unique. We are very successful, and the reason why we are is because it is a wraparound, holistic service. Ms

Wellington will talk a little bit more later about what the Network of Alcohol and other Drugs Agencies [NADA] has had to say about that.

The CHAIR: What is NADA?

Ms WELLINGTON: It is a peak body for drug and alcohol services. When we talk about holistic, that has been thrown around, as you would know, in the last few years—everyone talks about holistic services or innovative services—and we get a little bit sick of that because I guess what we have been doing for many years, even well beyond our 35 years, is running holistic services. What that means is that when a woman presents at Waminda she does not have to jump through the hoops that she would normally have to jump through if she went to a mainstream health service. She can walk into our service, as they do at Oolong as well, and be coming in to see a nurse or a health worker or a GP—it could be for a cut on her child's leg—but from that experience of literally walking in that door, she is seeing an Aboriginal health worker practitioner, there is an Aboriginal intake worker who can be seen. If she needs case management you are able to access that immediately.

What happens is she might come in and sit down with the health worker and then they might start having a yarn about what her needs are, and the cut on her child's leg turns into a discussion about her drug or substance use and the difficulty that she is having because when she went to school to talk about what her child's needs are child protection issues came up. So now she is really fearful of what is going to happen within her family. So out of something quite innocuous, it often comes for us—with 1,200 women that we see come through our doors a year with their families—that they have myriad issues that are going on for them because of systemic racism often in community, and they are able to come forward and then be able to have a safe place where they can explore any number of things. Drug and alcohol and other drug use is a significant part of that.

Over 50 per cent of the women who come through our service in a year have some sort of substance misuse issues, and often it is comorbid issues as well. Mental health and drug and alcohol is a huge issue for us, and being able to then support those women across a life spectrum through pregnancy, postnatal and antenatal care, all the way through to palliative care, housing, homelessness, legal, police, getting to court. Traversing matters in terms of FACS or housing is incredibly complicated. That is what Waminda does well. A lot of women can come through our services also through our health and wellbeing program; they can come through Waminda by an exercise program and not think they are coming to Waminda or to a service, but by purely coming in, presenting and getting involved in an exercise program or a healthy eating program or just a gardening circle for elders, often, especially in a group format, a lot of those issues that they may have around substance misuse are shared and then they can be dealt with.

Ms Wellington is a senior practitioner in our service around drug and alcohol and we have a number of services in drug and alcohol, clinical services, case management, domestic violence, accommodation services, that can work with women in a whole range of different ways. At the centre of that I guess is culture. Everything that we do comes back to that, and that is why these services work and that is why other services do not work; that is why short-term services do not work. That is why if you have only got brief intervention, if you have only got detox services, it is not enough. People have to come back into community, they have to come back home. So what do we need to do to be able to wrap around those community members when they are coming back from jail, when they are coming back out of rehab, when they are too scared to go to rehab in Benelong's Haven or Bila Muuji at Orange and leave their kids behind with whom? That is a huge issue for us as a service because we are lucky enough in the Shoalhaven that we have got our men's rehab—there is nothing for Aboriginal women and their families to go to, nothing. On that note, I might hand over to Ms Wellington because that is probably where she picks up.

Ms WELLINGTON: When we first spoke about NADA, there was a commissioning tool that was published by NADA and what they had said in that toolkit is that there needs to be a specific Aboriginal and Torres Strait Islander resi rehab. This is a priority as there is no such rehab that currently exists within New South Wales.

The CHAIR: What would that mean in practice? That point you just made, what would that mean if it was implemented?

Ms WELLINGTON: Currently, with the rehabs that are currently out there, for us that we can access services in the Wollongong area or services that are over in Canberra and then we will go above and beyond that. But there are specific rehabs for Aboriginal people, like Benelong's Haven, for women, but also men are involved in that service. Weigelli, like we do alongside Oolong, there are women and men that can access that service but there are no specific family services for women that can access that. I think if there was, what it would mean is that it would be culturally appropriate at meeting the needs of our people, to ensure that there is that holistic service, that it wraps around with the community services that are on the ground, but also taking

into account the cultural issues that our people deal with when we talk about racism, when we talk about the stolen generation—looking at all of those underlying issues as to reasons why people may use substances.

Mr ARDLER: I just wanted to share one more item with you. If NSW Health have not informed you then they should be giving you and sharing information. There are five Indigenous funded non-government residential rehab services in New South Wales.

The CHAIR: A total of five?

