

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 , Clarence Valley Healing Centre, Grafton, on Monday 25 June 2018

The Committee met at 9.50 a.m.

PRESENT

The Hon. Greg Donnelly (Chair)

Dr Mehreen Faruqi

The Hon. Paul Green

The Hon. Courtney Houssos

Mr Scot MacDonald

The Hon. Dr Peter Phelps

The Hon. Bronnie Taylor

The CHAIR: Welcome to the sixth hearing of Portfolio Committee No. 2 – Health and Community Services inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales. The Committee is examining a range of matters including the type of drug rehabilitation services available as well as the funding, cost and accessibility. The inquiry will also consider if there are any gaps or shortages in the provision of services. I acknowledge the people from the Bundjalung nation and pay respect to elders both past and present. I acknowledge the Gumbaynggirr and Yaegl nations which lie within the Clarence Valley boundary. Today is the fifth regional hearing for the inquiry. The Committee's final regional hearing will take place in Lismore tomorrow. Today we will be hearing from representatives of the Northern NSW Local Health District, several local drug and alcohol services, two Aboriginal medical and health organisations, the coordinators of various local specialised drug and alcohol programs and representatives from Clarence Valley council.

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 remind media representatives that you must take responsibility for what you publish about the Committee's proceedings. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside their evidence at the hearing. I urge witnesses to be careful about any comments that you make to the media or to others after you have completed your evidence as such comments may not be protected by parliamentary privilege if another person decides to take an action for defamation. The guidelines for the broadcasting of proceedings are available from the secretariat.

There may be some questions that a witness could only answer if they had more time or with certain documents to hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 10 days. Witnesses are advised that any messages should be delivered to Committee members through the Committee staff. To aid the audibility of the hearing today I remind Committee members and witnesses to speak into the microphones. In addition, several seats have been reserved near the loudspeakers for persons in the public gallery who may have hearing difficulties. Finally, would everyone please turn their mobile phones to silent for the duration of the hearing.

DEE ROBINSON, General Manager, Mental Health, Drug and Alcohol Services, Northern NSW Local Health District, sworn and examined

CORINNE MAYNARD, Manager, Richmond Clarence Drug and Alcohol Services, affirmed and examined

WAYNE JONES, Chief Executive, Northern NSW Local Health District, sworn and examined

MITCH DOBBIE, Manager, Tweed Byron Drug and Alcohol Services, sworn and examined

The CHAIR: We have the whole-of-government submission which is marked submission No. 34 for this inquiry. I am sure you are familiar with that. It can be taken as read. The Committee members are familiar with its contents. In terms of the contribution today you do not need to go into that in detail. You may wish to refer to parts of it. Would one, some or all of you like to make an opening statement? I request that it be kept relatively short and sweet so we can dive into the questions.

Mr JONES: We have consulted and if people are comfortable I am happy to make an opening statement on behalf of us all. It details what we do locally. We acknowledge the traditional owners of this country and their continuing connection to the land, sea and community. We recognise the heritage, culture and contribution of our nation's first people. We pay our respects to them, their culture and elders past and present and all Indigenous people here today. We would like to thank you for the opportunity to appear before the Committee today and commend the Committee for this inquiry. The Northern NSW Local Health District [LHD] is committed to delivering specialist alcohol and other drug treatment services along with the continued strong partnership with the community-managed organisations sector to a quite vulnerable client group.

The LHD services include inpatient withdrawal unit, outpatient opioid treatment programs, stimulant treatment services, Magistrates Early Referral Into Treatment, drugs in pregnancy, the community engagement program and the intensive drug and alcohol counselling for people with severe to acute substance dependence. Clients are triaged, assessed and referred to the most appropriate drug and alcohol service according to their needs. The inpatient withdrawal unit is a 14-bed unit located in Lismore at the Riverlands Drug and Alcohol Service. It is the only New South Wales public health inpatient withdrawal unit receiving clients from Newcastle to Brisbane. The inpatient withdrawal unit provides services for people with substance dependence issues who require a nurse-led medically supervised detoxification service. There are nursing staff 24/7 with medical support from addiction medical specialists and visiting medical officers.

Recent improvements to the models of care are supporting the patient journey from a streamlined intake admission process to improve triage and transfer from the emergency department and wards to ensure the client is in the right service at the right time. The Stimulant Treatment Program [STP] consultation and liaison staff provide services to patients presenting to either the emergency department and/or admitted to hospital inpatient wards whereby substance use is an underlining comorbidity to the admission diagnosis. Staff work alongside the ED to stream and ensure appropriate care for non-admitted patients requiring drug and alcohol outpatient community services.

The STP advises and supports clinicians regarding withdrawal management options and provides specialist alcohol and other drug training and education to all hospital staff regarding drug and alcohol management and referral to the inpatient withdrawal unit as required. The STP has a priority focus on patients identified with amphetamine use and provides case management referral to a variety of community services. The specialist intensive drug and alcohol counselling service comprises trained drug and alcohol clinicians, who provide counselling information, education and referral to individuals who have significant alcohol and drug dependency within the community. This service works with those clients with moderate to severe substance dependence who also have complex psychosocial issues.

The Community Engagement Program is an assertive outreach program working with individuals who have been identified either with a high number of emergency department presentations and/or increasing presentations at various services because of substance use and have not been able to successfully engage with any drug and alcohol service. The community engagement team works with individuals by facilitating access and reducing barriers to treatment often occurring within clients who have comorbidities, including mental health, physical health and/or social issues. This is a proactive program to improve client outcomes and their quality of life.

Across Northern NSW Local Health District drug and alcohol services, the trend in substance use is the following top four: alcohol at 38 per cent, opioids at 24 per cent, cannabinoids at 19 per cent, amphetamines at 15 per cent. This is a representation of the type of substance identified by a self-report service and not a reflection of the level of drug use in the community. In comparison to the New South Wales trends for principal drugs of

concern, northern New South Wales trends in the community are similar in pattern from the 40 years and above demographic, with the highest use reported as alcohol, then opioids and, thirdly, cannabis. However, the inpatient unit has seen a slight increase over the last 12 months, putting amphetamine-type stimulants in third place. The increase in amphetamine withdrawal admission is likely due to better pathways to treatment by clinical liaison in the emergency departments and hospitals.

Northern New South Wales has identified four overarching themes in which alcohol and other drugs services development and delivery will need to be shaped for the future. These include the significant population growth, the large and growing aged population, low socio-economic status and a high proportion of Aboriginal residents. With those issues outlined, one of the primary principles to meet those challenges is a strong partnership with community-managed organisations across northern New South Wales. This allows alcohol and other drugs as a whole sector to provide access to the right service at the right time for treatment and support, recognising the chronic nature of alcohol and other drug dependence and the need to individualise care to the person's circumstances. Thank you.

The CHAIR: Just so we have got a sense of the boundaries of the territory that the area covers, could you give us a general from where to who?

Mr JONES: Slightly south of where we are at the moment—somewhere between Woolgoolga and here is the cut-off line—and we go as far as the Queensland border and out as far as Bonalbo, which is slightly east of Tenterfield.

The Hon. PAUL GREEN: Did I hear you correctly that Lismore has 14 beds and there are no other beds between Newcastle and Brisbane?

Mr JONES: That is correct.

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

Mr JONES: They are direct detox beds. Obviously there is drug and alcohol management within general beds in hospitals.

The Hon. PAUL GREEN: I cannot think of the unit that we are going to go and see tomorrow.

Mr JONES: That is the inpatient unit managed by Northern New South Wales as part of Riverlands. The distinction would be that they are the public health beds. There are other beds.

The Hon. PAUL GREEN: Is that The Buttery?

Mr JONES: No.

The Hon. Dr PETER PHELPS: The Riverlands is 14 dedicated public health beds.

Mr JONES: Correct. Within the hospitals.

The Hon. Dr PETER PHELPS: But that does not mean you cannot cut into your existing—

Mr JONES: Correct.

The Hon. Dr PETER PHELPS: But how often do you do that?

Mr JONES: It depends, because if drug and alcohol dependants require an inpatient management we prefer to put in a specialist unit at the drug and alcohol centre, which is Riverlands, which is across the road from the base hospital. So it is separate.

The Hon. PAUL GREEN: In Lismore?

Mr JONES: In Lismore. The Buttery is a community-managed organisation in Bangalow. What we tend to do with drug and alcohol management in the wards, it is a secondary issue, not necessarily their primary reason for admission.

The Hon. PAUL GREEN: So 14 beds—what would be the take-up of that situation and the statistics of how many of those beds would be needed in real terms?

Mr JONES: If you go on occupancy as a proxy in that regard, occupancy has been sitting around 60 per cent until recently. The changed models of care we spoke to in our opening statement that are a more streamlined admission process through the emergency department, the wards and other areas, that is now sitting slightly above 70 per cent and we expect that to rise. For example now the 14 beds are seven inpatients and three admissions coming through the door.

The Hon. PAUL GREEN: How many beds do you think you would need in real terms?

Mr JONES: Based on current demand, I think the 14 beds are adequate, supported by the generalist bed support. I believe it is a complex thing to be answered whether we need more beds or not because it is such myriad support individualised. I would say the current 14 beds is adequate.

The Hon. PAUL GREEN: It just seems that 14 is so small between Newcastle and Brisbane.

Mr JONES: If I could just take a State figure on this, as the report points out, 47 or 48 per cent of inpatient rehab beds have been in regional New South Wales. So there is a demand there, I agree, but it also reflects that that demand is being met to a large extent.

The Hon. PAUL GREEN: In terms of substance abuse, we have taken a lot of evidence that substance abuse first of all seems to be alcoholism and then secondly it seems to be that the drug of choice at the moment is ice. Would that be consistent with what the area is facing?

Mr JONES: No. Alcohol by far is our biggest challenge and continues to be. The next one is opioids, and then in the community it is cannabis and then amphetamines under the broader umbrella. What we have seen in the last 12 months in our inpatient setting—and we like to think it is because of the changed pathways, the easier way for people to access—we have seen amphetamine use jump cannabis as the third reason people are having inpatient rehab services.

The Hon. PAUL GREEN: Is cannabis a problem?

Mr JONES: This is the north coast.

The Hon. Dr PETER PHELPS: There is absolutely no relationship between the north coast of New South Wales and Indian hemp.

The Hon. PAUL GREEN: In terms of mental health problems—schizophrenia, all those types of psychoses that come with using THC, is it a problem?

Mr JONES: I am not an expert, but there is certainly a relationship between cannabis use and psychosis in certain quarters, without a doubt.

Dr MEHREEN FARUQI: Thank you very much for coming in this morning. You said there are 14 beds at Riverlands. Are there detox beds at the Maclean District Hospital as well?

Mr JONES: No, they are general rehabilitation beds and/or orthopaedic, not drug and alcohol or rehab beds.

Dr MEHREEN FARUQI: How is the detox connected then to rehabilitation services? We have heard a lot during this inquiry that it needs to be a wraparound service for drug rehabilitation. How does that work?

Ms MAYNARD: When patients want to access the inpatient unit for detox they are strongly encouraged to have an after-care plan. Most of our patients that come through the inpatient unit will have some form of after care because it is around a seven- to 14-day stay in the inpatient unit. Obviously it is voluntary and any after-care plan is also voluntary; however, we do strongly encourage patients to consider a rehab and, as you have said, there are two rehab services in our area—one is The Buttery and the other one is Namatjira Haven. The Namatjira Haven is for Aboriginal men and The Buttery is open for anyone. We do have really good links both with The Buttery and Namatjira. If we take patients that have got a booked bed in Namatjira Haven or The Buttery we time their detox stay to go straight from detox to rehab because we know that that is a really smooth pathway for people.

Dr MEHREEN FARUQI: Do you have any records of how many people do that or are people coming back for detox?

Ms MAYNARD: We do not have records of how many people come from the inpatient unit into rehab; however, we do receive annual reports from The Buttery and we are aware that there are about 25 to 30 per cent of people that do come from the local health district that are actually in The Buttery. But we do not have specific statistics on that.

Mr JONES: I think it is fair to say that we adopt a principle of wraparound services as much as we can, recognising that the drug and alcohol issue is supported by other challenges in their life, and we do recognise that abstinence is an ongoing journey for people and quite often they will relapse, and we need to be there to support them.

Dr MEHREEN FARUQI: What are your views on harm minimisation and prevention, or harm reduction specifically? Does Health have any role in that? Research and evidence shows that harm minimisation is the way to go. What programs do you have?

Mr DOBBIE: We have run all of the programs from a harm minimisation perspective. The issue there is we understand that people do not want to necessarily stop, so what we are encouraging them to do is to manage their drug use to a point where they can make a choice whether they may go to abstinence, but also in regards to how they might manage reducing their drug use. Most of our programs are based around that and we develop them around the harm minimisation approach. It has been around for so long, it is just part of our structure.

Dr MEHREEN FARUQI: The Committee has heard from some people that it is not possible to eliminate drug use.

Mr DOBBIE: No.

Dr MEHREEN FARUQI: It has always been there and always will be. It is harm reduction and minimisation that we should look at. Are there any specific programs for women, young people or children? Some people have highlighted under 18s as an issue. Do you have any specific programs directed to them?

Mr DOBBIE: One of the programs we have is the Drugs in Pregnancy program. That identifies mothers who come into the hospital or through that program and we work with those mothers who have a drug and alcohol issue. That is a bit of a wraparound service in maternity for us. We then look at how we can support them to reduce their drug use. Also too, the other part of this as well is we look at the safety of the child in regards to the level of the chaos within the family. That has been quite successful.

Dr MEHREEN FARUQI: Do you think there is an issue with under 18s and how is that addressed?

Ms MAYNARD: We have a counselling service that Mr Jones alluded to earlier. The intensive counselling service does see people from 16 up. The majority of our other services are 18 and up, but Mr Dobbie has a youth worker in the Byron area, so he can talk to that.

Mr DOBBIE: We are seeing a growing trend, whether it is because we have changed the pathway a bit, we are starting to see younger people trying to access the detox unit as well. We have been managing that this year. Yes, we have one youth worker in Byron who works a lot with the schools, not so much in the case of going into the schools to do the education, but working with anybody who is identified in the school who has a child in the school, as in a high school, that might want some counselling. Also, we find that sometimes it is about them having identified their parents. This worker is also able to work with that young person about how they manage that, because they are having to try and manage an adult situation as a young person.

Mr JONES: We have a child and adolescent mental health service unit and there is a good support relationship between alcohol and other drug services and mental health and child and adolescent. So there are services available.

Dr MEHREEN FARUQI: Where is that?

Mr JONES: In Lismore.

Ms MAYNARD: We have a drug and alcohol consultation and liaison service that goes into the hospitals, including the child and adolescent unit, and the worker that we have in Lismore for consultation and liaison has been saying that she has been seeing younger people coming through the hospital and through the child and adolescent unit with substance use issues, not necessarily dependence, but certainly substance abuse issues.

Dr MEHREEN FARUQI: The submission from the Royal Australian and New Zealand College of Psychiatrists raised a concern about increasingly merging alcohol and other drug services with mental health services. Their concern is that while substance abuse is comorbid with other mainstream health services, the target groups could be significantly different and need different treatment. What is your view on that?

Mr JONES: I think it is never black and white in that regard. I tend to operate these services in a field of grey, and there are certain population groups that benefit from merged services. But, correct, there are certain populations within both of those that require specific trained expertise relating to drug and alcohol and mental health. I think the literature, and now evidence, is fairly clear that there are groups in the middle. Whether drug and alcohol came first or mental health, they are comorbid conditions that present to our organisations.

Dr MEHREEN FARUQI: Do you have that expertise here? The Committee has heard that finding qualified staff in this area is quite difficult? Do you have enough Aboriginal people?

Mr JONES: Specifically Aboriginal staff, no. We have, I believe, one Aboriginal drug and alcohol worker. In saying that, our answer to that is we structured our entire Aboriginal health services with more of a recruitment retention employment focus to increase those numbers, and not just in drug and alcohol but broadly across the services. As we know, there are not that many out there who have alcohol and other drugs as a qualification. We are very fortunate that we have an attraction to our geography that does lend itself to people

wanting to live and work up here. We do attract all levels—doctors, nurses, allied health people—with those qualifications who have a willingness and a desire to work. I understand that from the community-managed organisations as well, they also have a fairly healthy workforce.

Dr MEHREEN FARUQI: With one Aboriginal worker. When did you start your program to increase or attract more Aboriginal staff?

Mr JONES: We only signed off the structure about six months ago. The new director of Aboriginal Health Services starts in two weeks time.

The Hon. COURTNEY HOUSSOS: You mentioned that the Riverlands service is a seven to 14-day stay. What is the current waiting list?

Ms MAYNARD: The waiting list currently is between seven to 10 days, which is fairly reasonable.

The Hon. COURTNEY HOUSSOS: The Committee has been told that is only available to people over 18, is that correct?

Ms MAYNARD: Yes.

The Hon. COURTNEY HOUSSOS: Is that a detox service for children?

Ms MAYNARD: No.

The Hon. COURTNEY HOUSSOS: Do you give priority to people from your local health district?

Ms MAYNARD: We do. We have a few different priorities that we triage on intake. Yes, the priority is from our LHD. The only time we really take people not from our LHD generally is if they are going into a rehab in the area. However, as Mr Jones said, there are no other detox centres from Newcastle to Brisbane, so we do take from out of area, yes.

The Hon. COURTNEY HOUSSOS: Will you take someone from further south, who is not technically in your LHD and perhaps not coming to a rehab within your LHD?

Ms MAYNARD: We will try to, absolutely. As I say, we have other priorities as well that we—

The Hon. COURTNEY HOUSSOS: I appreciate that your responsibility is to provide services to people within your LHD.

Mr JONES: It is a broad catchment. If someone from, say, south of Mid North Coast requires a bed, if we have a vacant bed, we will take them.

The Hon. COURTNEY HOUSSOS: Do you have any programs to upskill your Aboriginal workforce, or would that be part of your new Aboriginal medical services?

Mr JONES: Yes, we currently have programs in place. I think the focus for us is to strengthen and therefore increase the numbers of Aboriginal workers in our organisation. We have about 4.6 per cent of the population who identify as Aboriginal and Torres Strait Islander. We believe we need more Aboriginal and Torres Strait Island people in our organisations across the board. There certainly is cultural training for non-Indigenous people, obviously, to reflect that what we provide is culturally safe care across the board. We believe one of the best ways to do that is if people from an Indigenous background come in and are being cared for by Indigenous people it makes it more culturally safe and acceptable.

The Hon. COURTNEY HOUSSOS: Do you have a figure for how many Aboriginal workers you have across your LHD?

Mr JONES: We sit around 2.8 per cent. I can confirm that and come back to the Committee.

The Hon. COURTNEY HOUSSOS: That is just the one within—

Mr JONES: Within Drug and Alcohol Services, yes.

The Hon. COURTNEY HOUSSOS: The Committee heard earlier there was a Federal \$300 million package and a State \$75 million package for ice. Do you have any specific programs within this LHD as a result of that funding?

Mr DOBBIE: In one of our programs we got money through the Stimulant Treatment Program and we used the consultation liaison as a framework for our program. What that meant was that we had clinical nurse specialist grade 2 [CNS2] who went into the hospital as a consultation liaison. They had a focus on picking up on amphetamine clients who were in there because they are doing consultation liaison, but they also picked up on all drug users in the hospital. This has been quite successful. What we have found is that that funding has done a

number of jobs within the hospital itself—namely, it has picked up on that and it has given support to nurses within the hospital who now feel a lot more confident working with people with drug and alcohol in the community itself or within the hospital.

The Hon. BRONNIE TAYLOR: You have upskilled them.

Mr DOBBIE: Absolutely, and they had someone to call on who had that skill to be able to do it. We did a bit of an audit on the files and we found one of the measures was a return rate by 90 days—that is, when the intervention was done for those people they made contact with, we found that up to 87.9 per cent did not return in the 90 days. What would happen is, if they identified anything other than amphetamines they would then do a referral through to our Intensive Drug and Alcohol Clinic. So they would then follow them up in the community and clinical liaison [CL] workers would also then provide four sessions to anybody who was identified with amphetamines.

The follow-on from that is that we have also received additional funding for what we call community engagement, which is the assertive follow-up teams. In other words, if someone came to the hospital on numerous occasions but never engaged with drug and alcohol, these people were identified and they would be taken into the intake. The counselling team might have offered them a number of counselling sessions and they never turned up, so this team would then identify and that person would try to assertively follow them up to encourage them to come and get the service. The issue is that there might be other barriers, rather than their drug and alcohol—they may not have access to transport, they may be homeless, there may be some hypothetical issues that they are not able to do that. Linking it all up, it is a great service.

The Hon. COURTNEY HOUSSOS: Was it just in the Tweed and Byron Bay?

Mr DOBBIE: No.

Ms MAYNARD: There are four stimulant treatment program workers across the LHD and we have put them in the main hospitals if there is a hospital liaison service—in Tweed, Grafton, Lismore and Ballina.

The Hon. COURTNEY HOUSSOS: But it did not increase residential beds across the LHD?

Ms MAYNARD: No.

The Hon. COURTNEY HOUSSOS: Did the money from the Federal package go through the primary health network [PHN] or did that come—

Mr DOBBIE: Yes.

The Hon. COURTNEY HOUSSOS: So limited contact with you?

Mr DOBBIE: I guess the benefit is that one of the packages that has just come out is the aftercare package. We know which community-based organisation received that, so we are now working with them on how we can do that complete flowthrough. So if we identify someone before they come in and do the assertive follow-up, they might get the counselling and then through to their aftercare, and we can transfer them across to that community. I think it is an exciting time from the point of view of what we can do.

Mr JONES: We work very closely with the North Coast Primary Health Network [NCPHN] and have done so for a number of years. We adopt a very, very strong position that we develop services for our region, not for the silos of the funding models. We are often recognised at a State and Federal level as one of the more effective relationships in developing integrated care models, including drug and alcohol and mental health.

The Hon. COURTNEY HOUSSOS: Sometimes we have heard conflicting reports about that, so that is very good to hear. Do you have many involuntary admissions to your Riverland's facility?

Mr JONES: We have none.

The Hon. COURTNEY HOUSSOS: Is that because it is a policy decision or you just do not have any?

Mr JONES: It is a voluntary service. The capital is not designed for mandatory detention, the staff are not trained in that regard and the people who go there do so on a voluntary basis. That would change the milieu of the place enormously. No, we do not have mandatory detention through the place.

Dr MEHREEN FARUQI: Given your experience, do you think involuntary detention, as you call it, is helpful? Does it work?

Mr JONES: Let me apologise for the word I have been using. Let me say first of all, I welcome any option put on the table that increases the debate about what services, options and programs would work for this very challenged group. It is certainly my experience that involuntary care for drug and alcohol dependency is not

as effective; people need to want to change. If people are not ready or willing to change it is my experience, over many years, that the results are not great.

The Hon. Dr PETER PHELPS: You mentioned that opioids remain your second greatest problem. Is that for presentations or for—

Mr JONES: Both, general use in the community and presentations.

The Hon. Dr PETER PHELPS: Do you mean heroin or things like OxyContin?

Ms MAYNARD: Again, certainly with the inpatient unit and our opioid treatment program there has been a shift over the years from heroin to more prescribed medication—OxyContin, et cetera. There is still heroin in this LHD but it has just shifted slightly.

