

**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 Fountain Room, Lismore City Hall, Lismore, on Tuesday 26 June 2018**

**The Committee met at 9.00 a.m.**

**PRESENT**

The Hon. Greg Donnelly (Chair)

Dr Mehreen Faruqi

The Hon. Paul Green

The Hon. Courtney Houssos

Mr Scot MacDonald

The Hon. Taylor Martin

The Hon. Dr Peter Phelps



**The CHAIR:** I welcome everyone to the seventh hearing of the inquiry by Portfolio Committee No. 2 into the provision of drug rehabilitation services in regional, rural and remote New South Wales. The inquiry will examine a range of matters including the types of drug debilitation services available as well as funding, cost, and accessibility. The inquiry also will consider if there are any gaps or shortages in the provision of services. Before I commence, I acknowledge people from the Widjabul and the Wiyabal people of the Bundjalung nation, who are the traditional custodians of the land. I also pay my respects to elders, past and present, and extend that respect to other Aboriginal people who may be present later today.

Today's hearing will be the sixth regional hearing for this inquiry. The final hearing will be held at Parliament House in Sydney on 3 July. Today we will be hearing from two Aboriginal residential facilities, two drug and alcohol treatment facilities, and representatives from the Lismore Legal Aid office and the Lismore City Council. Before we commence, I will make some brief comments about procedures for today's hearing. The hearing is open to the public. A transcript of today's hearing will be placed on the Committee's website when it becomes available shortly. In accordance with the broadcasting guidelines, while members of the media may film or report Committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that you must take responsibility for what 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 you may make to the media or to others after completion of your evidence as such comments would not be protected by parliamentary privilege, if another person decides to take an action for defamation. The guidelines for the broadcast of proceedings are available from the Committee secretariat. There may be some questions that a witness could answer only if they have more time or with certain documents at 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 the Committee members through the Committee staff.

To aid the audibility of this hearing, I remind both 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 have a hearing difficulty. Finally, could everyone please turn their mobile phones to silent mode for the duration of the hearing. I welcome our first witness, Mr Parer.

**WARWICK MARTIN PARER**, Managing Director, Gunnebah Addiction Retreat, sworn and examined

**The CHAIR:** Welcome to the hearing today.

**Mr PARER:** Thank you.

**The CHAIR:** It is great that you have been able to make yourself available to attend. The submission from the organisation you represent has been received. It is submission No. 26. You can take it that the submission has been read, but we would like to invite you to make an opening statement to set the scene. After that, we will open the proceedings to questions from Committee members. Are you okay with all that?

**Mr PARER:** Yes. That is great.

**The CHAIR:** Please proceed.

**Mr PARER:** I will just give the Committee a little bit of history about me because I am fairly new to the industry. I was a captain in the Army Reserve. I was 15 years a lawyer. I have worked in finance, property, retail ship repair, and now in addiction rehabilitation. I have had a pretty diverse career. I have been married for 27 years and I have six children. In May 2017, my wife and I—my wife is a doctor—purchased the property which is now the Gunnebah Retreat. We opened it in September so we have been open only about eight months. I probably do not have the depth of knowledge of some of the other people who will appear before you, but I believe there is a benefit in that I do have a fresh set of eyes.

The point of my submission to this Committee is simply that, from what I have observed so far, I believe the private sector can better complement the government and not-for-profit sectors in providing residential rehabilitation services. However, at the moment the gap between the private sector and the other services is very large. My submission is simply to the point that if the Committee sees it as a benefit to find a way to close that gap, that would take pressure off the other sectors. We have capacity now and we could produce a lot more capacity but, as I said, the gap at the moment is a little big. I invite the Committee to consider funding rehabilitation on a per bed basis rather than on an overall cost basis. That may give the Government another way of looking at the way in which it allocates its funding. I believe the private sector can provide beds fairly quickly.

It has been a lot of work, setting up our first facility, but I believe that setting up a second or a third facility would be a lot quicker. I believe we are providing a very high-quality program. I believe that if the Government was to consider funding on a success basis, it would be a very simple administrative exercise, and therefore inexpensive. That is my basic submission. We provide a fairly intensive residential program at just under \$7,000 a month. That is very cheap. Probably the norm is closer to about \$10,000 a month and goes upwards from there. Put simply, if in some way the Government was to contribute to that—say, a portion of that—that simply closes the gap. We have many people who come to us and say, "I can't afford \$7,000 a month. I could afford \$2,000 or \$3,000 a month", something like that. We have capacity. The demand is out there. It is not being met at the moment simply because the gap between the non-government and the not-for-profit sectors is just too big.

**The CHAIR:** That is very good. I want to ask a question, which is not a trick question. You used a word that has been used by a few witnesses before the Committee, and it is about the issue of "success", and defining what that might be. Might I say that up to this point it has been a very slippery term. I do not mean that in any pejorative sense. People have not been trying to mislead or be unclear about it. Can I ask you, in your own words, to tell us how you define or measure success?