Mr ARDLER: You have heard about some of them from Ms Wellington, and they are all represented by their CEOs on the NSW Aboriginal Residential Rehabilitation Healing Drug and Alcohol Network [NARHDAN], which is under the Aboriginal Health and Medical Research Council, which is funded by the New South Wales Government. Its peak body is the National Aboriginal Community Controlled Health Organisation [NACCHO], the Commonwealth national body; it is managed by Matthew Cooke, elected by the Queensland people. I wanted to share that with you. The importance of it is that any residential rehabilitation services that it established would automatically come within the NARHDAN and they would meet regularly, share their information and their skills so they can better support one another as an individual, focused service. It was something that Minister Kevin Humphries wanted put in place quite a few years ago. I know this for a fact because I was the chairperson for a couple of years on the NARHDAN. It is a very helpful, structured body with Indigenous people, helping manage the affairs of the people in their State.

The things that Ms Worner is talking about, the things that we need in our communities, are very important and crucial, and the problem we have with the other services that are a bit fractured is that they are only taking a smaller number of people, and if you look at the Drug and Alcohol Community Adult Team [DACAT], it is not the population that is getting the help out there in the community. Oolong was one of those services that was considered a State-attracting service. So we were taking people all over New South Wales and now it is becoming more regionalised. Through the Aboriginal Health and Medical Research Council we have been providing them very clearly with medical research from our clients' outcomes and the drug of choice that they are most attracted to, and they use that information now. So we are becoming more in line with Queensland Health than we were before in collaborating and research. Now we have an Indigenous college at La Perouse where staff from Aboriginal medical services and drug and alcohol treatment services can get trained in the minimum requirements for drug and alcohol. These are important things.

The CHAIR: I am very pleased to hear about that.

Mr ARDLER: I wanted to share that with you so you can get the picture.

The CHAIR: I was not aware of it. How long has that facility been open at La Perouse?

Mr ARDLER: Five years, I think.

The Hon. PAUL GREEN: What is the output of that college?

Ms WORNER: It is quite substantial.

Mr ARDLER: One hundred and fifty a year.

The Hon. PAUL GREEN: And what areas? What are they putting out?

Ms WORNER: From drug and alcohol through to health workers. There is a range.

The Hon. PAUL GREEN: Nurses? psychologists?

Ms WORNER: Not psychologists, I do not think.

The Hon. PAUL GREEN: But drug rehab?

Ms WORNER: Yes. Definitely counselling.

Ms BLOXSOME: Yes, counsellors.

The Hon. PAUL GREEN: Thank you for giving evidence today. Uncle Ivern, your reputation goes before you.

Mr ARDLER: I am happy to share.

The Hon. PAUL GREEN: Uncle Ivern, it is good that you are here today, because you are a legend in this area.

Mr ARDLER: The brief we have for you is very good. It is missing one fundamental factor that we were not asked in the questions and that is if there was something that was unique would you say what that

might mean. Oolong is one of the smaller established of the rehabs because it was a maternity hospital converted to a drug and alcohol rehab. In the year 2000 NSW Health and the State Government added on some extensions so it could be converted to a proper residential facility, and that is how it operates. But in all honesty it is not big enough and we are now working in partnership with the local health district. We are hoping in the future things like the need for a local detox centre, services that Ms Worner is talking about, and a better structured residential facility for Oolong could actually happen.

The Hon. PAUL GREEN: I would have liked the Committee to come and have a quick tour of Oolong. It would have been really helpful—

Mr ARDLER: It would be very nice.

The Hon. PAUL GREEN: —just to see how it is sitting up there in the middle of town but in a residential area and how it works.

Mr ARDLER: Yes.

The Hon. PAUL GREEN: I want to ask a couple of questions to make a very clear point: Are there any detox beds in Shoalhaven?

Ms BLOXSOME: In my experience, for us, no. We are having to send people to Orange, Sydney, and if we need a person to come in and we have a bed available for them, I have a person for whom today was his third attempt to come into our facility because he cannot get clean from ice.

The Hon. PAUL GREEN: Is that detox or is that rehab?

Ms BLOXSOME: Detox.

The Hon. PAUL GREEN: So you do have the detox beds.

Ms BLOXSOME: No.

The Hon. PAUL GREEN: I need to clarify this very important point.

Ms WELLINGTON: I am not sure whether Mr Reid or Ms Mains said previously the detox beds that are available at the hospital, but in saying that, in order to get someone into those beds, if they do not have a high risk of medical issues then you cannot access those beds. As Mr Adler and Ms Bloxsome have said, we are transporting people five hours away to get them into a detox bed.

The Hon. PAUL GREEN: That is what I wanted to hear.

The Hon. Dr PETER PHELPS: Can I follow up on that? What you have is a situation where, if you are very low risk, you can go into Watershed; or, if you are very high risk, you can go into hospital; but there is a very big gap in the middle where there are no services available for people who have what might be called moderate conditions.

Ms WORNER: You are right. I add that it is incredibly difficult for the Aboriginal community if you are very high risk to feel that you can access those detox beds culturally safely.

Ms BLOXSOME: That is correct. I agree.

The Hon. Dr PETER PHELPS: Could you explain that a little more than that? Is that only if you are an Aboriginal woman?