The Hon. Dr PETER PHELPS: But nevertheless amphetamines are on the rise?

Mr JONES: In the inpatient setting. In the community setting we are still seeing it ranking fourth, around about the 15 per cent mark, but we have seen an increase.

The Hon. Dr PETER PHELPS: But as far as you are concerned surely the problem is presentations? I mean if you are a functioning addict then that is not really a concern for the Department of Health?

Mr DOBBIE: It is the ones who present to our services.

The Hon. Dr PETER PHELPS: So presentations for amphetamines. I am trying to work out whether there is something distinctly different about the North Coast, in that the general State trend is that alcohol presentations are down and amphetamine presentations are up.

Mr JONES: If anything, I would say that it has plateaued or is slightly up on amphetamines. Alcohol still remains our number one challenge without a doubt on a percentage basis, and the repercussions of that. I would not see us out of sync with the State figures.

The Hon. Dr PETER PHELPS: Are the presentation figures related to the fact that alcohol is a legal drug and the others are illegal drugs, and that people who may wish to seek treatment are in some way dissuaded by the fact that those drugs are currently illegal and have fears about reporting?

Mr JONES: I cannot speak for those who do not present but I think that is a logical argument to pose. We can only go on making our systems of intake and entry into our organisation as easy and without stigma as possible. We would like to think that we have seen an improvement, and if we go on the inpatient numbers through Riverland's we are seeing an increase in people self-presenting. So we like to think that we are addressing some of that but I think that the argument you pose is a logical argument.

The Hon. Dr PETER PHELPS: One of the things that the Committee has come across a number of times is the disconnect between detox and rehab and the unfortunate consequence of falling back after detox due to a lack of rehab facilities. I am very pleased you have mentioned that when people have booked into a rehab facility you can quite easily transition them. But in the situation when you do have an emergency presentation, what is the level of bottlenecking that you get following detox when trying to find appropriate rehab facilities?

Ms MAYNARD: I think it depends on what the client wants. Going back to the other point, it is not necessarily every client who comes to our service needs or wants a rehab, as in an inpatient long-term rehab. We do offer other options as well and that will depend on what the individual patient wants. We do offer other services like the counselling service. There are obviously community-managed organisations as well that can see clients on an ongoing basis.

The Hon. Dr PETER PHELPS: That is fine but my concern is with those who do want the rehab service. What level of bottlenecking do you have? What sort of time periods are you looking at? You may well have a situation where, fortunately, one is available the next day—

Ms MAYNARD: It is really dependent on—

The Hon. Dr PETER PHELPS: But it is something that is not available for six months. What is the general disjuncture between completion of detox and admission to rehab?

Ms MAYNARD: I cannot answer that, I do not have the statistics on that.

The Hon. Dr PETER PHELPS: Would they be available? Could you take it on notice, for example?

Mr JONES: We could take that on notice and you get what you get. But anecdotally, in absence of the data, we do not hear that is a major problem. There are certainly periods. These things are cyclical as we know, but generally speaking we do not hear that is a problem. We can take that on notice.

The Hon. Dr PETER PHELPS: It is just one of the things we have heard. It will come down to our recommendations. Other people have said there is a clear preference for collocation of detox and residential rehab facilities for the reasons mentioned, that is, the disjuncture between the end of detox and rehab leads to significant fall back. If you are operating on a system of detox which is not collocated with rehab but you still believe you are getting good outcomes then that would be an interesting and unusual analysis based on what we have heard previously.

Mr JONES: We have had years of relationships with organisations like The Buttery and Namatjira Haven. Those relationships now make it a relatively seamless process for that transfer of in and out. Again, your argument is very logical that you would want to have them collocated.

The Hon. Dr PETER PHELPS: Most of my arguments are logical.

The Hon. BRONNIE TAYLOR: Most people do not say that to the Hon. Dr Peter Phelps, but we will pay it.

Mr JONES: We have not seen that as a major issue being brought to our attention.

The Hon. Dr PETER PHELPS: One final thing, it goes to Aboriginality. We have heard previously that many Aboriginal people who might have addictions are reticent about approaching mainstream services and prefer organisations that are run, operated and controlled by Aboriginals in preference to mainstream services. What has been your analysis of that?

Mr JONES: Can I make a couple of comments? One is that we work very closely with Aboriginal controlled organisations, our Aboriginal Medical Service [AMS] and others and we have had a partnership going for 12 years. Again, they fall into that seamless arrangement where we share services quite extensively. We can only go on the numbers we see. If you look at cross-services in alcohol and other drugs Aboriginality represents about just under 14 per cent of people accessing our service. The inpatient setting—correct me if I am wrong, Ms Maynard—is about 18 per cent. We believe we are being seen as a service that people will come into when they are ready to come in. Again, on that individualism and taking in the culturally respectful safe environment we work very closely with our AMSs because we believe that they, in many cases, are the first point of call when people are in crisis. So, we work closely with them. Our numbers do reflect that we do provide a very broad service for Aboriginal people in our LHD. Those numbers are gradually going up. I do not believe that represents a worsening of addiction. I believe it represents an opening of the avenues for people to access those services.

The Hon. BRONNIE TAYLOR: I have a couple of questions I want to flesh out. Mr Dobbie, you said the CNS2 positions found a higher incidence of benzo use?

Mr DOBBIE: No, not benzo.

The Hon. BRONNIE TAYLOR: What did you say?

Ms MAYNARD: Amphetamines.

Mr DOBBIE: Yes.

The Hon. BRONNIE TAYLOR: Tell me if I am wrong. You said the nurses who were on the wards contacted one of those positions that were placed then had a lower rate of re-entry into hospital?

Mr DOBBIE: Yes.

The Hon. BRONNIE TAYLOR: Do you think that demonstrates the fact that there was a point of contact for the nurses to speak to?

Mr DOBBIE: Yes, and I think that is what that is. I do not think that that nurses do not want to do anything about it, but the problem is that at times they are not as upskilled in regards to that or confident. What we have found is that having someone in the hospital itself whom they know gave them confidence about the information they were getting; it upskilled them.

The Hon. Dr PETER PHELPS: Just a quick follow-up on that. One of the things we have also heard is there is an absence of actual trained people coming out of universities who have alcohol and other drugs [AOD] specialties. Would it be your view that we should be putting more effort into creating more alcohol and other drugs graduates?

Mr DOBBIE: It is logical.

Ms ROBINSON: Certainly in the undergraduate training there is really limited knowledge being shared in respect of alcohol and drugs. Certainly in the last five to 10 years there has been a flurry of postgraduate qualifications through a number of universities.

The Hon. Dr PETER PHELPS: If you are going to do a postgraduate qualification, why would you not do something that is materially much more advantageous to you?

Ms ROBINSON: In terms of a specialty of AOD, that is what you would do.

The Hon. Dr PETER PHELPS: Would it not be better if we promoted AOD at the undergraduate level, maybe even through a scholarship arrangement? That could be a recommendation, that we move towards the funding of limited scholarships.

The Hon. BRONNIE TAYLOR: Mr Dobbie, I am going to keep you on track, even though the Hon. Dr Peter Phelps is trying to divert the questioning. Would you say that demonstrates that even if we can work in health services and be professionals in health services sometimes we do not know who to ring within our own enormous LHD and perhaps that central point of contact is important? Those people existed.

Mr DOBBIE: Yes.

The Hon. BRONNIE TAYLOR: You talked about this great team that you had that were doing lots of work and you talked about how you were trying to encourage those people that you were meeting through emergency department [ED] presentations who did not come back for a counselling session, or whatever it was. Does that team do home visits?

Mr DOBBIE: Yes. What we have found is that sometimes it might be with mental health that they do a home visit to that person and they try to make contact with them as well. It is not involuntary. They make sure they try to contact that person to see whether they are happy for someone to come and see them and things like that. That is where the CNS comes in. They might contact them in the emergency department up on the ward, they do a bit of a presentation, might do an intake with them, and they will refer them through. When they do not turn up and they have done that a number of times, then they follow it up from there. Yes, some do.

The Hon. BRONNIE TAYLOR: We should really have everyone home visiting if we cannot get people into our health services, should we not? It is a less threatening environment.

Mr JONES: I think there needs to be more options to recognise the individual nature of people. If you have only one treatment regimen you will fail.

The Hon. BRONNIE TAYLOR: I want to go back to the issue that we demonstrated through those positions that are CNS2 and having a central point of contact. If you are treated by an acute team within a health facility and you have detoxed and then you have gone to The Buttery and you have done your rehab, if you could make contact with the same person that was there for you when you were doing your physical medical detox, then somehow part of that team could visit you at home. Continuity and safety for the client is enormous.

Mr DOBBIE: I think that is what we are looking at in the sense of that continuation of care.

The Hon. BRONNIE TAYLOR: Yes, I understand that. I understand the words and terminology and it all sounds fantastic. I guess at the end of the day if it is not that same team and you are outsourcing that to one of 10 non-government organisations that is another person they have seen that they do not know. That whole continuity that you have demonstrated through those positions gets lost.

Mr JONES: The counter to that is whilst we provide an excellent service, there are many people who come into our service, particularly in alcohol and other drugs, who prefer the environment of a non-government organisation, organisations such as The Buttery and Namatjira Haven. I agree with your point, the point of connectivity, consistency is very valuable.

The Hon. BRONNIE TAYLOR: It is interesting, because there is a research paper I read a few years ago now and it said if I was the nurse going into visit someone and I said to you, "Wayne, I know you have been really unwell but I am coming. I have spoken to Jan, who I know you saw in hospital, and we have discussed your case". It is demonstrated clinical evidence but we have this mishmash of everything going on. That is my point and thank you for answering, Mr Dobbie. The last thing I wanted to flesh out was in relation to education for workers. The Hon. Dr Phelps very kindly assisted with that. We talked about being an undergraduate and Mr Jones spoke of increasing the Aboriginal workforce to assist you. We were recently in Broken Hill and I was speaking to one of the general practitioners there who runs one of the generalist clinics. They have a university centre open. I know here you have access to universities and you are lucky. One of the things that struck me was he also spoke about what you spoke about and the fact that you cannot have that workforce you are looking for and when you want to upskill someone they have to move away. What about the potential to look within your own workforce about who is there and who you can upskill?

Ms MAYNARD: There are two sides to that. Firstly, what we have set up in the last 18 months is a postgraduate placement through drug and alcohol. Nurses that are just qualified can do a 12-month rotation. We

are having new nurses coming through into Riverlands and they spend about three months there working in the detox unit.

The Hon. BRONNIE TAYLOR: Is that part of their postgrad year?

Ms MAYNARD: Yes.

The Hon. BRONNIE TAYLOR: It gives them that exposure?

Ms MAYNARD: It gives them that exposure, but there are also scholarships through the LHD for the postgrad addiction studies, and we are encouraging staff to do that.

The Hon. BRONNIE TAYLOR: Can they do that locally?

Ms MAYNARD: It is online. We have got a few staff members that have just gone through that program. A couple are currently studying.

Mr JONES: We strongly believe in fostering the people we have on deck already because they are the backbone of everything we do. So we are enhancing the learning and development component of a lot of our services, including alcohol and other drugs. As Ms Maynard has pointed out, the rotating of that first postgrad year, you are getting them fresh and you are getting them to appreciate, because alcohol and other drugs and mental health are examples of daunting areas when you are graduates. If we can expose them and integrate them in a controlled, supported way—

The Hon. BRONNIE TAYLOR: Everything is daunting when you are a new grad, let me assure you.

Mr SCOT MacDONALD: We have been talking about rehab. Can you give me any more anecdotal feedback about the cheapness of liquor at the moment and the proliferation of more and more liquor outlets? Is that having an impact on what you do?

Mr JONES: The short answer has to be yes. Not only the accessibility; the price and the diversity of alcohol products in the market today does make it challenging because of the access to them, as you are alluding to. It is far too easy in many cases to buy cheap alcohol.

Mr SCOT MacDONALD: And cheap spirits in particular?

Mr JONES: I cannot comment on spirits specifically, but I know you can get large volumes of alcohol-dense products relatively cheap.

Mr SCOT MacDONALD: If you are in rehab and you are bouncing in and out—it might take you a few goes—and if you are someone that is struggling with it, there is no break, there is no screening, let us say. You can go back into any bottle shop, any club or pub anywhere and there is no duty of care. "Here is someone with a problem, yet I am going to load up your boot with Tequila", or VB or whatever it might be—there is no linkage. What I am trying to get to is that if you are a gambler the clubs and pubs, to some extent arguably, identify you and say you are a problem gambler. I think the clubs particularly have some duty of care to say, "We should keep you away from the machines for a certain time" or put certain limits on whatever there might be, but there is no break if you are an alcohol-dependent person.

Mr JONES: Let me go back a step for a more positive spin. We have alcohol accords with a number of our communities. If I look at Byron as an example, Byron will always be a challenge for us but we have seen improvement in that governance, that duty of care, by providers, particularly some of the organisations that just open the doors and let the young people flood in, and there is cheap alcohol at various spots.

Mr SCOT MacDONALD: Does that go to the bottle-ohs?

Mr JONES: The difficulty is that Aldi now sells alcohol; there is no way you could organise checking of that. I am not picking on Aldi, I am just saying it reflects how easy it is to buy alcohol.

Mr SCOT MacDONALD: The Committee has to make recommendations. If you had a magic wand, what would the recommendation look like around the supply and availability of alcohol?

Mr JONES: In nirvana? If we as a health organisation are saying alcohol is the number one problem we are dealing with, if we could identify that Wayne Jones has an addictive issue with alcohol, then if there is some way I could identify Wayne to the provider supply chain that would limit my access to it.

Mr SCOT MacDONALD: Whether it be Aldi or whether it be the club?

Mr JONES: Wherever. Then that could possibly direct Wayne more to treatment. I am saying nirvana, but—

The Hon. Dr PETER PHELPS: Maybe we could compel them to wear a big red A on the front of their jackets.

Mr JONES: I take your point.

Mr SCOT MacDONALD: You might self-identify too because the gambler in many cases self-identifies as a problem gambler and has that dialogue, whatever it might be, with the club. Some of them do self-identify.

Mr JONES: The challenge with self-identifying, I think, in some regards ignores the addictive nature of the products they are dealing with. People in the cold light of day will say, "Yes, I have a problem it is causing me", but that addictive need drives poor decision-making.

The Hon. BRONNIE TAYLOR: Mr Dobbie, you talked about your youth workers and what a great job they are doing and how people can access them and they stream into all your different groups, but you did not say that they actually go into the schools. Why do they not go into the schools?

Mr DOBBIE: They do not provide drug education.

The Hon. BRONNIE TAYLOR: Why?

Mr DOBBIE: That is not their primary function.

The Hon. Dr PETER PHELPS: It is not Healthy Harold.

The Hon. BRONNIE TAYLOR: That is prevention.

Mr DOBBIE: Your non-governments and others do that as well.

The Hon. BRONNIE TAYLOR: Would it be helpful if you had people doing more of that preventative education in schools?

Mr DOBBIE: It is more the case of it is not that we do not do it.

The Hon. BRONNIE TAYLOR: I know, but would it help if you had designated people within those doing more proactive preventative work?

Mr DOBBIE: Yes.

The Hon. BRONNIE TAYLOR: Like a school nurse?

Mr DOBBIE: Yes.

Mr JONES: Can I just respond to that? I would not narrow it down to a school nurse model because I think that brings back a different model, to me, in the past, but I think there should be a partnership arrangement between education and health that allows that sharing.

The Hon. BRONNIE TAYLOR: Whatever that particular place needed.

Mr JONES: Whatever that looked like.

The CHAIR: Could the dedicated 14 beds you referred to at Lismore hospital effectively be described as detoxification beds?

Mr JONES: Yes.

The CHAIR: With respect to a person after either the seven or 14 days, who is the principal person at the end of that who has the last conversation with the person about where they are going to from there? We hear the argument time and again that only when they are ready in their mind can a person enter into detoxification and then into rehabilitation. When the prospect of rehabilitation is successful, in their mind they have to be reconciled to being at that point of wanting to be rehabilitated. I cannot help but wonder about the capacity to just—it is a phrase that is used in different contexts—nudge them towards it. I do not want to appear to be naive about this, but the point I am getting at is what if that person at the point of detoxification is not one who is inclined to gently nudge? I know this is being very simplistic, but for the purposes of a discussion here, what about asking a person to consider, if they have not done it before, the issue of rehab and trying to make that very much a core focus of the individual?

Ms MAYNARD: There are services that we provide that do that, and Mr Dobbie has mentioned that, and one of those is the hospital consultation liaison. If a patient comes into a general hospital with a primary or secondary drug or alcohol issue, they are gently nudged in that area in as much as "This is what it seems like is going on for you. You've mentioned that you're drinking this much per day. Have you thought about coming into

services? Here's a brochure or you can ring me if you want to or you can come and see me after you get out of hospital and we can talk about how we could get you into services." That STP role does that as well as the community engagement team. We do have services that do gently nudge people.

Mr DOBBIE: I think it is the normal practice of any counselling skill that you have got motivational interviewing. If someone does seem to go that way you would use that to try and get them to move into it. If the assessment comes up that they probably need to go into rehab, then that is what you would use.

Ms ROBINSON: There are often other factors that will cause a client to pause, such as their housing. Things like a person wants to go into rehab and who may not because their housing is affected by them being absent, or they may have to pay for rehab and they have to still pay for their housing. So that is one factor. People may say, "Look, I would like to do that, but I have these other things going on", either with the family, accommodation, employment, all of those sorts of things that will actually deter someone from going into rehab at that point in time, because of other circumstances.

The CHAIR: Is there any capacity to help address that beyond listening and exercising some sympathy?

Ms ROBINSON: I think part of the community engagement team is about reducing those barriers and facilitating access, so it is looking at transport and those things. One of the challenges with clients with alcohol and other drugs issues is that there is such a range of social determinants that impact on their ability to make better choices, because there are all of these other things going on. You try and work cross-sector, you try and work with education, you try and work with Justice, and it is setting up those relationships and it is setting up those pathways. It is also the client themselves not wanting different agencies to know what is going on for them at the time as well. This is a bit of challenge there for services to work together if a client says, "Well, I am working with this group but I actually don't want them to know." It is navigating that as well.

The CHAIR: On the issue of detoxification, just to clarify, is the only place in which a person should receive detoxification in a hospital setting? If the answer is no to that, where else are people detoxified from alcohol and other drugs?

Mr JONES: In the community, in their homes, in general wards, across the board.

Ms MAYNARD: Their general practitioner practices.

The Hon. COURTNEY HOUSSOS: Do you have any data—and I am happy for you to take the question on notice—about how often that occurs within general wards?

Mr JONES: I will need to take that on notice, I am not sure.

The Hon. Dr PETER PHELPS: That is one of the other key matters that the Committee has come across.

The Hon. COURTNEY HOUSSOS: If you have this data available, I would be interested to see whether you would expect there to be a higher proportion outside Lismore across the LHD, given that people in Lismore have easier access to the wards.

Ms ROBINSON: That may be difficult data to get, only because often what happens in hospital wards is that a person presents with, say, an abdominal complaint relating to something, or a broken arm and invariably it emerges that there is some substance abuse dependence, which therefore needs to be managed. It is all interwoven in the notes. We could certainly try, but that will be challenging.

The Hon. BRONNIE TAYLOR: It might be included as a fracture.

Ms ROBINSON: Yes, and it is a secondary presentation.

Mr JONES: Unless someone has coded the secondary issue as drug and alcohol, but we will have a look.

The CHAIR: In the past six months what are the conditions that people have presented with that have been the basis for their entry into these 14 beds? Is it a particular drug, or drug and alcohol and is that information retained somewhere? How does the Committee find out on what basis these people were allocated a bed?

Mr JONES: Health is the most data-rich service in the world. We just do not get the really good stuff. We can identify, and whether it is the last six months or—actually the last six months has changed—alcohol, opioids. As Ms Maynard referred to, we are particularly looking at prescription opioid concerns starting to emerge. We are doing a lot of work with the primary health network and doing some research now on that and working with the general practice and our specialists that deal with that. Then you have cannabis, and then amphetamines. But now in the inpatient setting, amphetamines would be the third.

The CHAIR: Where does cannabis fit in the uptake rate—to use that phrase—for people presenting and saying, "I have a problem. I have an addiction. I am using cannabis. I need some help"? Does that happen very often, or is cannabis treated as a low key, perhaps not so dangerous addiction?

Mr DOBBIE: In Tweed we have a cannabis specialist who looks into that all the time.

The CHAIR: What does he or she do to treat a patient who presents with a serious cannabis addiction?

Mr DOBBIE: Again, they use the harm minimisation approach to it. In other words, looking at they might able to manage their cannabis use and whether they want to abstain from it or not. A lot of it is around what the client wants and what the patient wants. A lot of counselling in regards to that.

Mr JONES: I think you raise a good point in that we need to keep the message there that cannabis is not a soft drug. In some cases cannabis is actually—

The Hon. PAUL GREEN: It is a gateway.

Mr JONES: Gateway is a good word to use in that regard. We have a very strong marketing—not marketing, it is the wrong word—but we want to make it clear to people, "If you feel you have a problem, come and talk to us." This is one of the benefits of having a connection between health, public and community-managed organisations, because people tend to find community-managed organisations less restrictive, less concerning that they are going to go and tell the police, they are going to tell another agency. That is why we need to have a very good relationship with them, so that if they come through any door we all work together with them. Cannabis is an issue. It is not something that people should believe that they can take without ramifications. In some cases, yes. But in other cases, sadly no.

The Hon. Dr PETER PHELPS: Opioids and cannabis are essentially downers. You do not take OxyContin and feel like going and punching someone, whereas alcohol and methamphetamine, or amphetamines more generally, have greater proclivity towards violence on the part of the user. Would that be a fair assessment?

Mr JONES: Yes.

The Hon. Dr PETER PHELPS: One of the things this inquiry is looking into is mandatory detoxification and rehabilitation. In those instances would there not be a strong argument—particularly for alcohol and methamphetamine, or amphetamine addiction generally—for mandatory detox, at the very least, and mandatory detox and rehab? Or are you saying that the evidence for mandatory programs is so poor that it is not worth spending the money on?

Mr JONES: Again, I come back to my previous comment, I welcome any option on the table to look at. It needs to be right place, right time, right person situation. Our experience, and my background is nursing, predominantly in emergency departments—you get a lot of these presentations coming through and, yes, there are a small percentage that can be quite aggressive. You detain them, you let them work through that, the alcohol or whatever amphetamine slips away, and then you can start dealing with them. But unless they are ready to want to be dealt with, all you are doing is detoxing them, drying them out. You are not actually going to solve it being the next problem. I understand the attraction to that. Do not get me wrong, from a community perspective I can understand the attraction to that approach. I am just saying the literature does not necessarily say it is overly effective.

The Hon. Dr PETER PHELPS: If you want to get dangerous ice addicts off the streets and out of the State's emergency departments, and get them help where it is most needed, why would you not have specialist mandatory detox and rehab facilities, at a bare minimum? Or are you saying that is inefficient?