**Mr PARER:** It is such a loaded question.

**The CHAIR:** That is why I am up-front about it.

**Mr PARER:** I know it is not meant to be a trick question, but every organisation defines it differently and measuring it is nearly impossible. The simplest definition of success would be that, once someone gets treatment, they do not use that substance again. But then you add the other question: For how long? And what if they are using multiple substances? There is an incredible number of variables in that question. How do we define success? If someone is not using that substance again, then that is success, ultimately. But like anyone that you may know who has tried to give up smoking, for example, very few people give it up the first time. The first time might be a day and then they have one the next day, and the next time might be a week, and the next time might be a month, and then it is three months. After seven tries, ultimately they are successful. When someone comes to us, we are not sure at which stage that person is at—whether it is going to be their first one or their last one. That does not mean that the first attempt was a failure. It just means that that step was a step in that process.

Ultimate success is them becoming clean and sober. Failure really only happens when they give up. They are still in the process of trying to get sober and get off whatever it is they are on. As long as they keep trying and

getting back on the horse, so to speak, then I do not believe they have failed. If someone has been using heavily and gets off for three months and has not been off for three months in 10 years, and then after three months they lapse again, I find it hard to look at that as being a failure. But, is it ultimately success? No.

**The CHAIR:** I think that is a very fair answer.

**Mr PARER:** It is the best I can give you.

**The CHAIR:** I am grateful for that. I think that does set up some parameters.

**The Hon. COURTNEY HOUSSOS:** Thank you very much for your time and for your submission.

**Mr PARER:** You are welcome.

**The Hon. COURTNEY HOUSSOS:** In your submission you talk about a success payment.

**Mr PARER:** Yes.

**The Hon. COURTNEY HOUSSOS:** Given what you have just said, what would you then classify as success for payment?

**Mr PARER:** People staying in rehab would be the starting point because you cannot say with any certainty when they leave whether they are going to stay successful. At this stage, we are seeing that there is a big demand out there for residential rehab that is not being met. A lot of people do get into rehab and then do not stay there as well. If you were to have a simple thing that someone is in rehab for a month, then you get a certain rebate provided that, of course, the Government would have some sort of sign-off on the program. You cannot simply take someone in the doors and not offer them any services. That is the other part of my submission.

If there is some simple oversight such as the Government appointing a clinical psychologist and probably a doctor to oversee your program to see that you are using best practice—again, another difficult question to answer is: What is best practice? So if there was some sort of oversight of the program providing some level of industry-accepted service, then if you have got someone in for a month, some sort of rebate would come back. That way the Government would be paying only once someone had been in there for a certain period of time.

**The Hon. COURTNEY HOUSSOS:** How much data do you keep on your residents after they have left? Do you track them for a period of time?

**Mr PARER:** At this stage, 100 per cent.

**The Hon. COURTNEY HOUSSOS:** And for how long?

**Mr PARER:** As long as we need to. We are in touch with all of our previous guests who still want to be in touch. We have had a couple who have gone off the radar too, but we have only been open for nine or 10 months.

**The Hon. COURTNEY HOUSSOS:** Yes, I appreciate that.

**Mr PARER:** In that time we have had 350 people. I am in touch with all of them, except for two.

**The Hon. COURTNEY HOUSSOS:** Are you aware of this kind of success payment, for want of a better term, being used anywhere else in the country or in the world?

**Mr PARER:** Not that I know of. My thinking was simply to try to provide an easy system that would be an efficient way. As I said, it is all about the gap for me. We do not get any Medicare rebates. We do not get any private health cover. We do not get any other Government assistance at all; nor does anyone else in the private sector that I know of, unless you are a private hospital. Typically the private hospitals tend to be more short-term stays that probably are better categorised as detox rather than rehab.

**The Hon. COURTNEY HOUSSOS:** Do you provide specific programs for Aboriginal people?

**Mr PARER:** No.

**The Hon. COURTNEY HOUSSOS:** You have one program for everybody.

**Mr PARER:** Yes.

**The Hon. COURTNEY HOUSSOS:** Can you give a breakdown of what kind of drugs you are treating, or other issues?

**Mr PARER:** Seventy per cent plus is alcohol, often together with a lot of prescription medication— heavy doses of prescription medication. The other 30 per cent is a little bit of everything: marijuana, ice, cocaine;

you know, all the others put in. In a short period we have not had anyone with opioid addiction other than prescription ones. We have not had a heroin user through yet. But, as I said, it is a fairly small sample group.

**The Hon. COURTNEY HOUSSOS:** Do you put parameters on the people who are coming into your facility? Do they have to be detoxed and for how long?

**Mr PARER:** My wife is the doctor, so she can do mild to moderate detox. But if it is acute detox, we generally will get them to go to hospital for a medical detox beforehand.

**The Hon. COURTNEY HOUSSOS:** At Riverlands?

**Mr PARER:** There, or Currumbin Clinic. Often they are coming from interstate, so wherever their most convenient detox happens to be. We are not a medical facility in that sense. If we consider someone to be in danger in any way for the detox period, we say, "You need to get that sorted out first."

**The Hon. COURTNEY HOUSSOS:** What is your current waiting list?

**Mr PARER:** We do not have one. We are currently set up with about 12 beds. We have got seven occupied at the moment. We think our facility can comfortably go up to about 20 beds. It could go larger but my personal view is to get the best outcomes. If we go larger than that we will start to lose people in the system. Ultimately, I would like to open one more facility. I am very keen to open a juvenile facility down the track, if we can. I would rather open another facility and keep that personal treatment than get a bigger facility. That is just my personal opinion.