Ms WORNER: No—an Aboriginal person in this community. Ms Mains would agree with me—because we are working on cultural immersion within the local health district at the moment—that our local health district and our hospital in particular have a long way to go in terms of being culturally appropriate. Every single day we are dealing with Aboriginal people who are not able to present to the hospital in a safe way to be able to stay or be treated with any respect. Often communities and families do not want to go to the hospital and will not stay at the hospital because of the experiences that they have.

The CHAIR: I think you should be a bit more explicit about that. What is the shortcoming? What is missing that needs to be there?

Ms WORNER: It is a systemic issue. The hospital is a very racist place.

The CHAIR: It is worthwhile putting it on the record if you wish to do so—in what respect?

Ms WORNER: I can give you some examples.

The Hon. PAUL GREEN: Maybe reflect on a couple of anonymous cases.

The CHAIR: You do not need to give names.

Ms WORNER: I certainly would not give names. We are working on this at the moment in a really constructive way with the local health district, from Margot Mains right through her leadership team it is being addressed from maternity all the way through to the emergency department [ED]. We will have people—women in our instance or women and families—who will present up at the hospital and be treated appallingly and not be respected how they should be in order for them to feel that they can stay there and receive the service. I am trying to put that as clearly as I possibly can. It is an incredibly racist experience that most Aboriginal people have at this local hospital.

Ms BLOXSOME: To be honest, to attend the hospital as an Indigenous person, it is very hard to get a person to a hospital to seek treatment in the first place, so the fact that when they do turn up at the hospital and the treatment that they do receive there—they would rather just not go.

Ms WORNER: They would rather not go. If that is the only option, they would rather not go.

The Hon. PAUL GREEN: Is that because it is a repeated situation they have had at the hospital and they have had a negative experience before that?

Ms BLOXSOME: Yes.

The Hon. PAUL GREEN: It is not just someone fronting up for the first time; it is normally—

Ms WORNER: It could be. It definitely could be.

The Hon. PAUL GREEN: We know that Oolong House has been really good. Can you give us the completion rate? We heard how important the completion rate was for those who backslide, as we call it in the church, because they have not completed their full provision of the program. Can you give us some stats of how successful your programs are?

Ms BLOXSOME: I could not give you exact stats. That is something would have to provide later.

The Hon. PAUL GREEN: Could you give some rough stats?

Ms BLOXSOME: We have I believe at least a 60 per cent rate at this time. It would be interesting when you have a look at our statistical information. It was in about 2012 that ice started going through the roof. In that case there were a lot of people not understanding how it worked and what went on, so a lot of people were coming in and leaving because the addiction to ice in itself makes it extremely difficult to stay clean for so long. Our later statistics show that people now on ice need a holistic, encompassing and covering approach—it is true—so you cannot just address a drug issue. It is not as simple as that. You have to address nearly everything. To answer that, I think it is about 60 per cent.

The Hon. PAUL GREEN: Are there any other comments?

Ms WORNER: Yes, I guess we have different experiences because we do not have a rehab locally and we do not have access to services similar to Oolong, which is the wraparound service. Ms Wellington could probably talk about the experience of people not finishing, because that is a big deal for us.

Ms WELLINGTON: Speaking with the majority of our families or the women that actually enter into treatment, they actually have to go away for treatment so they miss family—they get homesick. For some of them, mum is the only person in the family so if she has older children who are over that age of 12—in some of these treatment facilities that is the cut-off age for children—then she is worried about those children: Who is going to care for those children while she is there? How is the rent going to be paid—when they are paying around 85 per cent of their income? Particularly if they are on Centrelink benefits, where are they going to get the money to pay for the rent? For some of them transport is a big issue—we are transporting people six hours into treatment just to go to treatment.

The Hon. PAUL GREEN: I light of time, I will probably just try to get to the bottom line for this particular set of questions, because I know other members will have it. What would you like to see in Shoalhaven in terms of services that could complement the current services? What do you think we need as an area?

Ms WORNER: The bottom line for us is an Aboriginal women's and children's rehab—that is the bottom line. And we believe we have the ability not just in the Shoalhaven but in the South Coast. We have got really strong partnerships from Illawarra Aboriginal Medical Service all the way down to Katungul. I believe you are going to be speaking to or have spoken to the chief executive officer of Katungul. All of the Aboriginal services along the south-east coast of New South Wales are partnered already and committed to working up and down the coast to support a facility of that kind. We believe that if that is done within the therapeutic model and

done culturally appropriately, and takes into account the wraparound approach that is required to support Aboriginal people and Aboriginal women and their families, there will be a far higher success rate of people being able to complete treatment.

Mr ARDLER: That is a very relevant point, because what the Commonwealth and State governments did some years ago was decide to come up with funding for an aftercare worker, and all they did was put one in a rehab. They did not take into consideration the community. This is what is coming from Waminda because they do not get funding for these types of services to work closer. I know Oolong works very closely with Watershed and we have referred people there for level one detox and the local DACAT service in Nowra. Oolong gets funded through MERIT beds.

