

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 Batemans Bay on Friday 6 April 2018

The Committee met at 10:00 am

PRESENT

The Hon. Greg Donnelly (Chair)

Dr Mehreen Faruqi
The Hon. Paul Green
Mr Scot MacDonald
The Hon. Dr Peter Phelps

The CHAIR: Welcome to the second hearing of the Portfolio Committee No. 2—Health and Community Services inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales. This inquiry is examining a range of matters, including the types of services available, as well as their funding, cost and accessibility. The inquiry will also consider if there any gaps or shortages in the provision of services and will specifically examine the services that are available for treating ice addictions. Before we commence I acknowledge the people from the Yuin nation who are the traditional custodians of this land. I also pay respect to the elders past and present and extend that respect to other Indigenous people who will be joining us later today.

Today is the second regional hearing for this inquiry and, as it has a strong regional focus, the Committee will conduct a further four hearings in regional areas in May and June. Yesterday the Committee visited Nowra and we had a site visit yesterday afternoon in Batemans Bay. Today we will be hearing from Lives Lived Well—Lyndon, Community Life Batemans Bay, Pathways Eurobodalla, the Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug and Alcohol Service and the Katungul Aboriginal Community Corporation and Medical Service.

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 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 a witness may say outside of his or her evidence at this hearing. I urge witnesses to be careful about any comments they may make to the media or to others after they have completed their evidence, as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. The guidelines for the broadcast of proceedings are available from the Committee secretariat. There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. Witnesses are also advised that any messages should be delivered to Committee members through the Committee staff.

JULAINE ALLAN, National Research Manager, Lives Lived Well—Lyndon, affirmed and examined

The CHAIR: I now welcome our first witness, Dr Julaine Allan from Lives Lived Well—Lyndon. The Committee has received your submission—submission No. 14 to this inquiry. The Committee members have read that submission but you are more than welcome to make an opening statement. The Committee will then proceed to questions.

Dr ALLAN: Thank you very much for giving me the opportunity to talk to the Committee today about our submission. I also thank the Committee for holding an inquiry into drug rehabilitation. It is a really important area to investigate and troublesome to take some action on. Lyndon is a non-government organisation that was merged with Lives Lived Well last September but as a New South Wales-based organisation we have operated for 30 years. I have worked there for 10 years. We have got a good history of providing drug and alcohol services in rural, regional and remote areas.

The Committee will have seen in the submission there is a small map that sets out the areas that we provide services in. I want to emphasise the people we work with and the situation that most of them are really in. I would say that poverty is one of their biggest problems. They have got chronic mental health and physical health problem, often intergenerational involvement with child protection systems and criminal justice systems. They are very rarely employed. We are not working with the middle-class drug and alcohol user; they are not our clientele. We are working with the very disadvantaged population. Can I give the Committee a couple of documents?

The CHAIR: You may.

Dr ALLAN: I noticed when I printed off our submission from the website that there are a couple of charts in the middle. The legends are missing so basically they are unintelligible. What that shows in brief, if you look at the blue line, is the increase in people presenting for treatment for methamphetamine problems.

The CHAIR: This is in South Wales?

Dr ALLAN: The top left-hand box is all of New South Wales in 2006 and the right-hand box is Lyndon in 2006. You can see that the lines sort of look the same. The bottom box is just Lyndon but the blue line is methamphetamine treatment—dotted for men and solid for women. What it demonstrates is a significant increase in presentations for methamphetamine treatment, which is not a secret or new knowledge to anybody. But what is different for us is the number of women who are in that cohort. While men are still the largest group in drug and alcohol treatment, younger women are proportionally greater than men in that age group under 30, and those women usually have children and they come to us via the child protection system most of the time.

That is new and I do not think that that would be unusual for other drug and alcohol services in New South Wales to be seeing that sort of change from older people who are dependent on alcohol primarily, younger people who are dependent on cannabis and mostly men is our older story but now we are seeing more women, and I think that that is an important change and something that we need to respond to.

The CHAIR: Are those women typically in a stable relationship or a relationship of some sort or are they single?

Dr ALLAN: Not typically, no. Domestic violence is very prevalent and multiple relationships, I guess. The other thing I wanted to say about the challenges that we have talked about in the submission, of course in rural and regional areas there are distance and just population—just numbers of people for employees particularly is a challenge. One other thing I would like to table that is not in the submission because I had not seen it at the time, but you may well have seen it, is something from the Australian Institute of Health and Welfare [AIHW]. They do an annual or a biannual report on the alcohol and other drugs minimum dataset. All government and non-government drug and alcohol services in Australia contribute to that dataset, which we have to report, and that data is collected and reported on by the AIHW.

What that chart shows is the number of government-funded services and non-government-funded services by State. New South Wales is on the left there. You can see that by far the largest number of drug and alcohol services are government funded and government provided, whereas non-government organisations [NGOs] are a small proportion at the top. We still provide nearly half of all drug and alcohol treatments in the State, and that is contained in that report. You can see next door, Victoria, no government-provided services; government funding and service provision goes to NGOs. I think that is an important thing to consider about the way services are designed and provided in New South Wales, that predominantly the NSW Health system provides drug and alcohol services or gets the bulk of the money.

The Hon. Dr PETER PHELPS: So who gets better outcomes, New South Wales or Victoria?

Dr ALLAN: I do not know, and it certainly does not say anything in that report, because outcomes is a fraught area. What is an outcome? Who is it good for? That dataset is called the minimum dataset and it is very minimum; it is some demographic information and treatment completed or not completed and the reasons. Treatment completed is usually considered a good outcome, but how that is determined varies widely from service to service and person to person.

The Hon. Dr PETER PHELPS: It is a fairly key point though, is it not? If Victoria is getting better results than New South Wales is, or at least comparable results, and we work on the presupposition that NGOs are generally more dollar efficient than government organisations are, then would there not be a strong argument for a government vacating the market and delivering more funds to NGOs to deliver services?

Dr ALLAN: I think that is the way New South Wales has been heading, to fund NGOs more frequently than government-provided services. It would be very interesting to investigate the outcomes of the Victorian model, and, as I said, I do not know what they are. But there is a split in the types of services that government and non-government agencies provide in New South Wales and the non-government agencies are nearly all of the residential rehabilitation programs and various community supports, whereas the government services are opioid treatment, community health and hospital-based withdrawal services and those sorts of things.

The CHAIR: And detoxification beds that may be in a hospital at a given point in time and utilised through the public health system?

Dr ALLAN: Yes, although we have a withdrawal unit, a detox, in Orange in New South Wales—one of the few NGOs, I think, to have that funding. That is Commonwealth funded and has been operating since 2000 now. I think there are four other NGOs in the State that have residential withdrawal services. We have some walk-in, walk-out, like day program services in the NGO sector, but mostly that service is hospital based.

The CHAIR: Thank you for that. We will share the questions around and we will start with Government members.

The Hon. Dr PETER PHELPS: Just following on from what you said then, is there not a benefit in having a residential rehab service directly linked to a detoxification program?

Dr ALLAN: Absolutely.

The Hon. Dr PETER PHELPS: And preferably co-located with that program or reasonably proximately located with that program?

Dr ALLAN: Absolutely.

The Hon. Dr PETER PHELPS: Because you could foresee a situation where if there is an over reliance on a hospitalised detoxification program there could be a significant gap between the finish of that detoxification program and the ability to get into an NGO residential rehab program. Would that be correct?

Dr ALLAN: Yes, absolutely.

The Hon. Dr PETER PHELPS: And during that period of time people could fall back to their old practices, go back to their old communities and have the same problems which led them to substance abuse in the first place?

Dr ALLAN: Yes.

The Hon. Dr PETER PHELPS: Would it be your view that this Committee should be pushing stronger for funding of co-located or proximately located detoxification programs with residential rehab?

Dr ALLAN: Yes. There are some programs that have that capacity now; ours does by virtue of being on the Bloomfield Hospital campus in Orange. Calvary Riverina Hospital in Wagga Wagga and Freeman House in Armidale have withdrawal programs that are in the same building, so you just move from room to room basically.

The Hon. Dr PETER PHELPS: Presumably that would also allow the organisation which is conducting the treatment to better schedule the whole-of-life outcomes for that person because they could say, "There is no point in putting you in a detox program because by the time it is finished there will not be a residential spot." However, in a week's time or in three days' time or four days' time that ability to take the detoxified person and then put them into residential rehab would be clear because they would have the proper planning in place.

Dr ALLAN: Yes. There are health reasons for that as well. Thirty years ago when Lyndon started as a residential rehabilitation program, people were not detoxed, and that has serious health implications. I really think it is important for the physical aspects of detox to be monitored and for people to be looked after rather than just go into rehabs and perhaps detox accidentally. Hospitals generally can detox people—like just take them in for that purpose, but very few do. In this region here on the South Coast, the Bega South East Regional Hospital has dedicated withdrawal beds and they always have. The people running the drug and alcohol service in this region really pushed and really had the support of the whole district to provide that service in a hospital. The other places that do detox often and effectively are Wellington hospital, because there is a general practitioner [GP] there who works in the hospital who considers that his responsibility, and Brewarrina. They do quite a few detoxes in Brewarrina. I guess it is not what you would expect, but it is what they do.

The Hon. Dr PETER PHELPS: You raised something which has been raised by witnesses previously, and that is:

There are no undergraduate university courses with D&A subjects relevant to clinical practice and few social work, psychology and similar allied health courses with any drug and alcohol content at all.

Dr ALLAN: Yes.

The Hon. Dr PETER PHELPS: Could you expand on that a little? I think I know what you are saying and where we would like to go.

Dr ALLAN: We have people coming out of university courses who have the potential to work in the drug and alcohol sector. They have the skills. They have learned about counselling and case management and working with people with ranges of problems, but they do not consider drug and alcohol, perhaps, to be their first choice and they have not had any exposure to how to work in drug and alcohol to harm reduction philosophy—the sector in general.

The Hon. Dr PETER PHELPS: That is what I was getting to. Do you believe that if they had some exposure to drug and alcohol [D and A] coursework and practical work during their undergraduate degree it might prompt people to think, "Well, there is a career there for me and I should be moving into that area."

Dr ALLAN: I think it is worth a try. It is certainly the way rural health and GP and doctor education has gone—let us expose people to the setting and the work that they do and see if that recruits people more effectively.

The Hon. Dr PETER PHELPS: I have to say, I am very surprised to find that social work and psychology does not have a mandatory D and A component to it.

Dr ALLAN: It would really vary from university to university. Having a social work background, I did start a trawl through all the social work courses in Australia and their subject lists. They occasionally have a drug policy subject but not that really practical side of how to work with people. I am less familiar with psychology courses but they are very technically based. They learn particular types of therapy rather than learn about the field where those things might apply.

Mr SCOT MacDONALD: I want to ask you about your recommendations, which is good for us because at the end of the day we have to put up recommendations. You are talking about funding for five years which will give you a bit of certainty to employ the right people. Why did you come up with five years? What is this sort of handout funding doing at the moment, which we heard about yesterday and various other places?

Dr ALLAN: I thought five years would be a bit less scary than 10, because 10 would be great. Last December we closed two Aboriginal drug and alcohol programs in this region—one for young people and one for other people on the far South Coast—because the funding contracts had come to an end and that money was redeployed. That is seven people out of a job and that service shut down. While the money will be redeployed and I believe it will be redeployed in drug and alcohol, it takes time for another service to start up, to recruit people, to start delivering services and potentially—

Mr SCOT MacDONALD: How long will the new group have funding for?

Dr ALLAN: Three years, I expect. That is sort of standard. We have some other programs, mostly in the Commonwealth health sector that are rolling on year to year, 12 months to 12 months. The introduction of primary health networks and devolving of funding responsibility to them has really shortened contract times and just tipped everything upside down.

Mr SCOT MacDONALD: Mr Phelps mentioned people thinking about a career, where they want to work and all that sort of thing.

Dr ALLAN: Well, they do not have job security. We can offer people a permanent job in our organisation but it is not really permanent. It is completely dependent on the funding for that program, or that contract, or that area.

Mr SCOT MacDONALD: I have had representations about this in different fields, including FACS, and it is very hard. You get the angst of the organisation that is losing it, and when you go to Government, they say: "We think we have something better. It is scarce taxpayers' money. We are going to redirect it to this new mob, and we think it is better, and we feel an obligation to do that,"—FACS or whoever it might be. How do you reconcile that?

Dr ALLAN: In reality the funding, until recent years, had not changed that much. Thirty years of our residential rehabilitation program funding was from NSW Health, but at times we have only had a month to go and we still do not know about the next contract.

Mr SCOT MacDONALD: Within this five years you say you need six months advance warning whether you are in or out?

Dr ALLAN: Yes. More would be better. I am also saying that a lot of the time we are in but we cannot necessarily retain staff because if they have mortgages and school fees and things like that they cannot wait until the last minute to find out whether they have got a job.

Mr SCOT MacDONALD: This is a key area that you think we should be looking at for a recommendation?

Dr ALLAN: Yes.

Mr SCOT MacDONALD: Whenever we inquire into this field or domestic violence, we see a lot of well-meaning community organisations, and there is no taking away from that. Equally, I look at them and I think that some are better than others. They all have the best of intentions and the best in mind for their community and their clients. You talk about the reporting system. Can you talk about the quality across these organisations? I will finish with improving the reporting systems, which you are also recommending although you did not put it in your recommendations. First, the variability and the quality of some of these community organisations and; second, reporting.

Dr ALLAN: The expectation of accreditation, quality systems and quality improvement, those sorts of things, varies a lot across different sectors. Drug and alcohol usually sits in the health sector and there is an expectation that we will take on accreditation and quality improvement activities. In other community sectors, perhaps through Family and Community Services or other funding sources, there are different expectations for quality. I would say that having worked in and out of the non-government sector for the past 30 years, things have really changed—really changed.

Mr SCOT MacDONALD: From the NGO side of things?

Dr ALLAN: Yes, and they have changed a lot in the past 10 years. The expectation of funders to be able to see what is provided and to know that there is some safety and some standards for people who are coming into services has changed and it has been a really big and good change.

Mr SCOT MacDONALD: Even though we all hear that is making it tough, particularly for some of the smaller outfits?

Dr ALLAN: Yes, for some of the smaller outfits because you have to put resources into that. You have to have somebody who can look at standards and see what you need to do.

Mr SCOT MacDONALD: Someone who can understand all of that—yes.

Dr ALLAN: Yes, and that is money taken away from direct service delivery.

Mr SCOT MacDONALD: Should the State Government be helping them jump through those hoops to get that accreditation or is that something you think they should just be able to do?

Dr ALLAN: That is a tough question. I think if there is an expectation of accreditation then some help needs to be provided at least initially to get people started. The very small organisations that struggle with those sorts of things are looking at merging and collaborating and building, just as we have. Lyndon was only a small organisation with 65 staff, 45 full-time equivalents. That is pretty small, but we chose to merge with a bigger organisation for all of those economies of scale. For those standalone management committees with small boards and four staff that is a very difficult place to be.

Mr SCOT MacDONALD: In your submission you say that the current reporting systems are useful for identifying how many people enter and exit treatment services but not what they achieve by doing so. Is that a recommendation we should be looking at to get better data and better reporting about outcomes rather than the ins and outs?

The Hon. Dr PETER PHELPS: How long is a piece of string?

Dr ALLAN: Outcomes are really difficult and they are particularly fraught in drug and alcohol because there is an expectation by many people of abstinence—that you go into a drug and alcohol service and you come out abstinent after whatever period of time and stay that way.

Mr SCOT MacDONALD: It is a black-and-white sort of thing?

Dr ALLAN: Yes, and I think that harks back to older views about substance dependence being a moral problem—that you are a bad person—when really now we understand it is a health condition. In mental health, outcomes are seen along a continuum where people with a mental illness will go up and down through their life depending on the stressors that they are experiencing and how they are taking their medication and things like that at the time. We do not have that understanding of drug and alcohol, so I am nervous about what might be considered an outcome. There is talk of outcomes-based funding but we cannot decide what an outcome is. That makes me nervous about the future.

Dr MEHREEN FARUQI: You raised in your submission that there are no qualifications or licensing requirements for private or for-profit residential rehabilitation services and that they only require local government land use approval. For me it seems to be an issue to have no accreditation if you are a private provider in that sense.

Dr ALLAN: If you had enough money or the willingness to set up a residential program and you had a venue for it you could open one tomorrow.

Dr MEHREEN FARUQI: Without any licensing or anything?

Dr ALLAN: No. You might need a development application for the council.

Dr MEHREEN FARUQI: That is what the submission says. Do you see that as an issue and think that it should be more regulated?

Dr ALLAN: It has certainly been an issue in the number of places popping up not so much in New South Wales but in Victoria and Queensland. Private providers, in response to methamphetamine use increasing and a bigger demand on treatment, are charging \$30,000, \$40,000 or \$50,000 for a three-month period and there is no oversight of what they are doing or how they are doing it. The regulations and licensing is sort of discipline specific. If you are a clinical psychologist you join the Australian Health Practitioner Regulation Agency, that pathway, and it looks after your own qualifications and credentials but that is not a service delivery thing.

Dr MEHREEN FARUQI: You spoke about funding. Other people have raised the issue of the uncertainty of funding and said that there are no long-term guarantees. Issues have also been raised about the restrictive way in which funding applications are required to be filled out. They are not necessarily based on the needs of the communities on the front line but they are based on the needs of the funding organisation. Do you think that needs to change as well?