Ms ROBINSON: I think one of the issues with detox is it is the first part of treatment, it is not the answer. It is just an episode in time. One of the challenges with doing anything in a mandatory sense is that you are forcibly moving people into treatment, and whilst, yes, the substances are coming out of their system, they are being managed well so that they are safe and they come through the other end, but then you have got to deal with what were the drivers that were actually pushing that person into that area, to using, for instance, ice in the first place. It is quite complex because if you have got all these drivers, having this person move to ice because it is elevating their mood and they may be somewhat depressed, or they need the energy level so they start using ice, so of course incrementally they end up using the substance to the point that it has now become a major problem.

The other thing is that the substance itself also drives this behaviour. It is complex in the sense that the drug itself is an issue, and the drivers behind it. So you take someone through a mandatory treatment program, they have come out the other side and if they have not engaged wilfully and meaningfully, we have actually reduced their tolerance, they are likely to go out and keep using. Then the issue is if you reduce someone's

tolerance that they end up having some kind of misadventure because of the type of, or the amount of, substance they have used.

The Hon. Dr PETER PHELPS: Would it be fair to say that your view, based on the literature, is that mandatory detox and rehabilitation is less effective and if any funding were to be provided then it would be better provided for voluntary detox and rehabilitation?

Mr JONES: It certainly would be my view.

Ms ROBINSON: And supporting the community.

The Hon. BRONNIE TAYLOR: You gave the example that if someone in public housing wants to go into detox then they have to pay for it. They also have to pay for the housing and they may not want FACS to know. At the end of the day when we work in the public system it is our responsibility to put our clients first and we treat that person for whatever their issue may be. But time and again—I have only been a member of Parliament for three years, before that I was a nurse—at every inquiry we do no-one talks to each other. The departments are not talking and the health services are not talking to non-government organisations. Indeed, you have alluded to what a massive problem that is. When is it the responsibility of government services to start talking to each other and to put the clients first, so the clients are central and the information is shared? It does not matter which inquiry, and I am sure the Chair will back me up on this because he has been on many inquiries with me, it is the same thing. Things are not getting any better. What is your responsibility as workers to start fixing this?

Mr JONES: Can I start the answer on this one? Let me first of all agree with you. The disconnect of agencies does make it a lot more challenging for us as providers, let alone those who are trying to get services. Up here we have joint planning groups; we do not develop individual plans. I will use the Aboriginal Health and Wellbeing Plan as an example. We developed that in a partnership with FACS, the NSW Police Force, Justice, PHN, you name it, we were all at the table. We are developing a plan for the geography not for the individual service—that is step one. Then everyone puts some skin in the game and we start talking about: What are the models of care? What are the programs? We do a lot of shared work in that regard with predominantly the PHN and the Aboriginal Medical Service, we also do it with Education, FACS and Housing. We can do it locally, get to know the agencies, develop our local pathways and integration models and then hopefully establish something that the broader system can replicate. That is our view anyway.

The Hon. BRONNIE TAYLOR: You talk about developing, facilitating and building a partnership, but at the end of the day it is your responsibility as providers to talk to each other and to share that information so that your clients get the best outcomes.

Dr MEHREEN FARUQI: One of the submissions raised concerns about the lack of oversight and accreditation systems for private providers in this space. Do you know how many and which private providers you have in this region? What sort of government oversight and interaction is there with them? Is that a concern that there may be some that you do not know about?

Mr JONES: No. I am actually smiling because we have just engaged with the primary health network as a third-party consultant to undertake mapping of our footprint to understand exactly what services are out there. We can tell you with confidence in the services we partner with that we hold high standards both in the general corporate but also clinical governance arrangements. So we are very comfortable that our partners provide very good care.

Dr MEHREEN FARUQI: Is there an accreditation system?

Mr JONES: We obviously do through us; the non-government sectors have their own arrangements through different parties. But it varies, it is a bit of a patchwork in many regards. When we are talking private providers we are doing a mapping exercise to understand which psychologists in our footprint specialise in drug and alcohol. Are their private psychiatrists doing some work? There is a bit of lack of clear vision on those providers who we are undertaking that piece of work with. We have done some work with the primary health network and we can group them quite readily. There are a massive number of providers out in our footprint and we are just updating that database to make sure that we have captured everybody. I cannot comment on the level of governance and oversight for individual private providers except through the governing registration body, if they are registered through agencies such as the Australian Health Practitioner Regulation Agency.

Ms MAYNARD: Just add to that, NSW Health has actually just increased the number of key performance indicators for the private providers they fund and one of those is that all of the community-managed organisations that NSW Health funds have to be accredited. So that is going to be coming in next year.

The CHAIR: Thank you for appearing before the Committee today.

Mr JONES: Can we just thank the Committee because, as members can see from our comments, we are passionate about this. We look forward to reading the Committee's report.

The CHAIR: We appreciate the great work you do on behalf of the citizens of this State.

(The witnesses withdrew)

TRISH COLLIE, Drug and Alcohol Addiction Specialist, Bulgarr Ngaru Medical Aboriginal Corporation, sworn and examined

TREVOR KAPEEN, Drug and Alcohol Addiction Worker, Bulgarr Ngaru Medical Aboriginal Corporation, sworn and examined

The CHAIR: Thank you for appearing before the Committee today. Would one or both of you like to make a brief opening statement to give the Committee a general overview of the work your organisation does or about any other aspects you would like to draw to our attention?

Dr COLLIE: Firstly, I acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and future. Thank you for the opportunity for Mr Kapeen and I to provide information to this inquiry. We are clinicians. We have no managerial responsibility and are not involved in policy or planning. Our answers today will be based on our observations as clinicians, rather than policymakers or management. In 2014 Mr Kapeen competed a graduate diploma in Indigenous Health, specialising in substance use, at the University of Sydney. He is employed at the Aboriginal Medical Service [AMS] as the Aboriginal drug and alcohol and family health worker.

Mr KAPEEN: And a child and sexual abuse worker, a little bit of mental health and that sort of thing.

Dr COLLIE: My background is an addiction medicine physician. I am contracted through one of the primary health network tenders to the Aboriginal Medical Service for six hours per week. This work supports Mr Kapeen in his multiple roles, supporting the general practitioners of the Aboriginal Medical Service and any allied health staff to manage patients and clients with substance use problems. Prior to that I was actually employed at the AMS as a general practitioner. I have a long association with the Aboriginal Medical Service here in Grafton. It has been a blessing for me because the funding model has changed from general practice, which is very much Medicare-based funding. Trying to manage someone with substance use under Medicare models is quite difficult because that patient has to be sitting in front of you. You cannot bill Medicare unless that person is sitting with you and the work that you do is with them sitting with you. You cannot bill for anything else outside of that.

The tender I put in was to be billed at an hourly rate as a specialist. The majority of my work is working with Mr Kapeen, predominantly when the patients are not there. Trying to facilitate what we were talking about with the previous people trying to facilitate communication between agencies and do all those kinds of things and get people where they need to be. Addiction medicine physicians are trained through the College of Physicians as an advanced training position and most training positions are in urban centres. I am probably the only fully trained regional addiction medicine physician, which was difficult, but possible clearly because I am here. I finished in 2016, I have been doing the job for 18 months.

I work for the local health district as a visiting medical officer at Grafton Base Hospital predominantly in the opiate treatment program; one day a week in private practice in Coffs Harbour and part of that is including provision of medical services to a residential rehabilitation service in Maxville; and two days at the University of New South Wales Rural Clinical School as a lecturer involved in teaching and regional workforce development. It is a busy week. We have reviewed your terms of reference and previous transcripts and feel that the social determinants of health such as employment, housing, education and transport, particularly in regional areas, needs to be addressed as part of the review as rehab services alone will not provide successful outcomes if the patient or the client returns to exactly the same circumstances on discharge.

The importance of after care services that are well coordinated cannot be understated. It is one thing providing people the option to attend rehab and detox but if they are coming back to the same environment without something in place it is almost impossible and we see the cycle go over and over. In that vein, as a clinician I do wonder about the awarding of short-term contracts via the primary health care network for tenders for 12 to 18 months because it is very hard to engage a process and continue a process when it is short-term funding. It is also very difficult to attract professionals to a service when they have only got 12 or 18 months worth of guaranteed funding. It is hard for them to provide a service that is ongoing and continuing.

Again, raised by you in the last discussion was the difficulty accessing or communicating with services. We find it is really difficult as clinicians who understand the services—we think sometimes—to communicate with Health, FACS, Housing and Centrelink and it is far more difficult for our patients, particularly in the Aboriginal Medical Service when they already have ongoing substance use to navigate that system. Their health literacy is very low and it impacts on their ability to access services which I think can then be perceived as the patient not wanting to participate in their recovery, but they are just not capable because they are trying to survive, eat, find somewhere to live while living out of their car. There are all these other things and people perceive them not wanting to access treatment at the right time.

Regionally we have some specific concerns. Grafton and the Mid North Coast have few options for residential rehabilitation, particularly for Aboriginal patients. Benelong's Haven, which was in Kempsey, has recently been shut down. That had 60 beds. It was a facility that had options for women, partners, people on the opiate treatment program. We do not quite know what we are going to do with losing 60 beds in our region. We have not been given an option for what the future holds for those people who were going there. There are additional rehabilitation services planned in this region but they do not cater for women, they do not cater for families, they do not cater for people on the opiate substitution program and they certainly do not cater for specific Aboriginal identified patients.

The CHAIR: Can you explain the opioid substitution program? Could you explain what that means?

Dr COLLIE: They are patients who are on the methadone or buprenorphine program to manage their opiate dependence. Again, I look after a lot of people who are successful in the opiate treatment program in that they are not using opiates any more because they are on the opiate substitution program but they still have problems with methamphetamine or alcohol or benzodiazepines. Because they are on the opiate treatment program they are often then excluded from the majority of rehabilitation services. They cannot go into a rehab. There are a few, but not very many. Therefore, that closes that avenue for them.

The CHAIR: Because they are on the substitution program?

Dr COLLIE: Yes. And most of those facilities mandate for them to reduce off that while they are in rehabilitation. That is all from me.

Mr KAPEEN: I think you said everything. I do not think I can say much more other than field questions. You will bring the best out in me.

The CHAIR: That has set the scene nicely and we will get some purchase off that opening statement.

The Hon. PAUL GREEN: It is a bit concerning that 60 beds are lost. Can you tell us the history and why 60 beds are suddenly closed?

Dr COLLIE: I am not aware of the history. It is in Kempsey.

The Hon. PAUL GREEN: They were all rehab?

Dr COLLIE: They were all rehab.

The Hon. PAUL GREEN: No detox?

Dr COLLIE: No.

The Hon. PAUL GREEN: Who ran that facility?

Mr KAPEEN: I think it was just Benelong. It was an Aboriginal-run service, 60-bed place for Aboriginal people and their families to go. I am not too sure why it closed down. I have an idea why it closed down but I cannot really say why it closed down.

The CHAIR: Roughly when did this happen?

Dr COLLIE: About three, four months ago.

The Hon. PAUL GREEN: Was it run by the Aboriginal community?

Mr KAPEEN: The Aboriginal community owned the rehab. It was leased to the people running it. The Aboriginal land council owned the rehab, from what I understand.

The Hon. PAUL GREEN: What was it called?

Dr COLLIE: Benelong's Haven

Mr KAPEEN: It was at South West Rocks.

The Hon. PAUL GREEN: The second point, you talked about short-term relationships in terms of programs and funding. It is an issue when you are trying to get good staff, never mind being undercut by those who can pay them more. Can you tell us what you think is an ideal for the funding term?

Dr COLLIE: It is difficult for me to say.

The Hon. PAUL GREEN: It is not 18 months.

Dr COLLIE: I think the length of the tender is too short for people to make inroads and I think the perception is often that the funding is almost so short-term that people get a really good service together and

funded and then it becomes defunded and so they lose interest and motivation to continue providing those services. You assume that it is not going to last past 18 or 24 months. It is disheartening if you are in that situation.

The Hon. BRONNIE TAYLOR: It is hard to retain staff.

Dr COLLIE: It is. And people who have mortgages want certainty in employment and so they will not apply for short-term contracts unless that is the only thing on offer.

Mr KAPEEN: Getting down to the basics, I think that if the government want to do something about drug and alcohol rehabs and detox they would push for more funding for permanent positions of drug specialists like Dr Collie in those positions because otherwise it is just a bandaid job and we as counsellors and Aboriginal workers within the community have to deal with that as a bandaid solution picking up the pieces here, there and everywhere. You need something stable for people to get better. We were talking earlier on if someone had a heart attack they are rushed into hospital straightaway and there is something there for them. For a person with addiction it is hard to get them anywhere in a hurry.

The Hon. PAUL GREEN: Not only that, there is the outcome of getting better from a heart attack when you leave as opposed to rehab where you get to go back to a community or country where there are more drugs and alcohol and all your friends are doing it. It is a little different in terms of that.

Mr KAPEEN: Yes.

The Hon. PAUL GREEN: We have heard that is an issue for the Aboriginal people returning to community in country. What do you think you can do differently to get these patients out of that situation? What are the options?

Mr KAPEEN: There are a lot of options. We had a bit of a yarn this morning. The thing is, first of all, get them into detox. Because I have people come and knock on my door saying, "I want to detox. Can you get me into detox? I want to go to rehab." First port of call is detox. The only place we have is Riverlands in Lismore with 14 beds. They do have two emergency beds for young teenage mums that are expecting. They open those beds up for them. Getting them through the door there, then you have to make sure the door is open for the rehab for them to go straight through to.

What I tend to do is I take them to Riverlands, I pick them up from Riverlands and I deliver them to the rehab. The rehab I take them to, which I have booklets here for you, what we have done, is Jessie Budby in Queensland. I ring up today, there is a vacancy and they say, "Bring them in tomorrow." I need them to go straight from detox to rehab. Some clients have been going to detox and released with no rehab to go on to. That defeats the purpose of detoxing them.

The Hon. PAUL GREEN: We have heard of that. The people who sort of just drop in on your doorstep and say, "Hey, Trevor, I need to go to detox", how many of those would be doing that because they have got a court issue and they are looking for an easy way out?

Mr KAPEEN: Believe it or not, self-referrals more outweigh the ones going to jail, because they know they have got to do something about themselves. But getting them through the door is the hardest thing with self-referral because of the shame factor—people know that they are using.

Dr COLLIE: And you have a very critical window to actually make that happen and if you do not make that happen within that critical window then people do not trust you to do that for them next time. So if we lose that opportunity of trust when they come and ask for help it is very difficult. A lot of my clients say, "I've asked somebody and they didn't listen to me", whether it be in a hospital situation or general practice, or, "They treated me like I was idiot," or, "They didn't take me seriously."

Mr KAPEEN: When they come to the door you have got to take them in, you have got to listen—the first thing you do is listen to what they want, and act on what they are talking to you about.

The Hon. PAUL GREEN: If you can. You cannot make miracles happen if you get detox beds that do not exist or rehab that does not exist.

Mr KAPEEN: I understand that. But then again, you are there for them and you are listening. That might keep them at abeyance for a little while before something does come up.

The Hon. PAUL GREEN: There are no detox beds and there are no rehab beds for whatever reason, because the turnover is too high and they are just not available. Do you do some outreach stuff? Another question is to you, Dr Collie. We just heard comment about 14 beds seeming to be about right between Newcastle and Queensland in terms of the public system. Do you have a comment on that?

Mr KAPEEN: What was the question about outreach?

The Hon. PAUL GREEN: Do you do outreach stuff?

Mr KAPEEN: I do.

The Hon. PAUL GREEN: Not outreach—outpatients. Because you cannot get them into a detox, do you do much outpatient detox?

Mr KAPEEN: I just do counselling, I do home visits and things like that. That is all I do.

The Hon. PAUL GREEN: You do outpatient detox?

Mr KAPEEN: Yes, I do outpatient visits.

The Hon. PAUL GREEN: How many of those would you—

Mr KAPEEN: At the moment I have about 70 on my books for the year, and that can fluctuate; that can go up pretty quickly or just spiral. When I say "spiral" I mean they do not really want to come in because they do not seem to think they are ready for it. The community will tell you that they are ready, but then it is up to the individual to come in and say, "I'm ready." I cannot act until they come in.

The Hon. PAUL GREEN: The second question was that 14 beds seem to be enough.

Dr COLLIE: I think there always have to be some more. In my experience in Coffs Harbour, which is where I do my private work, people who are going into hospital with an acute other condition, as was discussed previously, will start detoxing whilst they are an inpatient, but there is not the priority for that person to finish their detox whilst they are an inpatient because of the bed load. So if there was some opportunity for that person who was then identified as needing to detox to somehow or other stay in that facility or a similar facility to complete their detox, that would not then necessitate the need for them to go to the specified detox bed.

The Hon. PAUL GREEN: So you need to go in with chest pain and get detox?

Dr COLLIE: As soon as your primary complaint goes, the problem is that the detox is not the priority anymore.

The Hon. PAUL GREEN: Sorry, that was just a cheeky nurse's comment.

The CHAIR: Dr Collie, this question has been exercising my mind throughout this hearing. Given that alcohol and drug addiction is not new and has been around for such a long time, why is there such a scarcity of people like yourself?

Dr COLLIE: In training medically?

The CHAIR: Yes, in other words, addiction specialists on the ground. Why are there so few in New South Wales outside the major cities of Sydney, Newcastle, Wollongong?

Dr COLLIE: Up until Medicare gave addiction medicine physicians item numbers, which was really only 18 months ago, there was no funding model to be a private addiction medicine physician under Medicare. All of your addiction specialists were hospital-based VMOs or staff specialists. The only way to train as an addiction medicine physician is to train in a hospital under a supervisor who is an addiction medicine physician. It is very difficult to train regionally as an addiction medicine physician when you do not have a supervisor who is an addiction medicine physician; you have to go to the city and then you get a job in the city as a hospital doctor and—

The CHAIR: How long does that training take underneath the addiction—

Dr COLLIE: Three years full-time, or for me it was six years part-time while I was trying to be a general practitioner at the same time to fund being an addiction medicine physician.

The CHAIR: When you say "fund", for you to complete this specialist training it cost you—

Dr COLLIE: I had to go backwards. I had gained a fellowship of the College of General Practitioners and then had to go back into hospital as a career medical officer or a registrar, which was a significant drop in pay, to retrain.

The Hon. BRONNIE TAYLOR: A specialist.

Dr COLLIE: Yes, to retrain to become an addiction medicine physician with the hope that the item numbers would come. It was fortuitous that it came at the time when I graduated because otherwise I probably would not be able to be working financially as an addiction medicine physician because it is just not worth it. I would have gone back to being a general practitioner.

The Hon. BRONNIE TAYLOR: That is why there are not many of you, because that Medicare item did not exist: Why would you do it if you cannot earn a living from it?

Dr COLLIE: Yes.

The Hon. COURTNEY HOUSSOS: I want to extrapolate some of this stuff as well. I know that is your personal experience, but I think it is also useful for us given that there are so few addiction medicine specialists. Was it through your work with the Medical Aboriginal Corporation that encouraged you to do it?

Dr COLLIE: Probably in hindsight it was through my interest through medical school. It was just something that I was interested in. I had some very good role models. I think Professor Batey has talked here; he was one of my lecturers at uni. I think having the right people around me while I was deciding on what path to follow was critical, which is why I would like to go back and work for the university now, just giving medical students a little bit of a taste of what drug and alcohol medicine is like.

The Hon. COURTNEY HOUSSOS: You said you had to work six years part-time. At which hospital were you doing that?

Dr COLLIE: I started off at Coffs Harbour hospital and then, unfortunately, my supervisor was removed, so I had a break for a while. Then I moved to northern New South Wales, to Grafton. I finished off my training at Grafton.

The Hon. COURTNEY HOUSSOS: Basically, if you do not have an addiction medicine specialist, an actual trained one, the chances of training new ones is impossible.

Dr COLLIE: Correct.

The Hon. COURTNEY HOUSSOS: Especially in regional New South Wales.

Dr COLLIE: Yes.

The Hon. COURTNEY HOUSSOS: Just to circle back to this question of short-time tenures, we find that with short-term tenures in country areas there is a specific problem because if it is short-term in the tenure in the city then maybe you can find—

Dr COLLIE: You can move somewhere else, and I think there is probably not funding in regional areas for a full-time addiction medicine specialist, which is what you need to train another addiction medicine specialist. So it is unlikely to continue.

The Hon. COURTNEY HOUSSOS: Do you think that if there were more rehabilitation services that that would encourage more of the ancillary staff such as yourself to be located in regional areas?

Dr COLLIE: No, because I do not think that the funding model to go into a rehab service—I go to a rehab service in Macksville two hours a fortnight and I cannot bill as a physician because those people do not have a GP so they do not have a referral. So it is financially again—I do it as a labour of love rather than as a funding model for me to continue doing it because there is no scope.

The Hon. COURTNEY HOUSSOS: This is way down a rabbit hole. Two hours a fortnight you are in Macksville?

Dr COLLIE: Yes.

The Hon. COURTNEY HOUSSOS: How do you bill those hours?

Dr COLLIE: I bill as a GP, as a home visit, which is \$40 or \$50 a patient, and then it goes down the more patients I see. It is not a financially viable model for a clinician as a doctor, maybe another clinician, to go to a rehab because they are quite complex and they take a lot of time.

The Hon. COURTNEY HOUSSOS: You emphasised in your opening statement that you direct practitioners, that is the role you have. We have received evidence saying that the biggest problem on the north coast is alcohol, followed by opioids, followed by cannabis, and methamphetamines is perhaps third or fourth depending on what it might be, and that might be their primary interaction with the health service. What are your feelings on the scale of what are the drugs that we are dealing with?

Mr KAPEEN: Are you talking to me?

The Hon. COURTNEY HOUSSOS: Either of you. Your 70 clients, how many of them would be facing methamphetamine use/addiction?

Mr KAPEEN: With methamphetamines I would say 60 per cent of them would be using. They know they are using, they come and tell you, "I'm using this, Unc. I want to get off it, I don't like it. It's just doing my head in", but boredom sets in so they have got to do something else, so they decide to take up cannabis with the methamphetamines.

The Hon. COURTNEY HOUSSOS: What about the patients that you see?

Dr COLLIE: It depends on the location. In a hospital situation I am only contracted to do opiate treatment. Obviously, there are opiate dependent people. In private practice it is probably a combination of alcohol and opiates and methamphetamine, probably in an equal distribution, to be honest.

The Hon. COURTNEY HOUSSOS: The Committee has received feedback that there is a lack of detox beds, which my colleague talked about earlier. Do you think there is more need for detox beds now because of the changing nature of the drugs that we are addressing, or is it just that there is more understanding that people need to be removed from the environment in which they are operating and that is a more effective way of treating them?

Mr KAPEEN: I think detox beds have been there for a while. We have only just found out that detox beds have been there. As an Aboriginal community we just thought we will wait for rehab, no detox. We now know that detox is there and it takes between seven and 10 days, or whatever the client is on. I think that is the case now. Rehabs will not accept them now if they do not go through detox first, because if they just turn up on the doorstep and want to go into a rehab, they go off their face and they upset other patients within the service. Now they are all calling for detox first before rehab.