Under the MERIT funding we work closely with the DACAT services because they have to assess the clients and provide a report to the court. It is very important that these things are explained to you. The services where everyone is connecting, there is no connecting. We tried to do this some years ago with the Aboriginal Medical Service that was given a role from the Aboriginal and Torres Strait Islander Commission. They were funding them prior to the Department of Prime Minister and Cabinet to get chief executive officers together to work closer. It was starting to work and there was a share of information but it fell away, and it was very sad.

The Hon. PAUL GREEN: The Waminda submission is dated 12 May 2017. Have you received any feedback?

Ms WORNER: No.

The Hon. Dr PETER PHELPS: Earlier this week there was a report in the *Daily Telegraph* that there would be Aboriginal waiting rooms in every hospital. What is your view of that proposal? Would it help to correct the problems of Aboriginal people presenting and then leaving before they receive treatment?

Mr ARDLER: I think it is a bit of a contradiction in terms. If you are an Indigenous family having a child, and the child is not well, they will be referred to another hospital. So in emergency cases like that, that is how it works. Everybody is treated differently. I am not aware of any situation where there are designated beds. Shoalhaven hospital 10 years ago did make a decision to have two beds for detox but they only did it once in a year and offered the detox to Oolong for two clients.

Ms BLOXSOME: In answer to that question, if there is going to be a room for Indigenous people that room needs to be culturally appropriate. There is no point in having a room for Indigenous people if you are going to have non-Indigenous people. There has to be somebody familiar; it has to be an Aboriginal person or otherwise you are faced with the same situation but a different room.

Ms WORNER: That is a good point. We are having discussions with Margot Mains at the moment about when you present at the hospital and you are incredibly unwell in terms of social, emotional wellbeing or mental health. It is a pretty daunting place. We have all been up there and worked in the emergency department. There is no safe space for anyone, to be perfectly honest, but there is definitely no safe space for Aboriginal people to be able to see someone safely, to be able to connect with another Aboriginal person or to sit somewhere and feel that it is okay, or to have their family there. I would encourage any move in that direction as a positive thing as long as Aboriginal staff are employed. At Shoalhaven hospital there is one Aboriginal liaison officer. It is a very big hospital. You cannot find an Aboriginal staff member at that hospital to support people from your service if you require that. I think any move in that direction, if it is done properly, would be a positive thing.

The Hon. Dr PETER PHELPS: The Committee heard from non-government organisations about the habit of NSW Health poaching people for its service. Has that been the experience of your organisation or those organisations with which you have worked? It is almost insuperable, but is there a solution to it?

Mr ARDLER: There was, but the head office had broken down and funds have now been transferred out to the local health district. That poaching was going on but it was normally done selectively with the department and people within the public service.

Ms WORNER: From our point of view we probably do have a solution to that too. It certainly has been our experience over the years that we might have a particular midwife or a clinical nurse consultant, or whatever, that we have trained up and we often cannot match the public service wage. But what we have done—and I think we have done it successfully—is to keep somebody like Lisa Wellington within our service who used to work for NSW Health. I actually poached her from NSW Health.

The Hon. Dr PETER PHELPS: You got your own back.

Ms WORNER: Yes, I am pretty good at that. Oolong is an incredibly good place to work. We have flexible work arrangements, a family friendly environment and about 90 women at our workplace so we have to have an environment that suits women to work. NSW Health does not do that. The bigger footprint that we have, the more that we can employ people on a decent wage. That certainly helps. But we have flexibility in the workplace and we ensure that there is a career trajectory, especially for Aboriginal health workers. If you work in NSW Health as an Aboriginal health worker you do not have a career per se and you cannot become a clinician; whereas in an Aboriginal medical service or an Aboriginal health service like ours you can.

The CHAIR: In NSW Health why can they not become clinicians?

Ms WORNER: It is not within their policy framework. If you are an Aboriginal health worker at the moment in NSW Health, that is what you are.

The Hon. Dr PETER PHELPS: You are a health worker. You just incidentally happen to be Aboriginal as opposed to being an Aboriginal health worker.

Ms WORNER: That is pretty right, whereas in Waminda, for instance, or in Oolong if you are an Aboriginal health worker you are a clinician so you operate clinically. So you see people yourself and you can become a practitioner and operate like a nurse. It is its own career rather than just being a transport officer.

The CHAIR: I understand the point that you are making.

The Hon. WES FANG: Do you see the same ratios in the use of alcohol and amphetamine? Is it stable or is there an increase in one over the other in the people who are coming through?

Ms BLOXSOME: Our statistics—and we have worked with the University of Wollongong—show for the 2017 calendar year, alcohol as a primary substance choice was at 27 per cent. Amphetamine use last year was at 69 per cent. For 69 per cent of clients who came into our rehabilitation service that was their primary drug of choice.