Dr ALLAN: Sometimes the requests for proposals have very, very strict criteria. We applied recently for a Juvenile Justice based residential program. The criteria for the application for that was so specific that it nominated the site, the staffing and the therapeutic program that would be delivered to the young people who would be in there. That is very tight. We had to say, "Yes, we agree that the program can achieve good outcomes for those young people so, yes, we are prepared to deliver it." Other calls for proposals are not that strict. Sometimes what people see as a need in a community is very population specific or it is very focused on the single area rather than considering how widely spread that problem is and how it needs to be addressed. Once again, it is one of those things. For the smaller organisations it is really difficult to put those proposals in and get the money.

Dr MEHREEN FARUQI: Many witnesses have said that there are just not enough qualified people around to staff facilities. Do you find difficulty in acquiring staff for your services?

Dr ALLAN: We do. We sometimes have vacant positions because we cannot fill them with people that have at least the minimum qualification that we require. We do not want to put people into jobs who cannot do the job; it is not good for them or the people that they are working with. It is really important to us that we have people with qualifications and, ideally, experience. The tree changers—that is a nice idea but there is not

hundreds of them. We do look at people with qualifications that are similar. If people have counselling or social work or psychology qualifications they are in the realm of where we work so we can train them in the drug and alcohol stuff that they need to know. We have student programs and that is a way of building up capacity.

Dr MEHREEN FARUQI: I am very interested in the graphs that you presented to us earlier and the increasing number of women presenting with drug and alcohol problems. Specifically you said it was methamphetamine. Is there some study being done as to why that is the case?

Dr ALLAN: Most of the people who we see are polydrug users and they use what is available. Also when they come into a treatment service or they are doing an assessment for their needs they will be asked to nominate their principal drug of concern. That is how it is reflected in the data collection. They usually nominate the thing that has got them into trouble this particular time. They might well use cannabis, drink alcohol and take prescription medication but methamphetamine is getting people into trouble because they are so wound up and out there. We had a heroin epidemic before 2000. It sounds silly but people on opioids are a lot sleepier than people who are on methamphetamine. There is a lot more action happening. They are getting into more trouble. The other thing is that the community is interpreting any sort of unusual or bizarre or heightened behaviour as a methamphetamine problem when in fact it might not be.

Dr MEHREEN FARUQI: We visited Hope House yesterday, which was an amazing facility. Do you think there is a need for a women-specific place like Hope House around this area?

Dr ALLAN: Yes. Absolutely. Women are about one-third of the drug and alcohol treatment population and in residential settings they are in with men who are often domestic violence perpetrators and perhaps not the nicest people in the world. I do not think that is a great environment for women if they have experienced domestic violence or trauma in their lives and they have to live in that situation.

Dr MEHREEN FARUQI: One of the terms of reference of this inquiry is to look at mandatory detoxification programs for people who might self-harm or be subject to an apprehended violence order. Do you think that mandatory treatment is effective for detoxification?

Dr ALLAN: I was really surprised by that item in the terms of reference. It had not been something that I had heard discussed around the place, in the sector or in other settings. I guess detox is a process that is just clearing a physical thing—where you clear your body of the drugs that you have been using. It does not necessarily have any relationship to your likelihood of being violent or self-harming. I cannot see the connection. I know from discussions we have had with Legal Aid and the Aboriginal Legal Service people in Dubbo that in that area they are so sick of seeing the same guys coming in and getting bail and then reoffending, usually drug or alcohol affected. I understand why they would see—I am trying to think of what the guy called it—a bail house. One of the solicitors up there talked about a bail house where people would be bailed to a dry environment and they would have to stay there so they could not go back out and use the drugs the next day and beat their partner or get into trouble. That is not a thing I have heard about in Australia but I can see why in the legal setting that seems like a good idea.

Dr MEHREEN FARUQI: Yfoundations has also made a submission to this inquiry. In that submission one of the things they talk about is the criteria for entry into rehabilitation. They say it varies from service to service but there are two conditions that are mandatory and, in their opinion, problematic. One of them is to have had some engagement with the justice system before they can enter into rehabilitation programs. Do you think that should be a condition?

Dr ALLAN: I actually think a bigger problem is that people are excluded because they are involved with criminal justice system. That would be my experience of reasons why people are rejected from rehabilitation programs because of their offences—perhaps sex offenders, violence—people cannot come from jail to a residential program. That is the way I see the problem being, not the other way round.

The Hon. PAUL GREEN: In your submission you talk about a seven-day average stay. How do you ascertain that a person is through their initial detoxification emergency?

Dr ALLAN: We have a medical unit. We have doctors and nurses and they do withdrawal scales—there is an alcohol withdrawal scale and a cannabis withdrawal scale. It is a physical examination of people's physical state. I think the actual physical withdrawal can happen quite quickly but often people are pretty foggy mentally for some weeks after.

The Hon. PAUL GREEN: The Committee has found that the use of cannabis and its impact are coming up quite a bit. Can you give us a snapshot as to why cannabis is an issue? It is number three in the list—alcohol, methamphetamines and then cannabis. How is that affecting people?

Dr ALLAN: I guess generally in the community, not everybody but a lot of people, they think of cannabis as a safe drug, but it has the same problems as any other substance that is overused. You can become dependent on it to the point where you are constantly spending time looking for it, paying for it and using it to the exclusion of other activities. Cannabis can cause people problems in the same way alcohol does or nicotine or any of the other drugs. I guess that is not understood more broadly.

The Hon. PAUL GREEN: What happened to the continued care of the seven clients of the program you spoke about that was taken away because it lost funding? Did they just fall off the radar?

Dr ALLAN: Yes. For some people we tried to refer people who had quite serious health problems to the hospital, to the health staff and to hook them up with general practitioners and other services in the area. But for other people who are more in the case management support, regular group work, that sort of thing, if they are not part of our men's group, which is the service that we still have down in Bega, then they are not getting a service until something else comes along.

The Hon. PAUL GREEN: The table in your submission shows the organisation you represent with payments and costs of about \$130 a week, the next one is a residential at Wattle Grove at \$270 per week and the third category is community residential and that is virtually at no cost.

Dr ALLAN: Not residential, non-residential. So it is no cost.

The Hon. PAUL GREEN: How does a community-based non-residential service survive with no cost? How do they provide a service?

Dr ALLAN: We get government funding.

The Hon. PAUL GREEN: So they are subsidised?

Dr ALLAN: All of our services are completely reliant on government funding. If that goes then there is no service.

The Hon. PAUL GREEN: In the graph you gave us we were looking earlier at the funding in Victoria but they have nothing.

The Hon. Dr PETER PHELPS: No, that is service delivery.

The Hon. PAUL GREEN: You say in your submission that you get 30 calls per day from people looking for rehabilitation beds?

Dr ALLAN: Yes.

The Hon. PAUL GREEN: That is an extraordinary amount, is it not?

Dr ALLAN: Yes. It is a huge demand and nearly all of those 30 people will be told no. There is an overreliance on residential rehabilitation. There is a push towards residential programs from courts and child protection. People say, "If you want to change your drug use, you need to go to rehab." I do not think that is true. A lot of that push is people being told—people will come out of jail, they may have been in jail for a year or two years, and they have to go to rehab to get out. They are ringing everywhere in the State to try and get a bed so that they can get out of jail.

The Hon. PAUL GREEN: There is just not enough, is there?

Dr ALLAN: No. Why do they need to go to rehab if they have been in jail for two years? Even if they are using drugs in jail it is not going to be at the same level they could use on the outside.

The Hon. PAUL GREEN: Unless there is a commitment to change it means very little, does it not?

Dr ALLAN: There is a big debate in the sector about whether people are motivated to change and whether there should be a requirement of motivation before you can come into a program. The research has found that it does not matter how people come in, they are just as likely to be helped. In the past some places have screened for motivation—we do not do that.

The Hon. PAUL GREEN: Your success rate?

The Hon. Dr PETER PHELPS: How do you define success?

The Hon. PAUL GREEN: The usual terms.

Dr ALLAN: We did a research project with the National Drug and Alcohol Research Centre a couple of years ago. It is a particular intervention model called the community reinforcement approach, which is a bit of a dud name. The truth of that is 70 per cent of people will reduce their drug and alcohol use by undertaking

this program. When we did the research project we found that that was in fact the case. But as most treatment effects are that people come in using a certain amount, during treatment that goes down, at post-treatment it is quite low, at three months some people have increased, and at six months, you have a graph that shows that decrease and increase. I think in the submission somewhere it says about 60 per cent of people will relapse, and that is talking about alcohol specifically.

The CHAIR: We have gone over time. I have a question but I will put it on notice. I have sat here listening intently and can I just say that it is very refreshing to have some straight talk from someone who has been obviously working in this area for a long period of time—and I am not saying that to reflect on other witnesses we have had in this inquiry, but you did not equivocate in your answers to the questions, you simply gave straight answers.

The Hon. Dr PETER PHELPS: Which is why you are going to cop more.

The CHAIR: Straight talking with reflections on experience at the coalface will help us as members of the Legislative Council in our deliberations and it is greatly appreciated. Thank you for your submission and for coming along this morning.

Dr ALLAN: Thank you, and I hope it has been helpful.

The CHAIR: Very helpful. Thank you very much, Dr Allan.

(The witness withdrew)

SHIRLEY DISKON, Manager, Hope House, Community Life Batemans Bay, sworn and examined

DENNIS JOHN HUGHES, President, Community Life Batemans Bay, sworn and examined

The CHAIR: We are down a couple of members; one had to go back to Sydney yesterday afternoon and one has had a family emergency this morning and has had to leave and go back to Wagga. In any event, we still have plenty of members here and we are very interested to hear from you this morning. I thank you both very much for your hospitality yesterday. For me, I enjoyed the first part of just looking through the place and meeting some of the gentlemen who reside there as current residents and particularly, impressively, the couple of gentlemen who have been through the program and are serving as volunteers in mentoring and are an example to the other fellows who are coming through. There is nothing like going to see a place and observing firsthand and talking to the people operating it compared to reading something on a piece of paper.

Ms DISKON: It was very good that you could take the time out to come and visit us.

The CHAIR: We have members here who are eager to ask you some questions, but first would either or both of you like to make an opening statement to set the scene? We have received your submission and you can take that as read, but you might like to make an opening statement before we commence questioning.

Mr HUGHES: Just to start at the very beginning, we established Community Life in 2006 when we recognised an issue in our community for people that were lost, lonely and homeless. We started off by running a program called Hope Fellowship, which just brought those people in together to share with others their problems. As a result of that we noticed that there was a huge problem with homeless men and people with drug and alcohol addictions within our community. So in 2009 we established Hope House, where at the time we could rent a property which allowed us to keep five men at any one time, and we set up a couple of programs running from between three to six months when they could stay as residents. Since then, over the last four years, we have had the rectory from the Anglican Church which have graciously rented that to us and assisted us in running it. With Shirley's help over the last few years, we are always relying on funding from outside or the rent from our tenants to keep the place operating. We struggle day to day to keep operating but we are determined to continue to help those in need in our community.

The CHAIR: Ms Diskon, would you like to add to that?

Ms DISKON: I just want to thank you for the opportunity to put forward the issues that I deal with every day on a day-to-day basis with every client that we have with drug and alcohol and mental health issues as well as criminal behaviour, and being homeless and domestic violence—they just present with so many issues and we try to deal with all of them, and we do deal with all of them. We thank you for the opportunity to be here to let you know.

The CHAIR: We will start questions with the Hon. Paul Green.

The Hon. PAUL GREEN: I just want to say that we have delivered on a commitment to you guys to bring the inquiry south, knowing what a great job you do. It is great that the Committee would commit to come down here and I thank the Committee for taking time out of their lives to come all the way down here for this moment, which is much needed to hear the good work that you do. I will start with the funding. Ms Diskon, I know you could probably tell us everything we really need to know but I think we will try and pull some answers from you. I have been on a bit of a journey with you guys with the funding and the homeliness and how Hope Place was shut down. Hope Place was basically collecting quite a lot of the homeless who were coming south of Sydney, sort of the end of the train line and then ended up in Batemans Bay, and your service picked them up. They were from situations like you say—lost, lonely, homeless, domestic violence, and a lot of women and kids were in that program, yet it fell over due to the funding. Is that right?

Ms DISKON: Yes, correct.

The Hon. PAUL GREEN: And yet a lot of those government agencies would farm these people to you knowing very well that you were going to look after them.

Ms DISKON: Yes.

The Hon. PAUL GREEN: My take on that was that the government agencies had the money to look after these people and when they gave them to you they did not necessarily fund you to look after those people. Would that be correct?

Ms DISKON: That was definitely correct: They did not. We had single men with children as well, because they are families to us, are they not?

Mr HUGHES: I addressed this with Brad Hazzard when he was the Minister for Family and Community Services. We had a meeting on it, and the single biggest issue was the definition of families. We define a family as parent or parents with children and Hope Place was set up for families in emergency situations. It was not a long-term place. We then worked with other agencies to find them permanent accommodation. The biggest single issue we had was because we would take in men with children, it did not comply with the Government regulations, if you like.

The Hon. PAUL GREEN: So the men had nowhere to go?

Mr HUGHES: We would refuse to refuse men with children in the middle of winter when it was pouring rain so they could go and sit under the bridge when we had a spare room.

The Hon. PAUL GREEN: That would not be very compassionate to leave them under a bridge.

Mr HUGHES: We would take them in. We had 24 hours.

The Hon. PAUL GREEN: In that particular service, how many people would you administer to every week?

Mr HUGHES: I think it was up to about 45.

Ms DISKON: Forty-eight, I think.

The Hon. PAUL GREEN: Up to 48 people.

Ms DISKON: Yes.

The Hon. PAUL GREEN: I want to make it clear I am not coming down on the Government, because through Andrew Constance and Brad Hazzard the Government took this concern and tried to do some things and it was financially unsustainable. That was where the department landed, hence you made an executive decision to shut it down. Where would those 48 people be today?

Ms DISKON: In cars, under the bridge, temporary accommodation on lounges, wherever they can find anywhere to go. We have a family in Batemans Bay with three kids—a mother with three kids who is actually sleeping in her car. She is getting these kids ready to go to school from her car.

The Hon. PAUL GREEN: That lady could have been in something like Hope Place?

Mr HUGHES: Yes.

Ms DISKON: Definitely.

The Hon. PAUL GREEN: At this current moment are there any other facilities around Batemans Bay regional area that does the same thing that Hope Place was doing? Is there anywhere else that those people can go to?

Ms DISKON: No. The only thing that we have for women is the women's refuge and that takes women and children from domestic violence. They have a youth refuge for up to 18, I think it is. There is nowhere for people aged 18 to 24 to go, except we do take single men aged 18 and upwards if they need to come. But there is nowhere, absolutely nowhere, for these women and kids to go.

The Hon. PAUL GREEN: It is pretty crazy. I want to put on record that you guys did an awesome job with Hope Place. You were putting a roof over people's heads who were sleeping in cars and under bridges and it could not be sustained by the Government. We would think that would be a higher priority than people living under bridges or in cars.

Ms DISKON: Yes.

The Hon. PAUL GREEN: My goodness, it does not matter how bad things get, surely in the worst-case scenario we could provide a roof over their heads so they eat a meal and put their head on a pillow.

Ms DISKON: And a lot of it was not their own fault, like marriage breakdowns or domestic violence.

The Hon. PAUL GREEN: I will move to domestic violence and drugs next.

Ms DISKON: Also, when we went to a homeless forum, Anglicare noted that since Hope Place closed, the homelessness in this area has tripled. Their client base tripled after that.

The Hon. PAUL GREEN: And those government agencies are having to do something with their budget and look after these people somehow, even though those figures are still climbing?

Ms DISKON: Yes.

The Hon. PAUL GREEN: Let us go to drug and rehabilitation. It is very important. You have Hope House. Can you tell us about the funding? Obviously these people are not wealthy individuals?

Ms DISKON: No.

The Hon. PAUL GREEN: Tell us how you manage the funding for Hope House?

Ms DISKON: I do all the grant applications, but the grant applications are very specific. They do not cover day-to-day costs, running costs, wages or things like if you have to put in a fence or a—

The CHAIR: Driveway.

Ms DISKON: Driveway, yes—thank you very much—security lights, those sort of things. They do not actually employ the staff. So when the guys come to us, they are down and out, they do not have any money; they do not have a cent. Some of them do not have a doctor, they do not have a driver's licence, they do not have Medicare cards, they did not even have clothes. So we have to find clothes for them, we have to find food for them. The funding has been absolutely terrifying. We live day-to-day. We live absolutely day-to-day. I do not know if I go into work today if I am going to have a job.

The Hon. PAUL GREEN: There are no other men's refuges around, is there, where can they get such support?

Ms DISKON: No, none whatsoever. It is really, really hard. We would like to employ some staff to make the service a lot better, instead of having just one paid employ and 30-odd volunteers.

The Hon. PAUL GREEN: This comes to the point we have been talking about. The Victorian Government does not have any program delivery services. Here is a classic example. We are in a regional remote area that does not seem to have the agencies that can cope, and we have a non-government service provider doing a very good job but you cannot get funding to sustain yourself.

Ms DISKON: And we are at a loss to understand what we need to do or why we cannot get funding. What is the biggest issue here? They say we do not fit under their umbrella because we do not only do homelessness. Well, everybody is 100 per cent homeless. Everybody who comes to us has a mental health issue. Over 90 per cent of the guys present with drug and alcohol problems; 95 per cent have records for criminal behaviour. We cover the whole range. They say that because we do not just focus on homelessness or we do not focus on mental health, they cannot help us. They say, "Go to mental health. They have buckets of money."

The Hon. PAUL GREEN: Everyone has buckets of money except for you guys.

Ms DISKON: We have got none.

The Hon. PAUL GREEN: And you are doing all the work.

Ms DISKON: Yes. We do a lot of work for a lot of agencies around here. They ring us up and say, "Have you got a vacancy?" Even some of the specialist homelessness services ring up and say, "Have you got a vacancy?" Yes, we take that person on, but we do not get any support from those agencies.