Dr COLLIE: It is really important to have a plan before they go into detox and rehab for when they actually come out of rehab, because that is the hardest bit, finding a coordinated response to somebody when they are coming out and they have done well, to not get them go back into the same environment that they are in and often that is hard because housing is the same. We spent a lot of time with a particular patient. A lot of that time has not been direct patient contact, but she is homeless, she has no Centrelink benefit, she has no regular general practitioner so that GP cannot provide a Centrelink certificate for her medical conditions. She cannot communicate effectively with the services because of her anger—the whole situation, I think—and then that gets her into more trouble. Until we can actually provide a service on discharge from rehabs to help people, we will just keep going around in circles.

Mr KAPEEN: I will give one example. I look after Aboriginal clients from the valley, that also extends to Casino and Coraki, Wardell, that area. I got a phone call that this client needed to be going to a rehab. They kept ringing up and saying, "Can you take her to rehab?" I teed up one time, then they rang back and said, "No, she is not ready to go." I did end up picking her up a couple of weeks later on the highway on the way to Brisbane, to Jessie Budby. Her mother met me there. We got her out of the car. I had another client with me so I said, "Just be patient, I'm just going to get this other one." I got her out of the car. I said, "When was the last drink?" She said she had not had a drink for about four days, it is just alcohol-related.

I help anyone. This one is different because this one could hardly walk. She had sores and everything on her, just drank alcohol, laid in bed, did nothing, no nutritious foods, nothing. I ended up taking her up to the rehab and told them the situation. She got out of the car. She just laid on the grass. Because this one wanted to go to rehab, they called an ambulance. She spent four days in hospital before she could get into the rehab. We saved her life. It was just alcohol-related. She wanted to go to rehab but just kept putting it off. All these conditions built up on her. She has not had a drink now for 18 months and she thanks me every time she sees me for what we have done. That is what you have to do. You do not care who you deal with. You do not care what they look like. You never take anything like that into consideration. You just do your job, and your job is to help your people. That is all.

The Hon. Dr PETER PHELPS: The Committee has heard there are problems around New South Wales finding specific services for Aboriginal women. Is that also a problem on the North Coast?

Mr KAPEEN: Yes.

The Hon. Dr PETER PHELPS: To the extent that there are no specific services for Aboriginal women?

Mr KAPEEN: No.

The Hon. Dr PETER PHELPS: I noticed in the figures from NSW Health that there is a noticeable age distinction in addictive substances. Is that your experience as a clinician?

Dr COLLIE: In terms of?

The Hon. Dr PETER PHELPS: In terms of different demographics, for example, OxyContin users are far more likely to be of an older demographic. No?

Dr COLLIE: I tend not to see that. No, I would say even in Aboriginal communities it varies from very young people to elderly people. We have just had someone in the opiate treatment program who is 77.

The Hon. Dr PETER PHELPS: That is my next question, is it heroin or is it OxyContin?

Dr COLLIE: OxyContin up here on the Mid North Coast.

The Hon. Dr PETER PHELPS: It is everywhere.

Dr COLLIE: Yes, and fentanyl, particularly.

The Hon. Dr PETER PHELPS: Benelong's Haven used to take men and women, did it not? Its closure is the reason that there are now no residential rehab services available for women?

Dr COLLIE: Yes.

Mr KAPEEN: The nearest one is Weigelli down near Cowra.

The Hon. Dr PETER PHELPS: It is a long way to go.

Mr KAPEEN: It is.

The Hon. Dr PETER PHELPS: The Committee has heard two different views, that non-Aboriginal people who have been treated for addiction have removed themselves from their communities. Whereas we have heard exactly the opposite from Aboriginal people who have recovered successfully from addiction, and that is that they have to be treated and returned to their communities. If the problems that they face led them to addictive lifestyles in the first place, how does returning to your community not cause those problems which led to the addiction to re-emerge?

Mr KAPEEN: That is very hard because I would like to see people who go to rehabs return if they are fit and strong. I take clients to rehabs all the time. I drive them to Brisbane, up to the Jessie Budby Healing Centre, 400 kilometres—it is nothing. The thing is getting them there. It is easy for me to get them there. It is a conversation on the day. If you put them on a bus, put them on a train, they are not going to get there so I drive them there, I come back. If they were to come back here, they need support structures in place. They need to talk to a counsellor like myself and have other agencies on board that they can turn to and talk to, otherwise you will have the people supplying the drugs knocking on their doorstep as soon as they get home. They know they are home. They say, "How are you cuzo? You want a hit?" You want this, you want that? Vulnerability strikes then. They are in. Bang; they are gone like that. I would like to see them go to a halfway house once they are released from rehab, somewhere we could teach them living skills, budgeting skills. Obviously in rehab they have other programs and everything else.

The Hon. Dr PETER PHELPS: Or have a rehab which is a rehab house, for example, the longer programs which go for six months.

Mr KAPEEN: Longer program, long term.

The Hon. Dr PETER PHELPS: You start with basic skills then move to real life. How do you manage your life?

Mr KAPEEN: Give them another six months in there and give them the support structure and let them look for accommodation outside of there, look for employment outside of where they are from. I know the rehab has those sorts of things but three months is not enough. Most rehabs will take them up until nine months and that is still not enough in some people's minds; they need longer.

The Hon. Dr PETER PHELPS: That is exactly the evidence the Committee received in Shoalhaven.

Dr MEHREEN FARUQI: Your organisation receives funding from both the State and Federal governments, is that correct?

Mr KAPEEN: Yes.

Dr MEHREEN FARUQI: Is one better than the other for the period of the grants or are they much the same?

Mr KAPEEN: They fund me, I am happy. But as we talked earlier on, the funding side of things and the decisions that are made at the head that collects the funding in, they just say, "I have got this job for you to do."

Dr MEHREEN FARUQI: You do not know about funding cycles?

Mr KAPEEN: I do not know much more than that.

Dr MEHREEN FARUQI: Earlier you raised the issue of transport being crucial for people getting to detox or rehabilitation. The Committee has heard that in every region because public transport especially is bad. That is a long-term issue to improve public transport but, in lieu of that, what else can be done quickly to change that situation?

Dr COLLIE: I think some AMS—and we do up at Yamba—provide a transport officer. So Mr Kapeen actually going and doing the transporting whilst he is being a clinician is really successful. I think we need to look at other similar models for medical care even amongst non-Aboriginal patients, because there are still a lot of people who I look after who do not have the ability to go the AMS and transport is their main factor. They cannot get to a hospital every day to do a program.

The Hon. Dr PETER PHELPS: Where is the AMS located on the North Coast?

Mr KAPEEN: We have one in Bacon Street, Grafton, one over in Skinner Street, South Grafton, one in Maclean, we have three here, then we have one in Casino and we have one at Tweed Heads. They are run under Bulgarr Ngaru. We have a pretty big footprint. When someone needs to go to detox I will drive them because they have got to be there before a certain time. You know, it is good. You get that bit of a conversation while they are going there, you give them support and everything else.

The Hon. Dr PETER PHELPS: A two-hour mandatory therapy session with Trevor.

Mr KAPEEN: They cannot use public transport to get to the detox. They are going to get off at the first stop because they have got time to think about getting out.

Dr MEHREEN FARUQI: The Weigelli Aboriginal Corporation at Walgett, as well as the Dharriwaa Elders Group, raised the interesting idea that for every new skilled position, for example, as a drug and alcohol worker position a full-time Aboriginal trainee position must be provided. That was their idea about how to increase Aboriginal trainee positions. In their view this would also provide two-way learning. Is that something you would support?

Mr KAPEEN: I think it would be a good idea if we could do that.

Dr MEHREEN FARUQI: So you think that would be a good idea?

Mr KAPEEN: A very good idea. For instance, the AMS is funded under government grants—either a year-by-year or three-year tier structured grant. We need to get more Aboriginal people trained in the AMS to deal with the on-ground stuff that is happening at the moment. We do understand that we need nurses, doctors, dieticians and all that, but we really need more Aboriginal people in there because the workload of one worker—for instance, in my role I am flat out five days a week. I would love to squeeze things more in but I am running out of hours each day. We need extra workers in there to give support to people who come through the door.

The CHAIR: How many Trevor Kapeens are on the North Coast?

Mr KAPEEN: With me with four hats on, one in this area. We have a drug and alcohol worker at Casino but he is just predominantly a drug and alcohol worker. I do drug and alcohol. I do family and domestic violence. I do child and adult sexual assault. I do mental health. I deal with all those issues and when you look at it people are taking drugs and alcohol because of their background, their growing up, what has happened. I am dealing with the whole lot. I will give an example. If you go to Community Health then you have all different specialists there. If you come to AMS you might have one worker like me who has got to deal with the lot. You have got to not only know what you are doing but also respect the person who comes through the door and what that person wants. You have drug and alcohol workers I am sure throughout—I think you have got one at Galambila, which is at Coffs Harbour, you have got one at Casino and you have got myself. There are none in Tweed Heads out at Bugalwena and because we have got that footprint I may be going up there one day a week, I do not know.

The Hon. Dr PETER PHELPS: Your model is quite a good one but you have to do four different things. You are offering a holistic service, are you not?

Mr KAPEEN: That is right.

The Hon. Dr PETER PHELPS: But there are not four Trevors; there is only one.

Mr KAPEEN: No.

The Hon. Dr PETER PHELPS: If there were four Trevors you could provide an holistic service for family issues, including domestic violence, alcohol and other drugs, and that range of things. You could actually fix the whole person but the trouble is there is not enough of you to go around.

Mr KAPEEN: That is right.

The Hon. Dr PETER PHELPS: You are the right model, rather than siloing a particular problem.

Mr KAPEEN: As I say, all those areas I work in come under drug and alcohol and then something leads off into one of those areas. It is great having Dr Collie there every Monday because her and I sit down and talk about patients. We talk about what is going on. We keep each other updated. Even when she is at another practice I give her a little old text and say, "Listen, I have got this going on." We do keep that rapport.

Dr MEHREEN FARUQI: There are obviously many gaps in the services across the State, especially in regional areas. What is the one thing that you think needs to be done, and needs to be done now, to improve the situation?

Mr KAPEEN: I know that in Grafton we have a big Aboriginal population but I also know that we seem to be the city of jails, correctional centres. For the Government that was a priority, more so than keeping people out of jails, keeping them out of correctional centres. Common sense is they know what the rehabs up and down the coast are that they fund and there is none in Grafton. They should have put their hat on and thought, "Hang on a minute, why throw another correctional centre here because we are going to have an influx of people coming in to visit their family in jail and while they are here and the drugs are around we are going to have more numbers go up?"

Dr MEHREEN FARUQI: Is not the biggest jail in Australia being built here?

Mr KAPEEN: Yes.

The Hon. PAUL GREEN: I was a member of the Committee that ran that inquiry and one of the reasons for doing that was so that people could stay in country in this area when they were in a correctional centre.

Mr KAPEEN: I understand that but if we had a rehab maybe people would stay in country, not a correction centre.

The Hon. PAUL GREEN: I agree with that too.

The Hon. Dr PETER PHELPS: Is there a diversionary program at the magistrate's level?

Mr KAPEEN: I think there is that—what do you call it?

Dr COLLIE: The Magistrates Early Referral Into Treatment [MERIT] program.

The Hon. Dr PETER PHELPS: There is a MERIT program up here?

Dr COLLIE: There is, yes. I saw in some of the other Committee transcripts that people are interested in the Drug Court. Interestingly, most of my patients at Macksville in the residential rehab are from the Drug Court in Sydney and Newcastle. I would suggest that would be a really positive—

The Hon. Dr PETER PHELPS: A clinician's point of view would be actually very useful because we have heard the legal one on the managerial side of things but if actually believe that the MERIT program is something that we should be rolling out everywhere—

Dr MEHREEN FARUQI: And the Drug Court, I think.

Dr COLLIE: For many years I have been keen on that.

The Hon. BRONNIE TAYLOR: You said you got your qualifications through Sydney. Did you have to go to Sydney?

Mr KAPEEN: I did block release in Sydney.

The Hon. BRONNIE TAYLOR: And that was tough. Would it have been easier if you had done it all here?

Mr KAPEEN: It was tough for my wife. Look, you have got to do what you have to do. If you want to work in that field you are going to have to go and do the training and back.

Dr COLLIE: It is actually good to keep in contact with your colleagues in the city because it is very easy to become isolated in a regional and rural area. I find that very difficult where I am because I do not have clinicians around me who know the latest research. I do have to go to Sydney often.

The Hon. BRONNIE TAYLOR: But for some it is very hard to get there.

Dr COLLIE: It is.

The Hon. BRONNIE TAYLOR: You probably had a lot of support to get to Sydney?

Mr KAPEEN: No.

Dr COLLIE: No. You just do it.

The CHAIR: Thank you for appearing before the Committee today. The Committee has resolved that any answers to questions taken on notice should be returned within 10 days to the secretariat.

(The witnesses withdrew)

SONYA MEARS-LYNCH, Program Manager–Reconnect, Getting it Together and Youth on Track, Social Futures, sworn and examined

MELINDA PLESMAN, Family Referral Service, Homelessness Youth Assistance Program, Clarence Valley, Social Futures, sworn and examined

The CHAIR: Would one or both of you like to make an opening statement to set the scene for us and once that is done members will ask questions.

Ms MEARS-LYNCH: It might be nice for Ms Plesman and I to introduce ourselves and let you know a little about what we do in our roles, a little bit of background.

The CHAIR: Explaining a bit about the organisation, its history and the like would be great.

Ms MEARS-LYNCH: I manage the youth programs in Social Futures and that includes Reconnect, which works with children and families that are at risk of homelessness from the age of 12 to 18. I also manage the Getting it Together program, which is drug and alcohol counselling and casework for young people 12 to 25. The emphasis is given to young people 12 to 18. It really is an early intervention program and a diversionary program with drug and alcohol. We also have the Youth on Track program. The Youth on Track program works with young people 10 to 17 who have had some contact with the law, a couple of cautions, maybe a warning from police, and again it is a diversionary program specifically around trying to prevent criminogenic behaviours from continuing.

Our caseworkers work with the families very intensively along with the young people. We know, whether it is drug and alcohol, criminogenic behaviours or homelessness, when we are working with young people under the age of 18 to work just with the young people gets us only mediocre results. We get much better results if we are working with the family as a whole. A little background information about the organisation. We used to be Northern Rivers Social Development Council. We started up in Lismore in the mid 1980s and it was very much an advocacy service at that point and a social justice service for community. Over time we have morphed into something a little different and hence the change in name and we are now known as Social Futures. We have a number of different programs working with community, including Connecting Home, working with adult and youth that are homeless or at risk of homelessness. Ms Plesman will talk about the family referral service. We work with local area coordination with the National Disability Insurance Agency [NDIA] and implementing that, which has been quite a journey in the last 12 months.

Mr SCOT MacDONALD: In what way?

Ms MEARS-LYNCH: In what way? Do not get me started. Maybe the next inquiry. We have Ability Links, which works with people 12 to 64. They do not need a diagnosis, they can be anyone who has some form of disability that may need a hand as far as inclusion into the community. We have the High Up program that works with young people that are out-of-home without parental consent between the age of 12 and under 16, and that was to fill a gap in service because of the pressures Family and Community Services [FACS] have working with younger people. We found that was an age group that was slipping through. The Homeless Youth Assistance program—

Mr SCOT MacDONALD: Are they children not going to school?

Ms MEARS-LYNCH: Most of them are not. Most of the children we are working with, one of the first things that drops off during the complexities of their lives is education. One of our main areas is trying to get young people back into education wherever we can and/or learning and employment, it does not have to be in a formal school setting.

The CHAIR: Your footprint as an organisation is from roughly where to where, give us some boundaries?

Ms MEARS-LYNCH: It is Tweed Heads to Port Macquarie for a lot of our programs, but with the local area command we are actually based out west as well, so from Dubbo, through Orange. I cannot remember how far we go out west, way west. That is only for local area coordination with the NDIA at the moment. Primarily we have been based on the Northern Rivers area up until very recently.

The CHAIR: Would you like to add anything to the opening contribution?

Ms PLESMAN: I work under the umbrella of the Family Referral Service in Social Futures. We have been going for about five years, possibly six this year. We work from Tweed Heads to halfway between Grafton and Coffs Harbour.

The CHAIR: Halfway Creek.

Ms PLESMAN: Halfway Creek, yes, you are right. I am the Clarence Valley worker. That is quite a large area. The Clarence Valley is quite a big area and I am the sole worker. The Family Referral Service I suppose comes out of the Wood royal commission that looked into child welfare and working with families. I am the one-stop-shop. We are the one-stop-shop for a lot of organisations that want to find out how to link families into services that they need. My role is to work more intensively within the Clarence Valley to support and identify families that need help to access those services, mainly advocacy. It is very broad—transport, lots of different things. Referrals are also very broad, they come from everywhere. They are consensual referrals. The only ones that are not, we do get police referrals through and all manner of reports. The schools as well can do non-consensual referrals that come through the principals and the police do ones mostly related to domestic and family violence.

The CHAIR: As you know our inquiry is specifically looking at the provision of drug rehabilitation services in regional, rural and remote New South Wales. The questioning will be focusing on that. The issues of drug addiction fall within a domain where individuals or families often have complex needs. That is your day-to-day experience, no doubt.

The Hon. Dr PETER PHELPS: I have one quick question to Ms Mears-Lynch. A submission from the Port Macquarie Community College Inc. states:

- (4) A Recovery College model, which PMCC is championing for the setting up first pilot R and R one in Australia, is the best way to engage young people in a non-stigmatised support, "just as students at college". (i.e. not as recovering addicts etc with "problems" and thus negative labels).

A college of people who are being educated and just happen to have addictive behaviours. Would you agree with that model?

Ms MEARS-LYNCH: In theory I think it sounds like a lovely ideal. The hard part is that within small communities, particularly if it is in a rural area, communities will know if you require a diagnosis or if you are a recovering person that has had a polydrug misuse issue. They will soon know. Even though you can say there is no affiliation or there is no need to be a recovering person to come through that college, if the perception in the community is other than it is only in theory. You know what I am saying?

The Hon. Dr PETER PHELPS: But looking specifically at under 18s, if the option is no schooling or schooling within a structured environment of a college designed for education and rehab of people, is that not a better option, or do you disagree with the submission?

Ms MEARS-LYNCH: I think it is a good option but it is overly simplified. Maybe I can give an example of what happens for us with some of our disengaged students in the valley. Schools are always looking at ways to re-engage students that have been out of education for a while, and certainly in one of our schools that included having a tutorial centre so that the young people would not actually attend school classes, and these were young people with behavioural issues, sometimes aggression, there were reasons they were trying to keep them in an educated system but without proving extra risks to the other students.

Because there was separation from the mainstream students and because it was physical separation even though it was within the school, a lot of young people just refused to go because they felt like they were being locked away or they were somehow being targeted as being different. So it has not actually worked as well as we had hoped. The same with having distance education coming into schools within a school complex, again there is a separation from the distance ed students, and they feel it. That feeling of isolation and that feeling of difference is hard for them to come to terms with and hard for them to put aside.

The Hon. Dr PETER PHELPS: I agree with you. I just wanted to get some sort of analysis of this proposal because it struck me as simply restarting Kinchela Boys Home by any other name, a new one where the defining feature is not Aboriginality but, in fact, addiction. Why would you move to a model which has separation and removal even at that point?

Ms MEARS-LYNCH: If you can create something that young people would go to willingly, then it is a matter—

The Hon. Dr PETER PHELPS: They do not even go willingly to normal schools, much less a school where—

Ms MEARS-LYNCH: But that is also indicative of what our education system is at the moment. It is fairly linear and a lot of our students' learning does not fit into that linear system. I think there is the possibility of looking at some new learnings and some new techniques, particularly with our Aboriginal young people—there

are some lovely Aboriginal-run schools that are working and finding that their attendance rate is going up. There are some models out there that I think are working. I do not know if that is a model that would work.

The Hon. Dr PETER PHELPS: That is fine. I just wanted to get it on the record. This is a proposal and I was immensely struck by it is nice in theory, but the practicalities of it lead to someone—

Mr SCOT MacDONALD: Supplementary to what the Hon. Dr Peter Phelps is asking, can you give me an idea of numbers? The reason I ask is that we are wrestling with this a bit on the northern end of the Central Coast: kids who are disengaged, not even suitable for the Alesco College type environment, that the standard schools do not want for the various reasons that you say and then they are at high risk of either drug or alcohol issues and then the consequences. It is very hard to get a handle on the numbers. I wondered what you are looking at here.

Ms MEARS-LYNCH: Within our Youth on Track program we see 60 young people over the course of the year.

Mr SCOT MacDONALD: That is the valley?

Ms MEARS-LYNCH: That is Coffs Harbour to the Clarence Valley area, yes. The same as our police LAC.

Mr SCOT MacDONALD: The district.

Ms MEARS-LYNCH: Yes, the district runs over the same area. Within that population of young people that we see, probably only 10 per cent are attending school.

Mr SCOT MacDONALD: Of the 60?

Ms MEARS-LYNCH: Of the 60. We have 10 per cent of them that would be attending some form of schooling. That can be distance education, it can be some special colleges in Coffs Harbour.

Mr SCOT MacDONALD: So that is 50-odd out of that system who are basically at home or on the street or downtown or whatever it might be?

Ms MEARS-LYNCH: Yes.

Mr SCOT MacDONALD: Is it a stereotype to say that they are the source of a lot of issues around town?

Ms MEARS-LYNCH: That is a tricky question.

The Hon. Dr PETER PHELPS: I will fix that: Is it true to say?

Ms MEARS-LYNCH: I think by the very nature that we then have young people in teenage adolescent years where risk-taking is part of their development that, yes, we end up with some problems within community with those young people out of school. The skate parks do end up being quite an area where they will gather. If we then have a presence at skate parks they usually find somewhere else to gather. With our Reconnect program, where we see 90 young people in a year, I would say only 10 per cent of them are not attending school; so that is 10 per cent that we are working with to reintegrate to education. But we work very closely with schools and probably we are brought in much earlier to that system as an early prevention and intervention to youth homelessness. So we get in there earlier and that seems to help. With our Getting it Together program—and I am bringing these figures but do not hold me fast to them; it is the ones that I know—we are probably looking at about 20 per cent of young people that are out of any formal education system.

Dr MEHREEN FARUQI: Where does your funding come from?

Ms PLESMAN: NSW Health.

Dr MEHREEN FARUQI: So you work with them on referrals and other things?

Ms PLESMAN: Not particularly, no. Referrals come through a broad range.

Dr MEHREEN FARUQI: A variety of places?

Ms PLESMAN: Yes.

Dr MEHREEN FARUQI: There are many other services here as well. Do you have any particular links and connections with the other alcohol and drug services? How can you operate in a more integrated manner? Does it matter; does it not matter?

Ms PLESMAN: I will just be brief. For the Family Referral Service and child protection, we all try to work collaboratively with different organisations and I have to do quite a few referrals and I work with FACS. We also coordinate Families in Focus meetings, which is all around child protection, that we hold monthly at FACS in Grafton, and that is an invite-only to specific stakeholders in child protection and people who are working in that. Education is very much in that meeting because the truancy rates are high and a lot of those kids are on the streets in the day and there are often family issues and what are quite complex issues around those children. That would be one of the main ways that we collaborate through that meeting and we are really looking at child protection.

The Hon. BRONNIE TAYLOR: Once a month?

Ms PLESMAN: Yes. We are always working through the Family Referral Service with other organisations.