The CHAIR: Is this your Indigenous service that you are talking about?

Ms BLOXSOME: This is our service. Obviously the ratio is about 60:40 or 70:30 Aboriginal to non-Aboriginal clients, so it is both. The 69 per cent is high when you consider that in 2008 it was only 8 per cent.

The Hon. PAUL GREEN: Earlier Mr Reid said it was not a problem. Do you contest his comments?

Ms BLOXSOME: According to our statistics, what he said is not correct.

The CHAIR: It is certainly a different figure.

The Hon. Dr PETER PHELPS: I do not want to justify Mr Reid, but could it be the case that people do not see themselves as users. For example, "I drink a lot of alcohol. I don't have a problem." Alcohol is legal. In others words, people would self-assess their own incapacity based on, "Ice is illegal. I am using it regularly. I am probably just as out of control as if I was purely an alcohol user." They would see it differently and hence the impetuous for referring themselves or seeking help is greater because of its illegality.

Ms BLOXSOME: I would say no to that because in 2013 people who presented to our organisation with alcohol was at 56.8 per cent. So that is still a high thing. In an Indigenous community that is who we are. We are who we are and we will tell you. If I am an alcoholic, I will tell you I am an alcoholic. If I am a drug user, I will tell you I am a drug user. When a high percentage of people come in, we are just straight like that. But for the 2013 period you can see that is still high. But have a look at the percentage for last year which is 27 per cent. There is a huge difference. I believe the difference is the increase of ice becoming the dominant drug of choice.

The Hon. Dr PETER PHELPS: Because it is cheaper.

Ms BLOXSOME: Exactly.

The Hon. Dr PETER PHELPS: Cheaper than slab.

Ms BLOXSOME: You walk down the street and you can see a deal going on like that as you walk past.

The Hon. Dr PETER PHELPS: That is part of the problem. We treat alcohol as a problem but what do we do? We legalise, regulate and tax those industries, whereas with ice we just say, "We will rely upon criminal sanctions and it will go away", which is why I could not believe the health official who was saying that criminal sanctions lead to demand production. They do not lead to demand production. They might lead to supply reduction. Even if supply is reduced there is product substitution so you will go somewhere else.

Ms WORNER: That is right.

The Hon. Dr PETER PHELPS: You will take legal opioids or illegal opioids. You will go back to alcohol, you will go back to cannabis or you will go somewhere else. The whole idea that criminal sanctions lead to demand reduction I think is ridiculous.

Ms WORNER: It is incredibly naïve.

The Hon. Dr PETER PHELPS: It is a basic economic point of view. The only thing that leads to demand reduction I would suggest would be proper rehabilitative treatment, including the provision of a range of life skills to get people out of the personal circumstances which got them into drug addiction in the first place.

Ms WORNER: You are absolutely right. It is what Tanya Bloxsome and Lisa Wellington said before. You do not just start becoming a drug user; you do not just have a problem with alcohol. What has happened prior to that? What has happened to your family for a couple of generations? Where have you come from and where are you going to go? Across these two services and other Aboriginal services, we have been able to work with people with transgenerational trauma, and have people coming out of the side of that and, through care, become accommodated, have jobs and hold them down, and then do quite incredible things with their lives. But you have to pay attention to that, and it has to be a health-economic approach. We cannot keep having the trajectory of Aboriginal women going into jail. It is out of control.

The CHAIR: Bearing in mind that your two sets of documents contain some application material, are both organisations okay with the Committee publishing them, as part of the inquiry? They would be in the public domain.

The Hon. Dr PETER PHELPS: You could have bits that you do not want—

The CHAIR: Our normal arrangement is that we receive material and publish it on our website as part of the inquiry. You would not have known that until now, so I will just let you think about it. If there is anything you would like us to hold back, we can do that. We will ask you at the end; is that okay?

Ms WORNER: Yes, sure.

Ms BLOXSOME: Thank you for that.

The Hon. COURTNEY HOUSSOS: I will be very brief. I just wanted to begin by thanking both of you for the incredibly important work that you do. It is really encouraging for us to hear such positive feedback. Obviously there is more that can be done, and we will make recommendations about that, but I would like to place on the record our sincere thanks for the incredibly important work that you do in rehabilitation support and the wraparound service. I am going to ask two specific questions. There has been both a New South Wales ice package and a Federal ice package—\$75 million from the New South Wales Government and \$300 million from the Federal Government. Did your organisations receive any funding from that, and do you have any reflections that you would like to provide on the effectiveness, or not, of both packages?

Mr ARDLER: Our answer is yes. We are partly funded by the drug treatment branch of the Commonwealth's head office in Sydney.

Ms BLOXSOME: Not with the ice money.

Ms WORNER: We did not get ice money.

Mr ARDLER: No, not the ice money. There is no funding at all for ice.

The Hon. COURTNEY HOUSSOS: That is right. Okay.