The Hon. PAUL GREEN: You just need a hand.

Ms DISKON: Definitely need a hand, an ongoing hand, not just a hand today but something for the next—

The Hon. PAUL GREEN: Sustainable.

Mr HUGHES: Yes, sustainable, keep us operating.

The Hon. PAUL GREEN: In your submission you note the shortage of health professionals.

Mr HUGHES: Yes.

The Hon. PAUL GREEN: Can you put something on the record?

Ms DISKON: We have gentlemen turn up and they do not have doctors, they do not have medical records, so we have to get them a doctor and a mental health care plan and health. There are only two GPs in this local area that bulk bill, because these guys cannot afford \$70 and get \$30 back. So we have to find these two doctors; their waiting list is huge. They go to the doctor and a lot of the time they are told their doctor is shopping or they are this or they are that, or they are treated very badly. So then they have to get the records from where they were last time and some of them do not have records, and they are very—they do not want to prescribe drugs or health plans or anything like that because they do not know these people, so we have to get all that information.

The CHAIR: They do not know their history.

Ms DISKON: That is right, they do not know their medical history, so then we have to try to find that. Then in order to get the mental health care plan, we have to go through the mental health care line to get them into community health to get them in to see a psychologist, or we can get a local one. There are a couple of local psychologists around here who do support Hope House, so they can go and see them, but the gaps are huge.

The Hon. PAUL GREEN: Who pays the psychologist?

Ms DISKON: Medicare. But there is only one that will work with Hope House. We did try to get an arrangement with a clinical social worker, but they still have to pay \$15. You know, when you pay your rent and buy your smokes—because they all smoke—and your coffee and your sugar and your tea, then they are basically living from pay day to pay day, and that is why we are lucky we have so much support from bakeries and things.

Dr MEHREEN FARUQI: Thank you very much for coming in today, for all that you do and for showing us around with such warmth yesterday.

Ms DISKON: You are more than welcome.

Dr MEHREEN FARUQI: I want to explore how people find Hope House a little bit more. Is it through referrals or is it people knocking on the door? How do they find out about your service?

Ms DISKON: It is a mixture of both. We have agencies like Housing, Link2home, Anglicare, South East Women and Children's Services, mental health, hospitals such as Goulburn and Bega and a lot of self-referrals. They just knock on the door. We had two young fellows turn up last week and say, "I'm homeless. I need help." If we have got a vacancy, we take them in.

Dr MEHREEN FARUQI: If you have got a vacancy, you take people in who knock on your door?

Ms DISKON: Yes. As Mr Hughes said, we cannot see them sleeping under the bridge or whatever. Then we ascertain whether they want to do the whole program or whether they are just homeless. We have taken in temporary people before but they only stay for about three or four nights and then they move on. They are just waiting to get a bus or they have just got down here and lost their money or drunk it all or whatever. They just need a place to stay.

Dr MEHREEN FARUQI: Is there an average length of time that people stay with you? What is the range?

Ms DISKON: It ranges from about three to five months for most of them. About 75 per cent have stayed from three to five months. We have had people that have stayed six to seven.

Mr HUGHES: We have had a couple that have stayed longer than that.

The Hon. PAUL GREEN: Because they needed it.

Ms DISKON: Yes, because they needed it.

Mr HUGHES: We could see that it was helpful to them. We are not going to throw somebody out because they have been there six months. They leave when they are ready.

Ms DISKON: We try to help them find accommodation and achieve their goals. We try to move them on to somewhere like either share accommodation or a caravan or their own place, that sort of thing. We try to help them a lot. We do not just say, "Your time's up. See you later." We also do outreach as well with these guys. The two gentlemen who you met yesterday have come back to help us and we keep them close. Steve had his grandson run over. You probably heard about it; it was in Sydney. We kept him close and had him there. He needed the support and the help. He has come through that and he has come out the other end. He did have one drink but he put it down and said, "No, I can't do that. I've gone through all this. The support I've had and where I've come from, I can't do this any more." He has picked himself up.

Dr MEHREEN FARUQI: I would like you to talk a little bit more about the impact that your services have had on people. We heard some amazing stories yesterday. I think for the record it would be really good if you talk a little bit more about the impact your services have had on people's lives.

Ms DISKON: You were talking about outcomes earlier. Outcomes to me or our service are measured on individuals. We had a gentleman come who was highly addicted to valium. He had been in and out of jail since he was 16. He deliberately trashed a police car so he could go back to jail. He had a son and a girlfriend but he had lost contact with his son because of his drug use. He was also into ice and all the other drugs that go

along with it. He lost contact with them. He came back to us out of Corrections. He had been in and out of jail for petty thieving and all that sort of stuff. He came back to us, we took him back in again, we helped him again and his girlfriend made contact. He saw his son and now he has got a daughter. He has got a job. He has got a car. He has moved to Canberra. To me, that is an outcome. He wanted to get back with his son. He has achieved that and a lot more. To me, that is an outcome.

We have had another guy that has turned up who was down and out. He had lost his kids. He has got access to his kids now. He has got a job. He has got his own place. To me, that is another outcome. That is a success story. That is how we measure it. You cannot measure it when you go to put in for a grant and say what your outcomes are going to be. We cannot actually explain it in that, but that is what, to us, an outcome is. Then you have got another guy that was really down and out on ice, in and out of trouble all his life. He got bashed up by his wife and he ended up in jail. He had stitches in his head, but because he was a male they took him as the perpetrator and he ended up in jail because of it. He came back to us as a high level ice user. We got him into Oolong House. He went kicking and screaming. He hated me because we got him into Oolong House. Part of his parole was he had to go to rehab, so we got him into rehab. That was nearly two years ago. That guy is engaged, got a job, got his own place. It is stories like that that to me are the biggest outcomes.

Mr HUGHES: We have our biggest single success, and I am very proud to say this. We had a fellow who was so addicted to alcohol that he was gone. The medical staff had given up. They said, "No, his liver's gone. His kidneys are gone. There is no hope whatsoever." There was: Hope House. We took him in. He was with us for quite a long time—more than the six months—but we were able to assist him to break that addiction. The doctors had said that he had no more than a month to live. I am proud to announce that now he is a qualified nurse and works for the National Disability Insurance Scheme. He has done that since he left Hope House.

Ms DISKON: He started to study at Hope House and then he continued it once he left.

Mr HUGHES: That is a real success.

Ms DISKON: That is the kind of impact we have on people.

Mr HUGHES: I am not saying that everybody is a success, by the way.

Ms DISKON: No, we do have some failures, but in the last 18 months our success rate has been over 75 per cent of people achieving their goals like a house, a job, their kids back, they are back with their family. We had a guy who got sent to us through domestic violence. He stayed with us. He got a place in Narooma and now he is back talking to his wife. His family has got back together. But he came through parole. We have got a very good relationship with the Department of Justice here. The judge is very supportive of Hope House and what we do. Like Nathan said yesterday, if it was not for Hope House, he would be doing two years in jail. But the judge saw that I was there and he was at Hope House. I work very closely with Corrections. The lady that we knew that did the intake said, "Yes, I'll do that for you. We'll do a community service order only because of what you're doing at Hope House." He has gone ahead in leaps and bounds. He is going to get his children back. That is a big outcome.

Dr MEHREEN FARUQI: On page 4 of your submission it is stated that Brad Hazzard committed \$25,000 to support Community Life Batemans Bay Inc. but no funds have been forthcoming. Have you had any progress on that?

Ms DISKON: Yes, we have. We got a phone call yesterday from Andrew Constance's secretary and he has committed \$50,000 to us as a one-off donation hoping to be a bridging grant until we can get some buckets of money from somewhere else. At this stage it is just a one-off \$50,000.

Dr MEHREEN FARUQI: When does your funding run out? Have you received any funding in the last financial year from the Government?

Ms DISKON: No, only from the club. ClubGRANTS have given us a lot of money, the Batemans Bay Soldiers Club as well as the Catalina club. If it was not for them, we would have been closed last year.

Dr MEHREEN FARUQI: You completely run on donations, am I right?

Ms DISKON: Yes, and the rent from the gentlemen and any grants from the club or something that we can pick up along the way. The Snow Foundation has been supportive as well.

The Hon. PAUL GREEN: And a lot of heart.

Ms DISKON: Yes, and a lot of hours not being paid for.

Dr MEHREEN FARUQI: If there is one recommendation that you think the Committee should make—and I know it is hard choosing just one—what would it be?

Ms DISKON: Detox and rehab together, and maybe ongoing support after rehab. Detox is so hard to get into. Here you have got to ring up. It is actually in the hospital. There is no set place for a detox. There used to be but that is not there anymore. Now they just have a bed in the ward anywhere and they do a risk assessment and all those sorts of things to see if they can take patients in. It is not ideal. Then you have got to try to line detox up with rehab, and that is so hard. You just cannot let them out when they have detoxed. They let them out on Friday as well, because detox only goes Monday to Friday, and it is set up for failure. What do people do on Friday, Saturday and Sunday when there are no services available? They bust. My recommendation would be to have a detox centre and a rehab all in one or close together and then maybe a place like Hope House that would carry that on and then move them out into the community. That would be my recommendation.

The Hon. Dr PETER PHELPS: Would it be fair to say that substance abuse is not the problem but that substance abuse is the manifestation of a symptom of a broader range of problems in most cases?

Ms DISKON: Definitely. For a lot of the guys who come to us the alcohol and methamphetamine is a bandaid. They have had trauma in the past, they have had trauma growing up. One gentleman who came to us was 21. He had been in and out of jail. His father died when he was four and his mother gave him up for adoption at six- years of age. He had just run amok—drugs, alcohol, criminal behaviour. The underlying cause is not dealt with but with the programs we have we try to deal with what has happened in the past as to why they do the alcohol, the drugs and the criminal behaviour.

The Hon. Dr PETER PHELPS: Would it be fair to say that your success comes largely from triaging your patients and saying it is not just a drug, violence, criminal problem or homelessness problem but they are all interrelated to varying degrees—for example, some may have experienced homelessness and drugs but have never had experience with the criminal justice system. It is getting them out of the whole problem rather than the specific problem that allows them to move on with their lives?

Ms DISKON: I agree. You go to Mental Health and they say, especially if you have had a drink, "He is drinking. That is why his mental health is like." He is drinking because of his mental health, it is interconnected. It is also interconnected with his family breakdown or his criminal behaviour or lost relationships and being homeless—being homeless is a huge thing. Just imagine sleeping in your car for so many months or walking the streets or sleeping under the bridge? Then you drink and then your mental health goes down or they have a mental health issue anyway. The whole thing makes up this one person and you need to focus on why the person is doing what they are doing. You need to get to the root of it and deal with that. Once you have dealt with that then that person can open up and have a better life, get away from the drugs, from the mental health issues and all the other things that go along with it.

The Hon. Dr PETER PHELPS: One of your former residents spoke yesterday, and I thought it was interesting, about the sense of community he felt for the first time. He actually got that sense of community by leaving his physical home community and moving to an entirely different community that offered him support.

Ms DISKON: Like I said yesterday, they call me nanna.

The Hon. Dr PETER PHELPS: Is there something to be said for someone removing themselves from their original community, which has so many memories of why they have turned to substances, and putting them into a different community to give them an opportunity to understand what a communal experience is like but without the negative consequences?

Ms DISKON: Most of the time their community is based on what they call acquaintances or friends but they only have one thing in common—the drug or the alcohol or whatever. They have got to get out of that area away from their old friends because they are bad and they can influence them. They need to break the cycle. By coming to Hope House we try to give them a sense of community. We try to build them up and support them until they can support themselves. They are very broken when they come to us. They have only been used to the kind of community where they have been yelled at or whatever has happened to them, whereas we try to give them the other side—a bit of love maybe, a bit of support, a bit of kindness. They have never basically had that before; they have had to struggle from day-to-day. We give them a roof over their heads, some nice food and we offer them support as well.

The Hon. Dr PETER PHELPS: More than that, you also give them the springboard back to what might be called normality?

Ms DISKON: Yes.

The Hon. Dr PETER PHELPS: Computer skills, adult education—

Ms DISKON: White card and traffic control.

The Hon. Dr PETER PHELPS: A white card, a driver licence, the sorts of things which can allow them to move to a situation that might be described as average Australian normality?

Ms DISKON: Yes. Otherwise they feel sort of isolated because they do not have those things. When they come to us, like I said, they do not even have a Medicare card or a driver licence, they do not have anything. We get them all of those. Then we work towards getting them their L plates and their P plates—a lot of them cannot get their licences back because they have been suspended but the ones who can we work with on doing that. Then we get them adult education with computers, jobseeking skills, we help with interviews, how to dress and all those sorts of things. With adult education we do white card and traffic control. So they have actually left with something. As well as a sense of worth, they have actually got qualifications and a driver licence so they can drive to a job, and white cards so they can actually get a job.

The Hon. Dr PETER PHELPS: You have said that even your successful residents are in and out of jail. Presumably you would support an expansion of diversionary programs—for example, drug courts of deliberative magistrates to make greater use of the Magistrates Early Referral Into Treatment [MERIT] program to allow diversion into rehabilitative treatment programs rather than going into jail?

Ms DISKON: When I was in Sydney and down here I am also a SMART Recovery facilitator, which is a self-management and recovery training program that is well recognised by courts as well. I noticed that a lot of MERIT programs and that—I do not think jail is the answer for a lot of these people. I think they need to be helped with their drug and alcohol and their mental health. Just putting them into jail is not the answer. I believe that MERIT programs and SMART programs would be more beneficial to these people.

The Hon. Dr PETER PHELPS: It might well be argued that, unfortunately, drugs are still quite prevalent within the jail system?

Ms DISKON: Definitely.

The Hon. Dr PETER PHELPS: So someone who would like to get off them in fact is materially disadvantaged by being sent to jail where, lamentably, there is still the ability to access a wide range of narcotic substances?

Ms DISKON: A story that I hear quite often is, "I have got drugs in jail. We do this, we do that." Apparently you can get those nicotine patches and do something with them. I have no idea how to do that but—

The Hon. Dr PETER PHELPS: But for a person who is self-aware enough to realise that they have got a problem and if they go back then it is only going to get worse, if they do not have the ability to go into a diversionary program then essentially you are simply committing them to a cycle on returning to criminality, drug use, criminality, drug use?

Ms DISKON: That is the biggest cause of reoffending. Travis McGeaghy is on the other side.

The Hon. Dr PETER PHELPS: I wish Mr McGeaghy was here because I am using all the questions I wanted to ask him.

Ms DISKON: He got caught up in court and could not make it.

The CHAIR: We appreciate that.

Ms DISKON: He was saying that if a guy said, "I put my hand up. I am hopeless. I need help." There is no detox and no rehab. There is nowhere to go. What is the other alternative—into the community or into jail? He has got to go to jail, there is no other alternative.

The Hon. PAUL GREEN: The other annoying thing is that it costs about \$200 per day to keep a prisoner in jail. Why not put that money into something like Hope Place for someone, as Dr Phelps was saying, who wants to do something about their life and have a better outcome?

Ms DISKON: You are going to get a better success rate and less reoffending. We did some statistics and in our last lot of statistics 68 per cent of people we have helped are still on the straight and narrow and still have not gone back into custody. It is astounding what these guys have actually done. We have got one guy who was unbelievably in and out of jail. He came to us and went through the program twice—but he got it the second time—and this was like four years ago. He had a huge ice problem but now he is doing really well. He has not got a job but he is not reoffending, he is not drinking, he is not doing drugs. As they say, "I'm doing a bit of a pot," because they think pot seems to be the—

The Hon. PAUL GREEN: Safe drug.

Ms DISKON: Yes, a safe drug or it is not that bad, not that bad consequences.

Dr MEHREEN FARUQI: Do you think Australia and New South Wales should look at decriminalising the use of drugs and basically looking at it from a social and a health perspective?

The CHAIR: I appreciate the question but Dr Phelps was asking a question and we sort of cut in. We will return to that if we have got the time.

The Hon. Dr PETER PHELPS: I will hand over to Mr MacDonald.

Mr SCOT MacDONALD: Just two quick questions to finish. If you are in child protection working for the Government, the Police Force, FACS or whatever, the people who are dealing with these difficult situations get counselling and downloads. I was just wondering with NGOs—you are at coalface—how do you look after yourselves, basically? How does your staff look after themselves?

Ms DISKON: The girls and I get together and have a debrief session. That clinical social worker I was talking about, we go and see her as well on a one-to-one basis once a week or once a fortnight on a regular basis.

Mr SCOT MacDONALD: Is that enough?

Ms DISKON: And I have got my husband.

Mr HUGHES: We have the Anglican Church just in front of us and there are people there all the time.

Mr SCOT MacDONALD: If you are in the public sector there is process and there are formalities and resources. That sounds a little bit ad hoc to me. Visiting you and seeing other places like Freeman House I wonder about the infrastructure. You are in a building there that is someone's private house, it is 30 years old or whatever it is, you are living hand-to-mouth with your operational money. Sooner or later that infrastructure—the capital is just not going to do the job. Whether it be fire safety or the kitchen or whatever, you are going to have to spend hundreds of thousands of dollars sooner or later. Where does that end up? As I say, you are not on your own; there are many other NGOs that we visit and all of us see in other roles, but it is just not going to do the job in the years to come. Where are you going to be in 10 years' time infrastructure-wise?

Mr HUGHES: We are still using the rectory of the church, the church has supported us in that and the renovations recently—I think we showed you the kitchens and the bathrooms—were done by the church. We did get the house painted and the flooring all replaced; that was under the work with the old program. So we rely on those sorts of things totally to keep this thing up and operating.