**The Hon. PAUL GREEN:** I am interested in the funding based on successful beds. You said you have had about 50 clients through. You do have any dropout? Are they included in those 50?

**Mr PARER:** We have had two people whom we have asked to leave because they were being naughty. We have had one who, you could say, dropped out.

**The Hon. PAUL GREEN:** I was in Wagga Wagga last week and it is not unusual that they drop out. They have had enough or they do not have the capacity to carry it, like you said, first time round, second time round, third time around. They build resilience, it seems, as they go.

**Mr PARER:** I imagine because we are a private facility and people are paying to come to us, they are a little more reluctant to walk out the door when they have paid the money. If we do not feel we suit someone, we will refund them any unused portion of what they have paid, so they are not forced to stay. It is a pretty pleasant place. It is not hard place to stay if they are committed.

**The Hon. PAUL GREEN:** I am not reflecting on where they are staying; I am reflecting on the behaviour matters of the drug-addicted person or substance-abusive person. The boundaries and the ability to give themselves to something is usually quite hard when they are vulnerable.

**Mr PARER:** We have had one person—

**The Hon. PAUL GREEN:** I understand that being a private practice you can pick and choose, which is why you get a good success rate. That is not a negative thing, by the way. It is saying, "I know that we could add something to the presentation and maybe see some success". In terms of the cost, can you take the Committee through that a little bit? Before that, where do the clientele come from?

**Mr PARER:** I wish I could answer that. It is not an easy question.

**The Hon. PAUL GREEN:** Just loosely to give us a catchment.

**Mr PARER:** General Practitioners, psychologists, other drug services.

**The Hon. PAUL GREEN:** Local or far and wide?

**Mr PARER:** We get people from Melbourne, Sydney and Brisbane—east coast. I would say we have had only east coast people so far. Yes, medical professionals, psychologists, drug service people and Google. People find us on the internet.

**The Hon. PAUL GREEN:** Can you walk the Committee through the costing? One of the things that we find is that some of these facilities cost a lot of money. Mum and dad will sell the farm to try to get their loved one into a facility. I would not mind a bit more evidence on what the costing structure looks like. Can you walk us through why it is unaffordable, because I think that is a really important point.

**Mr PARER:** I saw a few things in the media recently. The Queensland Government has just announced that it is doing a 42-bed one in Rockhampton for \$14.3 million, that is \$340,000 per bed—establishment cost plus the ongoing running costs. We set up our facility for \$1.5 million. As I said, it is 12 beds at the moment and it will

go up to 20 fairly easily without much additional cost. It works out to be \$230 a day to come to our facility, so \$6,700 a month. Plus we have a \$1,500 booking fee. What else would you like to know, as far as costs? That is all-inclusive. That is medical care, all their psychology, all their activities, all their meals, all their accommodation. It is all-inclusive.

**The Hon. PAUL GREEN:** How long does the program go for?

**Mr PARER:** We have a minimum of 30 days. Our program is not a set program in the sense that you have to do steps one to 10. We very much treat people as individuals and they always have a pretty unique journey in. Even what they are using is usually unique—a combination of things. Whatever trauma or reason they have for doing what they are doing is unique to them. They are unique in and we take them out uniquely as well. We have some group therapy but we have a lot of individual therapy.

**The Hon. PAUL GREEN:** What is the average time a person would stay at your facility?

**Mr PARER:** Sixty days for most people.

**The Hon. PAUL GREEN:** That is \$12,000.

**Mr PARER:** Yes.

**The Hon. PAUL GREEN:** Your brochure states it is world-class, highly qualified, which is all good, and then it says that the team provides the latest evidence-based practice in addiction treatment. Can you tell the Committee what the latest evidence-based treatment is?

**Mr PARER:** We are not wedded to one particular treatment. We are not a 12 Steps program, but we support 12 Steps and offer 12 Steps. One of the things that I have noticed, being new to the industry, is that the success rates are not great but people tend to be wedded to their particular program or their particular theory, whether it is 12 Steps or one of the others. Because we are trying to individually tailor the program we are trying to expose people to as many of those things as we can and then let them identify which one works for them. Dr Porter, who is our clinical director, is world renowned for what he does. He still lectures all over the world. He is well published and he has a very open mind as to where rehab treatment is going. We basically are watching all the time what is happening. If something is working here, we will try that. If that is working, we will try that. So we see it as an evolving, open process, rather than being wedded to one particular theory of rehab.

**The Hon. PAUL GREEN:** You talk about per bed funding rather than the other model, which was something different.

**Mr PARER:** Excuse me if I am not up to speed with the whole industry funding model, but the impression I get was that organisations get a certain amount of money and then do their best with it.

**The Hon. PAUL GREEN:** The reason I ask is in the public model, we can write cheques until the cows come home—this is the problem. You have used an example in Rockhampton in which something was built for \$14.3 million whereas you have done it for \$1.5 million. We really should be looking at what is the cost per bed. If you do a cost per bed in the public system, people do not have the ownership necessarily of their addiction and their behaviour, so they leave. You can have 12 detox beds and have a line-up like nothing else, but the client coming in might stay for five minutes or might stay for the whole program. The funding follows the client, not the bed.