Ms BLOXSOME: So the answer is no to that. I think that organisations like ours—both of them—should have at least received something because New South Wales has the highest Indigenous population. The Shoalhaven, in itself, has a very high population of Aboriginal people, yet money like that the ice taskforce money goes to mainstream organisations which may have one Aboriginal person in the organisation, who classifies it as culturally appropriate; whereas they have 75 per cent Aboriginal staff members and we have 85 per cent Indigenous staff members. Aboriginal people know Aboriginal people. We know how to help our own people recover and heal using culturally appropriate approaches and healing things that go back for thousands of generations. We all know that it takes money to do that. Therefore, I think we should have been amongst the first set of people to be approached: "How can we help your organisation help your people?"

Ms WORNER: Can I just back that up? I think that is what is going wrong in the funding regime, currently. Unfortunately we have been around for long enough to see things go around and around. We know what works. If this was an approach to garner what works, what has worked in the past, why it did not continue,

what you need to have that continue now and what would work in the future, we know the answers to that. Often the Ministry of Health or Federal Health will come and say, "We've got an idea. This is what we want you to do. We want to see how you are going to fit into this idea. What are you going to come up with?" instead of coming from the other point of view and saying, "What do you need, collectively?"

In our instance we cover a huge area up and down the south-east coast of New South Wales. Thousands and thousands of Aboriginal people are within our catchment area. We have been doing that work for a really long time. Some of that can be done better. Some of it we are doing better than anybody in the country and internationally. We are presenting internationally on the work that we are doing. So we are in a really good position to be able to come. We are connected with many universities—the University of Wollongong, the University of Sydney, the University of New South Wales, the University of Technology Sydney and the University of Queensland.

So we are in a really good position to get value for money, which I know is a key element when we look at how funding needs to be rolled out. We are not living in a place that is unrealistic. We do not want money for money's sake. We know that Aboriginal services are the cheapest form of healthcare in the country. What happens, though, is that a lot of Aboriginal health funding does not go straight into the community. It might go into other forms of service delivery.

The CHAIR: Like what? Give me an example.

Ms WORNER: Other services—mainstream services. I could name them. For instance, yesterday I got a phone—

The CHAIR: They are redirected?

Ms WORNER: Yes. Those services can apply for Aboriginal health funding, like out-of-home and other drug funding—for instance, the ice money. Those mainstream services might be able to pitch a program that is evidence based that they can roll out across the community. That service may, however, be in Victoria, and say that they will roll it out across the South Coast of New South Wales. Those services usually have clout. Because they have done that work before and they can prove what they have done they will get funded. What happens—it happened yesterday—is that they will knock on my door or Ms Bloxsome's door and ask how they can do that in this community. They ask us what doors we can open for them to the Aboriginal communities and Aboriginal people in order for them to roll out programs.

Just that is flawed. That does not work in Aboriginal communities. What works is these organisations having boards of people who are from the Aboriginal community. We have seven Aboriginal women on our board from all communities across the South Coast. They are representing many, many family groups across this region. They know. They are living in community. It is their community so they know what works best in their community. They are articulate, intelligent, professional women who are on our boards from community. The answers are there, and that is why we need to turn this on its head, often, and be able to say what will work.

With due respect to David Reid—we work very closely with David Reid, and he has been a very big supporter of Aboriginal services for many, many years—it is critical for you to know that his organisation has two Aboriginal staff. It has two Aboriginal staff for the whole region—not just in Nowra. I do not know how many Aboriginal staff the other organisations here have; we have 78 at the moment just in one organisation. That probably speaks for itself in terms of impact, and the ability to do the work, the ability to work from a grassroots point of view and to have that constant approach to alcohol and other drug work. As David Reid rightly said—Margot Mains said this as well—it is not something that happens overnight. It will take another generation, but you need to be able to consistently do that work, and do it in a way that has a wraparound approach that does not stop—that is not for three months. Three months of rehabilitation will not be the only thing that has to happen for that family or that man or that woman.

The CHAIR: We still have some further questions.

The Hon. COURTNEY HOUSSOS: I just wanted to ask about the existing provision of supports and whether there are enough that are culturally appropriate, but you have answered that already. So, thank you very much.

Ms WORNER: Okay.

Dr MEHREEN FARUQI: Thank you for coming in, and thank you so much for the amazing work that you do. I want to talk about the funding issue. I guess what you are saying is that the way funding applications are framed is quite restrictive. It is based on the experience of the funder, not the on-ground experience. Obviously you want that to change as well.

Ms WORNER: Yes.

Dr MEHREEN FARUQI: The other thing we saw in some of the submissions was the issue of the much larger service providers crowding out the space and making it really hard for smaller organisations. You are not that small but you are still small compared to others.

Ms WORNER: We are community based.