The Hon. Dr PETER PHELPS: You are speaking of formal consultation?

Ms PLESMAN: Yes. There are lots of informal.

Dr MEHREEN FARUQI: We have heard many witnesses calling for more drug courts, especially in rural and regional areas, and Legal Aid NSW in its submission called for the reintroduction of a fully funded Youth Drug and Alcohol Court. I am just wondering if you have had any experience of drug courts and what your view is on that.

Ms MEARS-LYNCH: Firstly I will go back to our funding to answer the question. We have a number of programs that are funded from different areas of government. Our Getting it Together program is State funded through FACS, our Reconnect program is funded through the Department of Social Services, and our Youth on Track program is funded through Juvenile Justice. We have a number of different streams where our funding comes through and we do work very collaboratively in this region. I think, particularly for our Clarence River area, which is where I am from—I have been here many years—sometimes when there is a lack of service in rural areas, individual people and organisations become very adept at making the most of what we have got, and part of that is collaborative practice. I would say we work very closely together with what programs we have available.

At the moment we have a program from The Buttery that has newly come down, which is drug and alcohol counselling. What we have found in the Clarence Valley area over the last 10 years is that our Department of Health has slowly dwindled. We used to have a very functional and effective drug and alcohol counsellor in the health system. That has changed over the years to where I would say most people do not even know if we have a drug and alcohol counsellor within our health system in lower Clarence and in Grafton. That would be something to look at, having more counsellors available specifically for drug and alcohol. I might have gone off question here. Bring me back if I run off on a tangent.

Dr MEHREEN FARUQI: That is good to know. I was asking about your view on drug courts and should there be a specific one for young people.

Ms MEARS-LYNCH: With the criminalisation that we are working with, with drugs, a lot of our young people with Youth on Track come up with criminal charges because of drug use. Part of that question is even if you brought in drug and alcohol courts, where to from there? What are we actually looking at if we decide that they are going to be charged or something is going to be held with that? It is still a where to from there to try and effectively have young people coming out in the form of recovery, rather than just going in the circles that we have happen at the moment. The Magistrates Early Referral into Treatment [MERIT] program is good. Again, in country areas the MERIT program is functioning very well in Coffs Harbour. We did have it in Grafton. It still is in Grafton.

Mr SCOT MacDONALD: It depends on the magistrate, does it not?

Ms MEARS-LYNCH: It does and personnel changes too. Within rural areas people get used to one person in a position, then they will move on and it will change, and there is always that little bit of lag time catching up. That is also around our service providers to see who is who, who is doing what in the area. You have to keep abreast of that all the time.

Dr MEHREEN FARUQI: You brought up the aspect of criminality and the illegality of drugs. Does that prevent people from seeking rehabilitation services? What in your view is the impact of that aspect particularly?

Ms MEARS-LYNCH: Sometimes. The young people who we work with in the Getting it Together program will admit freely to using cannabis. Funnily enough it is only usually occasional alcohol that we work with, it is mainly cannabis which is the drug of use.

Mr SCOT MacDONALD: At that age group?

Ms MEARS-LYNCH: At that age group. However, what we find is that that is what they will admit to in the beginning, but they disclose, if we can keep them engaged. After about two months they will often disclose that they are using methamphetamines in particular in this area, but it takes a long time before they will actually admit to that. And sometimes it is after we have done some work around the other, education and drug and alcohol information, which we always include a number of different drugs, it does not matter exactly what they are necessarily using at the time. I think that is kind of the broader picture that we are looking at.

The Hon. COURTNEY HOUSSOS: My questions are about residential rehabilitation and detoxification services. The Committee has heard that there is a lack of services for people under 18. I appreciate that this is anecdotal and you do not need to worry about clarifying that, but do you see the need for either detox or rehabilitation beds, or both, on the North Coast?

Ms MEARS-LYNCH: Yes, both.

The Hon. COURTNEY HOUSSOS: Even for people under the age of 18?

Ms MEARS-LYNCH: Yes. I will qualify that for why it is such an emphatic yes to that. At the moment we have Junaa Buwa!, which is in Coffs Harbour. I am not sure if you are familiar with that?

The CHAIR: You might explain.

Ms MEARS-LYNCH: Yes. Run by Mission Australia, they do a fantastic job. They have eight beds. Of those eight beds they can only be referred to from police and/or Family and Community Services. It is not open for other referral through our community services, local organisations cannot refer through.

Dr MEHREEN FARUQI: Is that for under 18s?

Ms MEARS-LYNCH: Yes, 13 to 18. The program they run is fantastic. It is intensive, it works on a multifaceted approach and it can run for quite a number of months, which is good, so the supports are really in there. Part of the question around rehabilitation centres is what happens when they do come out of a rehabilitation centre. And that is something that Ms Plesman sees a lot with working with families. Our families are really perplexed as to why their young people have taken to drugs in the first place. Often there is minimal understanding in families around the use, the effects, long-term effects, other than what they experience from behavioural differences and emotional differences. So the families really struggle on how to support a young person in that predicament.

Yes, rehab would be fantastic but I think there also needs to be the supports when people come out of those environments. Again, we come then into whether mandatory reporting into a facility will have as good an outcome as someone who is willing to go in. In Junaa Buwa! they do quite an astringent assessment, because they are really just wanting to work with young people who have reached the point where they want to make a change and say, "Yes, it's time to make a change." And young people who do not want to make the change are very unlikely to get in.

The Hon. COURTNEY HOUSSOS: It strikes me that there is a range of very good, very niche services around the State, and this is another one, but it does not necessarily cater for the broader community.

Ms MEARS-LYNCH: No. And cost is often prohibitive, and that is our only youth oriented one in our area, but we do have some adult systems. At the moment the only place we can do detox for anyone is Riverlands in Lismore, which I am sure someone else will have spoken about in this conversation. Then even in the adult system unless you have detoxed you will not get into rehab. You will not get into rehab unless you have follow-on service for when you come out of rehab. There are so many barriers for people going in. I did have some conversations with some of our polydrug users that we work with. What came through very loud and clear was often when the window in their own mind is opened that they would like to make change, they will ring up a rehab centre, and it is, "Well, you have to detox and, oh, there is an 18-month wait list." What happens to the person in those 18 months is their window of wanting to change closes.

The Hon. Dr PETER PHELPS: Is there an 18-month wait list for detox?

Ms MEARS-LYNCH: I do not know with detox, to be honest, but with rehabilitation sometimes it is that long. We have The Buttery. Do you want to talk about The Buttery?

Ms PLESMAN: Yes.

The Hon. PAUL GREEN: We are meeting with them tomorrow.

Ms PLESMAN: They are very good.

The Hon. COURTNEY HOUSSOS: We have received some submissions.

Ms PLESMAN: They are very good and they do outreach down to here on various things. You do have to do detox, and it is lining that up.

The Hon. COURTNEY HOUSSOS: My question is about family use. The Committee has heard from some rehab providers that if a young person is using there is a high incidence of using in the family. Is that your experience as well?

Ms MEARS-LYNCH: Yes.

Ms PLESMAN: There would be, yes.

The Hon. COURTNEY HOUSSOS: That is obviously where they are coming into contact with it. Can the young person then be an agent for change within the family?

Ms MEARS-LYNCH: The young people that I spoke to who have managed to come out into recovery, some of them are in families that do not have ice use, or any other substance misuse. They certainly have a much better chance of having their recovery last longer, and hopefully indefinitely. A lot of the young people who are trying to keep themselves in recovery have had to change their whole peer set to do so. Some of these young people have not been through any rehab centre, this is just something that they are trying to do with the family help and community help. The things they do is they do not have a phone. Where possible they do not come into town, and certainly not on Centrelink pay days. They do not have any social media and probably one of the biggest things we see that makes positive change for young people is they end up with a partner who does not use. That is huge in having that turn around. It also is that ongoing support to help them make the right decisions. I might have gone off topic already.

The Hon. COURTNEY HOUSSOS: That is very useful, but it also shows that you need to line up a lot of these things in order to make lasting change. I think that is one of the challenges, is it not?

Ms MEARS-LYNCH: It is, and education I think for the families of what to expect and particularly we do see a lot of methamphetamine use in the area, more than we used to, it seems to be on the rise. Again, that is anecdotal.

The Hon. COURTNEY HOUSSOS: That is the best evidence for the Committee, thank you.

Ms MEARS-LYNCH: I was going to say that because of that we have seen rise to some self-help groups and support groups just at the moment in the lower Clarence area and with the very best intentions there are some dangers in that. We know that sometimes people will infiltrate into those support groups and their very reason for being there is to deal.

The CHAIR: It is pernicious, is it not?

Ms MEARS-LYNCH: It is. Sometimes a support group is a two-edged sword. People are really going to get help and to try to do the right thing but it does not take much to upset that balance.

The Hon. COURTNEY HOUSSOS: The issue of youth suicide across this particular region has been well publicised. Given that you work predominately with young people, is there anything you would like to tell the Committee about that? I am happy for you to take the question on notice.

Ms MEARS-LYNCH: No, that is okay. I would say, as we would all be aware, any kind of drug use, polydrug use, is often associated with mental health conditions. It is very hard to separate sometimes what comes first and how they interrelate. I think the suicide rates that came through for our region are around mental health and possibly also some association with drug or alcohol use. I do not know that a rehabilitation centre for drug and alcohol use is the best place to start if mental health is underlining that. What do you think?

Ms PLESMAN: I know that the rehab units that currently run find it very difficult to work on that. Some like The Buttery, which you will probably hear about tomorrow, will not even take people who have mental health issues who are usually on medication and stuff because they cannot deal with that, probably having doctors and people who could deal with all that. One of the things that I would like to put in about a rehabilitation centre is that I have worked with a lot of young parents, sole parents. The majority of them are women who have young children in child protection and they have drug addictions. It is really hard to find a place where they can go and take the children.

That is really an important issue because a lot of the time there are no family supports. They are complex families and for three to six months that that would be necessary, there is nowhere to leave the children. Also, the parents—because of drug use and stuff—are disconnected from their children. Some of the young women I have worked with who have actually got into the one in Brisbane have found it so beneficial because it helps to repair

their relationship with their children. It helps them to get on track with their parenting. It really is something that needs to be considered as well when we are looking at what we are going to do, particularly with young people under the age of 25 who have children, because they are out there using amphetamines.

The Hon. COURTNEY HOUSSOS: Were you referring to Benelong's Haven?

Ms PLESMAN: I cannot remember the name of the one—

The Hon. COURTNEY HOUSSOS: The one in Kempsey.

Ms PLESMAN: No.

The CHAIR: You were referring to a facility in Brisbane?

Ms PLESMAN: Yes.

The CHAIR: Do you recall the name of that facility?

Ms PLESMAN: No, I cannot recall the name.

The CHAIR: That is alright. The Committee might ask you a question on notice about that and you might be able to find out for us?

Ms PLESMAN: Yes. That is something that would be valuable.

The Hon. BRONNIE TAYLOR: That is just for women and children?

Ms PLESMAN: Yes, it is mainly women and children.

The Hon. BRONNIE TAYLOR: And there is support for them to continue with their lives as well?

Ms PLESMAN: Yes.

The Hon. BRONNIE TAYLOR: And the children are staying with their mother?

Ms PLESMAN: The family stays together and the parent actually gets the help they need.

The Hon. BRONNIE TAYLOR: The Committee has heard several times that people can get into detox but then they have to get into rehabilitation. Should we not have a system where the whole thing has to work together?

Ms MEARS-LYNCH: Yes.

The Hon. BRONNIE TAYLOR: From one to the next and then follow-up care for six to 12 months?

Ms MEARS-LYNCH: Yes.

The Hon. BRONNIE TAYLOR: That probably needs to be under the one team.

Ms MEARS-LYNCH: That is what we were discussing.

Ms PLESMAN: A detox and a rehab that all works together.

Ms MEARS-LYNCH: And then the follow-through into community.

The Hon. BRONNIE TAYLOR: I find it quite staggering, not having a lot of experience in drug and alcohol myself, that this just does not happen. I do not know how people are meant to have a chance if they cannot line up all the ducks to go from one to the next. Ms Mears-Lynch, I do not want this to sound as if I am baiting you, so please take me on face value. You said there were no longer any great services for drug and alcohol in the LHD. I got the impression that maybe there was a really good worker and they have moved on?

Ms MEARS-LYNCH: We did have a good worker who has moved on. Then a lot of those positions have changed and continue to change so it is very hard to build up a relationship and in country areas relationships go a long way when you are working with people.

The Hon. BRONNIE TAYLOR: When representatives of the LHD were giving evidence before the Committee earlier today they told us about all these fantastic things they were doing.

Ms MEARS-LYNCH: There could be a disconnect in the information that comes through. That was in no way meant to be a—

The Hon. BRONNIE TAYLOR: No, I did not take it that way. There are always two sides to a story. My other point goes back to youth suicides. I have done a bit of research. You have Our Healthy Clarence program,

which people are talking about all over the State, and that program was formed because people did not even know what services were here.

Ms MEARS-LYNCH: Yes.

The Hon. BRONNIE TAYLOR: Some people are saying that you have got great services but you, being on the ground, are saying that the services are not as great for whatever reason. You had a youth suicide crisis in your area and you had to call a town meeting because no-one knew what was available. That says a lot, does it not?

Ms MEARS-LYNCH: It does. Communication is—

The Hon. BRONNIE TAYLOR: That is no reflection on any of the organisations. Our Healthy Clarence has been such a success and, as I said, I have been doing a lot of research and people are talking about it everywhere.

Ms MEARS-LYNCH: I think the big difference is also that it is community driven. It is important that it is community driven.

The Hon. BRONNIE TAYLOR: People are being funded to help our clients and whether we agree or disagree we now have record spending. It does not matter which party is currently in office because that is what is happening. Yet we have a situation where we have a drug and alcohol crisis or whatever crisis and the community has to come up and say, "We don't even know what is available to us to get help." What are we doing and how can we solve this?

Ms MEARS-LYNCH: By coming together more, which is what Our Healthy Clarence has brought in. The New School of Arts Neighbourhood House Inc., which brought in Our Healthy Clarence, has done a fantastic job with that. It has really broken down any silos that were existing, which is great. I think the funding is running out so hopefully it is going to be funded again because it has worked very well. I would say also that we only have resourcing for so many caseworkers or our programs. That is not only in Social Futures but also across all of our organisations.

The Hon. BRONNIE TAYLOR: But the issue was not the resourcing or that there were not really great services on the ground, the issue was that people did not know what was there. They have not asked for more services.

Ms MEARS-LYNCH: No.

The Hon. BRONNIE TAYLOR: They have just asked to be connected to what is there.

Ms MEARS-LYNCH: Yes.

The Hon. BRONNIE TAYLOR: You say that the interagency meets once a month and that it is by invitation only—I do not know if it is called the interagency.

Ms PLESMAN: There are lots of interagencies in the Clarence. This is just one that is concerned particularly with child protection. What I would say is that since that happened we have got a headspace. We have got hubs that are happening in the area for young people to drop in and for families to find out. I actually dispute, particularly so far as clinicians we do not or did not have—you will let me know what you think about this?

Ms MEARS-LYNCH: Yes.

Ms PLESMAN: We did not actually have clinicians that can work with young people on mental health. There are school counsellors in the schools, and they do a wonderful job, but they are across the board for those large schools. It is very hard to get in to see a psychologist, particularly for young people. For instance, family workers can do a certain amount but we need to be able to refer on and have the services there, particularly for mental health and they need to be there for a while to support families. I do not know that there is that much happening around that these families could have accessed. We need clinicians, we need people who are psychologists.

The Hon. BRONNIE TAYLOR: I guess the issue is they felt they did not know where to go.

Ms MEARS-LYNCH: I think what Ms Plesman is trying to say is for clinical advice you have to go through mental health. The only way to go through mental health is to contact the access line and do a triage. To do a triage you normally need help from other people to do that triage with caseworkers. Then when you get through they can only take so many people. Our youth and family team and mental health do a great job. There was a gap in service because of the resourcing of how many staff are on the ground. The resourcing does come

down, not just in our non-government agencies but government agencies, to how many staff are available and how many people they can work with on an intensive basis. We do now have headspace.

Ms PLESMAN: We do have headspace.

Ms MEARS-LYNCH: That is lovely. The other thing is it is the pieces of the pie that we all work with. I am not a clinician, so I can help refer on to someone that can help them but I cannot necessarily help them in that or any of my caseworkers. We can help hold them and help families work out the right direction that works for them and they also have to be the ones to say, "Yes, we want this." Sometimes what happens is when young people and families are in crisis they say, "Yes, we want it." And two weeks later everything has changed and then they say, "Actually, no, we do not want this, and we are not going to engage with the youth and family team at mental health." How long can they carry someone who is not coming in to appointments before they have to be closed. They do not have the structure where they can go out and pick up people because it is not within their roles. It gets complex is what I am trying to say.

The Hon. BRONNIE TAYLOR: Everything is complex when you are dealing with people.

Ms MEARS-LYNCH: It is.

The CHAIR: On behalf of the Committee, thank you for making time available.

Ms MEARS-LYNCH: The time has gone already? We had so much more.

The CHAIR: The Committee has resolved that with questions on notice that may have arisen in the exchange or after reading *Hansard*, which will be provided to you by the secretariat, you are required to answer those questions in 10 days to help us with our deliberations.

Ms MEARS-LYNCH: More than happy to do that.

The CHAIR: Thank you again.

(The witnesses withdrew)

(Luncheon adjournment)

ROBBIE LLOYD, Community Relationships Manager, Port Macquarie Community College, sworn and examined

The CHAIR: We have received your submission numbered 38, but we will allow you to make an opening statement and from that we will begin questions.

Dr LLOYD: I wrote a late letter. Thanks to the secretariat for receiving it on 7 May. I was told that the Committee was keen to hear from me in person. I have been around a fair time. I am 22 years in recovery as an alcoholic. I come from a long line of alcoholics—my parents, my grandparents, my brothers and some of my children. I have five kids, two sons who have both been addicted to marijuana—thank God they are out of that period now—and three daughters who have all had serious mental health challenges with anorexia, depression and anxiety. I am passionate about community mental health and recovery work for all ages. My grandmother was addicted to Physeptone, an opioid that was prescribed to her by her general practitioner to help her. She must have spent 30 years addicted to that stuff.

I have had 25 years working with Aboriginal communities. I have worked a lot with Maori brothers and sisters in New Zealand, especially in Hamilton. I am also a great admirer of Professor Mason Durie's Maori house of health model—the mind, body, spirit, culture, family, community model. In the global mental health movement founded by Professor Vikram Patel, now at Harvard, but he was at the London School of Hygiene and Tropical Medicine, as he put it, being a Goan Indian by birth, "The colonies have taken over." That movement has been expanding around the world since 2007 when a fabulous evidence-based series in the *Lancet* showed that respecting local people to take charge of social and emotional wellbeing frontline work and respecting local culture, healers and medicines 50:50 alongside western clinicians and medicines was a bloody good idea.

It has been working extremely well, but not in Australia. I have tried to argue with the primary health network in Darwin that we needed it in remote communities. I have spent seven years working in the Northern Territory going remote and seeing lovely Irish nurses on three-month working holidays in clinics in the remote Northern Territory doing the best they could but offering absolutely nothing to sustain an ability to deal with the crisis for Aboriginal people throughout the Top End. I have worked with Professor Ernest Hunter from James Cook University and the Cairns Institute since 2006 in the Creating Futures movement: rural, remote, Indigenous and Islander mental health.

Last year we hosted the biggest ever conference on mental health and alcohol and other drug issues in the Pacific in Suva in September. There is a crisis all over our region and it is because we keep pumping money at middle-class people to do nice middle-class jobs with people. It is not working. I ran headspace in Alice Springs in 2009 and I argued with the headspace head office that this model does not work as it is. I changed the model to be 20 per cent in the clinic and 80 per cent in the community. We had an elders and youth joint committee. We used to meet around the camp fire. We get the young people talking to the elders to see that someone gave a shit. It was amazing the difference it made.

Sadly, Chris Tanti, who was running headspace then, came up to Alice Springs and went away saying I was a wanker for the model we were trying to run there. It was not only hurtful to me and the local people but it was stupid. All they were interested in was churning Medicare business through middle-class white headspace offices, which is still what is happening. It is happening in my town in Port Macquarie. The kids who need it do not go near it because that is just like going to the doctor or going to the emergency ward at the hospital, so I will avoid that. So I will avoid that. We have a crisis because of good people trying to do good work but not listening to the local community and because it is convenient to pump a whole lot of money into the NGOs that have all been part of privatising welfare since John Howard left us with that legacy. These NGOs have become huge bureaucracies, and it is a tragedy that the Productivity Commission did not expose that when they had their inquiry into health and human services, because they were just interested in promoting more privatisation. What we need is accountability and transparency.

As my friend in the back has been saying, we got no accountability or transparency out of the Productivity Commission's hearing on what is happening to these massive NGO bureaucracies that get all the money, that have secretariats that put in all the tenders. They get the tenders and it is convenient for governments at all levels to give these successful tenders. We have tendered at my college for alcohol and other drugs work, for community mental health work, but we cannot get a look-in because we are not seen as experts in the field. The truth is that we have got enough experts. We need more ordinary people helping mums and dads and grandparents and cousins and brothers and sisters to get alongside the people who have got trauma, who have got pain, who are seeking pain relief with drugs and alcohol and gambling and social media, which we must not leave out.

When I came back from the Northern Territory in 2014 to Port Macquarie—I could not stand Sydney any longer and I felt for my children and grandchildren Port Macquarie was close enough—we founded the Mid North Coast Human Services Alliance, a group of NGOs all community run, interested in maintaining community values, person-valuing, community-building NGOs, accepting all the neo-Liberal value system of having to be efficient and effective. Okay, we get that. We want to be efficient and effective but we also want to remain community responsive and community listening and community involved so people can find a community of belonging where they can recover. That is what we need.

We have got beautiful clinicians in the Mid North Coast Local Health District's alcohol and other drugs section—they are respectful of people; they do not stigmatise people; they help them in their initial detox and the beginning of their recovery journey. After that, nothing. And especially if you are an under 18 young person—zip. So we went for the tender for that and did not get it. When I spoke to the people in the secretariat of the Ministry of Health I just felt like nobody listens to this stuff. We know because we run one of the many special assistance high schools in New South Wales now, started by Workers Educational Association—Hunter in Newcastle in 2006, the so-called Alesco model after they chose the Latin word "alesco" to nominate that we are trying to give a bright future to these what might be known as bogan young people—the ones who get kicked out of mainstream, lazy, industrial high schools who are only interested in university futures for people.

These kids are wandering the streets at 14 and 15, headed for a career with Corrections, and why would they not pick up drugs and alcohol? They have been shamed and blamed all of their school lives; many of them are traumatised; some of them are couch surfing because they are homeless. They self-enrol in our school because they want to belong to something, but they do not want to go to mainstream schools where they just are not welcome. They have got enough brains to question the didactic teaching that is happening there, worshipping that land and the HSC, which is okay for the minority of people who are headed to a university career. I could say a lot more but that is probably enough to begin with.

The CHAIR: I think you have set the scene very nicely for a very good period of questioning.