The CHAIR: I have one final question. I do not come with any authority from the Government in terms of what I am about to raise but I will raise it with you anyway. In terms of Hope Place, which is now closed as a facility, would you be open to further discussions afresh with the Government and the relevant Minister or Ministers to discuss the possibility of some venture along those lines in the future? In other words, what came before has been in the past and is now behind us, but there clearly is a need in the community, particularly in regards to women. Obviously you are working day to day to keep Hope House going but do you have the will and the wherewithal to have a discussion with the Government if the Government was open to want to talk to you about the possibility?

Mr HUGHES: We certainly have the will for it, yes.

Ms DISKON: Definitely, absolutely.

Mr HUGHES: One of the major issues in this region is finding accommodation. The old Hope Place was partially burnt. It is on the market at the moment. It was partially burnt about six months after we closed the place and they did find some asbestos in there. I do not know what the situation is—

The CHAIR: My comments were exploratory in nature because I have no remit, obviously.

Mr HUGHES: We are certainly there. Our aim is to help the community.

Ms DISKON: And definitely women and children as well—and men with children.

The CHAIR: On that note, we will conclude. We stole an extra five minutes of your time. Once again, thank you very much for yesterday—it was a wonderful opportunity and experience for us all—and thank you for coming in and being so frank and straight with us in terms of your thoughts and reflections about the important work you are doing and what needs to be work done with the community here in Batemans Bay and surrounds. Thank you very much.

Ms DISKON: You are welcome.

Mr HUGHES: We appreciate being invited.

Ms DISKON: Any time you want to come back down, our door will be open.

The CHAIR: We may have some questions on notice which are questions that arise from our questioning of you this morning. We have a 21-day turnaround time for the secretariat to liaise with you and for you sending answers back.

Ms DISKON: That is more than welcome.

(The witnesses withdrew)

(Short adjournment)

GLENDa McCARTHY, Team Leader, Pathways, Eurobodalla, affirmed and examined

STEPHANIE STEPHENS, Acting Chief Executive Officer, Directions Health Services, affirmed and examined

KAYLENE MALLOTT, Team Leader, Pathways Goulburn, sworn and examined

The CHAIR: I welcome the three of you. Thank you for making yourself available to provide some information to us today and, perhaps more importantly, providing the opportunity for us to ask some questions. We normally proceed with an opening statement from one or all the people at the table. That is a matter for yourselves to work out. When you have done that, we start with questioning. We have representatives from the Government, the Opposition, the Christian Democratic Party, and The Greens. There are two apologies from members who, for reasons beyond their control, had to leave us and get back to Sydney and Wagga Wagga respectively. That does not affect the hearing in respect of our interest in what you are about to say. I invite you to make an opening statement and then we will start with questions. Is that format okay with you?

Ms STEPHENS: It is.

The CHAIR: I will you allow to commence your opening statement.

Ms STEPHENS: I have a rather informal opening statement to give you an overview of our experience as well as our scope. We are a not-for-profit NGO with charitable status. We have been based in the Australian Capital Territory [ACT] for roughly 40 years and expanded into New South Wales over the past two years. We are a specialist AOD service. That is our one main—

The CHAIR: So far as acronyms, please use the full phrase or word the first time.

Ms STEPHENS: We are a specialist alcohol and other drugs service in the Australian Capital Territory and now in New South Wales. We receive funding from the Commonwealth, the PHNs—primary health networks—in New South Wales and ACT; we receive Ministry of Health funding from New South Wales as well as ACT health funding. We have a variety of services that span the full spectrum of drug and alcohol addiction. In the ACT, we have a needle and syringe program. For people who are in active drug use we provide clean injecting equipment as well as harm minimisation information on safer injecting and we meet holistic needs around diet, clothing and referral to homelessness and other services.

We have a primary health service in the ACT which has five GPs, two nurses and a psychologist which provides outreach to homeless areas and housing estates. It also provides a primary health service for those who may not be comfortable discussing their addictions with their GPs, or those who may not have a GP or have sought help at some time—they may be pregnant and using drugs, for instance—as well as psychology and a trauma-informed approach to addiction.

We have also got a counselling case management treatment and support service in the ACT which we provide to inmates at the Alexander Maconochie Centre [AMC], as well as outreach to housing estates and headspace. We also have Arcadia House on the grounds of Calvary hospital, which is a rehab and detox and day program facility, which I will tell you a bit more about. It is an 11-bed facility and one of those beds is funded for the southern New South Wales region by a coordinator of the PHN. In New South Wales we have a variety of community-based treatment services.

Back in the day, rehab was really all bed-based but our idea now is that we are taking it to the streets and it is better value for money, so all our New South Wales services—apart from the one bed in Arcadia House—are community based, and they are the Pathways services. Ms Mallott manages the Goulburn one, which is our first growth into New South Wales, then we went to Wagga and Griffith, the Murrumbidgee and then to Eurobodalla, so from Batemans Bay down to before Bega, below Narooma, and the smaller areas in between. We are also in the Monaro, based in Cooma, but we outreach into that region as well.

The Goulburn and the Murrumbidgee programs started with ice task force funding to target methamphetamine specifically, as well as polydrug users with methamphetamine as the drug of concern. It is an intensive case management and counselling service. The intervention happens outside the bed-based residential system, but we support the transition from community in and out of bed-based detoxes and rehabs. In Eurobodalla and Monaro, they are general drug and alcohol services so it is open to all drugs of concern. We recently expanded the Goulburn service to treat some general AOD as well as methamphetamine also in Wagga, and that has been very welcomed by that community.

The CHAIR: It is alcohol and drugs that you deal with?

Ms STEPHENS: Correct. Alcohol is our most common drug of concern across all of our services, except for where other drugs are excluded to focus only on methamphetamine. It is then followed by methamphetamine. Where people are injecting drugs, it is primarily methamphetamine and that is a big historical change, especially in the ACT where it was heroin. In November, it was overtaken by methamphetamine for the first time.

So we are a company limited by guarantee. We have accreditation with QIP, Quality Innovation Performance. QIC is Quality Improvement Council, so QIP is similar.

We just went through our latest round of accreditation with them. We are accredited with AGPAA, Australian General Practice Accreditation Agency, and we are about to undergo accreditation with the Australasian Therapeutic Communities Association, which is the ATCA, and that is a recent accreditation that has become available. We are preparing for that to officially be a therapeutic community, although we have been operating that way for a long time.

One of the things that makes Arcadia House original is that it is a therapeutic community with a very strong cognitive behavioural therapy [CBT] underpinning, so it is evidence-based. We have been using outcome measures for a long time, which I noted in the terms of reference was a point for exploration. We have been measuring our outcomes with standardised tools for a number of years. In the past that has not been able to be benchmarked because standard measures have not been used in the sector. All of our services use the ATOP and the ADOM—Australian Treatment Outcome Profile and Alcohol and Drug Outcome Measure. They are able to be benchmarked and we have been using them for quite some time now in an attempt to show that the work we are doing is of a good standard.

The Arcadia House program is unique in that a part of it is detox. It is within the same facility. It is non-medicated, which means that for heavy alcohol use or use of benzodiazepines, for instance, we require a medicated withdrawal, so we have partnerships with medicated detox facilities nearby to facilitate transition between the facilities. Those who do a non-medicated detox with us in Arcadia House are receiving intervention while they are detoxing. One of our concerns in the region is that a hospital-based detox or withdrawal is without intervention. So you might not be improving living skills, you might not be addressing the traumas that contribute to people's addictions, you are simply physically detoxing a body and then hoping that when they exit they do not just bounce back to their previous habits. That is one strength we see at Arcadia that we would like to see more of.

The CHAIR: Do you think that is a flawed consideration to just have detoxification and then end it? Are you arguing you that is inefficient or has some shortcomings associated with it?

Ms STEPHENS: I am arguing you could be getting better outcomes and probably for not much increase in funding really, especially with pre and post support, which our Pathways services provide. So before and after entering a bed-based service—if you enter a bed-based service, that is. Our experience locally and across both New South Wales and the ACT is that most people do not want or need a residential service, whether that is sadly or not. A lot of people with drug and alcohol dependency do not want to fully give up their substance of choice but they may want to reduce some of the negative impact it is having on their life. Although those that do choose to really do need options available to them so that you can optimise that motivation that they have got. But our community-based services like Pathways have been working predominantly with people who really want to manage the impact of their addictions, not necessarily cease and live a completely sober life.

A clinical governance framework I think is something to consider in considering local options. There have been a lot of very charitable attempts to address the needs locally. We were really pleased to hear Hope House speak. We work closely with Hope House and we do inreach to them at least weekly at the moment to provide alcohol and other drugs [AOD] intervention. One of our case managers does inreach, but our experience across all the regional areas in New South Wales where we are is that the clinical governance framework for staff that work in these services is really important. We would love to see consistency in that across the NGOs as well as better collaboration and support for staff who are working in these areas. Our observation in the regions is for those staff who are working in AOD and other helping professions like homelessness and mental health, for instance, need really significant support to get the job done and get it done well because they are living and working in a community with really complex needs.

The CHAIR: That was a very thorough and detailed opening statement. Thank you for that.

Ms STEPHENS: We have some statistics on drugs of dependence outcomes, pricing of our rehab and other details if you are wanting it.

The CHAIR: Is that written down so it can be tabled?

Ms STEPHENS: It is not in a pass-on-able format. I can relay it.

The CHAIR: We can receive it as a supplementary submission. We will follow it up. It is useful information that we would like to receive.

The Hon. Dr PETER PHELPS: You said that you did not see that there was a great need for most users to be in residential rehabilitation. That is different from a lot of evidence we have had previously in relation to the importance of residential rehabilitation even for harm minimisation programs to allow people to keep their addiction under a reasonable level of control. Could you elaborate on why you believe it is not important for the majority of users?

Ms STEPHENS: I think it is important that it is available but I think that not everyone is open to residential rehabilitation. Not everyone is able to suspend their life to go into residential rehab. If we are focusing only on residential options we forget a large portion of those who are impacted by dependencies, as well as their families. For those who are in employment where maybe their addiction has not reached a point where that has suffered it would mean suspending employment in most cases or leaving family, often children, unless it is a rehabilitation service that enables children to come with them.

The Hon. Dr PETER PHELPS: Why would we need to worry about people who are able to maintain what may be considered to be a normal life even if they have a level of addiction to a substance?

Ms STEPHENS: As an early intervention option. With rehab we are looking at a very severe end of the spectrum and there is a whole spectrum to remember. That is my point.

The Hon. Dr PETER PHELPS: But where does the grey area end between occasional use and addictive behaviours?

Ms STEPHENS: It is a good question. I suppose in our experience in our observation we see severe addiction daily. These are people who are not willing to enter a rehabilitation service and the treatment that is provided in the community is the only treatment that they are willing to engage with. Some of them may hold down some jobs. Many will not. Many will live lives in touch with the law and difficulties in their family lives. Not all will be as extreme as some of the residents in Hope House, for instance.

The Hon. Dr PETER PHELPS: But are there instances of people having methamphetamine addictions that allow them to maintain normal lives?

Ms MALLOTT: I think that when the Government decided to fund the Pathways program the program works more on intense case management. That intense case management allows us as an NGO or us as how we were funded to be able to work much closer with our clients and to be able to be reactive to their needs. We are an outreach program. That means we can pick them up. We can go to their homes. We can go and have coffee with them. We can take them to the park. We can take them to the doctor. We work as far as Yass, Crookwell, Braidwood, Gunning and around all those areas.

If we had somebody that was severely addicted to ice and we started working with them we could go to the doctor with them and the doctor could then prescribe a regime of medication for them to help them with their withdrawal. They would then have a nurse that would check in on them on a daily basis, and that might last for five to seven days or until they were over those main symptoms. Mind you, the symptoms of ice withdrawal are not hard. They are not like heroin, they are not like benzodiazepine and they are not like alcohol. It is a much easier detox.

The Hon. PAUL GREEN: Because we are learning all sorts of things, can you tell us the symptoms of coming off ice?

Ms MALLOTT: The symptoms of ice withdrawal are certainly stress and anxiety. They may have a few aches and pains but nothing worse than a flu. It is the anxiety that is probably the biggest problem. A doctor would probably prescribe valium, which is a benzodiazepine, but it would be a regime. They may start on 30 milligrams a day and that would decrease over a five- or seven-day period. That is about it. Of course they have cravings, because it affects the dopamine and the serotonin in the brain. It depletes the dopamine, and the dopamine is the part of our brain that makes us feel nice. They wake up of a morning when they have stopped using and they do not feel very nice. They do not feel good. That possibly would be the reason why they are wanting to go out and have more. That feeling of despair and anxiety pushes them to go.

If they have a regime of valium or something to help them and someone to visit them on a daily basis to talk them through that, to support them, to encourage them—ultimately it is their choice in the end. But we have had some success in conjunction with Housing. We did have someone homeless who Housing put into a motel as they do sometimes when they cannot find accommodation. They will put them into a motel for a week until

they find it and then they have got to pay for it. Also in our funding we have brokerage. We were able to provide the food for the week for that person so he did not have to leave that motel room, and he did not. He left there and then came down to Hope House, relapsed again, but then came back to Chisholm Ross, which is our mental health unit. He is now living drug free and he has been for probably nine months.

Ms STEPHENS: If you contrast the methamphetamine withdrawal to alcohol or benzos, which can be lethal if non-medicated.

Ms MALLOTT: Yes, the same as benzos. But ice, you can withdraw. Many people will withdraw from ice probably without any support at all. If they make a decision and they have family support of some type they can withdraw and stop ice use. Being able to be in contact with them or for them to be able to ring us up and we immediately try to go to them to help talk to them.

The Hon. PAUL GREEN: Could you give me a snapshot of alcohol detox and what that looks like over the immediate stage of detox?

Ms MALLOTT: With alcohol people can go into a fit and it can be lethal and people can die. If we had somebody that was drinking alcohol on a daily basis and they were drinking reasonable amounts and you were trying to get them into detox, you would tell them to continue to drink. You would not say, "Stop and stop now before we get you into detox", because that could be lethal. They would get the shakes and fit, and in fits they could die.

The Hon. Dr PETER PHELPS: Ms Mallott, you work in Goulburn. Do you have anything to do with immediately released prisoners?

Ms MALLOTT: Yes.

The Hon. Dr PETER PHELPS: What is the situation with them and their experiences of drugs in jail?

Ms MALLOTT: I worked in the prison system for 15 years, so I do know a fair bit about prisons.

The Hon. Dr PETER PHELPS: I had a conversation with a lawyer yesterday who basically said that a diversionary program is much better. If someone knows they are going to jail that means they know they are going back to drugs.

Ms MALLOTT: To be honest it does not necessarily mean they are going back to drugs. They can get drugs in there, but a diversionary program would be the most suitable and most sensible.

The Hon. Dr PETER PHELPS: Especially for those people who are perhaps approaching the justice system for the first time?

Ms MALLOTT: The ones for the first time that are going in may not be able to get drugs, but for those that continue to go back and back, they are going to be in the know and they are going to get drugs.

The Hon. Dr PETER PHELPS: Presumably you are aware of the Magistrates Early Referral Into Treatment [MERIT] system in New South Wales?

Ms MALLOTT: Yes.

The Hon. Dr PETER PHELPS: Do you believe that should be extended across Magistrates Courts throughout the State?

Ms MALLOTT: Yes.

The Hon. Dr PETER PHELPS: The consequent result of that would mean there would have to be a significant uplift in funding for services to provide the appropriate facilities and programs into which those people could be diverted?

Ms MALLOTT: If you look at small communities, I guess because I am working in a small community, that would not have to be a large facility. I did work in the Parramatta drug courts. So it has to be very big and open with plenty of rehabs to go into. But if you looked at, say, Goulburn, a five-bedroom house for people as a diversionary program would possibly be all you would need.

The Hon. Dr PETER PHELPS: Is it fair to say that a large amount of petty crime is drug related and that it is concentrated amongst a small group of individuals who, if they were diverted out of the criminal justice system into what we call life improvement programs would give them life skills above and beyond drug use and criminality. That would have not only a good moral effect but also a substantially better monetary outcome for governments as well?

Ms MALLOTT: It certainly would but it would possibly have to be part of their sentencing. It would have to be part of their sentencing, for example, "I am going to give you five months prison and I am going to give you two years of training." Once they are out of prison you have to get them into other training but they may not do it.

The Hon. Dr PETER PHELPS: But you would do it the other way, surely, if you were a magistrate?

Ms MALLOTT: Yes, one would hope.

The Hon. Dr PETER PHELPS: If you were a magistrate you would say, "You can have 18 months. Alternatively, you can go here and we expect you to complete all of these to the sufficiency of the court, otherwise I will see you back here and bring your toothbrush with you."

Ms MALLOTT: Yes.

Ms STEPHENS: It is something to consider in therapeutic communities where the theory of change is that it is the community that changes individuals, not an intervention I dispense to you. We work it out together and it is through honesty and through working together. Where mandatory referrals are made you need a balance of that community of those who are choosing to be there and those who—

The Hon. Dr PETER PHELPS: I would say you would need a majority of people who are choosing to be there.

Ms STEPHENS: Correct. That is not often the case. That would be helpful. Many of those who are referred and are mandatory often choose to stay and make the most of it. Not all will, but it is a real point for consideration.

The Hon. Dr PETER PHELPS: I do not know whether you were here for Dr Allen's testimony. She said that, irrespective of the reason—whether it was self-referral or mandatory referral—the outcomes were very similar; that is, it is getting into a situation where you have the ability to access the services you need.

Ms STEPHENS: That is true.

The Hon. Dr PETER PHELPS: Even if it is mandatory you are still looking at levels that are not as high but at comparable levels of positive outcomes for those people.

Ms STEPHENS: That is our experience where the screening is done to get the fit of the house or of the resident's right so that that community is cohesive, and where severe mental illness, impulsivity and impulse control aggression are adequately screened. But there is a risk there.