**Mr PARER:** Right. As I said, I am not quite—

**The Hon. PAUL GREEN:** No, my point is that if you fund the bed, you have more drive to succeed.

**Mr PARER:** I certainly do not, in any way, see what I am proposing as any sort of criticism of the public system or anything like that.

**The Hon. PAUL GREEN:** No. You are giving evidence. Believe us, we have been through a few now. Your model is different to other models. We want to drag as much information out of you so that when we come to write recommendations, we are writing good recommendations.

**Mr PARER:** On a simple day-to-day practical sense, we are seeing people who want to come to us but cannot afford \$7,000 a month. If it was a smaller part of that, if we were partially funded—as I said, on a success basis or something like that—then that would help us close that gap. If we close the gap, there is a much broader group of people that we can help. That is whole point of my submission, if we can somehow close that gap, because we do not get any private health cover. We do not get anything from anybody basically. It seems that there is the public-funded system which is part of your Centrelink payment or whatever, and then there is this huge jump to \$7,000 a month. My whole point is if we can somehow close that gap. I do not physically know how

we can do it any cheaper than we are doing it, because at \$230 a day with everything we put in there, it is incredible value for money. But \$7,000 is still a lot of money for a family that is battling with addiction.

**Dr MEHREEN FARUQI:** In your submission you say there are a number of people currently using public rehab who would like to go to a private facility. I am wondering what the basis of that is given that you have said that public facilities are pretty good as well. Unless they are on a waiting list, why do you think people would like to go to a private facility?

**Mr PARER:** I have no experience with public facilities. I cannot say they are good or not good because I do not have the experience. The people that come to us have often been through other facilities beforehand and for whatever personal reason they have decided they want to try something different. They see our facility and they say, "I would like to try that", but then simply say they do not have the money. That is the only experience I can pass on.

**Dr MEHREEN FARUQI:** Correct me if I am wrong, but you said earlier that for 70 per cent of the 50 patients that have been through your facility that alcohol was the substance of abuse?

**Mr PARER:** Yes.

**Dr MEHREEN FARUQI:** The remaining 30 per cent was mostly prescription drugs or were there other substances as well?

**Mr PARER:** Prescription drugs seem to be involved with almost everyone that walks in the door. Sometimes they are a problem, sometimes they are not such a problem, but they all seem to be on something. The other 30 per cent I would say it is a blend, whether it is cocaine or marijuana. But, often it is more than one thing at the same time. Most people do not just use one thing although often it is just alcohol. A marijuana user might use ice occasionally or vice versa and the marijuana smokers will often mix that with tobacco. It is a bit of a cocktail and you throw the prescription drugs in there as well. Very rarely is it clear cut that there is one problem, and then you throw in the mental health issues on top of that. It is a bit messy.

**Dr MEHREEN FARUQI:** You talked a little bit about the demographics of the people you see, which are mostly from the east coast. What about the gender, is it mostly men or women, or do you take under 18s as well?

**Mr PARER:** We would like to take under 18s, but our clinical director who has 30 years experience in this space says it is very difficult to mix a 16-year-old with a 60-year-old in a group therapy session and get any sort of connection. Our clinical director and one of our other counsellors both have juvenile—juvenile is probably the wrong word—youth experience. They said they are very specific and they need to be handled in their own peer group or it just does not seem to work. We have had quite a bit of inquiry from under 18s and we have just had to say, "Sorry, we cannot help you".

**Dr MEHREEN FARUQI:** What is the current break down gender wise and age wise?

**Mr PARER:** Gender wise is interesting. It is male-dominated—two-thirds male to one-third female. Interestingly, the feedback I have from our clinical director is that women find it hard to get to rehab because they have children, so going to rehab when you have children is really hard. We have a woman applying to us at the moment who has a young baby and we are trying to accommodate her but it is tricky. We will have to almost find her a separate accommodation section because if we put her in the main accommodation and the baby is up at night it will throw the whole group into a bit of a spin.

**Dr MEHREEN FARUQI:** That is what we have heard from many people, that women often need a facility where the children can come with them.

**Mr PARER:** My goal ultimately is to open several facilities. Not necessarily that demographically diverse because people are happy to travel a little way for rehab—mostly, not always. Our choice would be to open a boutique demographic—say you do one for youth, one for women with children, and so on. It all depends on how things happen.

**Dr MEHREEN FARUQI:** In your submission you said that too much government oversight could outweigh any financial incentive. Another submission said the opposite, that there is not an accreditation system for private operators and there is very little government oversight. Could you expand on that? What oversight do you have?

**Mr PARER:** I would actually agree with both those statements. At the moment there is almost zero regulation. Anyone can go and hang up a sign that states "we are a rehab" and they are a rehab. From that point of view it does seem a little bit scary and certainly one of the core reasons we got into this is my wife and I were a little bit concerned about the fact that it was so unregulated. I do agree some broad industry regulation is a good



idea. As I have said in my submission, any oversight should include at the minimum a clinical director and a doctor being part of the program in some sort of sign-off capacity. The other side of it is that my experience from working in a few government departments over the years—my primary goal here is to see that gap closed and if any funding package was put in place that involved a large amount of bureaucracy, for want of a better word, that would consume any financial benefit, or could consume it fairly quickly and defeat the purpose.