The Hon. PAUL GREEN: Dr Lloyd, I love what you said. I think if there is a solution it is with the community; it is not with more money. We see the vulnerability of drug abuse; it is so insecure and so unreliable to meet the treatment needs of the person. Can you elucidate a bit further? I have been saying for ages that one of the unsaid groups in this inquiry that we noted in Broken Hill is the church, which in itself is a wellbeing community that is able to carry—and I have seen it carry and I have seen many lives restored because the community comes in and it is not costing the government a cent to come in and get ministered to and loved and carried. What other groups have you seen be able to do that in the community, and what capacity is there for other groups?

Dr LLOYD: We have been lobbying to establish a pilot of the model called the Recovery College, which we tried to get Minister Davies to support for Port Macquarie, Coffs Harbour, Mullumbimby and Lismore. She did not come up with that funding so we went for Port Macquarie alone and that got rejected. What I am interested in is—I am sure Jesus would be very happy with this—it is fine for it to be a secular organisation or a church as long as no-one is being pumped with some ideology of any particular kind; it is about, what you say, a loving environment and acceptance and non-judgement. It is the stigmatisation and the judgement that is involved in people's recovery and rehabilitation.

I went to AA for a long time, it is a fabulous thing—so is NA, so is GA, they are all great. But there is still a degree of "You've been a bad person because you did whatever". What we need is not just the harm minimisation philosophy and practice but the idea of "What are you doing next? Now that you have started to deal with the physiological issue and recover, what are you doing next in your life?" That is why community colleges and all the other adult community education settings like the fabulous libraries in this State, the library and information and neighbourhood centres, men's sheds, women's sheds, cultural centres, are all places where adults or young adults can gather, along with churches, and have the three things they need: something to make them know that they are supported; a set of choices where they can begin pursuing their interests and passions and find something to engage their love to give them a purpose; and they can have access to learning and help both about their own issues—the sort of psychotherapeutic stuff—and also in the vocational pathway area.

I do not like the vocational education and training system because it is just about monkey-see, monkey-do training, cookie-cutter type models. However, vocational-oriented assistance for people to find a skill and get on with something else needs to be a partner of recovery, not just the clinical focus. We desperately need detox for young people. We have got kids in our school who are already addicted at 14.

The Hon. PAUL GREEN: But what you are saying there, what you just drew the illustration of what needs to be thought about next and what we do next—and what we have heard in the youth suicide inquiry that the joint select committee is running—are the very reasons: no hope, they do not believe there is any hope or any

future for them, and they believe the world has left them behind. So they either end up on drugs or they commit suicide. It is still the same solution, is it not? We have got to change the system and feed in that you have hope, you have got great value and there is a future for you.

Dr LLOYD: That is true, but it should not be branded with anything.

The Hon. PAUL GREEN: This is my point. Who cares if the person goes to church and receives Christ, and comes out a better citizen, a whole person and is able to fulfil their God-given call, as opposed to the person who does not choose Christ and goes through another system. What is the big deal between both of those persons if they got released from their addiction?

Dr LLOYD: I do not want to argue about religion. I had that same experience myself as a young person, and it certainly did not help me in terms of my addictive behaviours. However, I agree with the idea and I promote the idea of communities of belonging. Just let me say something about the detox though. We are desperately short of ways young people can be helped to address the initial phase of recovering of detox and rehab. We do not have that. We worked very closely with Benelong's Haven in the years it was still open, before it tragically shut, and that family model of recovery and rehabilitation is desperately needed, especially in a culturally respectful and celebratory way. We need to replace that with something else. But we also need places where young people can go which feel non-shaming within the family. For Aboriginal and for many multicultural people there is a degree of shame in it being known that they are in recovery. Church environments can be very much like that. They can be very judgmental, because certain people think that this is a sinful thing that you have taken on, blah, blah, blah. I am not promoting secularism as the only answer, but I know how much shame and blame happens in faith-based organisations.

The Hon. PAUL GREEN: It happens through people, not through the church.

Dr LLOYD: Okay.

The Hon. PAUL GREEN: People judge people.

Dr LLOYD: Anyway.

The Hon. Dr PETER PHELPS: Now that you have mentioned it, Dr Lloyd, do you know why Benelong's Haven closed?

Dr LLOYD: There were allegations of mismanagement. I think there was also a debate between different Aboriginal factional—I used to work in the Department of Aboriginal Affairs and I know a fair bit about land council politics. Kempsey Land Council is responsible for the land there and the elders of Benelong's Haven—who had been there since the beginning, since it opened in Marrickville years ago—were probably maybe a little bit out of touch with how to work the bureaucracy. I do not know the details, I just know that—in fact I offered to help Andrew Hegedus when he was running it, to set up an alumni from Kinchela Boys Home days and get a sense of support for people graduating from Benelong's Haven to go on in recovery and then get the start for jobs and get on with their life. But it was too late, the rot had set in somewhere and so it went down.

But I hope that Adele House, which does a wonderful job in Western Sydney and in Coffs Harbour, may show an interest in reviving that sort of model. We need that family-based rehab and we need places where young, adolescent kids can detox and start to be supported that does not feel like an institution, because that will just reinforce that institutionalisation that happens because you made a mistake and you picked up pain relief.

The Hon. Dr PETER PHELPS: On that point, inevitably if you set up an institution it is going to feel like an institution because it is not your home. Is what you are arguing for in that instance, not the creation of an institution but greater funding of community support services?

Dr LLOYD: Absolutely. And I would also promote—this does have a Christian connection—in the Northern Territory, and we have one of these in Port Macquarie, the Heritage Christian School, which is run by the Australian Christian Schools Association, it has a name something like that. They also run Marrara Christian School in Darwin and there is a college in the national park south of Darwin. They have a family-based model, houseparents model, which I think is something we could think about, to have young people who are in recovery being supported by parent figures who are non-judgmental of the fact that they have ended up in that condition. That is slightly more welcoming than what inevitably looks like an institution. But it has to be connected to the local community so when the kids are well enough they can come to somewhere where they then get on with a bunch of other choices and have a community of belonging to support them and they can find a purpose.

The Hon. Dr PETER PHELPS: What happens if it is a community of dysfunction though? Part of the problem I have is that the reason they are dysfunctional flows from the fact that there is something in that community which has led them to dysfunction in the first place. People do not decide to become addicts, they do

not say one day, "I am going to take up an addiction to methamphetamine or alcohol." There is something which drives them to it.

Dr LLOYD: We could have a debate about all this because if I look at the amount of advertising for gambling that is now all over the television, I cannot believe it. And we have people in the local Drug Action Team, which I helped the Human Services Alliance to found for Port Macquarie to support the 20-year-old community Drug Action Team. We talk about gambling a lot and the promotion of gambling as well as the fact that a lot of young people are disappearing down the computer screen into the virtual world to hide, even if they do not have a substance abuse problem. Look, whether it is dysfunctional communities, whatever it is, there are people in every community who are willing to help, but they need resourcing in this more intensive way at that early detox stage. But then we need mainstream environments like community colleges, where people can just become a student, they are destigmatised, they are no longer an addict in recovery, they are just a student.

You can go to Kogarah and the inner city now in Western Sydney and down in Murrumbidgee there is a recovery unit associated with the health district, an eight-bed unit, people can go there, I think it is 16 weeks they can have a live-in recovery there. But it is actually moving them into the adult community education world. It is this transition from what I call the clinical end of things into the community end that we are not doing at all well and we need to be able to get support from the mixture of NGOs, including churches, local government and then the State and Commonwealth agencies that have an interest in this to target a local transparent and accountable process where the money is being spent in the way the local community knows is going to work.

Mr SCOT MacDONALD: My question is more, I suppose, operational. The Adult and Community Education [ACE] colleges do a great job where I live in Guyra. They are very good at what they do, they are putting people through a range of courses. You say scale up and I am trying to visualise that. There would need to be quite a different skill set, would there not?

Dr LLOYD: Yes, and we have a \$2 million proposal with the icare foundation of the New South Wales Workers Compensation Commission to establish a pilot recovery college in Port Macquarie for rural, regional and remote New South Wales. We know that we need to train people up, but it is quite possible and global mental health works in developing nations all over the world. This is not rocket science. It is: How do we get people started in learning the skills for the initial triage work? How do you identify when young kids and adults are vulnerable? How do you then direct them towards the sort of support that will help them deal with their pattern of behaviour? Then how do we support them also in this other journey of moving towards recovery? Guyra would be a great example, and Terri Johnson, who runs the ACE colleges, she is fabulous at this. She has been part of our pitch.

Mr SCOT MacDONALD: She would know many of the target audience would be coming through ACE doing various things at different times.

Dr LLOYD: That is it. That is what we want.

Mr SCOT MacDONALD: It is an add-on.

Dr LLOYD: I am trying to say that we can build a stronger partnership. I love this document here, I love the decision-making, published by the Department of Aboriginal Affairs. The two great examples that they invited from Canada and New Zealand are all about the same thing. They are all about us needing local decision-making and local accountability but it is partnerships that work. I think we can answer that issue that you are wondering about. There are people who can develop these skills and then multitask. What we have seen is atomisation of the customer. This is what has happened with the National Disability Insurance Scheme [NDIS], this is what has happened with aged care. The customer is a solo operator and increasingly the people who work with them are solo operators, sub-contracted little businesses delivering home care, delivering disability support. That is okay up to a point but isolating the customer and isolating the service deliverer removes all community and it is in community that people become unwell, such as you are saying about dysfunctional communities, and I know that extremely well from the town camps in Alice Springs. But it is in community that people get well and get stronger and then move forward. I think we have to address that issue and try to make those networks.

Mr SCOT MacDONALD: It is not insurmountable.

The Hon. BRONNIE TAYLOR: You talk about not stigmatising people. Having a separate place where people go to school, is that not stigmatising them before you start?

Dr LLOYD: No. Community colleges are—

Mr SCOT MacDONALD: They are pretty non-threatening.

Dr LLOYD: They are like public schools. It is an open invitation. Well, they are better than public schools in the sense that people have a range of choices there and everyone is welcome.

The Hon. BRONNIE TAYLOR: So it is not specifically for—

Dr LLOYD: It is not a ghetto.

The Hon. BRONNIE TAYLOR: I was not suggesting it was a ghetto. I thought you were suggesting that it was for people with a drug and alcohol problem or that could not mainstream.

Dr LLOYD: There are plenty of them. It is a mainstream thing. There are lots of people with issues.

The Hon. Dr PETER PHELPS: What is the Recovery College model? Could you elaborate on that a little because from reading that I assumed you were talking about a specific institution that would offer educational services, particularly for a class of people who were suffering from addiction?

Dr LLOYD: No. It is a generic model that has been in the United Kingdom and the United States for 20 or 30 years. One of the visionary managers at the South Eastern Sydney Local Health District, back in about 2012, said to the St George Community College and the City East Community College, "We would like to experiment with the Recovery College. Would you be interested?" So together they sent the wonderful Joanne Summer over to America to do a study tour. She came back—not that she knew all about it—and they began to develop this model, which is co-design and co-delivery. It must be 50:50 done by clinicians and people with lived experience, designing and delivering the program. As it runs in Kogarah and the inner city it is excellent. It is bringing the clinician into a more listening role, rather than wearing the white coat and being the expert, to respect the value of lived experience and then deliver the program where people can deal with their physiological recovery. Then they can get on with making choices for skilling up for other choices in life.

This is incredibly relevant for police, emergency services, Corrections, where we have massive turnover because the culture of those military-based vocations have no supervision, no debriefing at the end of a day's shift, a huge attrition rate and lots of compensation claims. The icare foundation is desperate to break that cycle. The Recovery College is equally valuable for those guys as it is for younger and older people with addictions because stigma is the biggest challenge—just as it is for people trying to recover from a stroke. We ran a three-month pilot trying to get stroke recovery into the college. The people who are the survivors of stroke and their carers suffer from massive shame and they will not come out. The clinicians do a fabulous job when they are in hospital, because they have to be in hospital, but once they leave they hide away at home. We need more of these welcoming ways of saying, "It is okay guys. Yes, you have got an issue but you are still incredibly valuable to our community."

The Hon. Dr PETER PHELPS: What is the material difference between what you are suggesting and some of the pre-existing programs, albeit done at a smaller level, of long-term residential rehabilitation, which incorporates as part of that rehabilitation upskilling, life skills and work skills?

Dr LLOYD: There are still rehabs and that is closer to the ghetto feeling for the graduates. We need something that is seen to be in the mainstream and not identified as a "rehab".

The Hon. Dr PETER PHELPS: I thought the rehab centre we saw at Shoalhaven did a very good job.

Dr LLOYD: That is great, but you have always got the Amy Winehouse factor.

The Hon. Dr PETER PHELPS: I quite like Amy Winehouse.

Dr LLOYD: Me too.

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

Dr LLOYD: "They told me to go to rehab and I said, 'No, no, no.'" What happened? Amy isolated and killed herself with her addiction. If she had been in a circumstance, whether it was the loving Christian environment or whatever other community belonging—

The Hon. Dr PETER PHELPS: She had no loving environment, that was her problem. Her best friend was her bodyguard.

Dr LLOYD: Yes.

The Hon. Dr PETER PHELPS: But that is by the bye. The advantage of residential rehabilitation is that it takes someone out of a bad environment.

Dr LLOYD: We definitely need it. I am not arguing against that. Some of the people I have met on my own recovery journey have massive issues with the physiological inability to break their cycle of addiction, as do

gamblers. My wife is a psychotherapist. She says, "I would much rather deal with a drug addict than a gambling addict because gamblers always believe 'There is one more shot left. We are going to get there.'" They will say whatever to get out of a therapy session to go straight back to the TAB, whereas people who live in rehab have got a serious chance of addressing their issue. But I totally agree, in a non-branded way, that you have got to have a spiritual solution. It is not good enough to say that this is a secular matter; it is a spirit matter. It is not a church matter, it has nothing to do with any branding. It is a human spirit matter. If you do not have something of the spirit to replace this other spirit, then you will never make it and part of that spirit comes in community.

The Hon. COURTNEY HOUSSOS: In your evidence you have touched on the question of lived experience and its relevance particularly to clinicians who offer alcohol and drug support. There is obviously a move towards more accreditation or recognised training for clinicians in particular but also for support workers. Is there a way that we can recognise lived experience?

Dr LLOYD: Absolutely there is. We have already got a strong movement for peer workers in mental health that a number of health districts are working on. I believe that we could have the same process for recovery from alcohol and other drug issues.

The Hon. COURTNEY HOUSSOS: Please excuse my ignorance, where are those peer worker programs?

Dr LLOYD: In all different local health districts across New South Wales.

The Hon. COURTNEY HOUSSOS: Any specific ones?

Dr LLOYD: The Mid North Coast Local Health District has it. They are in the city local health districts. The Ministry of Health could well inform you about the distribution of peer workers. I am promoting peer researchers because I believe that with participative action, research and appreciative inquiry, such as, "How is it going, Greg? What is working for you?" people develop agency and self-esteem when they are respected for what their experience has been. We use that as an empowering thing. I work very closely with the former industry skills training advisory council for health and human services, now known as SkillsIQ: Skills Service Organisation. They basically are the accrediting body for these sorts of things. Yasmin King who runs it used to be the NSW Small Business Commissioner. She says, "We do not need more experts. We need more ordinary people being skilled up and given a qualification." Now that is not a huge deal—it is not a certificate IV in training and assessment, which is now like a university degree—it is a skillset that can be relatively easily taught. That is why we are using SkillsIQ to accredit the global mental health model so we can get it taken more seriously by people like the primary health network for rollout in Aboriginal communities.

Dr MEHREEN FARUQI: In your submission you talk about the need for detox and rehab for under 18s. Earlier you said you were critical of the programs that are available for young people like headspace. You said also that it is inappropriate when these programs are available. Could you give another example of a program for young people that you think is not working under NSW Health?**Dr LLOYD:** Do not get me wrong about headspace. I love the model as it was designed, where it has gone wrong is how it was rolled out to end up as a middle-class thing.

Dr MEHREEN FARUQI: I guess the problem is that it is not available for under 18s?

Dr LLOYD: There is not much available for children who are addicted. My wife worked in sexual assault counselling in Darwin for five years at the wonderful Ruby Gaea sexual assault service where so many young children who had been affected by abuse had picked up drugs and alcohol for pain relief, and there is absolutely nothing for these guys. We need compassionate settings—whether they are family-based—in a broader community setting so that these children do not feel, "Okay, I am in an institution now. That is it for life." So they can be nurtured back to health and then helped to make choices, just as we are trying to do with the teenagers in the Alesco network of schools.

Dr MEHREEN FARUQI: Will the recovery college model that you are proposing cater for under 18s as well?

Dr LLOYD: It very well can.

Dr MEHREEN FARUQI: This inquiry is obviously focusing on rehabilitation services but there is the question of looking into the root causes of why young people take to drug addiction and drug abuse. How much effort should be put into that? Where should that effort go?

Dr LLOYD: You will get me started now.

The CHAIR: You have 10 minutes. You have plenty of time.

Dr MEHREEN FARUQI: I know it is not an easy question. I think we need to look at it even before we come to rehabilitation.

Dr LLOYD: We need to do something about the disaster of our school system. I started teaching in 1972. I became a journalist. I worked with Ita Buttrose when the *Daily Telegraph* used to be a newspaper in the early 1980s as an education writer. I was in and out of Parliament House all the time writing a lot about what happens in everything from child care through to primary school, secondary school, TAFE, university and business training. Everything about our education system in my view is wrong. It is linear, authoritarian, hierarchical and competitive based. It does nothing but scare people. It scares the children, and now they are even talking about doing this to little children in child care, for God's sake.

This is where it all starts. We stress people out with competitive ways of living. I know it fits the capitalist model, and people try to ease the pain by going shopping, but it does not do much, as we can see, to help them actually find who they really are because they are only told they are any good if they get a good mark at school. If we follow the American model as I found in Alice Springs where we have a lot of CIA members from Virginia at Pine Gap who used to send their children to Living Waters Lutheran Primary School, they were terrified of a black mark on their child's life if that kid needed something for their wellbeing because they worried that when they go back to America that would be it. They would have no future because they had a black mark for needing a mental health support process.

We have competitive schooling and worshipping of the universities who themselves have become sausage machines of meaningless processing of information, not reflection and critical thinking and innovation. I have been teaching in universities for a long time as well and I just think it is a tragedy that no teacher in a university has time to sit and think with students anymore. They are all just driven by the need to process information. Most of them are casualised anyway; they do not have tenure. They are all terrified. They will do what they are told and most of the students are online from somewhere else just paying the money and getting whatever they get. So at all levels of education they have stuffed it up. They are bringing this whole idea that meritocratic marks based, easily assessable, exam run learning is the way. That is where it comes from. We do not have community. We have people terrified that they are losing in the race. Then they go to church. Maybe that gives them some solace or they pick up all these things that are the problems that we are talking about today.

The Hon. PAUL GREEN: They feel like the world has left them behind.

Dr LLOYD: If we can do something about that, I would love it, but I have become a complete cynic about that. I have tried to argue it but is very hard to win. Then they all end up in court where my brother, who used to be the Chief Crown Prosecutor, is trying to keep some of them out of jail. I just took my wife to Kempsey yesterday to show her Kempsey jail that has a brand new wing opening up because here we have the growth industry in the maintenance of our reputation as the penal colony which we are because there is good money in it for someone. There is not much life in it for the people who are going to end up there because they will just be on that treadmill of going back in. Eighty per cent of them are there for drug-related crimes. It is shameful that the jails are full of people who should not be in jail. They should be in recovering circumstances getting a life and contributing to the community and not costing the taxpayer so much money. I am sorry if I seem to be whinging.

The CHAIR: No, not at all.

Dr LLOYD: I think it is wonderful what you are doing here. We really need your wisdom to influence what happens.

The CHAIR: We appreciate your insights this afternoon. The Committee has resolved that if there are questions arising after reading *Hansard* you might be good enough to consider answering them. The secretariat will liaise with you and deal with that.

(The witness withdrew)

DES SCHRODER, Director, Environment Planning and Community, Clarence Valley Council, affirmed and examined

SHARON MOORE, Community Project Officer, Clarence Valley Council, and, Chair, Community Drug Action Team, affirmed and examined

SARAH NASH, Community Project Officer, Clarence Valley Council, affirmed and examined

The CHAIR: Do you have an opening statement?

Mr SCHRODER: Yes. We did send some material around late last week—I do not know whether you have it?

Ms NASH: I have copies here.

The CHAIR: Thank you.

Mr SCHRODER: It has a few statistics and whatever on it. Clarence Valley Council does not pretend to be experts in the rehabilitation field. We do a lot of work, though, with community groups. I think we should talk later on about what has happened with the Clarence Valley Community Health initiative. It has been pretty successful I think.

The Hon. BRONNIE TAYLOR: Is that Healthy Clarence?

Mr SCHRODER: Yes, Healthy Clarence. You have probably heard about that.

The Hon. BRONNIE TAYLOR: Yes, I want to hear all about that.

The Hon. Dr PETER PHELPS: As opposed to Healthy Harold?

Mr SCHRODER: Healthy Harold, yes.

The Hon. BRONNIE TAYLOR: No, I have heard about Healthy Clarence right across the State. People are talking about what you have done everywhere.

Mr SCHRODER: I think we should talk about that because it is actually important probably for the model, I think. But we will talk a bit about that later and I will take questions on it. Generally—I guess what other speakers have probably said—we lack rehabilitation services across the region. There is a map on the back of the document handed up showing the particular situation of the Clarence. You can see where the rehabilitation services are—one hour, two hours, it depends on how fast you drive—a fair way away. The other thing about them is they are totally oversubscribed.

The bottom line is that there is a problem if you are talking rehabilitation. Really, in terms of those specific services, there are not many of them and they are overtaxed. They mostly cater for young males or males, and not so often for females, so there is a gender issue there too. In relation to the Clarence Valley generally, I heard the previous speaker talk about the jail. We are about to build a 1,700-people one out at Lavadia. It is being built as we speak. There are 600 jobs in it.

The Hon. PAUL GREEN: Great.

Mr SCHRODER: That is the positive part, but the jail will house 1,700.

The Hon. BRONNIE TAYLOR: That is very positive.

The Hon. PAUL GREEN: It follows the recommendation.

Mr SCHRODER: Yes, that is right. Again, the point probably is that a lot of the people in that jail will be there because of drug and alcohol problems.

The Hon. PAUL GREEN: That is not great.

Mr SCHRODER: That is not great. We can talk about what are the jail's ideas and about stopping the recidivism issues, but the reality is we know a fair bit about the modelling they are trying to do. That model is trying to keep people out. There will be a lot of work going on. That is something that we can talk about.

The Hon. BRONNIE TAYLOR: That is great. It is very positive.

Mr SCHRODER: We can talk a bit about that later, if you want to. Basically, as we said, we had a fairly big mental illness issue, which attracted a lot of publicity—bad publicity, and most of it was through the *Daily Telegraph* and others. The health initiative is actually starting to kick some goals. Basically we think—and

listening to your previous witness—there has been a community reaction to some of these issues, but you do need funding if you are going to be successful with these. What we found in the Clarence with some government cuts a few years ago is that we virtually lost all our youth services for a while there. We were under providing and deprived of service just about everywhere and we are in a big catch-up mode.