Dr MEHREEN FARUQI: Good morning and thank you so much for coming here today. I want to get a bit of an idea of your size. How many staff do you have in New South Wales for instance?

Ms STEPHENS: We have 76 at the moment. In New South Wales there would be more than a dozen. I cannot come up with a number for you.

Dr MEHREEN FARUQI: That is all right. Take the question on notice.

Ms MALLOTT: Twenty-three or 24.

Dr MEHREEN FARUQI: In Goulburn and on the South Coast?

Ms STEPHENS: On the South Coast we have four full-time equivalent [FTE] positions, in Monaro we have two, in Goulburn we have five and in Wagga we are currently recruiting for a couple of our positions. The FTEs are often split differently, as you would understand, in regional areas but the total is about four FTEs.

Dr MEHREEN FARUQI: Do you have problems recruiting qualified suitable staff? We have heard that that is an issue across the board—it is really difficult.

The Hon. Dr PETER PHELPS: And also once you have got them they get pinched by Health who can offer better rates.

Dr MEHREEN FARUQI: Yes, that is right.

Ms STEPHENS: Better rates, absolutely, they do. Yes and no. We have been incredibly fortunate in our regional areas. There have been struggles at times and some of those struggles are around finding people in the sector with management expertise as well. We have been really lucky here with Ms McCarthy and Ms Mallott and we have had no trouble recruiting at all when we set up a service here with five individuals. We expected trouble but we really did not have it. We do keep to qualification standards.

The Hon. Dr PETER PHELPS: I am sorry to steal some of your time, Ms Faruqi. Ms Stephens, is that because you have what might be called a sufficient weight of finances and people feel sure that if they go into any organisation it is not for a year and then they lose funding? Is it because you have a sufficient weight of financial resources which makes it more attractive?

Ms STEPHENS: I would argue no. People come to not-for-profits and stay if their values align with the values of the organisation. The thing that will keep me at Directions is the value that we give to our staff and our training is very generous. Our clinical governance framework is very generous. Our clinical supervision and the support we give our staff, I believe, is very generous. We have good retention rates for a non-government organisation, though we are not perfect.

The Hon. Dr PETER PHELPS: So short-term grants are not a problem in terms of staff recruitment for your organisation?

Ms STEPHENS: When we recruited in the Eurobodalla they were shorter contracts than we would have liked to have given because of the nature of Commonwealth to PHN funding, but we did not struggle.

Dr MEHREEN FARUQI: What proportion of your staff identify as Aboriginal and Torres Strait Islander?

Ms STEPHENS: Seven per cent.

Dr MEHREEN FARUQI: That is much better than the Illawarra region. It is only 2 per cent in the Illawarra.

Ms STEPHENS: Yes.

Dr MEHREEN FARUQI: And you are deliberately looking for people—

Ms STEPHENS: We currently do not have any identified positions, though we have in the past. We struggled to recruit to them and then de-identified and had more Aboriginal applicants. We encourage—as most people put in advertisements—Aboriginal and Torres Strait Islanders to apply. We have made efforts but I would not say that it is simply as a result of being overly targeted.

Dr MEHREEN FARUQI: You spoke earlier about the importance of not only having detoxification but also having some sort of intervention plan after that as well. Earlier today the Committee heard from representatives of Hope House and they suggested the Committee should recommend that detoxification and rehabilitation services should be together. As I understand your evidence, that there could probably be at least two pathways that people could take after detoxification?

Ms STEPHENS: Yes.

Dr MEHREEN FARUQI: One is rehabilitation and the other is facilities like those you provide.

Ms STEPHENS: That is correct. I suppose that speaks partly to my response to your question around that spectrum of need. Lots of people will try community-based services first and if their life is in such chaos or of such complexity that a residential service is the best fit then we do the pre-case management and support to create some stability or to maintain their level of motivation prior to going into that facility. Then we pick them up in case management afterwards to maintain some of the gains and to manage some of that risk of relapse afterwards. What you find with a lot of clients who go through rehab and detox is that there will be multiple attempts. That is incredibly common. One attempt is very uncommon. Often it is about finding a rehab that ends up fitting with the needs of the clients, as you can image.

Our rehab Arcadia is quite structured and a lot of our clients come to that because they have seen that they need it, whereas other clients might go to one with a really different approach and that suits them. A client might go into detox because they might see that they need that kind of structure or they might need the medication to deal with the withdrawal. Then we might pick them up for counselling and case management afterwards to implement some life changes and choices and maintain motivation afterwards. The risk of relapse is high afterwards but also the risk of overdose is consequently really significant, and that is really important, or they might go into residential rehab. So in Arcadia the beds for detox and the beds for rehab are no different. It is all the one, and the program is all the one regardless. You are doing the same suite of interventions and therapies as if you were doing either.

Dr MEHREEN FARUQI: You provide services in the Australian Capital Territory and New South Wales?

Ms STEPHENS: We have a greater variety in the Australian Capital Territory.

Dr MEHREEN FARUQI: What are the differences in those two jurisdictions? Could New South Wales learn any lessons from what is being done in the Australian Capital Territory?

Ms STEPHENS: The staff with me today have both worked in the Australian Capital Territory and New South Wales with us. They might want to add something.

Dr MEHREEN FARUQI: Is there something that the Australian Capital Territory is doing that you think New South Wales could be doing better?

The CHAIR: Or is there something that we should not be doing in New South Wales that the Australian Capital Territory does?

Ms STEPHENS: I am curious for needle and syringe programs to be considered. I cannot speak to it with statistics for New South Wales around harms that could be reduced if there were needle and syringe programs but in the Australian Capital Territory we are able to provide injecting drug users with a big variety of equipment to reduce the harms of injecting. In New South Wales the equipment available is far less and the equipment that does exist is far less available as well. I would be curious—

The Hon. Dr PETER PHELPS: Although individual health districts have their own needle and syringe programs?

Ms STEPHENS: But the range of equipment on offer is less.

Ms McCARTHY: The Australian Capital Territory is obviously a small jurisdiction with a lot of resources so the difference basically is that our work area is extended and there are less resources. In terms of detox and rehab, Pathways Eurobodalla has been going for about 10 months. We have found that 10 per cent of clients only want detox and 10 per cent want rehab. Ms Mallott was speaking before about the need for medicated or non-medicated detox. If you need a medicated detox you have got to go to the local hospital and that process which works, if you do not need to be medicated then you can go for an unmedicated detox and there are other options because some are attached to rehab—we have a designated bed at Arcadia and Watershed in Wollongong provides a non-medicated detox. I guess I am saying that so far our needs have pretty much been met in that respect but, as we were talking about, if you are having a non-medicated detox then the community wraparound—a detox alone is not much value, you need ongoing or wraparound care. If we have the capacity in the community to provide that then it is more cost-effective and doable really.

Ms MALLOTT: The other thing is that I found in small communities like Goulburn they do not have a detox bed at the hospital. You cannot go to the Goulburn Hospital and detox. If you are psychotic from using ice you might be assessed as suitable to go into a mental health unit but after three days—

The CHAIR: Through the emergency department?

Ms MALLOTT: Yes, from the emergency department. You will go down into Chisholm Ross and you are there for three days—most people can go three days without using ice and without having too many symptoms—and they are just getting out in time to start using again. Again, that is not a detox facility; it is a mental health facility. The hospital will not detox.

The Hon. Dr PETER PHELPS: Is that because they lack general beds or because they have a predisposition not to take part in detox? We have heard that Bega, for example, not only has detox beds but it also has a specific facility within the hospital complex facility?

Ms MALLOTT: I do not think it is a lack of beds. I know some years ago we certainly had detox beds. I do not know the reason.

Ms STEPHENS: I would suspect that it may be due to the return. You would get a cohort of clients who would just use those beds to detox off alcohol, have a clean week or two and then do it again.

The Hon. Dr PETER PHELPS: Which goes back to the initial problem, which I have raised with others, that detox by itself is essentially useless as a life-changing experience without some sort of either residential rehabilitation or alternatively community-based—

Ms STEPHENS: Yes.

Dr MEHREEN FARUQI: In your experience, both in New South Wales and the Australian Capital Territory, do you think that the criminal nature of drug use puts people off from actively seeking rehab and detox?

The CHAIR: The member knows that the Committee is focusing on rehabilitation.

Dr MEHREEN FARUQI: I am asking if that is putting them off rehab or detox?

The CHAIR: The member knows that the matter of decriminalisation of illicit substances is not specifically part of what this inquiry is about.

Dr MEHREEN FARUQI: It is not, but it is linked with people who are seeking that service.

The CHAIR: I have observed over a number of hearings that the member has dropped this in.

Dr MEHREEN FARUQI: I have not dropped anything in. It is a question. If the Chair does not want me to ask this question then I will move on.

The CHAIR: I would ask the member to move on. Before the inquiry commenced we talked about the focus being on rehabilitation—

Dr MEHREEN FARUQI: Absolutely.

The CHAIR: Decriminalisation is a separate area of criminal law and we agreed on that.

Dr MEHREEN FARUQI: In my view it is linked, but I will move on.

The CHAIR: The member took part in the terms of reference being put together. The member well knows what this inquiry is about.

Dr MEHREEN FARUQI: I do know what this inquiry is about. Earlier you spoke about the support for staff who are dealing with AOD services as well as domestic violence and mental health. I want to explore that a little bit more. What sort of support do you mean and who would provide that support?

Ms STEPHENS: From clinical supervision, for which best practice is that your line manager does not provide it—a registered trained professional like a social worker or a psychologist does—so we employ psychologists and social workers on a contract or a fee-for-service basis to provide that for our staff on a monthly equivalent for full-time staff, and that is kept private from their line management to support them as a whole person in the work that they are doing. They also have line management with their line manager and team meetings for both admin and case review. So there is lots of debriefing, a lot of talking about cases, not just people out, kind of rogue, trying to cope with difficult clients. We have also got a range of in-house mandatory trainings, like domestic violence alert training, mental health, first aid, escalation training, and cultural awareness, because these things sit alongside drug and alcohol.

Dr MEHREEN FARUQI: And obviously that is part of when you apply for funding—that is included in those funding packages?

Ms STEPHENS: Yes, and our funders are very explicit in asking what our qualification standards are or outlining them to us. Our standards of staff study are high.

The Hon. PAUL GREEN: You talked about access to beds. You have got maybe one in the local hospital if needed, I gather.

Ms McCARTHY: I do not think it is a designated bed, but there are two local hospitals—

The Hon. PAUL GREEN: That means it is if needed.

Ms McCARTHY: Yes, Batemans Bay or Moruya, but we have not had difficulty. They have specific processes to go through. The difficulty has been for us to learn the process.

The Hon. PAUL GREEN: Is that a risk-based process?

Ms McCARTHY: We have not been knocked back yet.

The Hon. PAUL GREEN: So they are accessible?

Ms McCARTHY: Yes.

The Hon. PAUL GREEN: Has there ever been a situation where you have got more clients that need those beds than they are able to achieve locally?

Ms McCARTHY: Not in the 10 months we have been open.

The Hon. PAUL GREEN: You talked about Watershed at Wollongong and then you talked about somewhere else.

Ms McCARTHY: Arcadia House in Canberra.

The Hon. PAUL GREEN: Where was Arcadia House?

Ms STEPHENS: Arcadia House is in Canberra. One of the beds is funded for here.

The Hon. PAUL GREEN: The affordability of trying to get this, what is your experience with affordability?

Ms STEPHENS: Of clients being able to afford the weekly fees?

The Hon. PAUL GREEN: Yes.

Ms STEPHENS: In some of our funding contracts the wisdom of the Ministry of Health with the PHNs has been to include a percentage of the budget for client brokerage. That is incredibly wise because on a case-by-case basis if there is financial hardship we will reduce the fees at Arcadia and supplement that by brokering costs through that funding so that that is still possible. Because the funding we receive to run the rehab is not sufficient; we have to supplement it by client fees. The importance of the fees is that it is a representation of client commitment to the process as well. It also leads into teaching people to manage finances. So there is value in the meaning of paying a fee. But certainly it is a stretch at times. When clients in government housing can have their rent reduced to free up the funds to contribute to rehab, that is really helpful, but people in private rentals may not have the cash flow to pay for their private rent as well as the rehab fees.

The Hon. PAUL GREEN: One of the other points is accessibility. To go up to Watershed or to Canberra, if you have got a young family you are away from them, the transport and then everything to do with connectivity, to try and be near those you love and also get treatment is pretty hard.

Ms McCARTHY: And if you are in rehab anywhere you do not get out for quite some time. So there is no access—

The Hon. PAUL GREEN: You do not have access to the kids—at all?

Ms McCARTHY: Unless you are in a rehab that takes children with you.

Ms STEPHENS: Or unless they are able to come to you for a weekend visit if you are granted the visit.

Ms McCARTHY: And that would be when you are through the process quite a way.

The Hon. PAUL GREEN: One would think those sorts of visits would be strategic to your healing.

Ms McCARTHY: Yes, certainly.

Ms STEPHENS: Usually it is in the later phases of rehab that you are looking to transition people back to normal life.

The Hon. PAUL GREEN: What sort of period of time are we talking about for rehab? Three months or—

Ms STEPHENS: Arcadia's residential program is three months. For Australian Capital Territory [ACT] residents the first eight weeks are fully residential and the final four are day programs; so that we are doing a step down. Then after that final twelfth week they go into case management, so it is step down gradually. But for those who are coming in from New South Wales to the ACT or have a significant distance to travel and do not have transport, the full 12 weeks is residential but each four weeks is a stage to stage 1, stage 2, stage 3. Stage 3 residents are the senior residents and they take on different roles and duties so that there is responsibility. They can apply for day leave on the weekends and to have more autonomy and the community decide what is granted and what relapse prevention strategies are suitable. It is a team effort so that they are transitioning ready to be released back to community.

Ms MALLOTT: The women and children's programs are very few and far between. So for women with young children it is almost impossible.

The Hon. PAUL GREEN: That is my point about having regional infrastructure.

Ms STEPHENS: Next Friday, Calvary have a formal launch of their women and children's in the Murrumbidgee.

Ms MALLOTT: That is in Orange, the new one.

Ms STEPHENS: Yes, from that round of funding.

Ms McCARTHY: I have also noticed in this area there is very little public housing. In the ACT there is a lot but down here there is not much, so people are in private rentals, which are subsidised slightly. Down here it is a huge issue to go away because you cannot maintain your rent.

The Hon. Dr PETER PHELPS: In relation to the gender nature of addictions, we heard evidence earlier about the growing use of methamphetamine amongst young women in particular. Does that replicate your experience?

Ms STEPHENS: Anecdotally yes. I do not have data to back that up but anecdotally. I suppose, just to speculate for a second, with the restriction of over-the-counter opioids, codeine-based drugs, our experience is that—

The Hon. Dr PETER PHELPS: They substitute.

Ms STEPHENS: Yes, and a lot of people using those who were dependent on them and able to get them were young women. Why methamphetamines and opioid? It would be a very available alternative, so I would not be surprised if we do start to see some issues.

The Hon. Dr PETER PHELPS: An unintended consequence of the crackdown on—

Ms STEPHENS: It is just speculation.

The CHAIR: Thank you all very much, that has been very valuable evidence to this inquiry and very insightful.

Ms STEPHENS: If there is anything we can add to how we might have differed?

The Hon. Dr PETER PHELPS: We had some pretty shocking things which were presented by Dr Allan earlier in relation to that.

The CHAIR: I am sure there will be some questions on notice that will come through as a result of the questioning today. There is a 21-day turnaround period for answers to questions on notice. The secretariat will liaise with you on the form of those questions by Committee members. Once again, thank you for making the trip here and thank you for the great work you are doing on behalf of very vulnerable people both in the ACT and in New South Wales.

(The witnesses withdrew)

(Luncheon adjournment)

FIONA BESTON, Acting Manager, Strategic Coordinator Partnerships, Access, Rehabilitation and Recovery, Mental Health, Drug and Alcohol Service, affirmed and examined

TIM LEGGETT, Acting Executive Director, Mental Health, Drug and Alcohol Service, Southern NSW Local Health District, sworn and examined

The CHAIR: Thank you for coming along this afternoon to give evidence to the inquiry. We have received the whole-of-government submission, which you are probably aware of.

Ms BESTON: Yes.

The CHAIR: That is marked as submission number 34. You would also be aware that we had representatives from NSW Health give some evidence yesterday in Nowra. We are pleased to hear from you this afternoon. Take the submission as read, but one or both of you might like to make an opening statement. If it is okay, we will ask questions. We have members from the Government, the Opposition, Christian Democratic Party and The Greens to probe and press you this afternoon. If you would like to make your opening statement, we can get underway.

Mr LEGGETT: We can table the document.

The CHAIR: That would be helpful.

Ms BESTON: We can table our opening statement; it has been approved by our chief executive.

The CHAIR: That is very important.

Ms BESTON: That is very important in New South Wales Government. We have prepared an opening statement. I will talk to it as I go. Southern NSW Local Health District encompasses the local government areas of Bega Valley, Bombala, Cooma-Monaro, Snowy River, Eurobodalla, Goulburn Mulwaree, Queanbeyan Palerang, Upper Lachlan and Yass. It covers an area of 44,534 square kilometres with a population density of 4.5 residents per square kilometre. The estimated population at 2015 was 201,756 with a projection of a population growth to 220,050 by 2021. I thought I would give you some context of what we are covering in our region. The percentage of population who currently identify as Aboriginal and Torres Strait Islander is 3.5 per cent in our region.