We are certainly not concerned about anyone looking at our program from a clinical perspective. We are doing our absolute best and we are doing a very good job of that side of it. I am also aware that if too many layers of paperwork are put on top, it kills it. That is part of my submission, that success-based funding would make it easier rather than getting government involvement from the beginning. We were able to set up our facility quickly and inexpensively because we did it ourselves, and the whole program. If we say, "Here it is and if it is okay can you help us with the funding?" then that is very much faster and more efficient than from day one getting levels of government involvement in picking the location and so on. We are happy to be under scrutiny but let us get the job done and then scrutinise us rather than scrutinise us from the beginning and all of the good intentions disappear in paperwork.

**Dr MEHREEN FARUQI:** It could be different for different operations?

**Mr PARER:** Absolutely. All we are trying to do is complement the existing system by closing that gap.

**Dr MEHREEN FARUQI:** My last question is about your structure. Is there a board?

**Mr PARER:** We are only a small organisation, it is me and my wife and we have a clinical director, two other counsellors, a cook and a few other miscellaneous staff members. We only have a group of about seven at the moment.

**The Hon. Dr PETER PHELPS:** Is there literally no available rebate from private health insurance?

**Mr PARER:** Not that I am aware of. Our friends, I read, from the Byron Private Holistic Treatment Centre made a submission about that. I do not have a lot of experience in that area but I do know at the moment it is not available unless you are a private hospital. We have looked into it. I have approached the private health insurers to see if we can get a foot in the door and I got my foot slammed. I am not sure why because I would have thought it was good value for money at \$230 a day compared to hospital costs.

**The Hon. Dr PETER PHELPS:** They are too busy offering free movie tickets.

**Mr PARER:** Perhaps. I have had a look at the American system. The satirist John Oliver did an article on the American system where they get private health cover and it has become a bit of a feeding frenzy. I do not know where the answer is on that. It would be great if we do get private health cover because most people we get in the door have got private health cover, they just do not get any funding to come to us.

**The Hon. Dr PETER PHELPS:** In relation to your light touch regulation recommendation, do you envisage a situation where independent government doctors or psychologists will say this is a potentially valid program rather than saying you must follow a particular program?

**Mr PARER:** The diversity of treatment out there for addiction at the moment is pretty wide. It is very hard to put a rubber stamp on it and say this is the way it should be done.

**The Hon. Dr PETER PHELPS:** You do not want to get into a situation where, for example, you have an education of mandating certain things must be done as opposed to saying as long as you present a viable option for treatment the Government will recognise it and fund it accordingly.

**Mr PARER:** I think because of the lack of other regulation at the moment having some professionals involved in the sign-off of the program is really important. That is why I think having a clinical psychologist and a doctor involved in some capacity in any program proposal should be done so that it is not too far left of field.

**The Hon. Dr PETER PHELPS:** Just in relation to the proposed co-payment from the government, would you expect that this would be a replacement model for existing beds across the State so everyone moves to a system of a set figure per bed per month of treatment?

**Mr PARER:** That is way past my pay grade. That is what you guys are doing. All my proposal is what I see on a daily basis, which is this gap that I would like to see closed. If that is what the Committee wants to look at as a broader proposal that is your prerogative. I am just saying we would like to help a little more, and we have capacity. I think there is potential investment out there if we could see some sort of partial funding capacity but at the moment it is a pretty tough gig.

**The Hon. BRONNIE TAYLOR:** Thank you so much, it has been fascinating, and good on you. What an amazing career to then go into what you are doing.

**Mr PARER:** I think it is called a mid-life crisis.

**The Hon. BRONNIE TAYLOR:** We all have our different medicines for that. It has been very interesting to listen to and to read. I want to flesh out a bit more what my colleagues have said about the incentive payment, or whatever you want to call it. To put it in real terms, say I am coming to you, I might have \$2,000 but I do not have the rest for the first month and you turned to me and said, "Bronnie, if you're prepared to stay and stick it out you can have that place for \$2,000 and then the Government will pay the rest, but you have to stay. If you don't stay you don't pass that point, and that's it. Is that what you mean?"

**Mr PARER:** No. What I mean is that people have to pay something and at the moment we are at \$7,000. Let us say it was \$3,500. For someone with addiction, or a family, that is still a lot of money. If they paid that money they do not want to blow it, they do not want to lose it, even if it is something—there is a level of financial commitment there that they do not want to walk away from. I am not suggesting that we are ever going to get 100 per cent of people to stay there, but if you can imagine we are sitting at 95 per cent or something like that at the moment, and for those 95 per cent of people we get a rebate from the Government at the end of each month they stay there. That makes a huge difference to our funding model. It will not be 100 per cent. Obviously there is an incentive for us to keep them there, which is what the Government wants ultimately, anyway. We want people in rehab beds.

**The Hon. BRONNIE TAYLOR:** That is what I find. It has made me think about things a little bit differently hearing your evidence today too because the responsibility is on the person but it is also on the provider, is it not to say, "We don't want you to walk away"?

**Mr PARER:** Yes, and ultimately I think everyone is aligned on that. That is what the Government wants, that is what we want.

**The Hon. BRONNIE TAYLOR:** I guess too after hearing this evidence as well, there is no one fit, as you said so eloquently. We have got to be brave enough to try to do things because we want better outcomes, because, let us face it, what we have got at the moment is pretty disappointing.