We start from a fairly low base, and we are socio-economically disadvantaged too in terms of our population. We rate way down in the Socio-Economic Indexes for Areas [SEIFA] and that has some implications for the whole outcome. I think that is probably about enough on where we sit. But, really, there are some statistics in that document that was handed to you by Ms Nash. We rank seventeenth in the "hood"—I think I have to put it that way—in respect of a lot of things. There are some statistics on that page, which takes us through some of the incidents from drug-related offences, et cetera. Basically, that could be a lot better. That might be it, unless my colleagues wish to add something?

Ms NASH: I think the community rallying behind the mental health issues and youth suicide and actually really working hard to bring headspace to this community has been a great example of the support that the community wants to give to people who have issues.

The CHAIR: It has been a very sharp focus.

Ms NASH: Yes, as a direct response, and that has been part of our Healthy Clarence strategy as well.

Mr SCHRODER: I might just expand on that a little bit by going back. We had a lot of youth suicides in a row—a cluster, if you want to call it that. We try not to publicise them because they tend to create a same dynamic. Basically, as a response to that and driven partly by the council and partly by a lot of the other community groups, we formed the Healthy Clarence initiative. Part of that was about getting headspace, but a lot of that was just about getting services generally. As a result of that, we got a headspace in. The council actually handed over our community centre to fast-track headspace into the place.

The CHAIR: I am sorry to interrupt, but when you say a headspace service, does it also involve informing people about services that they would otherwise not be aware of?

Mr SCHRODER: Absolutely.

The CHAIR: Or where there actually are serious gaps in services?

Mr SCHRODER: We should have a copy of it, but we will send you the Healthy Clarence strategic plan.

The CHAIR: Thank you.

Mr SCHRODER: But a lot of it was multifaceted. It was about education and, yes, you are right: What was happening is that a lot of people with skills and services were available but actually they were not known. First of all, the Healthy Clarence initiative was trying to document where those services were. That is not an oversupply, but at least there were some. But people did not know about them, so that was part of it. We could probably draw some real parallels here, I think. That was part of it. The other part of it was trying to get more services, especially youth services, into the valley. That was a big push—not just headspace, by the way. As a result, there has been some other government money coming in through the local member here, Chris Gulaptis, and co, to actually form youth hubs, et cetera, which have been fairly successful. On top of that, with a lot of lobbying, we got the headspace initiative, which is funded now for quite a while—five or six years in current funding, and it will continue on, hopefully. That gives you that detailed political response.

The Hon. BRONNIE TAYLOR: Were they not drop-in centres so youth could go somewhere to then know where to be directed to the myriad services?

Ms NASH: And, again, service coordination.

Mr SCHRODER: That is right. There are a few hubs still operating all around the place—one down at South Grafton and one downriver. They are there for kids to drop in to a non-threatening place. Actually, other people can probably speak a lot better than we can about it but, basically, it is that type of pattern. They are still operating, although the funding, again, is year by year. As people have said, casualisation of the workforce is an issue in this whole sector and ongoing funding. I know there have been funding submissions put into some of the first grants coming out of, ironically, the Grafton jail out of John Laing, who is one of the funding partners, out of their trust. They have elected to continue that on, but there is an issue of ongoing funding for these youth hubs. Headspace is probably locked in for at least the immediate future. The hubs, or that type of community reaction stuff, the funding for that depends on sourcing from multiple sources. I must admit that the Government has done a lot so far, but overall that is also subject to periodic funding, so it is a bit risky.

Ms NASH: The hubs have been working. One of them has been operating out of the centre here in recent weeks. Some of the feedback from the youth workers who are working there is that it takes about seven visits, on average, to actually connect with some of the children that are coming in—seven games of Uno, or whatever it is, to actually get to the root of why they keep coming back, what their issues are, and then obviously pointing them in the right direction to receive help.

The CHAIR: Ms Moore, do you want to add to the opening statement before I open it up for general questions?

Ms MOORE: No, I do not think I have anything by way of an opening statement.

The Hon. COURTNEY HOUSSOS: We have seen in some other parts of the State that issues of drug and alcohol addiction have been so much at the forefront of the community's mind that the council has taken a leadership role in terms of whether it is pushing for a Drug Court or just trying to address the follow-on issues. How much do drugs, and to a lesser extent alcohol, form part of the council's owning of the processes in terms of its community direction?

Mr SCHRODER: I will start with that before Ms Moore comments. The issue is that the council has done a lot about alcohol. We have done a lot with the alcohol accord. We have had a big alcohol program, which was quite successful. We reduced alcohol crime, for instance, by 25 to 30 per cent due to a whole lot of reasons. I must give the alcohol accord credit. All the local pubs come in to let you go around and put up posters around responsible drinking, et cetera. Whether that has had a big effect on alcoholism is another question, but what we have definitely had an effect on is alcohol-related violence.

Some people even say that it has got to a point at which—we have the Grafton races coming up shortly—the fun police have taken all the fun away. But, basically, the alcohol thing has been at the forefront and probably is, through the Hotels Association and councils involved in that—although it is probably just resourcing from a council's point of view because our budgets are limited—successful. That intervention has been successful. Whether it has just driven the alcohol message home, I am not sure. That has been there. Definitely on the mental health side we took a leadership role because that was absolutely urgent. It was causing all sorts of issues, not only from a social point of view but from even an economic point of view. We intervened and some of our staff have worked on that. Ms Moore and Ms Nash did a hell of a lot of work behind the scenes. They had a big impact on the mental health side.

I would say on the drugs side we probably have taken less of a leadership role. I think that would be fair to say, although we are involved. We have not taken quite probably the same role. I think the mental health thing took a lot of our resources for quite a while and that was very important. Touch wood, it seems to be working, but basically I think that was the urgent thing. Nevertheless, it is related. You see, they are all related. Ms Moore may wish to comment on where we are now.

Ms MOORE: Yes. The council is quite closely involved with the Liquor Accord, especially in Grafton, which is a really tight-knit, well-working group. Then there is the community drug action team [CDAT]. In that way, we try to get the community together. It is not so much of a leadership role. It is support. It is trying to connect to other people. I think drugs and alcohol has sort of taken a little bit of a back seat. I think the mental health issues, especially the youth suicide problem, have taken up a lot of our resources. We are kicking goals—great goals—in that regard. It does bring home that there are things happening, but not massive things.

The Hon. COURTNEY HOUSSOS: Previous witnesses have talked about the huge jail that is planned to be built. In terms of your forward planning, are you ascertaining that there may be some other social issues that are associated with that? Are you doing any planning for that?

Mr SCHRODER: I have all been involved for some years in the jail not only from a planning point of view but also from a social point of view. One of the things that we insisted on is that we wanted to know what impact the jail had socially on the community. If you want to read it, there is a great big social impact statement, about three of them that thick, that actually analysed the impact on the jails. The whole jail model here—and hopefully it is the model that they are going to implement—is based on the European jail model where the average recidivism, depending on which part of the society you are in, is Aboriginals come back within a couple of years. If you are in the white side of things, you come back maybe every three years or so. But, anyway, you come back fairly often into the system. About 50 per cent of people come back in again. There are safety issues and all sorts of reasons why they do it.

One of the performance criteria for the new jail is to keep people out. They get paid their performance bonuses by keeping people out of the jail. The way they will do that is rehabilitate and educate them. If they have a drug problem, for instance, get them out of that and get them educated and walk away with degrees. They have a very personal relationship. The people who are recruiting for the prisons are not the normal jail wardens that

you see on TV; they are after people with high emotional intelligence, basically, who can relate to people. The whole model, if you listen to the jail operators and the contracts—and we are on the edge of that—is actually about normalising life, trying to give people a life, even to the point of minimum security, albeit just like small town. So you work your way out of medium security—we have not got maximum here—into minimum security over time. When you get to minimum security, you will have your own credit cards, you will have your own shops, you will have your own resources, and you will basically operate in that town just like you do in any normal town. That is about a 400-people town.

That is the model. The social impact statement is based around that. They have looked other towns. There are some examples maybe where people have moved—this is the jail for northern New South Wales—probably they are trying to keep families at home. They are trying to get linked up with some monitoring of their internet activity, but they will be connected to the community. The days when somebody walks out with a box, looks around and there is nobody to receive them, that is not the model.

You need to talk to the operators. The model that Infrastructure NSW and others put in was really about trying to keep people out of the system. Otherwise, you are going to need another 1,700-people jail and another 1,700 on top of that. Yes, there is some that people will move into the community with issues or their families will have issues, but the evidence is not categorical from the social impacts work that has been done. There was a lot of work done around Lithgow jail and those sorts of jails. Maybe some of the western jails that have got issues around the towns might be a little bit different. We have been a jail town for a long time. There was a big protest about the Grafton jail being closed.

The Hon. COURTNEY HOUSSOS: I am familiar with it.

Mr SCHRODER: There were some issues but, overall, at the moment our crime rate is probably as low as it has been. Big infrastructure helps too when you have got people employed. The jail also brings 600 permanent jobs and so you cannot underestimate that. If you are out there at the moment, the people who are building it are employing 24 per cent of apprentices and about 14 per cent is Aboriginal employment, which is great. There are 370 on site, which will get to 1,400 before the end of the year. It is a \$750 million build. There is a lot of work going on employing people who would normally not be employed and giving them skills. It is all about the whole interaction; it is not just about one little segment. So you can get people employed, get them off the dole, et cetera. It makes a big difference.

The Hon. COURTNEY HOUSSOS: I appreciate that the jail has brought very good jobs to Grafton. That has been a longstanding thing and the closure was a huge issue.

Mr SCHRODER: You are right. We have got some concerns.

The Hon. COURTNEY HOUSSOS: I am thinking about it from a council perspective.

Mr SCHRODER: We have thought lots about it.

The Hon. COURTNEY HOUSSOS: Thank you very much.

Dr MEHREEN FARUQI: I must say that I find it a skewed model of trying to keep the people out of the system by putting them in jail. It does not fit with me at all. You were here when Dr Lloyd was speaking about his priorities and what he thought should be done, especially the Recovery College model. Given your experience, what is your view on that and the role that the community should play?

Ms NASH: I do not have experience specifically in what he was talking about, but in a lot of the services that we work with, and a lot of the feedback in doing the research for this has been that there are a lot of gaps in the loop. What he was talking about goes a long way to filling some of those gaps.

Dr MEHREEN FARUQI: Could you give a particular example?

Ms NASH: In the rehabilitation process, we do not have any public detox in the Clarence Valley. We do not have any detox services in the Clarence Valley. The three drug and alcohol positions we have in Grafton are currently vacant. We have got one drug and alcohol counsellor in Maclean. There are huge gaps.

Dr MEHREEN FARUQI: Training people the community to fill those gaps would be useful.

Ms NASH: Absolutely.

Ms MOORE: With my experience with people who sit on CDAT, they have quite strong opinions about this issue and hugely support the idea of having these services, mainly because if people want to get help it is really difficult for them to do that. If they want to get help as a family, as a couple, there are no facilities for that full stop. Your best intentions can be to get yourself well but the obstacles that you face to do that are huge.

Dr MEHREEN FARUQI: We are also hearing about the lack of facilities for women in rural and regional New South Wales and places where women can take their children with them. Do you think that is a big gap in terms of service provision?

Ms MOORE: Absolutely. Not only rehab services but also in domestic violence situations. If you have a male child over the age of 12, you cannot go to a refuge. You have to find a different solution, especially if you are someone who is addicted, who wants to get help and has children. I do not think there is anything for single women. There are a lot of facilities far away for men but not for women.

Dr MEHREEN FARUQI: With CDAT, I would like to know a little bit more. You said the main focus of the council at the moment is in mental health. What role does CDAT play in terms of mental health? What is its major role?

Ms MOORE: Their major role is to reduce societal harms of drug and alcohol. It is an initiative of the Australian Drug Foundation [ADF]. We are a community group. A lot of people who are members also work in services but they come as representatives of the community. We volunteer, we do projects. For example, the racing carnival that is coming up, they will be handing out information. At some of the youth events that we do, CDAT will hand out information and talk to the kids.

Dr MEHREEN FARUQI: About drugs and alcohol?

Ms MOORE: Yes.

Dr MEHREEN FARUQI: Is it more about harm minimisation as well?

Ms MOORE: Yes, harm minimisation and education.

Mr SCHRODER: Going back to mental health, the mental health initiative has done a lot of work with schools. The schools have got mental health plans about how they are dealing with kids. The reality is that the mental health theme, which is a good example, has moved through the whole spectrum. Although the education departments, which sit on Our Healthy Clarence at a lead level, are very involved in it. The issue is that there is this community-driven model, if you like, that has got a lot to go for it.

The CHAIR: I want to ask a question, reflecting on the evidence we have been receiving from the services provided by and through councils. At a council level, do you sometimes stop and wonder how it is that you got yourself into dealing with these issues now in such a comprehensive way when you look at what councils have done traditionally? It is quite extraordinary when you contemplate the range of work that you are doing around this area that, in the past, was never traditionally associated with the work done by a council in their local government area.

Mr SCHRODER: Yes, a comment on that. We have been going through the Fit for the Future thing and we have a special rate variation going through. One of the big things council has been doing is looking at what is core and what is non-core. In some ways these guys could be non-core sometimes, but they have survived. But, basically, that is the issue of core. It is roads, bridges, garbage.

The Hon. PAUL GREEN: Rates?

Mr SCHRODER: Sewerage, rates, rubbish, water, that stuff. We have had a bigger section in this area and there has been some cuts in our community development area, there is no doubt about that. Ms Nash is on half a week and Ms Moore is casual. That gives you an idea. We have definitely cut back in those areas. There are lots of other discretionary areas. We have had a big fight about galleries going on. Generally, the council has been right through its budget and trimmed what they call the non-core areas. They have still stayed in it in different ways. Our role we play is very strategic. We cannot be involved in the delivery and that is what these guys do.

The CHAIR: It was not designed to be a criticism but rather an explanation.

Mr SCHRODER: It is true and it is one of the big debates and council is seen as a go-to organisation to do something, do more and more and with less and less money to do it with. And other pressures like accounting for depreciation does draw away from other areas. To get our budgets balanced we have to account for depreciation and that makes a big difference, ironically, on the service you can deliver because you are doing joint accounting for depreciation. It is a big issue for councils at the moment.

Ms MOORE: I think we end up in that role as well because community members might need a little bit of help coordinating in the initial stages.

The CHAIR: As facilitators?

Ms MOORE: Yes, as support basically, community support. A lot of things can be kicked off and started, great projects. They need a helping hand at the beginning.

The Hon. BRONNIE TAYLOR: It speaks volumes about your council, does it not? Take the suicide issue for whatever reason, but there is so much stuff out there people do not know where to go so what did they do, they came and you have done this. I have raved on, but congratulations to all of you. You stepped up and created something that is working from the ground up. It embodies what everyone should be doing. People do not know. There are more non-government organisations and funded services out there. People cannot get the names right. I get confused because there is stepping up and stepping down and three quarters stepping around program. They have nowhere to go so they came to you.

Ms MOORE: You are absolutely right. One of the big roles we play is a simple one, it has been a directory of information.

Ms NASH: It is community driven, that is why it has worked. It is what they want and they are doing it for themselves, we have just acted as a conduit and introducing people and joining services and community groups.

Mr SCHRODER: What we also do is try to step out, try to step away, try to get it to a point where the community take over and help it to grow. Health has come in in a bigger way than they were before, but that again had to be pushed. I am not criticising them at all because they have pressures on their resources.

The CHAIR: Feel free to criticise them as much as you want.

Mr SCHRODER: Overall, we get the funding stream coming in and then the NGOs step in. We have the new school of arts called Theodore and they are doing fantastic stuff joining the hubs and they have more ability to pick up other resources and funding than we have. You are better off handing it over to an NGO, let them do the work because council is not good at doing that, and if you look a bit hungry as an NGO you probably get a bit more funding too. That is the model we work on. At the start we are the instigator and the communicator, we know where to go or know where to resource.

The CHAIR: Just when you did that mapping of existing services, what was your action when that task was done? Were you actually surprised by the fact that there was as much there that the community was unaware of, were there major gaps? What was the response? At the end of the day there are multiple services, perhaps in a smaller form and you had to increase the deal, what was the reaction to what happened? At least on paper there is a fair bit around?

Ms NASH: Yes, I think the process that they followed: The community meetings and gathering all the input, then the report and drilling that down into not even a four-page document, it is a two-page document that has five objectives and five strategies under each of those objectives that really shows where the gaps are and allows you to marry up what services are there to each of those different organisations.

The CHAIR: It is probably a productive exercise for many councils to do.

The Hon. BRONNIE TAYLOR: I am thinking, having read your work, that perhaps one of the Committee's resolutions should be when grants are given there has to be a proportion in service coordination—whether that goes to a different person to do it or for a longer term so people know where to go and people know where to find those services. What do you think about that?

Mr SCHRODER: It has some basis to it. Strategic stuff is always lacking. Just to do that work every time. If you are an operator dealing with mental health you have not got the time to do that strategic work. You need others to lift above the day to day and have the time to do the mapping, do the gaps and that is where council plays a role. Some other organisations can play a role, such as Health.

The Hon. BRONNIE TAYLOR: Someone needs to step up and play that role.

The Hon. PAUL GREEN: The buck stops with council because council is the grassroots. It does not matter whether it is State or Federal, council has to carry the community and it is good that you have a functioning community service. You are the catalyst, you bring the things together and release them to do what they are paid to do.

The Hon. BRONNIE TAYLOR: You are accessible.

Mr SCHRODER: We have been working hard on the Police Citizens Youth Club [PCYC] as well. If the government does the right thing and gives us some sports infrastructure funding we might even have one.

The Hon. BRONNIE TAYLOR: Get another plug in.

Mr SCHRODER: Plug, plug. We have identified the need, together with headspace, and we have been working away behind the scenes with the PCYC guys and if we can get that that is two more youth officers in town funded by the police command. They do a lot more than just the boxing that everyone epitomises PCYCs with. Again, it is another resource into the place which is long-term funded, sustainable money. That is what we try to work at. We have a council resolution to hand over the basketball stadium to the PCYC for not much, probably a dollar, on an arrangement with them that they look after the basketball teams that play there. It is to get the PCYCs in town.

The Hon. BRONNIE TAYLOR: Mr Schroder, I know you were at initial meetings for the country university centre that I was at, and a lot of things have come up about the ability to train people locally so local people can stay in the community but upskill their qualifications to fill service gaps. Do you think there is a real potential in terms of the drug and alcohol space and other spaces that if you were successful in getting that funding that would help the community with the establishment of one of those hubs?

Mr SCHRODER: Always. The country university is going pretty well. They are putting a report up to the mayor in order to get the development application fees for the new country university building which they have chosen. That will go up to this council meeting. I gather they are going to be putting it up. They have an architect working on the design to get half a million dollars funding available to do that. Education generally is trying to basically get education standards up and that education environment is crucial. What we lack too—I would not say intellectual capital—is that critical mass of people who can make a difference. The more university graduates you have they tend to take your community levels up. Basically, the more we can do that the better. That funding is another little piece along the line. I think our schools are doing great stuff. I think our schools are changing a lot. Their response to the mental health issues have come along. Anything that instigates more education, more jobs, keeps people employed, keeps young people locally—we still lose that 18- to 35-year-old sector, sometimes for good reasons, some of them go away and come back, but basically we are losing too many probably, although there is a bit of a change happening.

The Hon. BRONNIE TAYLOR: The other thing I was going to ask you—I suppose this is probably for you guys as well that have worked on that program—something we are trialling down in southern New South Wales is three school nurses. They are not the original sort of school nurse that people think of but the one we have employed in Young—they had similar issues to what you have experienced with youth suicide—he is a mental health worker but also a registered nurse and we have put him into the school for a two- or three-year pilot. I was wondering what you thought, from a service coordination perspective, to have school nurses based with a mental health focus in the high schools, whether that might have helped or potentially could help.

Ms NASH: We have got a youth advisory group here in the Clarence—Clarence Youth Action. I think any extra people for young people to talk to is going to be a benefit. I think a young school nurse—just seeing the way that kids have reacted to your youth advisory group and they come to them for information; they feel safe and comfortable coming to that group, and can then be directed to whichever service is more appropriate. I think that has shown that young people—

The Hon. BRONNIE TAYLOR: They trust.

Ms NASH: They will reach out if there is someone there that they can relate to, for sure.

The Hon. BRONNIE TAYLOR: Well done.

Ms NASH: A lot of other people have done a lot more.

The Hon. BRONNIE TAYLOR: Take the compliments while you can because, let me tell you, they do not come often.

The CHAIR: Thank you very much for coming along; it has been very informative to us for you to give us some very detailed perspective about the way in which a particular council has fronted right up to an issue which has been very challenging. It is a credit to yourselves as employees and officers of the council and the whole council itself for confronting and doing something about the issue. From the evidence that has been provided and from what we have heard generally speaking, you have had some real success in addressing some of the issues in the community.

Mr SCHRODER: I should have said before thanks for coming to the Clarence Valley.

The CHAIR: Following the reading of *Hansard* after today some of the Committee members may have some questions on notice relating to the evidence you have given. If any of those questions come forward the secretariat will liaise with you and the turnaround time to get answers back to the Committee is 10 days.

Mr SCHRODER: It just occurred to me that we might send you a copy of the Healthy Clarence document.

The CHAIR: That would be very good. I know that the Hon. Bronnie Taylor has had a long-term interest in this and knows it well but I have not seen it. You could provide a copy of that and any other information that you think might help us.

The Hon. BRONNIE TAYLOR: I did put it down for us to look at.

The CHAIR: Anything else that you think might help our deliberations would be greatly appreciated. Thanks for your great work.

(The witnesses withdrew)

JULIE PERKINS, Chairperson, Clarence Valley Aboriginal Healing Centre, Gurehlgam Corporation, affirmed and examined

JANELLE BROWN, Coordinator, Clarence Valley Aboriginal Healing Centre, Gurehlgam Corporation, affirmed and examined

The CHAIR: We will commence with providing you the opportunity to make an opening statement to set the scene and then we will share the questions around between the Committee members and drill down into the issues we want to discuss with you.

Ms BROWN: As I said, I am the coordinator of the Clarence Valley Aboriginal Healing Centre. The healing centre has been operating since about late 2013. We are funded by the Healing Foundation. We started with 18 months of developing a plan for the healing centre and then we were further funded by the Healing Foundation. Do you want me to talk more about the healing centre?

The CHAIR: A little bit about the foundation. Just set the scene for us and then we can launch into some questions.

Ms BROWN: The Healing Foundation was set up in 2009, a year after the apology to the stolen generation by the Labor Government. The concept of a Healing Foundation came from Canada where they were set up in early 2000 to assist the ex-residents of their residential schools, the First Nations people. Australia took that idea on board, as I said, in 2009 with the commencement of the Healing Foundation. The Healing Foundation then went on to fund several healing programs and healing centres Australia-wide, of which ours is one.

The CHAIR: Yours is located where?

Ms BROWN: This is located in the Clarence Valley, in Grafton. We service the five Aboriginal communities of the Clarence Valley, being Baryulgil, Malabugilmah, Grafton, Maclean and Yamba.

Mr SCOT MacDONALD: All physically here?

Ms BROWN: Yes. They are all located in the Clarence Valley local government area.

Mr SCOT MacDONALD: This building specifically?