Within the Southern NSW Local Health District drug and alcohol services, our service model is currently integrated in the mental health and drug and alcohol directorate. There are six community mental health, drug and alcohol teams across the region based in the local health services in Queanbeyan, Yass, Goulburn, Batemans Bay, Moruya, Bega and Cooma. There are five team managers responsible for the management of the local teams. Drug and alcohol clinicians are based in each team with the support of medical drug and alcohol treatment hours from general practitioner visiting medical officers, and a drug and alcohol staff specialist who is the clinical director of drug and alcohol. That is only a small full-time equivalent [FTE].

Governance, competencies and supervision is provided by three drug and alcohol clinical leaders across the region who are also responsible for the consultancy liaison and support within the general and mental health inpatient settings. Queanbeyan and Cooma are also covered by the Magistrate Early Referral in Treatment [MERIT] program. The integration of drug and alcohol with mental health services has ensured that all clinical interventions have a focus on comorbid mental health and drug and alcohol treatment needs, so we do a lot of joint assessments within our teams as a result because they have the one manager that sit within the teams and work collaboratively together at all times. I thought I would give you a snapshot of some our data as well. This is in relation to drug and alcohol treatment provided from July 2017 to March 2018. We had 756 newly opened episodes during this period. We average between 470 to 530 clients per month who attend for counselling with drug and alcohol clinicians.

The CHAIR: With "newly" there is no double counting there?

Ms BESTON: Yes, it is the way the drug and alcohol—

The CHAIR: That is okay. It could be a repeat, but that is a total aggregate?

Ms BESTON: Yes. The MERIT program provided treatment for, an average, 125 clients per month, and that is only for Cooma and Queanbeyan. We averaged 259 clients per month for the opioid treatment program. We provided 63 clients with withdrawal management support during this period, which was a combination of general inpatient admissions and community management so it was a variety, depending on the needs of the clients. It is important to note that a lot of our Queanbeyan clients will mainly access withdrawal

management support from the Australian Capital Territory [ACT] because they actually have detox beds available in the ACT so they will elect to go across the border to take on an inpatient detoxification.

The CHAIR: Does NSW Health get billed for that?

Ms BESTON: I think we do. That is my understanding. In terms of principal drug of concern across our region, and this is based on what our team sees, alcohol is still the highest substance issue that presents for support with approximately 50 per cent of our drug and alcohol treatment relating to alcohol, so that is how much work we are doing in relation to alcohol. The MERIT program has the highest percentage of illicit substance referrals with 40 per cent for cannabinoids and 26 per cent for methamphetamine, so I guess the referral from the justice system. I thought I would talk a bit about our partnerships as well.

Southern NSW Local Health District has long partnerships with the primary health network and local non-government programs. The local teams have ensured there is a collaborative partnership with Directions ACT, who were on before us. The Pathways program operates in Goulburn, Eurobodalla and Cooma. We have a strong partnership with Family and Community Services, particularly with the family case management program and a part of that is decision-making for at-risk children, and that is for drug and alcohol and mental health. We have strong partnerships with our housing supports programs and work collaboratively on increasing the psychosocial supports needed to increase the recovery journey for drug and alcohol clients.

Currently, we also provide one day per week of a drug and alcohol clinician in kind to headspace Queanbeyan and Goulburn, and we will look at a similar provision in the soon to be established Bega headspace when it opens. That is part of our consortium agreement with the headspace services. We also have good partnerships with our local general practitioners and our local Aboriginal medical services and will endeavour to work collaboratively as part of a bigger treating team. In regards to the opioid treatment program, this is the shared care arranged with private pharmacies across the region. Most of our clients are dosed in private pharmacies, but we provide the support and case management to enable that to happen.

The CHAIR: For the purposes of definitions, so we are clear, what does "dose" mean precisely?

Ms BESTON: It can be a number of opioid treatment programs, like methadone—

The CHAIR: It is provided, whatever it is?

Ms BESTON: Yes. It could be tablet, liquid.

The CHAIR: You use that phrase "dose"?

Ms BESTON: Yes, because it comes in many forms.

The CHAIR: Sometimes for the purposes of *Hansard* the language is not perfectly clear.

Ms BESTON: That is okay. We do, however, provide a small number of hospital-based dosing for very high-risk clients and that may be ongoing or short-term because they need extra support for their physical health or whatever is going on in their lives at the time. That is on a case-by-case situation. In respect of culturally appropriate services for Aboriginal clients, we have an Aboriginal clinical leader of one FTE based in Bega Valley who works across the district providing consultation and high-level clinical support for mental health and drug and alcohol clients. This position commenced in January 2018. Four of our community teams currently have Aboriginal mental health trainees within their teams—and that is within Queanbeyan, Bega Valley, Goulburn and the Eurobodalla—whose training will also include drug and alcohol treatment due to the teams being integrated. We still have a way to go to ensure culturally appropriate service provision but we are committed to moving forward in this direction. It is something that we are always trying to improve on and work on. There are still things that we could be doing.

I wanted to highlight that there are difficulties in working in a rural and regional area as large as this, because it is a big area. One is that public transport is limited or non-existent. That impacts on our clients greatly in getting to treatment when needed. Affordable low-cost housing, which I am sure you have heard other people report on, is becoming more difficult to obtain. These regions have suddenly become very popular. Even places like Cooma have gone up in price to live in at the moment. It is getting much harder for people on low incomes to find affordable accommodation.

Another gap is in psychosocial NGO support access. I guess I am thinking of something like in mental health we have the Housing and Accommodation Support Initiative, which has had fantastic outcomes in terms of reducing admissions and maintaining people's accommodation and giving them that extra wraparound psychosocial support. I believe it is something that could benefit drug and alcohol clients in the same way and has not really been something that has been considered. Certainly clients who have a comorbid mental health and drug and alcohol problem get access to that service and as a result do better because of the extra support.

Often their drug and alcohol issue settles and becomes less of an issue because of that extra accommodation support. There are a lot of benefits in providing psychosocial support to help people maintain their home environment. Another issue in our region is timely access to general practitioners. Sometimes there is a three-week wait because of the size of the community and the lack of GPs in our region.

The CHAIR: And a lack of bulk billing?

Ms BESTON: A lack of bulk billing, yes. There are not many bulk billing places at all. Southern New South Wales also is unique in that we have two holiday surges as we have the coast, which is a big holiday destination—particularly for ACT residents when they come here and they do not bring their resources with them. We also have the Snowy Mountains, which increases significantly during the ski season. I am not sure if you are aware that there is quite a lot of substance use during the ski season. We actually get quite busy in that region during that time. These situations will often put increased pressure on service provision.

In summary, it is important to note that the Southern NSW Local Health District drug and alcohol service provision is just one part of a range of services that clients can access. With the growth in NGO services and primary health network commissioning there is increasing opportunity for flexibility in treatment and an increase in wraparound services to improve the psychosocial outcomes for drug and alcohol clients. Southern NSW Local Health District is moving more towards an assertive case management model to ensure that high-needs clients are provided with treatment that will address their high-risk acute needs. We would like to work even more in collaboration with our non-government organisation partners to ensure that there is a clear transfer of treatment that has a step up and step down approach to reduce the risk of clients falling through the gaps. I guess we need to continue to work together to provide services that are flexible and sustainable.

The CHAIR: Mr Leggett, would you like to augment that with any comments?

Mr LEGGETT: No, that covers it all.

Dr MEHREEN FARUQI: You spoke about the challenges that service provision faces including transport, housing and many others. What would be your top two key challenges that you would like the Committee to make some recommendations on that could really improve the services that you provide?

Ms BESTON: Low-cost housing, number one, and inpatient transport too. If people need to be admitted to hospital but they have to travel, having the funds or supports available for them to access transport to do that would be a huge benefit as well.

Dr MEHREEN FARUQI: You also said that some patients go to the ACT because there are detox beds available. We know there are hardly any along the South Coast. Why is that the case and have you been advocating for more of those beds in the region?

Ms BESTON: Not specifically detox beds. I think I would agree with what Directions said previously that detox is a small part of the treatment. We are lucky in the Eurobodalla in that our general hospital is fantastic at taking our clients in and will detox them in the general hospital. It is recognising that a lot of people who need beds need them for medical reasons and it needs to be seen as a medical condition rather than as a drug and alcohol problem. The symptoms and the medical complexities associated with withdrawal need to be looked at. It is for those reasons that people need a bed. For example, with alcohol withdrawal there is a risk of seizures. They are the reasons. People with a lot of other substances can either go for replacement therapy like opioids and then gradually wean off, or we can look at a withdrawal supportive program in the community. It would be more about building the collaboration through our general health system.

Dr MEHREEN FARUQI: But you are still sending people to the ACT. That implies that there is a lack.

Ms BESTON: They are choosing to go there.

Dr MEHREEN FARUQI: Would you recommend other services for them like the ones you have suggested?

Ms BESTON: Only if we can get them in, but often it is their personal choice to go into detox there. All drug and alcohol treatment is voluntary.

Dr MEHREEN FARUQI: That is the way you think it is most effective?

Ms BESTON: Yes. It is all voluntary. Apart from the MERIT program, which is a court-ordered program, the rest of it is all voluntary. It is something they have to agree with. It is more of a relationship between Queanbeyan and the ACT. There is always a place to provide inpatient detox but I do not know if having specific beds is the answer. Increasing the knowledge and skills of our general hospitals to give them the

ability to provide that care could be even a better outcome because people can do that locally in their own communities and have their families nearby. They can also have their community supports, their NGOs or their community health drug and alcohol counsellor to support them through that process. If they go somewhere else they lose all that. Would you agree, Mr Leggett?

Mr LEGGETT: Yes. Can I add to your first question about the two top priorities that a third one would be the MERIT program and if we could expand that, particularly in Eurobodalla where the community have wanted that in the past in years gone by. It has proven to be fairly effective from our perspective. I guess it does not matter whether the government runs it or an NGO runs it, but providing that MERIT program for the local community I think would be beneficial. The second comment in relation to the detox in local areas is that often it is dependent upon the GP's willingness to do that in the home with people. Often their reluctance may be because of the lack of support from drug and alcohol staff to monitor that person in conjunction with the GP while they are at home doing that. They may prefer to actually admit the person to hospital for detox where they can be closely monitored as opposed to doing it at home.

Dr MEHREEN FARUQI: In submission No. 15 from Mission Australia it notes that rural and regional rehabilitation services have been forced to close down due to funding changes. They say that at the end of this year the Bega region will lose funding for the Wandarma Aboriginal Drug and Alcohol Service. Do you know whether that is the case?

Ms BESTON: That is Commonwealth funded, so I cannot comment on that because that is not funded through NSW Health.

Dr MEHREEN FARUQI: Do you know whether that is the only Aboriginal drug and alcohol service in your area?

Ms BESTON: I believe Katungul, who are going to talk after us, also have access to drug and alcohol staff, but I cannot comment on that completely. I can take that on notice. We certainly provide access for Aboriginal clients to our drug and alcohol treatment.

Dr MEHREEN FARUQI: You do not have a relationship with Wandarma?

Ms BESTON: I believe we do. I believe we have had a partnership there, but I cannot comment on its funding because I have not been involved in any of that. That is Commonwealth funded.

Dr MEHREEN FARUQI: We heard earlier from Lives Lived Well and Lynden. Their experience and their statistics show that there has been a recent rise in women presenting with methamphetamine use. There is no specific women's service here. Is that a concern for you? What can the local health district do about that?

Ms BESTON: Anyone can access our service regardless of their gender. I cannot comment on the statistics of women because I have not got that here. I can take that on notice and certainly find out how many women have presented to our service with methamphetamine use.

The CHAIR: You are aware that there has been an increase with respect to consumption?

Ms BESTON: Anecdotally, yes.

The CHAIR: When you say "anecdotally", are you challenging that?

Dr MEHREEN FARUQI: They have given us some statistics which will be made publicly available. According to that there has been an increase. Your statistics do not show that?

Ms BESTON: We do not have gender specific data, but we can pull that out if we need to. That is what I am talking about. I cannot comment on it because I would need to go down into our data. I would need to pull more data. We could do that but we do not do gender specific data; we just talk about client contact.

Dr MEHREEN FARUQI: We did hear that Hope House, which provided some emergency accommodation for women and children, has now closed down. Is the Southern NSW Local Health District considering women-specific services through government funding, or have you not considered that?

Ms BESTON: I guess we are directed by the ministry on our model of care and the direction we would take in regard to drug and alcohol services. All our direction comes from the ministry in relation to that and what our service provision would be.

Dr MEHREEN FARUQI: You do not advocate for specific needs in your region?

Ms BESTON: As much as we can, yes, and that is through our chief executive officer. Yes, we would but without knowing what that is. Certainly the staff have not escalated that to me as a major concern and they will escalate if there are those issues. Obviously it has not come up to them as a major concern. The issue

concerning domestic violence is more of a major concern for our staff, and that is across mental health and drug and alcohol. That is a big issue as there are gaps in support for women suffering domestic violence. That is probably what the staff flag more than anything. We certainly raise those issues with Family and Community Services at the joint forums that we have with them. That is where we are getting more alerts. Domestic violence is our biggest issue.

The Hon. PAUL GREEN: I want to check whether I heard you right. You were talking about in-house care in a home environment and you were talking about housing affordability or the lack of housing in that area?

Ms BESTON: Yes.

The Hon. PAUL GREEN: Are you entertaining the idea that it is better to try to help these people in their homes rather than through programs?

Ms BESTON: Yes, absolutely. You have to come out of a program and go back home to all of the environments that will often trigger you to reuse substances. They do not go away. Recovery is a longer journey than just a three-month inpatient stay. It is more than that. Some people recover very quickly but everyone recovers at different stages depending on their trauma background. A huge percentage, above 60 to 70 per cent of drug and alcohol clients, come from a trauma background. So most of our care has to be trauma informed and we have to realise that recovery is not linear; it goes up and down, depending on what is going on in people's lives. Having the nets around them in the community, from what we have seen, can improve that outcome.

The Hon. PAUL GREEN: It is a good point. Recovery from substance abuse is different to recovery of a person's broken life?

Ms BESTON: Yes.

The Hon. PAUL GREEN: My experience is that the recovery of a broken life takes a lifetime.

Ms BESTON: Yes.

The Hon. PAUL GREEN: Whereas recovery from substance abuse obviously is a process dependent on the person and their immediate environment, how it affects them and how they respond to it. It is an important point. Are you entertaining the idea that we should be redirecting funds to more wraparound services in the home? Is that what you are saying?

Ms BESTON: Yes, I am. I guess because we have seen it work in mental health and most of our mental health clients are comorbid drug and alcohol, particularly in the coastal regions. The improvement in their lifestyle has been phenomenal. It has reduced their readmission rates.

Mr LEGGETT: Dramatically.

Ms BESTON: Dramatically if they have a housing and accommodation support initiative, which has flexible hours that can go up and down depending on the needs of the client. Some of them have more than 35 hours a week of support but when they are well it might go down to five hours a week, just getting them to their general practitioner appointments and those sorts of things, particularly with our transport issues. They are less likely to have admissions into our acute inpatient units, which removes them from their family and from their home environment.

The Hon. PAUL GREEN: The distance?

Ms BESTON: As well as it is costly for the government.

The Hon. PAUL GREEN: Unaffordable?

Ms BESTON: It is extremely costly. It is far more cost-effective to provide wraparound services. But there are also better outcomes for the community, for the clients, for their families and for their children.

The Hon. PAUL GREEN: We heard from Aboriginal individuals that being in country is also an important issue. Being moved out of country to address some of their addiction is not helpful as part of their recovery.

Ms BESTON: No, they hate it. We are learning from our clinical leader that the trauma impact of being off country compounds their recovery even more. He has been educating the staff about that and the importance of us learning how important that is.

The Hon. PAUL GREEN: Is that a model that is in use anywhere else? Is anyone else saying, "This in-home drug and rehabilitation model is really successful"?

Ms BESTON: I have a feeling that Victoria went into the home-based assertive case management model instead of clients always coming to the centre for appointments and being voluntary. If someone does not turn up they think, "I am a bit worried about that person. Let us go out and see whether we can see them and see that everything is okay."

The Hon. PAUL GREEN: We would be much obliged if you could direct us to anyone in Victoria to whom we could speak about this issue. You could take that question on notice.

Ms BESTON: I know that years ago they were doing that in the city—I am talking about Melbourne. I cannot say anything about their regional areas, but I know they were certainly looking at a model there. No, I have to confess I think it has been a bit neglected in drug and alcohol. Even the National Disability Insurance Scheme [NDIS] has made an area for mental health clients but it has not really thought about drug and alcohol clients and their access to the NDIS from the Commonwealth.

The Hon. PAUL GREEN: That is a very good point. We have done it with the Richmond report, bringing people out of institutions, putting them in the home and putting in wraparound services. It had teething problems but overwhelmingly it has worked out well. We are doing it with mental health and we are doing it with the NDIS, so why not with drug rehab?

Ms BESTON: Yes. Most drug and alcohol clients are not purely drug and alcohol when you talk to our staff.

The Hon. PAUL GREEN: That is right. It is symptomatic of greater issues.

Ms BESTON: Yes, it is trauma, it is grief and it is loss.

The Hon. PAUL GREEN: Domestic violence.

Ms BESTON: It is domestic violence, it is mental health and it is a range of factors usually.

The Hon. Dr PETER PHELPS: You mentioned that at the current time you are getting about 125 referrals per month out of the MERIT program in Queanbeyan and Cooma alone. If that were to be extended across your entire health district could you estimate how many additional referrals that would lead to?

Mr LEGGETT: There are only two staff who do Queanbeyan and Cooma to do all of that. If we expanded to the South Coast to say Eurobodalla, with Eurobodalla's population I would think you would probably need two staff but if you were going to do it you would probably cover the whole coast—you would do Eurobodalla and Bega.

The Hon. Dr PETER PHELPS: Would you have a comparable numbers of referrals? Would you estimate 125 per month?

Ms BESTON: We would probably get more.

The Hon. Dr PETER PHELPS: More?