Dr MEHREEN FARUQI: Yes, I am talking about community based services, especially Aboriginal services, where services that are delivered around the country by Aboriginal service providers are so much better. How do we change that? What, in your view, can be done to change that?

Mr ARDLER: You cannot. You need to know that the neighbour of The Glen rehabilitation centre, the Salvation Army, for example, was given a 100-bed facility. They are trying to provide services from their 100 acres—or whatever they have there—for their residential clients, and it is a very difficult situation. There has not been any consultation at all, really, with any of these services. Waminda was funded by the Indigenous community a long time ago, and it is still going, even though it is one of its kind, because the communities here still support it. That is why it is still operating. It is very important for our people.

Ms BLOXSOME: It is important to note too that the Indigenous organisations here along the South Coast work together. It is not Oolong is going to go over there and do their thing; Waminda is going to go and do theirs, the Aboriginal Medical Service [AMS] is going to do their thing. For our community we have a passion and because we have a passion and because we want to see our people restored to health, their identities restored, we work together hopefully for that to come about. To be honest, funding—you are going to need a whole another parliamentary inquiry on this—for example, our next round of funding, we do not know, they do not tell you. Our funding runs out on 30 June this year. To this date, right now, you do not know if you are getting funding or not for the next financial year, and that is quite difficult because how do you retain staff who have a mortgage, car payments and that kind of stuff? They think, "Oh my God, I might not even have a job at the end of the financial year", and it is often very difficult to retain people, keep them focused on clients when they are worried about—

Dr MEHREEN FARUQI: There should be long-term, secure funding really.

Ms WORNER: Absolutely.

Ms BLOXSOME: There should be long-term, secure funding. Also, there are organisations like Oolong, Waminda and so on that are around for 30-plus years, getting results, often working at such a reduced rate—they are the cheapest health people around but do such a fantastic job—yet, when it comes to the funding stuff, where is the money? Where is that "show me the money"? Show us the money and we will give you outcomes. But when you are dripping money from a tap and you are expecting us to achieve the same kind of outcomes as the larger organisations, that is not going to happen. But, in comparison, what we do, I believe, is far more and beyond that which we get money for. So fund Aboriginal organisations who have proven themselves.

Dr MEHREEN FARUQI: With Oolong House, and I apologise if I have missed this, what is the capacity?

Ms BLOXSOME: We are a 21-bed facility.

Dr MEHREEN FARUQI: And 70 per cent you said were Aboriginal men and 30 per cent non-Aboriginal.

Ms BLOXSOME: Yes.

Dr MEHREEN FARUQI: Do you take non-Aboriginal men because you just saw the need?

Mr ARDLER: They are shared bedrooms.

Ms BLOXSOME: When it comes to reconciliation and all that kind of stuff, at Oolong House—drugs do not discriminate, we all know that; it touches everybody at all ages and, in fact, with ice now you are getting younger people, at eight, in Aboriginal communities. Issues with ice in Aboriginal communities are huge—people at eight.

The CHAIR: Can I ask you about what it costs? Do you know what it would cost? Consumption is obviously driven by price. Just anecdotally, have you heard what ice—

Ms WORNER: You can get a cap for \$15.

Mr ARDLER: In the Corporation (Aboriginal and Torres Strait Islander) Act [CATSIA] website you can look at our audits—they are available.

The CHAIR: I am talking about the cost of the drug—just anecdotally.

Ms WORNER: It is very, very cheap.

Ms BLOXSOME: It is very cheap. I have heard it is about \$8 to \$10. They are dealing in schools; all the time, you hear it. That is why at Oolong we enter into the local schools now and we do drug talks. It is really good; we need to do that. There is nothing out there for youth, I am telling you, and, in particular, Indigenous youth. I had a mother ring up saying, "My son is 15 years old. What can I do with him?" We have to sit with that. But there is nowhere for them to go, and then they expect them to stay addicted until they are 18 years old because when you are 18 you can go to Oolong. But by 18 you are already way addicted, past the door of no return, and you have got a criminal record as long as your whole body by that stage. The negative effects are just a roll-on. But I believe give the money to the people who know what they are doing, who have more than two people in their organisation for the whole region, and let us get that job done.

The CHAIR: You have been very generous with your time and we have gone well over, but are there any more questions?

The Hon. Dr PETER PHELPS: I have one. Given what you said, particularly you, Ms Worner, about the need for a holistic approach—because addiction is not a problem, addiction is a symptom of a problem—is there an argument for the de-mainstreaming of Aboriginal health services and welfare services and a direct allocation of money to, say, the New South Wales Aboriginal Land Council [NSWALC] or Local Aboriginal Land Councils [LALCs] and let them determine the appropriate level of addiction treatment, family services treatment? Is there an argument for the de-mainstreaming and the direct allocation either through NSWALC or through LALCs?

Ms WORNER: Yes, there most certainly is. Even if it was in the first instance to the Centre of Aboriginal Health in the ministry so the Centre of Aboriginal Health has some funding. But compared to, obviously, the bucket of health funding within the ministry, it is very, very, very small.