**Mr PARER:** It is tough.

**The Hon. BRONNIE TAYLOR:** I know it is only a thought you said and that you spoke to your clinical director who had experience in under 18s. Factually, we have a really big problem out there with our youth and substance abuse of whatever form. Do you think that perhaps if Government was brave to try something a little bit different and looked at providing funding for providers such as yourself to run a facility specifically for under 18s that is available to everyone, regardless of gender or anything else—I know you said that before, but are you serious about that?

**Mr PARER:** Yes. The critical part there is the Government's commitment. If the Government said we are going to try this for six months and see how it goes, I am not going near it because I am not going to spend the time and money to invest in a new facility and so on. You would want to have a medium-term commitment to a program like that. So if the Government said, "Yes, we want to do it and we are going to do a five-year to 10-year program, then it justifies me taking the risk of finding a facility, buying or leasing a facility, setting it up, putting the program in place, employing all the staff and doing all of that without any sort of assistance other than knowing the program is in place.

If we know the program is in place and there is a clear commitment that is not overcomplicated, then we can say: Okay, if we go to Dubbo, or wherever it is, and we set up a youth facility and we are going to get X dollars per person that stays there per month. You look at your numbers and you say: Okay, we will make that work. But if it was seen as being a trial or something like that as a private facility, we would just say, "We can't go there. It's too risky".

**The Hon. BRONNIE TAYLOR:** From a business perspective then, if they are able to say to you, "We are going to run a five-year trial"—imagine if we got bipartisan support or something and we could actually do something—would you be willing to invest in something like that?

**Mr PARER:** I am doing this for multiple reasons. One of them is I am a business person and I see this as a way of feeding my family. But also we are doing this because we want to do something that matters. I am wearing two hats. If I just put the business hat on, you go where the demand is and you go where the funding is. If we saw that demand was in the central part of the State and the funding was there to do it and the funding model was simple and achievable, then we and a number of others would probably look at it and say, "Okay, let's go there. Let's do this, let's do that." That is what business people do.

**The Hon. BRONNIE TAYLOR:** A lot of what we have heard and a lot of evidence suggests that there is a lot of effective communication between government organisations and non-government organisations and that

people get lost in the ether because all the departments are not talking to each other or the agencies are not talking to each other. We saw a situation in Clarence with youth suicide where people did not even know what was available. How do you find that communication between your private organisation and when you, say, refer on afterwards or you receive referrals?

**Mr PARER:** As I am new I am not as connected as Dr Porter is and the other counsellors we have got. They have been working there for over 30 years—everyone seems to know everybody in a clinical sense. They all seem to talk to each other on a regular basis and just catch up. As far as the services at a service level, I do not know. We run our own show; we are outcome-driven and we are just doing our best on our own resources at the moment. Because we are not part of the system as such, we just keep an eye on what is going on in our local area. We refer people to support services in their area when they are done with us; so if they are from Sydney we will find a good psychologist they can talk to down in Sydney and make whatever connections we think they need when they leave us, but that is as far as our involvement goes with the service sector.

**The Hon. BRONNIE TAYLOR:** You keep contact with your—

**Mr PARER:** As much as we can, with our guests—we call them our guests.

**The Hon. BRONNIE TAYLOR:** Patient, client.

**Mr PARER:** There is no good word, but we call them guests. We keep in touch with them.

**The Hon. Dr PETER PHELPS:** Can I just follow up on that? What is the sort of level of post-release follow-up you do? Do you have a standard post-release follow-up once they are back in the community?

**Mr PARER:** Again this is going to sound like I am ducking but I am not, we have some people that were with us seven months ago that I still talk to on a weekly basis and we have other people that walked out the door and said, "Don't call me, I'm done with this." They have shut that door in their life and they just want to move on and forget that ever happened. I have had two people who have done that and they are still absolutely clean and sober but they do not want to hear from us because they have said they have closed that door and they have moved on. So it is individual. Some people just want to keep in touch and other people need much more support in a clinical sense and we talk to them about how they are going.

**Mr SCOT MacDONALD:** Can I ask a technical question first. Did you get through planning? Was there a planning requirement to build this?

**Mr PARER:** The facility we took over was an existing yoga retreat; it had an approval for tourist accommodation. We do not see ourselves as a medical facility; we see ourselves as an accommodation facility. From a town-planning perspective, I did go through town planners and they looked at the zoning and said we should be okay with that zoning. We were lucky in that respect that the town planner we employed said that the existing zoning should have been suitable for our purposes.

**Mr SCOT MacDONALD:** That is Tweed Shire Council?

**Mr PARER:** Yes.

**Mr SCOT MacDONALD:** Looking at the people you have got on your staff—Dr Joel Porter, Dr Jennifer Parer, you have other people with various degrees. We have come across some, I guess you would say, well-meaning NGOs, and there might have been one person with qualifications or skills surrounded by a lot of well-meaning people, either paid or unpaid, because there are people doing a lot of unpaid work. Are people getting what they are paying for? There look to be a lot of skills there, experience, qualifications, that sort of thing.

**Mr PARER:** In our facility?

**Mr SCOT MacDONALD:** Yes, people making their choice.

**Mr PARER:** I hope so. I am always going to answer yes to that question, am I not?

**Mr SCOT MacDONALD:** What I am trying to get at is that the contrast is pretty stark between some of the more community-based organisations. It is almost like night and day. Is there also a gap in terms of delivery and quality? Did you identify a quality gap?