Ms BROWN: This is the healing centre here. We are just one service of Gurehlgam Corporation, which is an Aboriginal organisation that is based in this building and has been in existence for 10 years. We rent this building from the Sisters of Mercy and we use about four rooms of the building and then the rest of the space we rent out. I can talk more about what services Gurehlgam provides and we will give you a tour later as well.

The CHAIR: That will be great. We are looking forward to it. Ms Perkins, do you want to add anything to that to set the scene?

Ms PERKINS: No, I will not. As I said, I am the chair of the corporation as a whole. I just want to let you know that my day job—although I am not here in that capacity as such—is as the regional and community engagement manager for the Aboriginal Legal Service, and I believe you heard from the Aboriginal Legal Service in Sydney on our behalf. I am also sitting on the community consultative committee for the new Grafton Correctional Centre, which we have heard about today. I have had about 20 years in Justice, qualified in law myself and spent many years working as an official visitor in Corrective Services, got a real passion about justice and holistic healing, as Ms Brown has mentioned. I have probably gone a little bit off the script because I have sat in most of the day. I am very passionate about this issue and have lots of things hopefully to share.

The CHAIR: The Committee will be asking you questions and if we are not getting to the nub of some of the things you would like to share, feel free to add that in so you can make the best presentation that you would like over the next 45 minutes to 50 minutes.

The Hon. PAUL GREEN: You have sat through a lot of the hearing today. We know there are many issues, but in your view what is needed to deal with drug and alcohol detox and rehab in this area?

Ms PERKINS: I could start off because I have been sitting in all day. I think a lot of the speakers today have covered things quite nicely. Certainly, as we have heard many times today, a lack of facilities in terms of the detox and also the rehabilitation for our youth, for our women and the follow through services, which I am really passionate about. Ms Brown and I talk a lot about that with the Indigenous Healing Foundation. It is very hard to sit here and generalise because there are a lot of different individual circumstances. But what I have found in my professional life, and also in my personal life in terms of a lived experience—I have some pretty serious issues within family with various addictions—is that there is a real lack of coordination of services.

You may have heard the Local Decision Making [LDM] process being mentioned today by the gentleman who spoke quite nicely from Port Macquarie. I also sit on the regional Local Decision Making teams as well for State Government for the community. I am not fully convinced yet—and I am not speaking out of school, I state this in my committee meetings as well—of the processes of that, only for the fact that it has been in operation now for some time and what we are seeing is a lack of coordination still of services. From my professional hat of working for 20 years within Aboriginal legal services, again there are many organisations that are funded at various levels, both Federal government, State government and also, to a lesser extent I suppose, the local government, who we just heard from.

When you are on the ground, when you are either in family or in community, as we are, there is quite a lack of coordination. There is a lot of focus at times on the major towns, when a lot of our smaller communities are left out. There is also a lot of outreach, which is said to be carried out, those smaller outreach areas that have all those problems that we know of, such as transport in other areas. I heard the fellow again say accountability and transparency and I really, really think that is what we really, really need to focus on. I really think the organisations that are being funded—and if that is the Aboriginal Legal Service, well that is the ALS— whoever we might be, we need to work together with the other people in the area in the regions that we are in to provide these services. They are very ad hoc. There is a real—in my opinion—lack of follow-through. I listened to the people—and it is very hard to sit here and generalise—I sat in this morning on NSW Health, and I am not here to bag individuals or individual departments because it is a hard row.

I have also experience where I have a very close family member who managed drug and alcohol rehabilitation services. I have got it from various angles. Certainly, we all need more resources. I do not think anyone would doubt that. Certainly, I think some of the models—in my experience again—could be worked out a bit better. I sit on the community consultative committee for the new correctional centre. There is promoted to be a focus on rehabilitation and I would certainly hope so. I hope so from my professional background, but I also hope so from my personal background, because we all know the level of incarceration rates of Aboriginal people.

I would have liked to have seen—again from a personal viewpoint—I do not know what you would call them, maybe rehabilitation wings, or health wings, or something like that in these new correctional facilities. I know they are going to have hospitals, I know they are going to have detox beds and things like that, but a real focus in that area would be great. I do get a bit annoyed that we always focus at the end result. I know this inquiry is about rehabilitation, because we are lacking it so much. I think we all have to work together, including community. That is taking our responsibility as well at the front end. I really wish we would do a lot more of that.

The CHAIR: Could you elucidate on that point about the front end and the community taking more responsibility? What specifically are you saying there?

Ms PERKINS: This is about rehabilitation. My service that I work for is about legal defence work, predominantly at a court level. We have argued for many years, even within my own service, to put more funds, when I say the front end, at things like proactive community legal education, community awareness and things like that. Assisting those people who need that help up front, early intervention type stuff that we have worked on with the healing centre, instead of being at the back end, whereby we are meeting people at the court door. We are meeting people at the jail.

The Hon. Dr PETER PHELPS: Not merely drug courts but stopping people from that first contact with the criminal justice system, is that what you are saying?

Ms PERKINS: Somehow breaking that circuit, somehow getting in so that the circuit does not even start. Somehow getting there. I have heard many people speak today about some really great proactive programs, but also taking—when I say taking, I guess we all come here with our own values in life and our own lived experience in life.

The CHAIR: That is fine, we all do that.

Ms PERKINS: Yes, whichever angle one takes is probably from your own learnings or your own life experiences. I am a believer that through our healing foundation we know all the intergenerational trauma that we have suffered as Aboriginal people. But a part of me also says that we all have to take responsibility for our own actions at times. I am not talking about blaming victims, because some people have mental health issues, and I am no expert in medical or psychological issues. There are people with mental health issues, there are people with a whole lot of reasons, but within ourselves too. I heard many people today say you cannot make someone go and do something, we all know that as a base system. But sometimes unless you look inside or help our other community members at a grassroots level on the ground, sometimes someone may be so traumatised they are not actually seeing that. It is not blaming the victim but it is taking some responsibility. I am in that sort of camp, I suppose you could say.

The other thing which I want to say is I did pick up the comments about education from one of the gentlemen about the system. I am not sure if it is being ruined. I am passionate about education and I think education is the key. I am not sitting here and I would never sit here and say it is a wonderful system, and I have two teenage children. But I think whilst ever we are trying to make change to that system, which may not be perfect, we must embrace education because the jobs out there, even for Aboriginal people who have been to school, been to universities, they are few and far between. I fully embrace education. I have personally always promoted the need to have a solid education because I think that gives our children opportunity. I am not saying that one system fits all. I have heard all the vocational information about that. I know the program that the gentleman is running at Port Macquarie and it is very good, but I would never sit and say that we do not need an education as such. That is a key to a future and a key to making sound education and choices in life because, as I said, even as people who have been through school we are still missing out on jobs. If we did not have that sort of formal system we would be even further behind the eight ball. I am very passionate but I will let Ms Brown talk about some of the healing stuff and what she thinks is needed.

Ms BROWN: I truly believe that drug and alcohol addictions, and a lot of the other problems that we have in our society and in our Aboriginal communities, are actually symptoms of underlying trauma, grief loss and trauma. For Aboriginal people, that grief loss and trauma, as Ms Perkins says, has been intergenerational. From the first arrival of Europeans we have suffered from this trauma. Over the years there has been a lot of money put into Aboriginal Affairs to help us overcome a lot of the issues that we have like drug and alcohol addictions, not just in the Aboriginal community but also in the mainstream community. But until we really look at that underlying issue of grief, loss and trauma these addictions will continue and we will be no further ahead. I believe that there should be more programs that are trauma-informed and that are looking at healing from grief, loss and trauma. As Ms Perkins said, preventative programs and early intervention programs are the kind of programs that our healing centre works with.

Dr MEHREEN FARUQI: Could you give us an example of a couple of those programs? For example, how does your healing process work?

Ms BROWN: We run a lot of our programs in conjunction with other services simply because we are not funded a real lot. We ran a program called Season for Healing, which was created by an organisation in Sydney called Good Grief. They run a number of programs like that, educational programs on grief and loss. The Season for Healing is an Aboriginal-specific program. We started to run that in the Aboriginal community and we would like to continue to do that but it is lack of resources at the moment like funding and staff. We also run other short workshops. Just recently we held the Red Dust Healing program. That was a one-day workshop and it was created by an Aboriginal man, Tom Powell. That was all about healing from an Indigenous perspective. Coming up soon we are going to partner with Rekindling the Spirit, which is based in Lismore, to run workshops on country around suicide prevention. They are called We-Yarn. They are funded by the primary health network. There are programs like that that we are looking to run all the time. One of our major programs that we have started to put in place is our Healing Garden. We are trying to set this garden up. I will take you down later and show you.

Dr MEHREEN FARUQI: It is beautiful. I went there during the lunch break and it is really gorgeous.

Ms BROWN: Yes. We are trying to set this garden up as a place where people can come together—there are a lot of socially isolated people out there, lonely people—where they can connect and start to continue that healing process. It is around Aboriginal culture as well because healing centres are based on healing for Aboriginal culture. In our Healing Garden we have bush medicine, we have bush tucker, we have native bees. I do not know if anyone saw the bees down there but I can show you later. We have a veggie garden that we are trying to get up and running as well. As I said, it is about Aboriginal culture but it is also about people coming together and healing. I feel that there should be more centres like ours New South Wales-wide, Australia-wide. It really is about that prevention.

To keep someone in jail for a year costs about \$300,000 or \$400,000. If there were healing centres dotted all around New South Wales or Australia funded \$300,000 or \$400,000 to run the preventative and early-intervention programs, maybe we would not see so many people in jails or so many people having to go to drug and alcohol residential centres. It really is looking at preventative and early intervention. It takes a long time to heal; it is not an overnight thing. You are not going to wake up next morning and you are all healed, hallelujah! It is a long-term concept so that has to be realised. I really think that the governments need to start investing in healing as a long-term commitment.

The Hon. COURTNEY HOUSSOS: I came to this healing centre during one of our previous inquiries into the Stolen Generations. One of our recommendations in that inquiry was for more healing centres. When this Committee visited Broken Hill somebody there said that drugs and alcohol—and a lot of people have said it again today—are a symptom of the problem and not necessarily the problem that needs to be addressed. This inquiry is

looking particularly at detoxification and rehabilitation services. You have talked about \$300,000 or \$400,000 being used for early intervention or specific programs for drug addiction. Do you have any specific ideas about programs that you might be able to run out of the healing centre?

Ms BROWN: There are a lot of different programs certainly that you could run like a lot of Indigenous-focused programs on country and camps. We could run the Getting Smart program here. We could sponsor an Indigenous Alcoholics Anonymous] or Narcotics Anonymous group and that kind of thing. The ideas about what could be done are really limitless. We look at healing as being such a broad concept. To us it is anything that is going to help the quality of life of Aboriginal people, individually or collectively. That could mean anything—a range of programs. These days we are approached by other organisations like the Red Dust Healing and We-Yarn programs. They come to us and say, "Would you like to partner with us to run these things?" We are always looking at innovative approaches.

The Hon. COURTNEY HOUSSOS: Ms Perkins, do you wish to add something?

Ms PERKINS: No. I was reading some notes and listening to people talking about specific detox programs. I know it is a general comment but, in my experience, the people I have known in a lot of communities and people who have come through the Aboriginal Legal Service, but also personally, the home detox program has not really worked that effectively. That is sad but true. We have heard a lot today that people present at hospitals and emergency departments with other issues and underlying that is some sort of an addiction issue. More and more in community the people we see presenting are—I am not up on all the medical terms—addicted to prescription drugs, all this pain-management stuff.

We see so much "doctor shopping"—for want of a better term. People are going into hospitals for something else—a toothache or whatever—and asking for the various pain medications. It has been my experience that home detoxification is not the best. Sadly, in a lot of our communities a lot of our people are living in very crowded conditions at home. They may not have a home. It is a very hard thing to do when you are in the midst of other things, because of the reasons we have already spoken about. We call it trauma, dysfunction or whatever in the home. So it is very hard for a person to be singled out—trying to detox in a house.

There are crises. There are usually crises everywhere. So the people are straight back into it. It takes a lot of strong will and a lot of support. Sadly, I think for many people—maybe not for 100 per cent—you have to remove them, at least for the period of the detoxification. One of the things that we are finding—it has been raised here by more of the experts—is that the rehabilitation process is not long enough. They come out of rehabilitation and because people are homeless, they are living in crowded conditions and they have nowhere else to go, they are back in exactly the situation they came from. They are straight back into it again.

I was talking earlier about taking responsibility here in my own family group and in my community. A lot of the time someone will come back out or come out of jail—maybe for the fifth time—and straightaway someone will say, "Come on, let's have a beer or a smoke," or something. That person will think, "It's only one." I sit before you but I have not been an addict, I do not think, of anything. I am probably fortunate in one way, and I probably do not understand fully what it is like to be an addict. I probably have a little bit of a tough stance, to be honest with you, with some of the members of my own family, because I have not experienced that. I have not walked in their shoes in that addicted state, but I have in terms of poverty, intergenerational trauma and all that sort of stuff.

It is hard, when you come back out and the first thing someone offers you again is exactly the same thing that put you into custody or wherever you were. That is what I meant by the holistic—the taking of responsibility. I am not a real fan. I have seen many people come out of detox and wash their medication down, to be honest with you, with cheap casks of wine. That is the typical drink of someone like that, sadly, if they do not have a lot of money. I do not know what a cask costs; I do not think it is much. It might be \$4, \$6 or \$10—who knows? I have seen that many times with addictions.

I have listened to the debate in ALS. I have looked at the debate, as well, about mandatory detoxification. I think we all know, in the learnings, that if you try and make people do things it quite often does not work because you have to have the mindset to do it. But then I see people so bad, and presenting so many times to the emergency department [ED]. I have seen it in the family. I have come over to this side of the fence a little bit, thinking, "What are we going to do?" I know you should be waiting on the person and providing all the support—some people may have experienced it in ALS—but some people may not come to that stage. So I do not know. What do you do? Do you go in and out of jail? We had a person who was, I think, five or six times in the ED in two weeks. Look at the ED side of it. We know our hospitals are overworked and run off their feet, in ED particularly. What do we do there? Do we just take up all the beds in ED? I do not mean to be nasty. I know that is the job of ED. I have my job. But how many times do we do this? Does it come to a point where you say, "I'm sorry, this is where you are going."

I have written a little note here because I have investigated this, but I do not know much about it. There is a centre called Bloomfield in Orange, in the west. My investigation has shown that it can be a mandatory place. It is a last resort. I do not know the facts and figures on that and whether it works or not. I am a pretty left wing person. I am not about taking people's rights away, or anything like that, but I wonder about this other side, because my professional role sees, over and over again, so many people coming in and out. I am sure the ALS would be able to give you statistics on drug and alcohol offences as the underlying cause, which is obviously the symptom of something else. In my own mind I am tossing up whether there is a point when something becomes mandatory. We mandatorily put people in jail. It gets to the point where you have done something wrong. We do not give anyone a choice, then. We do not say, "Would you like to go to jail or not?" We put people there. So if we put them there, why do we not put them somewhere else in the beginning? People do not like it—I would hate it—but we might be helping them longer term. Once they do something wrong we do not give too many people choices.

Dr MEHREEN FARUQI: That does not work, necessarily, either.

Ms PERKINS: Jail does not necessarily work either, does it? You can just go in and out.

Dr MEHREEN FARUQI: That is what I mean. I was talking about jail. It is a very difficult issue.

The CHAIR: Thank you for briefing us. It is a very challenging issue.

Ms PERKINS: There is not a simple answer, is there?

The CHAIR: There is the issue of alcohol as well. When we started this inquiry at least in my mind it was about drug rehabilitation, but what struck me from the very first hearing was the alcohol. It is alcohol and drugs. It was a very simplistic view that I had that drugs were the primary thing. Clearly alcohol is a huge component, which is directly linked to so many instances of addiction with respect to illicit substances. Whether one leads to the other or it is done simultaneously it does not much matter. It is a very big problem. We have talked about issues of the relatively cheap cost of alcohol and its accessibility.

The Hon. Dr PETER PHELPS: My question goes to the nature of culture. One of the earlier witnesses said that there is a problem in Aboriginal communities about seeking treatment, because of the shame it will bring on your family. Is there not also a counterargument that shame traditionally played a role in keeping people in line—you were not abusive towards older members of the family? This came through in the elder abuse inquiry, where Aboriginal people said that in the past it would be inconceivable because it would be a terribly shameful thing to beat up your mother, your aunty or your grandmother. Is there not a problem now in that shame, rather than a measure to keep people in line with accepted social norms, is used to stop people from dealing with those contraventions of social norms? In other words, we would rather keep it quiet than have the internal argument of, "That shouldn't be done in the first place."

Ms BROWN: I think so. That can be a reason why people do not seek treatment when they know that they need to. It is not just because of shame on their family but because it reflects poorly on them, and not wanting to share that with people. It would be a big thing to admit to yourself and to others that you do have a problem where you need to seek treatment. It can be a really shameful thing.

The Hon. Dr PETER PHELPS: Is that not where the family comes in? I just want to get back to something Ms Perkins said, which also correlated with what someone else said previously. I asked them about going back into the same environment that led to their addiction in the first place. "No, no," I was assured, "because you will have your extended family and the broader community keeping you on the straight and narrow." In other words, there was a re-emergence back into the community. Getting treatment was a trigger point, which then allowed you to slip back into the norms of your community. You seem to disagree with that and say that going back into the community can simply lead to a reversion, rather than a correction of your previous behaviour.

Ms PERKINS: Again we are speaking for the generalists. Every family does not operate the same. From my viewpoint, yes, there is that shame element. Some people will be ashamed to admit that they have got all these addictions and whatever. I think some people said before the judgement on them, et cetera, et cetera. But then in my experience both personally and professionally there are also many instances where, I think—and this is probably a bit controversial but I will say it anyway—

The CHAIR: You are surrounded by controversialists.

Ms PERKINS: Maybe you just get tired sometimes, I do not know, and have had a bad week too. But sometimes I think there are people—just generally, not everyone does this—who just use excuses. I have family members who do that so I am actually not talking about someone else's family but my own, who sadly just use it as an excuse. Sadly, I am talking about a very close person who says, "Woe is me. Woe is me." They have had a bit of a tough life, do not get me wrong about that. "Woe is me, so the thing for me is the alcohol." They will use

it as a bit of an excuse and will not come to terms with the fact that this whole exercise of what they are doing—the other thing here in all of this—is such a huge burden on family members.

I am sure everyone here has family. We all stand up. In our Aboriginal communities we always really back our families. They are our rock. That is our extended clan and all of that, but there is a huge burden on families. We take that on the chin most times. But I do not think that is fair either. I do not think that is fair. There comes a point where you have got a whole lot of people who are actually paid in organisations, paid in roles and I think too often it is put back on the family and they say, "You look after it. You take care of so and so". Hang on, of course we all do it for family but when does it stop over-burdening the family, when the family starts to get the stress. Then we end up needing the help because you become too stressed out as family or sometimes you are leaving your own family behind. You are not looking after your own children to an extent or spending enough time with them, or your partner, or whatever else you have got in life—your nan or something.

That is why I think that it has got to be a really coordinated effort. We talk about the truth in the healing process. There has got to be truth and reality. The truths go each way. The truths are that there has been all this intergenerational trauma, which we know, and we are still in the lowest socio-economic status in the country. But on the other side, the truth is we have all had traumas in our life, we have come from absolute poverty, but you have got to try something.

The Hon. Dr PETER PHELPS: But you are not addicts.

Ms PERKINS: I am not going to rely on government to look after me.

The Hon. Dr PETER PHELPS: That is the question. Some people want to claim a structural basis for all addiction. In other words, that the circumstances of Aboriginality in Australia—dispossession, removal from families, economic disadvantage—are inevitable triggers but you are living proof that it does not have to be that way, surely that is the case. Then the question is: Why were you not subject to those purported structural pressures towards addiction?

Ms BROWN: I think it is because we are all individuals and we react differently to different situations.

The Hon. Dr PETER PHELPS: Yes, I agree.

Ms BROWN: I remember seeing—I am sorry, I am going to refer to Facebook—something on Facebook and it really stood out for me. It was a little story about twin boys, they grew up, their father was an alcoholic and one of the twins was a teetotaler. He did not touch drink at all. They asked him why he did not drink. He said, "Because I watched my father growing up." The other twin was an alcoholic and they asked him why he was an alcoholic and he said, "Because I watched my father growing up." It is how you react to things. We might all be growing up in the one family but it is how you react, how you respond. So it is an individual response: it is a choice in the end. Whether it conscious or subconscious, in the end it is a choice.

Mr SCOT MacDONALD: The Chair alluded to it before and you just mentioned alcohol addiction being number one. I looked at Dan Murphy's during lunch. Clean skins there started at I think \$3.35 or \$3.95 and some of the spirits were about \$20. Earlier I asked a witness about the pervasiveness of liquor. We talked about Aldi now providing liquor. Has it changed or has it had any affect on the community?

Ms PERKINS: I do not know. Certainly I guess alcohol is more readily available. I noticed it in Aldi stores too, so it is probably readily available I suppose. Over the years all the hours and more bottle shops have opened up et cetera, et cetera. I think just think too sometimes it has become a bit of a socially—you know, because alcohol is legal and the others are not so much legal, apart from maybe a prescription drug given out correctly. The others are sort of illegal as such, their use or gaining them, but alcohol is a legal substance. It is cheap and legal and does just as much or more damage. I said earlier about taking responsibility as a group, like, culturally—I do not mean as an Aboriginal culture—times have changed and it is really acceptable. I went to a function—I will not say which function—and I was alarmed because there were people talking about government services. It was not a departmental function, it was a different function, there were people talking about government services. It was a function where all the young leaders—it was not Grafton—were being introduced as a leadership model.

That was wonderful in the day but that night, much to my horror, and I did send a stern letter to the people, there was free alcohol galore. What I saw was—not so much the older persons there who might have had a beer or a glass of wine, but all the youth leaders who were 18 to 20 at the maximum. Because the alcohol was free, or the beer and wine was free I think, there were lines of people just going back to the bar. People would go and get the free drink and it was lined. There were glasses and bottles lined up across the front of the tables. I was really disgusted and I put in a letter of complaint to the group that funded it because I thought that was really, really wrong. That is what I am talking about.

I have son at a function now who is studying and off to something—I will not say what again—and I was reading the agenda. He has just turned 18 a couple of weeks ago. I noticed on the itinerary thing—which is a formal thing—they had blah, blah, blah in the day and then the evening was all at the pub. I said to my son, "You know my rules." He is 18, but you know what I mean. I think in that sort of thing it is like a real thing until something goes wrong. When people have depression, like Ms Brown has talked about, there are underlying issues and you cannot stop or you feel good for the moment.

The CHAIR: It is quite endemic.

Ms PERKINS: Which I personally do not like but I am just one of many.

The Hon. BRONNIE TAYLOR: A very strong voice actually.

The CHAIR: Your comments this afternoon have been very detailed, thorough and insightful. Ms Brown, you have some leaflets there.

Ms BROWN: Yes, I have some leaflets to give you.

Ms PERKINS: There was a lot of discussion on Benelong. A person of mine actually worked there. That is just some facts.

The CHAIR: Thank you. We are in your hands now. It will be great to have a look around.

(The witnesses withdrew)

(The Committee adjourned at 3.21 p.m.)