Ms BESTON: Because a lot of people are ending up in Nowra jail when they could be diverted through the MERIT program down here. That is what the drug and alcohol staff have informed me. I think some of them could have gone through a diverted program instead if we had that available down here.

Mr LEGGETT: We do not have access to that data but probably the local Magistrate's court might be able to provide some statistics on that.

Ms BESTON: Yes, they would be the best people to provide it. I would say it would be more based on what we see coming through the Mental Health, Drug and Alcohol Service, just through our teams. It is a high number of need.

The Hon. Dr PETER PHELPS: You also said around 50 per cent of referrals were in relation to alcohol. Is methamphetamine the second highest after alcohol?

Ms BESTON: No, cannabis.

Mr LEGGETT: Cannabis particularly in the younger population.

The Hon. Dr PETER PHELPS: Is that structure of alcohol, cannabis and methamphetamine to do with the fact that you are a government agency and perhaps people with methamphetamine problems are less likely to self-refer to what they see as a government agency or do you believe that in your district methamphetamine is not as severe a problem as it is in other health districts across the State?

Ms BESTON: I think even in the data from the emergency departments where you would see a lot of the people on methamphetamine come through it is still alcohol. The emergency departments are reporting that it is still more people with alcohol-related issues that come through the emergency departments than people with methamphetamine. Otherwise I have not got access to know, but it could be.

Mr LEGGETT: The ministry would probably have better statistics in terms of the breakdown of emergency department presentations in comparison with the Southern New South Wales Local Health District against the other LHDs. It is certainly the experience of our drug and alcohol staff that the drug of choice is still alcohol.

The Hon. Dr PETER PHELPS: That is what the consolidated government report shows. It also shows that methamphetamines are second and it is a significant increase. We do not know whether it is a straight line projection or whether it is a logarithmic projection in terms of use at this stage. If it is straight line then there is significant substitution of addictive substances in favour of methamphetamine but it is interesting to note that in your regional it is third on the scale as opposed to the other two.

Ms BESTON: And it varies from region to region. If you want to look at—we do have some drug of choice data for those periods. Cooma is incredibly low for methamphetamine but alcohol is 75 per cent in Cooma.

The Hon. Dr PETER PHELPS: Do you have any dealings with recently released prisoners from Cooma jail in relation to substance-abuse problems?

Mr LEGGETT: Not that I recall, not a great deal. Often when people are discharged from Cooma jail they go back to wherever they came from, they do not necessarily want to stay in Cooma.

Ms BESTON: Whereas they do tend to stay on the coast when they get discharged.

The Hon. Dr PETER PHELPS: The previous witnesses mentioned that they had a fair amount of dealing with prisoners released from Goulburn jail.

Ms BESTON: That would be true to say about Goulburn, not so much about Cooma. Absolutely in Goulburn we work a lot with people coming out of the correctional facilities in Goulburn. A lot of them do often end up living in Goulburn. Their families often move nearby if they are in for a longer period of time.

The Hon. Dr PETER PHELPS: Is there an argument for Goulburn having a specialised detoxification and rehabilitation facility?

Ms BESTON: It is only one part of the treatment and it really varies from person to person what works for them. You would really have to pull your data out to see what the success rate is for people in their recovery going into a rehabilitation facility. How are they sustaining their recovery when they come out?

The Hon. Dr PETER PHELPS: How does NSW Health determine successful outcomes?

Ms BESTON: Harm minimisation.

The Hon. Dr PETER PHELPS: Getting back to a stage of relative normal functionality even though addicted?

Ms BESTON: I am not saying that we would not recommend abstinence for someone who is quite significantly health compromised.

The Hon. Dr PETER PHELPS: One of the problems we have as a Committee is to find what system produces the best outcome. Everyone says, "It depends on this, and this and that."

Ms BESTON: I still think the best system is wraparound community-based services. That always produces the best outcomes in my view.

The Hon. Dr PETER PHELPS: The outcome being the return of a person to a functioning member of society rather than abstinence—

Ms BESTON: Yes, and learning to live with the environment that may trigger a relapse. You have to live in that environment. You cannot live out of it all the time.

The Hon. Dr PETER PHELPS: That is true to the extent that you can be a functioning alcoholic. Members of Parliament have been functioning alcoholics—

Ms BESTON: Surely not.

The Hon. Dr PETER PHELPS: —and probably still are. Similarly, with cannabis use you could go through that. Indeed, the famous American author William Burroughs used heroin every day of his life from the age of 16 and was functioning.

Ms BESTON: If you can afford heroin, heroin is fine. It is not a multi-system destroyer like alcohol.

The Hon. Dr PETER PHELPS: But a genuine addiction to methamphetamine renders one, to a large extent, functionally useless as a participating member of society.

Ms BESTON: It is not a clean drug.

The Hon. Dr PETER PHELPS: Would it be true to say that there is a qualitative difference with methamphetamines which the other more prevalent drugs can be ameliorated by?

Ms BESTON: There are a lot of risks. I mean certainly in behaviours associated with methamphetamine and the risk of psychosis, depending on if they have a predisposition.

The Hon. Dr PETER PHELPS: No-one has a couple of bongos and then goes out to pick a fight, do they?

Ms BESTON: But I cannot comment on whether everyone on methamphetamine does either. I cannot comment on that. I have not got the evidence to support that.

The Hon. Dr PETER PHELPS: It is an upper, not a downer, is it not?

Ms BESTON: Absolutely it is. We know that it is high-risk drug. I actually think that alcohol is a very high-risk drug but it is legal in our society. Alcohol destroys family. Police will always tell you that one of the biggest contributors to domestic violence in our region is alcohol abuse.

Mr SCOT MacDONALD: I am just trying to get a picture of the money. Submission No. 34 refers to \$208 million to alcohol and other drug-related health services out of a Health budget of \$22 billion. I work that out roughly to be less than 1 per cent. We seem to put a lot of energy and public interest into it.

The Hon. Dr PETER PHELPS: A lot of policing resources, a lot of prison resources, a lot of Family and Community Services resources.

Mr SCOT MacDONALD: It goes on to talk about Family and Community Services as well.

Ms BESTON: Housing.

Mr SCOT MacDONALD: Is \$208 million out of \$22 billion reflective of the size of the problem? Is there more public awareness than warrants the size of the issue? The budget is less than 1 per cent of our total Health budget. To me that means it is a relatively small problem but when we go out and visit the centres we hear that it is the whole universe sort of thing. I am just trying to get a picture.

Ms BESTON: I guess you cannot quantify it quite often. It is about the weight that it causes in a community. You have to think about how our populations are weighted. We have only maybe a small population but the mental health, drug and alcohol needs of the client could be comparative to, say, an outer suburb of Sydney because it has high poverty, social needs, big Aboriginal communities and high unemployment so that increases the weight of the needs of the population. That is where you will get communities crying out saying, "This is what we need", because wherever you have social—

The CHAIR: Dysfunction.

Ms BESTON: Dysfunction, social dysfunction and poverty, you will see a greater cost to the community as a result of that. So it is about addressing those issues first.

The Hon. Dr PETER PHELPS: Just on the issue of resourcing, we have heard from numerous NGOs about the problem of obtaining suitably qualified alcohol and other drugs [AOD] specialists in rural and regional New South Wales. Does NSW Health face the same problem?

Mr LEGGETT: Yes.

Ms BESTON: Yes, working across the board.

The Hon. Dr PETER PHELPS: What is the nature and extent of that problem?

Mr LEGGETT: For our LHD we have one staff specialist at 0.2 who comes, and that is spread across the whole LHD.

The Hon. Dr PETER PHELPS: Is he fly-in fly-out from Sydney?

Mr LEGGETT: Yes, basically.

The Hon. Dr PETER PHELPS: Is that because you do not have the resources or you simply cannot get the personnel at any price?

Mr LEGGETT: Pretty much the latter.

Ms BESTON: It is hard to get doctors to leave Sydney—specialists in particular.

The Hon. Dr PETER PHELPS: But you have Canberra next door. You have ANU Medical School, you have Canberra, you have Calvary and you have John James. Why would you not have a comparable attraction that you would—

Ms BESTON: I do not know. They do not seem to want to come across the border. That would be something that would be great. If the two governments could work more collaboratively on sharing the resources around, that would be fabulous for us.

The Hon. Dr PETER PHELPS: We could always abolish the ACT—that would be a good start.

The Hon. PAUL GREEN: Take it over.

The Hon. Dr PETER PHELPS: That is a little outside the scope of this inquiry. If the traditional argument is that medical professionals do not want to leave Sydney because of in-service education and training, professional accreditation or maintaining professional standards, that argument does not apply to your health district because you would have exactly the same opportunities—through the accident of circumstance, the geography, you have got Canberra next door.

Ms BESTON: I cannot answer that because neither of us are medical personnel.

Mr LEGGETT: The majority of our services operate by VMO GPs in terms of being Opioid Treatment Program [OTP] prescribers. The specialist that comes in works with the teams, the community drug and alcohol staff, to deal with the more complex cases that they may be seeing and also he works with the GPs in the local area in increasing the protocol, I guess. Being a resource to the GP is about managing people.

The Hon. Dr PETER PHELPS: Is it just that universities are not producing enough AOD interested individuals in the first place?

Mr LEGGETT: Drug and alcohol has only been recognised as a style of specialty since about 2002 or 2005 or something, as I understand it.

The Hon. Dr PETER PHELPS: Really? What was it considered before?

Mr LEGGETT: I might be wrong but my understanding was that it was not recognised as a specialty.

The Hon. Dr PETER PHELPS: Given Australia's history I would have thought that alcoholism is a recognised medical complaint.

Ms BESTON: I think it was always under the brief of psychiatry. It used to be managed by psychiatry—that is where it used to come under—and then it got separated out into its own specialty. We have had a coup in recruiting someone who has just completed psychiatry. He then specialised in drug and alcohol and he is starting with us soon; but, again, he is coming from Sydney.

Mr SCOT MacDONALD: Just on accreditation, reading some of the submissions I am generally a bit bamboozled about some of these NGOs when we look across them. I have said they all seem very well meaning but you see a variety of infrastructure—some of it does not seem great; you have people who, again, are well meaning but not necessarily skilled or qualified; you have got varying financial abilities, if you like, sustainability of services. Is our accreditation where it needs to be? I know there is mostly Federal accreditation but is there some State accreditation.

Ms BESTON: We do have a bit of State. New South Wales is a big State. My substantive position is partnership coordinator for this district and I tend to manage the governance over New South Wales-funded NGO programs. I have quarterly governance meetings with each of those programs to ensure that they are meeting the KPIs and meeting a high level of standard in terms of staff and hiring, and I usually sit on their interview panel, but I can only do that with ones that are funded through New South Wales.

Mr SCOT MacDONALD: I think we were having a conversation before with one of them; they are getting tougher, accreditation is getting tougher. Are you seeing some of the less sustainable groups sort of dropping by the wayside?

Ms BESTON: Yes, certainly that has happened with the National Disability Insurance Scheme [NDIS]; it is because a lot of them have lost their Federal funding as a result of that. I guess it is difficult because often they are not paid adequately enough to be able to attract the quality of staff.

The Hon. Dr PETER PHELPS: And also you do not want to fall into the habit of credentialism. It is well within the realms of reality that there could be a nominally uncredentialed service made up, for example, of former addicts who have, through the various systems they have been through, decided to set up their own service, which can, even though they are uncredentialed, provide outcomes that are just as good or better as—

Ms BESTON: That is what Alcoholics Anonymous [AA] is and Narcotics Anonymous [NA] is, that is exactly what they are.

Mr SCOT MacDONALD: But again we see some well-meaning, highly motivated individuals, but then they age or they move on or whatever and then the service is not what it was. How do you keep that sort of standard—

Ms BESTON: Succession planning. I think all of us could learn and do better at our succession planning, and I think that is across the State and non-government organisations. I think we are an ageing workforce in NSW Health as well and we really need to get better at succession planning; it is something that we are trying to focus on. I totally agree with you; that is something that could do with better planning around that.

The CHAIR: Your opening statement and answers to questions have been very, very valuable. I am sure there will be some questions on notice arising from this deliberation with you this afternoon. The arrangement is that there is a 21-day turnaround for the secretariat to liaise with you and for you to send back answers to any questions. Thank you both very much for coming along this afternoon and thank you for the very good work you do.

Ms BESTON: Thank you for your time and good luck with it all. It is good that you are doing this.

(The witnesses withdrew)

ROHAN MORETON, Aboriginal Health Worker, affirmed and examined

ANN KELLY, Clinical Nurse Consultant, affirmed and examined

MICHELLE DAVISON, Aboriginal Support Worker, affirmed and examined

The CHAIR: We have a tight deadline this afternoon and have to finish by 3 o'clock. If one of you could make an opening statement to set the context and then we will share the questions between ourselves. Do you have an opening statement on behalf of the organisation that you would like to make to set the scene, a general opening comment or general overview you would like to provide?

Ms KELLY: Can we share that?

The CHAIR: Yes, about five minutes.

Mr MORETON: I have been employed with Katungul Aboriginal Medical Service [AMS] for the past 18 months. I was employed to do the drug and alcohol service. We cover three sectors. Batemans Bay has an AMS, Bega has an AMS and Narooma is our central AMS. For 18 months I covered from Batemans Bay to Eden as a drug and alcohol community support worker dealing with referrals from drug and alcohol with probation, parole, the court system, the Aboriginal legal system, and with community health, and internal and external services.

The CHAIR: Do you have exclusivity with Indigenous men and women or is it non-Indigenous as well?

Mr MORETON: The Prime Minister and Cabinet funding is to deal with Aboriginal people, male and female and juveniles. As time went on, I started to deal with non-Indigenous people. I always thought there was something there to help other people who have an AOD issue. When we go through the PowerPoint presentation, you can see where we have come from 18 months ago to now.

The CHAIR: We will come to that document in more detail shortly. Ms Kelly, do have you some opening words?

Ms KELLY: Yes. Building on what Rohan said, I relocated to the South Coast two months ago, and I—

The CHAIR: Where were you before then?

Ms KELLY: Canberra Hospital, Drug and Alcohol Detox Unit. I was the manager there, and still am; I am on leave without pay. I wanted to relocate to the South Coast. I have worked in Aboriginal medical services previously in the Territory and in Sydney and Redfern for 12 years. So I am still the manager of the detox unit at Canberra Hospital, so I can give you quite a lot of information about Canberra and the disparity of resources, which is quite extraordinary. There are five drug and alcohol consultants at Canberra Hospital and none on the South Coast.

The CHAIR: Does that say something about Canberra?

Ms KELLY: There is a bit of a disparity of health care.

The CHAIR: Clearly so. That is fair.

Ms KELLY: We are building our service up. Rohan should be Australian of the Year; he is an extraordinary person. We are building up a team now. You have got myself as a nurse specialising in this area and Michelle has just joined us, but we envisage needing a larger team and we are very much community focused. We are doing some great work with very few resources other than the goodwill of the staff, and we have a great CEO, which is wonderful. At the moment we are really setting up services at Eden. We are getting more and more clients down there, so we split our time between Batemans Bay and Eden. We all happen to live around Narooma and Narooma seems to be the main clinic. That is where our CEO sits. We are trying to divide our time up evenly amongst the different clinics within the area.

The CHAIR: Where did you commence your operation and how long ago?

Ms KELLY: Katungul AMS is about 20 years old, is it, Mr Moreton?

Mr MORETON: Yes, 24.

Ms KELLY: It has gone through some administrative issues. Mr Moreton was the main first worker actually specialising in the AOD sector. It is only this last year we have got extra funding, and I happen to be very fortunate—

The CHAIR: That is from whom, may I ask?

Ms KELLY: From Prime Minister and Cabinet that saw a big need.

The CHAIR: The Commonwealth, yes.

Ms KELLY: They are very impressed with what we are doing. We are going to Canberra again in a couple of weeks to present more of what we are achieving on the coast.

The CHAIR: That is great.

The Hon. Dr PETER PHELPS: What do you do that works?

Mr MORETON: Works for me?

The Hon. Dr PETER PHELPS: Works for your community.

Mr MORETON: Culturally, it is working with grassroots people, that is getting on the ground, working with their drug and alcohol issues. You can work in mainstream, but for me that does not work. You have to be able to associate with Aboriginal people and work with their drug and alcohol condition, help them with where they need to get to, such as detox, rehab, with transporting them to detox, transporting them to rehab. That is one of the main issues that I targeted. If you do not do that, they do not get there and get their help. So in this area down here, there is a big epidemic with ice and other illicit drugs. So having been in it for 18 months, I just find that grassroots working with people, it helps them—it just beats them.

Coming from the police service as an Aboriginal community liaison officer for eight years, I found that grassroots work is the only way to work. You can work in the mainstream, but there are too many—it becomes a lot of red tape that you have to go through, especially for the detox units. We have got no detox unity, so we have to assess the hospitals. We cover from Batemans Bay to Eden, so each hospital has only one bed for detox. I am getting three and four referrals a week for detox for our clients. So the size of Bega hospital, they have got one detox bed. Moruya has got one detox bed. Batemans Bay has got one detox bed. The mainstream and our service are all fighting over one bed to put our clients in for detox. That is one of the biggest hassles.

The CHAIR: When you get a referral, is that a calling from a person who is themselves looking for a detoxification, or is this, say, a GP ringing and saying, "I have someone", or the courts?