**Mr PARER:** Part of the reason that we went into this is that—I do not know if anyone here saw it, "Rehab Inc." on *Four Corners* a few years ago? Write that down. You guys should really watch it. It is the reason we went into this. It was a *Four Corners* program, talked about the complete lack of regulation.

**Mr SCOT MacDONALD:** Anybody can put their shingle up.

**Mr PARER:** Yes, and it talked about there are some operators out there that are really dodgy and just taking people's money because of the lack of publicly funded beds available. My wife and I watched that, and that was probably one of the key reasons we actually went into this. I think we are well resourced because we are private, so we can put our money where it matters. We certainly got lucky with Dr Porter, but the other counsellors we have are excellent as well. We are very outcome driven. I am not sure how I can quite compare that to the other services, because again I do not have the personal experience. We are just trying to get the best people we can to do the best job we can, in the shortest time we can too. Having said that, you cannot rush some things and we are finding the longer people stay the better results they get. Overseas experience seems to push three months as being a good period of time. I know a lot of the public system ones go for nine months, 12 months.

**Mr SCOT MacDONALD:** Do people rate you? Is there a Trivago for drug rehabilitation?

**Mr PARER:** No, is the short answer.

**Mr SCOT MacDONALD:** Not yet.

**Mr PARER:** Not yet. There is one out there called Rehab Reviews, but we have not been able to get on it for some reason, I do not know why, there is something a bit funny going on there.

**The Hon. COURTNEY HOUSSOS:** In your answer to the Hon. Dr Peter Phelps you said that you have weekly contact with some people who were with you several months ago. Is there a therapeutic component to that, or is it just purely administration?

**Mr PARER:** No, it is not an administration thing. For us, part of the service we provide is to just keep in touch with people as much as they want us to as long as they want us to. It is really not that big a deal. For most of them it is a text message once every week or two just saying, "How are you going?" If we get a response saying, "I'm struggling, I'm having real difficulty," and so on, then that goes straight back to one of our counsellors and they then get onto them and say, "Hey, what is going on?" But most of the time they are coming back and saying, "Yep, all good." Or, "I'm in Bali, I'll talk to you later," or whatever their response is. I sent all of the messages yesterday. I got two responses that were a bit of a concern, the rest of them said, "No, I'm on track, I'm fine." It sounds like a big deal but it normally is not. Where the follow-up is needed, we provide that follow-up and see how they are going. We have had a couple come back a second time. I expect that will be normal. But when they come back a second time they sometimes do not need to come back as long. It might be just a top up, effectively.

**Dr MEHREEN FARUQI:** Is there any way of knowing how many private operators there are in New South Wales? There is no register, given that there is no real process of accreditation.

**Mr PARER:** I have tried to do a list myself, but I am sure I am missing a couple.

**Dr MEHREEN FARUQI:** It is just through Dr Google.

**Mr PARER:** Pretty much, yes.

**Dr MEHREEN FARUQI:** Is that a concern or should that be a concern?

**Mr PARER:** I did a lot of looking into it when I was setting this up because I did not know whether the demand was there or whether it was oversupply and that sort of thing. There are not a lot of private operators out there, genuinely private. You have got your private hospitals, and there is some pretty extreme diversity there. You have got some that are very expensive, and they provide a fantastic service. And you have got some that are very left of field, if you want to call it that, and provide some very unusual services. Then you have got some religious ones. It is pretty diverse. But as far as an actual register, I have not found such a beast.

**Mr SCOT MacDONALD:** Do you see a role for government looking at quality?

**Mr PARER:** Yes, absolutely. There is no control at all at the moment. I could be a landscape gardener and decide I am a rehab clinic tomorrow.

**The Hon. Dr PETER PHELPS:** But it still is light-touch regulation, and that is because an institution is offering a viable program, not necessarily a government-mandated program.

**Mr PARER:** Yes, absolutely, because of the diversity in treatment theories out there at the moment.

**Dr MEHREEN FARUQI:** Is it light touch or is it you do not want over regulation? You want to be able to do your job, but still have some basic level of accreditation.

**Mr PARER:** Sure.

**The Hon. Dr PETER PHELPS:** You do not want public health officials saying you have to use a 10-step program.

**Mr PARER:** No. With the low success rates at the moment, that would be insane. We have to be trying different things so we can get some—

**The Hon. PAUL GREEN:** We do not have enough beds as it is.

**Mr PARER:** That is right.

**Dr MEHREEN FARUQI:** But that does not actually happen—and correct me if I am wrong—even with organisations that receive government funding, such as the NGOs that we have looked at, the government does not stipulate to them that, "This is the 10-step program that you have to follow." On my understanding that is not the case.

**Mr PARER:** Not in this field at the moment. The only thing that seems to be any sort of evidence that people can rely on is the longer people are in treatment, the better results they get. That seems to be the only sort of hard evidence out there as far as what works and what does not work.

**The Hon. PAUL GREEN:** That is the other point, we constantly say hurt people hurt people and healed people heal people. Sometimes the healed people do not have the qualifications that regulation would try to put on them and that important factor of them being able to help someone to heal is missed. We have to be careful with this, it is not one size fits all. Basic regulation would ensure that people who are asking for money for their services are delivering those services.