The Hon. Dr PETER PHELPS: Who do you trust to allocate efficiently and effectively?

Ms WORNER: In a government department?

The Hon. Dr PETER PHELPS: In government expenditure across the range of social services for Aboriginal people?

Ms WORNER: What has worked in the past—and, again, we can go round and round—is that if you have got strong peaks in place, whether that be the Aboriginal Health and Medical Research Council [AH&MRC], whether it be NADA, whether it be whomever it is, we are all members of that. We participate and we invest in that membership and in those organisations. So if we are member of those organisations and we guiding and directing what happens within those organisations, if those peak bodies, whether it be LALCs or not, whether it be the centre within the ministry, if we have got a direct say and input into what happens as members—within our region we have got five really strong, key Aboriginal services—that is a pretty big voice for a start. What do we need on the South Coast? You only need to come to our regional forum to find out. But you are absolutely correct. Because, as a non-Indigenous person, what I am sick of is Indigenous funding going to non-Indigenous organisations and mainstream services that do not know what they are doing.

The Hon. Dr PETER PHELPS: They feel the need to subcontract out.

Ms WORNER: That is right, and they do. And how many subcontracts have we got? I hate to think. We have probably got 12 or 13 subcontracts with mainstream organisations that get the buckets of money, split it across the State or the country—

The Hon. Dr PETER PHELPS: But, of course, not 100 per cent of the funding goes to the organisations because the lead organisation takes its own share for administrative purposes.

Ms WORNER: That is right. And not just administrative; you end up with massive bureaucracies like the Primary Health Networks [PHNs]. The funds from Federal health in that instance come through the PHN, then they come to us and say, "We don't know drug and alcohol. What are we going to do about drug and alcohol funding?"

Dr MEHREEN FARUQI: With the criminal nature of drug use in Australia, what impact does that have on people who want to seek rehab services, and should that change? What is your view on that?

Mr ARDLER: One thing we need to do is to stop discrimination. Just one example: the Glen rehab is relatively new, although there were two of them and one had recently closed and they amalgamated—they should be a member of the AH&MRC and be treated respectfully as an Indigenous community service. On the same point, the same thing should go for Waminda. That needs to change. I do not know how you can do that but I think something needs to happen in that area, honestly. The more these services are working closer together the better outcomes people will get. I can only give you one example of that where there was a couple—an Indigenous woman with a child and a non-Indigenous man—and Waminda and Oolong helped them both at the same time, and they are still living in the community, as far as I know.

Ms WELLINGTON: There was a media release recently that there is a 17 per cent increase in Aboriginal women in prisons—and that was just in that short period of time, within a year or so—that there was a massive increase in Indigenous women in prisons.

Ms WORNER: We have got women who will come in with what are classed as minor drug offences but multiple, and they will end up in one of the three correctional centres that we visit every week. They get on that treadmill and that roundabout and find it incredibly difficult to get off unless there is that form of intervention that is supportive. I think it is what you alluded to before: it is about what do we need in a supportive way? A woman that has just come out of jail now has gone straight into rehab.

She cannot go to her home because she knows what is going to happen as soon as she goes home, so we have put her up in our accommodation service, hopefully for three months. We will get her work, so she will start at work experience. We will get her driver licence back. We will get all those things in place and get her stronger and stronger, connecting with her child and making sure that she can stand on her own two feet before she goes back to her own accommodation. While she is doing all of that, she will not be offending.

Dr MEHREEN FARUQI: This is what I am trying to allude to: Maybe the woman should not be in jail in the first instance.

Ms WORNER: At all. That is right.

Dr MEHREEN FARUQI: Because drug use should not be a criminal offence.

Ms WORNER: That is right. That is what we see.

Ms BLOXSOME: With that we also find—

The CHAIR: I am sorry but we have to wind things up. Thank you all very much. I think I share the sentiment with all the Committee members that we have had some real insights today at the coalface level of the challenges and the real issues that are faced by Indigenous communities. You have provided a lot of detail and rather intimate insights for us—I have certainly had my eyes opened. Thank you all very much for coming along and for the great work you do. There are going to be some questions on notice. The secretariat will liaise with you over questions you may need to reflect on or that the Committee might wish to present to you after this hearing. With respect to the documents themselves, I suggest we give you an opportunity to have a look at them first.

Ms WORNER: I will double-check.

The CHAIR: A member of the secretariat will liaise with you to ensure that you are happy with the publication of all or part thereof.

Ms WORNER: Yes—sure.

The CHAIR: We do not want to rush your deliberation on that, so take it away. We will not formally publish them but will liaise with you first, but it would be great. It is very useful and very detailed and it will be most helpful.

Ms WORNER: Thank you.

The CHAIR: Thank you very much.

(The witnesses withdrew)

(The Committee adjourned at 12:46)