Mr MORETON: In regard to referrals that we get as a team and that I have been getting for 18 months is all for probation or parole, all directives under section 12 and section 10 of the Probation act, courts, the Aboriginal Legal Service. Some of the referrals have come from our GPs. Aboriginal people who have had health checks and GPs have concerns for their social and emotional wellbeing. So, yes, it is growing all the time. The lack of service that can support us is just—

Ms KELLY: We are moving now to getting more referrals from family, from the person themselves, from other GPs hearing about our service. Like, before Rohan, which was the backbone of what we did—he has an amazing relationship with the magistrates in the area and the probation, parole and the Aboriginal liaison service, so he was getting pretty much all the referrals from there, which is wonderful work, keeping young men and women out of jail, if you can help it. But because our service is expanding, we are getting more referrals from elsewhere, which is what we really want to do, to meet the need of the community. We are getting more juveniles now.

The CHAIR: Self-referring?

Ms KELLY: No. Yesterday, we got a FACS referral for a whole family, six- to 13-year-olds using cannabis. I can give you many stories of how it works. You need to put the time and energy into the person. It is no good doing just bandaid stuff. You really have to work with that person, work with the community, see them when they come out of detox rehab, and we have built up good partnerships. I still have a very good relationship with the detox unit at Canberra Hospital, and we are referring a lot of our clients there. They have been very kind taking them. Then we are referring to rehabs from there.

I heard your other person presenting, but there still is a great need for detox and rehab care. When you are looking at the harm minimisation model, it is so necessary to have a facility to be able to put a 19-year-old who is off their head on ice somewhere safe. Then when you see them not on the drug—which we have an experience of with a young woman we sent up there a couple of weeks ago—they are a completely different person. She was presenting at the magistrate's court about to go to jail that day but he released her into our care.

You have got to put in the energy and the time. It is money but it is also about personnel. You need the right people doing it, the people that are committed to doing it. Aboriginal people in the community are committed to their community.

The Hon. Dr PETER PHELPS: You mentioned the lack of detox facilities on the South Coast. Is there not an argument that detox without post-detox rehabilitation is essentially a meaningless exercise?

Ms KELLY: Not necessarily, no. That is very interesting, and I used to think like that. I have come to a lot of realisations in the last couple of months. The harm minimisation model is really important. If it is your family member about to be incarcerated or about to fall under a bus is it not better that they go to a detox unit for seven days and somehow get some input into how to stay off the drugs in the future?

The Hon. Dr PETER PHELPS: Yes. It is better than nothing, but it is still not a high bar.

Ms KELLY: No, and a lot of rehabs will not take anyone unless they have been to a detox unit.

The Hon. Dr PETER PHELPS: As we have heard previously, the problem is the situation when people go into detox who need the life skills created by rehab but there is a gap there and they fall back into their old ways.

Ms KELLY: We have got a number of them on our books. That is absolutely right but it is a bit like the chicken and the egg. If a detox bed comes up and this person is about to go to Mulawa, you just hope that a bed will come up. I was managing that unit for seven years. Sometimes beds do just come up because vacancies arise and you have got good relationships with the rehab staff. Sometimes it is good just to get them into detox and hope a bed comes up while you are applying. But that is right, there are no rehabs down this way. There is nothing.

Mr MORETON: When you talk about the detox and rehab, there is a waiting period of about four or five weeks. Once I get a person into detox we have got to wait maybe three or four weeks to get him into rehab because of the beds. I deal with Karralika Programs in Canberra. I deal with Oolong House in Nowra. Triple Care Farm has just become a partnership of ours.

Ms KELLY: But Oolong House is male only and Triple Care is for under 25s. So there goes women, older women.

The Hon. PAUL GREEN: Where is Triple Care Farm?

Ms DAVISON: The Southern Highlands.

Mr MORETON: At Robertson. I have just started a partnership with them. They have been really good. Only about two weeks ago Oolong House established two full-time beds for us for the South Coast. As soon as two beds become available they are our beds to fill up. We have been with Karralika Programs for about 14 months working with them at the detox unit in Canberra Hospital.

Ms KELLY: We are also getting relationships with Canberra Recovery Services.

Mr MORETON: There is just a lack of services down here for us in detox and rehab. I wish we could have a detox and rehab residential service down here. I wish we could have that in years to come. That would cut a lot of corners.

The Hon. Dr PETER PHELPS: Yesterday we heard from Ivern Ardler, who used to be the chief executive officer of Oolong House, about the specific needs of Aboriginal clients and the idea that they are far more likely to attend an Aboriginal detox and rehabilitation service than a mainstream one. Would that be your view as well?

Ms KELLY: Absolutely. In fact, I will give an example. We had a young woman last week who was released to Mr Moreton and Ms Davison's care from the courts. She was a 19-year-old using ice with a lot of trauma history. She went to the detox unit and she almost had potentially a bed in rehab after that. Over the long weekend Mr Moreton was up in Canberra, his partner was very ill. Ms Davison was home and I was home on the long weekend. We got calls all weekend, the three of us, about this young woman because she just was not coping in that unit. There were no Aboriginal workers working, there were no Aboriginal liaison officers working. Even a social worker could not even come. Mr Moreton actually visited her twice there and we got calls all weekend. I think that says it all.

Mr MORETON: Basically she could not fit in with the people that were in the centre, being the only Aboriginal person and not having the Aboriginal staff to consult with when she was having her problems. Here is a young girl who is 19 years old who has got a lot of trauma issues from her mum and dad through domestic violence and her dad being in and out of jail. Here is a young girl who just could not cope with being in that

locked down confinement without any support from Aboriginal staff. So what do we do as staff that work on the ground at places such as Katungul? Where do we go? We have got to help them. We have got to support them. I was in Canberra because unfortunately my partner was in hospital. I popped over and saw her for two days. We got her through the week until last week when she came home. She is going really good now. But, again, it is the next phase of trying to get them into rehab. It is just waiting to get them into a rehab.

The Hon. Dr PETER PHELPS: We have heard repeatedly—and it is included in your report—about the importance of doing it on country. Is that a key component for successful rehabilitation or at least amelioration of addiction?

Ms DAVISON: Yes, absolutely. I have only been in the position for three weeks now but I have had intense counselling with a young lady. I took her up to Canberra and then I went and picked her up. We got down the foot of Clyde Mountain and she was just overjoyed. She said, "I'm home." Just to be back on the coast, she wanted to go and reconnect with her family down at Narooma. It was after five days or six days away.

The Hon. Dr PETER PHELPS: Why does it work for Aboriginal people when we have heard that white people often have to physically geographically remove themselves from that community and those friends to break the cycle of addiction? Why does it work in Aboriginal communities?

Ms KELLY: In my experience family is so strong it is hard to verbalise it. Family and community are everything to the Aboriginal people, and the land. It is everything. I think the wider community is very disconnected from community on one level. They are better off home, better off on country. Absolutely.

Mr MORETON: When we look at the individual Aboriginal person on the coast there are a lot of issues. Non-Indigenous people have got issues too, but a lot of our Indigenous people have got a lot of trauma in their backgrounds. We are just trying to deal with them individually as we go along with the Koori people. In the back of the booklet it says when I first started I started with one client last year. By the end of 2017, I had 83. I have been back in employment since January.

The CHAIR: Can you say that again, please?

Mr MORETON: When I first started 18 months ago I had one Indigenous client. By the end of 2017, I had 83. I was just doing this job by myself. As of 2018, this year, I started on 8 January, Ms Kelly came in a couple of weeks later and then Ms Davison. I have got 44 on my books now.

The CHAIR: In addition to that 83?

Mr MORETON: Yes, 44 referrals. As part of our contract to Prime Minister and Cabinet for our key performance indicators and statistics I have only got to get 60 for the year.

The CHAIR: It should not be too hard to do, sadly.

Mr MORETON: In saying that, you have to go out there and do your work. That is what you get paid to do. So of the 60 KPI stats that they say, I have got 44. That is where the service has come from in 18 months.

Dr MEHREEN FARUQI: I was looking at the current statistics and you say 85 per cent of your referrals in the past 18 months have come through the courts. I would like to know more about the breakdown of the clients. What sort of substance dependence or misuse issues do they have? Do you know percentages? Is the majority alcohol or is it other drugs?

Ms KELLY: Because we have just started—and, jeez, we have hit the ground running—we are going to be looking more at that. Anecdotally, we are collecting that data at the moment. Ice is a big problem but it is always alcohol and cannabis is a major problem. Everybody smokes cannabis as well. It may not be the main problem but cannabis is definitely the untold one—I heard the other lady say that, it is true. Alcohol, they go to the courts for drink driving charges. It is usually minor charges, isn't it, Mr Moreton? Maybe a bit of thieving and this sort of thing, but it is alcohol or ice. This young girl we are talking about was before the courts for ice use—a bit of poor behaviour while on the ice, assaulted somebody.

The CHAIR: What about heroin? Does it feature here?

Ms KELLY: Heroin is interesting. We are really just starting to get to know the community. I saw a lady in Eden a few days ago. We are going down there twice a week. She had a previous heroin problem and she started using it again nine months ago, smoking it. She had a long drug and alcohol history. I think it is there but I am just starting to tap into it actually. The problem with that is that there is only one prescribing medical officer in town and to try to get help for her that day—because she wanted to go back on the methadone program—was very problematic. The government resources here are very poor. There are not enough staff. You ring and you never get a call answered.

The CHAIR: Who are you calling?

Ms KELLY: I was ringing the local health district community health centre drug and alcohol worker, who was at Bega. I was ringing him to see who the prescribers were in town. He said, no, they all come through them. But he rang me back a day later, which was good—at least he rang back. Anyway, she wanted help there and then. I do not know what has happened with her. I have to see her again next week and hopefully we can get her on the opiate treatment program.

Dr MEHREEN FARUQI: Do you work with or have a partnership arrangement with Wandarma, which is in Bega?

Ms KELLY: Mr Moreton would know more about Wandarma, but I do not believe they exist any more.

Dr MEHREEN FARUQI: I thought they had funding till the end of the year.

Ms KELLY: We have got their funding, I think.

Mr MORETON: We had partnerships with Wandarma but there were complications between the two organisations and that had to cease. With me covering the whole area from Bay to Eden, Wandarma's service was really hard to tap into with the number of workers they had. They had 13 workers. I believe for the year they had 33 stats for the year. I had 83 for one year. Whether they were doing their job or not, I do not know. I cannot answer that question. That was a service that should have really knocked a lot of goals down there. It is a disappointment for the Aboriginal people that could not go to that service.

Dr MEHREEN FARUQI: How long are you funded for at the moment by the Federal Government?

Mr MORETON: As far as funding for us, I think it is up for review in a couple of weeks.

Ms KELLY: We think it is going to roll over and hopefully we will get more.

Mr MORETON: It is up for review with Prime Minister and Cabinet for us.

Dr MEHREEN FARUQI: We have heard that funding is a real issue and that it is often short-term and uncertain, so it is difficult to plan ahead.

Ms KELLY: I have got a nine-month contract, which is one reason I went on leave without pay. Ms Davison has only got a 12-month contract. It is hard to do really good work on that short-thinking model.

Dr MEHREEN FARUQI: What would be your recommendation for that? Should it be more certain and longer term?

Ms KELLY: Absolutely. I am a great advocate for Aboriginal medical services [AMSs], having worked in three now. AMSs are the way to go for Aboriginal people, I will tell you that much, having worked a lot in mainstream. I have been nursing for 33 years. You have to fund AMSs, because they are a one-stop shop. They are a great model of care where the doctor, nurse and Aboriginal health worker can all be Indigenous—some are not; I am not Indigenous. It is a great model and the people are very connected to the AMSs. The Aboriginal medical service is like part of the community.

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

Dr MEHREEN FARUQI: A submission by the Broken Hill working group raised the issue of the risk of people, especially women, losing public housing if they go into residential care programs. If women go into residential programs, their children might go into foster care and then they risk their children being taken away. This is what they have raised. We know that this risk is much higher, unfortunately, for Aboriginal people. Do you see any of that happening in this area?

Ms KELLY: With public housing, it is not the case that you lose your public housing. Public housing will let the person pay a nominal rent—it might only be \$10 a week—and the rest will go into the rehabs. I know for absolute certain, having worked in the area for so long, that the rehabs will then take what was going into the public housing rent. It is a problem and that is one reason why we want to expand it, because there are mothers with young children, and there is no way they can go into a rehab. Maybe they have family that can

care for the children, but what mother wants to be parted from her child for 12 months? Karralika have a family program. That is where you put your money. Karralika in Canberra is a great program.

The CHAIR: Is that run out of a particular hospital?

Ms KELLY: Karralika rehabilitation is a non-government organisation. They are one of the best rehabs in Australia. They have a family program where couples can go with their child. Couples that have a drug dependence issue can go with their child and the child goes to the local school. It is a good program.

Mr MORETON: Yes, it is.

Dr MEHREEN FARUQI: Is that something you would recommend for here?

Mr MORETON: It is a really good program, yes.

Ms KELLY: Particularly for Aboriginal people it would be good, I think.

Dr MEHREEN FARUQI: We do not have anything similar to that, do we?

Ms KELLY: We do not have anything down here at all. Mr Moreton and I are going to be doing SMART [Self Management and Recovery Training] Recovery. We want to expand it more too. Residential is not the key to it all but it is a large part of it. We are looking at starting up SMART Recovery groups soon. I am doing more one-to-one counselling at the moment. We are trying different models for different people, not one size fits all. If people have long addiction issues and if they can get to rehab, they learn really good skills in rehab, so it is worth the effort to try and get them there, but if they cannot for whatever reason—

Dr MEHREEN FARUQI: We are hearing again and again there are there is a real lack of services for women.

Ms KELLY: Yes, there is.

Dr MEHREEN FARUQI: That is something that is quite important.

Ms KELLY: Particularly if they have got children.

Dr MEHREEN FARUQI: Yes—and a lack of culturally appropriate services.

Ms KELLY: Yes.

The CHAIR: For Indigenous people it is important to return back to the community they are from and, from the example that you have given, they are obviously anxious when they are separated—it obviously creates great anxiety. Upon returning to the community from which they came, wherein lies some of the problems that led to their alcohol or drug addiction in the first place, it may not be necessarily under the same roof but in that community there are challenges with other people, is there a particular need to try to have some services operating at that point of return so they do not inadvertently slide back to the difficulties that caused them to become addicted in the first place?

Mr MORETON: Are you talking about people who relapse after being in rehabilitation for 14 weeks, six months or 12 months?

The CHAIR: Yes.

Mr MORETON: When they come back into society one of the things we find is that they relapse because we have not got the services or the finance for extra staff to help us support those people.

Ms KELLY: But we are working on that. It is a big need that we identify. There is no point sending people away—well there is a point because, I am not being dramatic, you are saving lives at times. Coming back, we are working on that.

The CHAIR: What services are necessary at that point of return over time to prevent that relapse from occurring?

Ms KELLY: Regular engagement. Even saying, "Hi. How are you going?" Doing SMART Recovery groups and doing one-on-one counselling.

The CHAIR: That is not present at the moment?

Ms KELLY: Like I say, we are doing some training. We are going to be running—it is in our submission—SMART Recovery groups. We are already doing appointment systems and follow-ups with people as they are coming out of rehabilitation. I have been there for two months now and I am starting to see them coming out. We are connecting with the workers at the rehab. They know that they are our clients and they will

ring us when they are coming out now. We are going to have follow-up appointments. That is a huge potential to do some great good—once a person comes out to really follow them up.

The CHAIR: Mr Moreton, clearly the presence of someone with your experience and background is quite important in influencing and encouraging people who are either sliding towards an addiction or have an addiction to look to see what they can do to try and get themselves out of that situation. How do we find more Mr Moretons?

Ms KELLY: I do not think that we could cope with too many Mr Moretons.

The CHAIR: I do not personally believe in human cloning so I cannot recommend cloning, but it is a serious question. Clearly with that wealth of experience when you walk through a door—

Mr MORETON: The simple way to answer that is by having grassroots respect. If you have got respect from the Aboriginal people they will work with you, they will ask you for help, they will come to you. My eight years in the police service working from Batemans Bay to Eden as the Aboriginal Community Liaison Officer set me up for where I am today, building up that relationship with all Indigenous services, non-Indigenous services and the Aboriginal community itself. Like I guess those 83 clients I built up last year, that is all through respect, knowing who I am and knowing the generation of the families I have worked with over the years. I have watched kids grow up and I have watched their kids grow up. If you get that rapport.

Ms KELLY: When Ms Davison applied for the job there was a young man down at Eden—

The CHAIR: Ms Davison how were you recruited? Did Mr Moreton come knocking on your door to recruit you?

Ms KELLY: We advertised. We interviewed a young man who was exceptionally good. Someone like him could do an apprenticeship and learn from Mr Moreton. You need like an apprenticeship system.

The CHAIR: To perpetuate it.

Ms KELLY: Definitely. If we get more money we have our eye on him. He is a very capable young man.

Mr MORETON: Yes.

The CHAIR: Part of succession planning obviously?

Ms KELLY: Definitely, yes.

Ms DAVISON: Just consistency from us workers I think.

The CHAIR: Being reliable and being there when you are needed.

Ms DAVISON: Yes.

The CHAIR: The information you have given to the Committee today has been very insightful and very helpful. We are acutely aware of some of the particular challenges that our Indigenous brothers and sisters face, particularly outside the big cities. The Committee very much appreciates your evidence. We touched on some of your PowerPoint presentation as we went through the evidence, but are you happy to have this formally tabled and ultimately published?

Ms KELLY: Yes.

The CHAIR: Do you wish to have a further look through it? We would normally publish this on the Committee's website so it will become a public document but we would not do that without your approval.

Ms KELLY: I think that is fine.

The CHAIR: Is there anything particularly confidential in here? Would you be okay with the Committee doing that? We will get the secretariat to liaise with you after the hearing to have that confirmed.

Mr MORETON: Yes.

The CHAIR: That will get published as part of your contribution. I again thank you for travelling to this hearing and for the wonderful work you do in your communities.

Mr MORETON: Thank you.

(The witnesses withdrew)

(The Committee adjourned at 14:56)