**Mr PARER:** And they have some sort of internal oversight themselves.

**The Hon. PAUL GREEN:** Accountability.

**Mr PARER:** So that there is someone in there, it does not even have to be a full-time staff member, but whoever designs their program and signs off on their program should have some level of qualification.

**The Hon. PAUL GREEN:** There has to be some sort of medical qualification.

**Mr PARER:** Yes, because at the moment there is nothing.

**The CHAIR:** On behalf of the Committee, thank you for coming along.

**Mr PARER:** Thank you for listening.

**The CHAIR:** This has been the Committee's sixth public hearing outside Sydney and it is the first time we have been presented with evidence such as this about a private provider and the work that they are doing. It has been very insightful. You have provided us with information about your organisation. May it continue to do good work for the people who need it.

**(The witness withdrew)**

**KYLIE BEATTIE**, Director, Byron Private Holistic Treatment Centre, sworn and examined

**DAVID BEATTIE**, Business Owner, Byron Private Holistic Treatment Centre, sworn and examined

**GARY THOMAS**, Director, Byron Private Holistic Treatment Centre, sworn and examined

**The CHAIR:** Thank you all for coming along today. The Committee has received your submission, which is submission No. 13 to this inquiry. Would any or all of you like to make an opening statement? In that statement it is not necessary to go through your submission again as the Committee has read it, rather I invite you to set the scene for some questioning by the Committee.

**Mr THOMAS:** I will make a very brief opening statement. I commence with an apology from David Godden, our clinical director. David submitted our documentation. Unfortunately, he is overseas. However, he had made such plans prior to today's proceeding.

**The CHAIR:** That is fine.

**Mr THOMAS:** Nonetheless, we are here and we appreciate the opportunity to be before the Committee. We, like the gentleman before us from Gunnebah Addiction Retreat, are representing a private institution, a for-profit institution. It is one that we feel plays a very significant and successful role in the treatment of drug and alcohol addiction in our area. We have been doing so for quite some years now with a distinguished, well-qualified team, run within a quality framework. This has tracked some very outstanding outcomes relative to a range of other institutions, both public and non-government organisations. In that context, we are not so presumptuous to think that we have a strong or instructive view on the allocation of public funding in the array of areas in which one could put that.

We do, however, think—as we observed the Committee discussing with the gentleman prior to us—that it is important in a regulatory framework, were there to be one developed in our industry, that the support of our private for-profit style of operation is fostered provided that it is done in a professional manner. Of course overregulation could, as the previous gentleman mentioned, be a source of concern for operators like ourselves. Equally, the public should be protected from operators that are unscrupulous and lack the professional staffing and framework within which they operate. Thank you once again for letting us appear and we welcome your questions.

**The Hon. Dr PETER PHELPS:** I note in your submission that because of the nature of the treatment you provide that you are unable to access private health insurance rebates, yet the Government will provide full treatment for veterans. It seems to be an unusual situation that the Government recognises the legitimacy of your treatment in relation to returning service personnel but not to ordinary members of the public.

**Mr THOMAS:** A point well made. It is perhaps an anomaly. We did make a submission to what was the creation essentially of a panel of operators that would be able to provide services for Department of Veterans' Affairs [DVA] clients. We were unsuccessful in that, essentially because our service is a private operator. That said, it was observed, we now understand from representatives of the DVA, that many of their clients, if I may refer to them as those, had multiple and unsuccessful presentations to the various services that were available at the time.

In that context they had, perhaps experimentally, sent a client to us with terrific results after a really long and morbid series of presentations elsewhere. On the basis of that they sent another client and another client and they have continued to do so, not in large volume but largely because, thankfully, of the results we are achieving. It is in that context that we continue to have that relationship with the DVA today. Only yesterday, in fact, we received a comment that it is relatively expensive compared to some other options but once you aggregate the cost of presenting to those multiple times it is a remarkably cost-efficient service that we have been able to provide to them.

**The Hon. Dr PETER PHELPS:** Do you do onsite detoxification or just rehabilitation?

**Mr THOMAS:** I would describe it as a very low-level detox, if any. We prefer to avoid high risk because we are not a medical facility by nature.

**The Hon. Dr PETER PHELPS:** Do you have a gap between detoxification and admission to your facility?

**Mr THOMAS:** Yes, generally speaking if there is any concern about that risk there would be some recommendation of detoxification prior to presentation so that they are stable and able to receive what is essentially a focus on the therapeutic elements of treatment, as opposed to the medical treatment.

**The Hon. Dr PETER PHELPS:** I may have asked the question wrongly. The Committee has found in a number of previous hearings that in many instances detoxification will happen but then entry into a facility will be delayed for a period of time because of the inability to access a bed in that facility and thus there is a relapse during that intervening period of time. Do you have a regular agreement between yourselves and detoxification facilities for guaranteed beds upon successful detox?

**Mr THOMAS:** No. We have a client-based set of principles around the timing. What we know is that it is critical to have a client enter our rehabilitation service as quickly as possible—it is a make the decision to do so. Willingness is a core component of the service we provide and as soon as they have completed any necessary medical detox we have them come and join us immediately.

**The Hon. BRONNIE TAYLOR:** Once they are discharged from your centre how does the follow-up care work?

**Mr THOMAS:** We have case management that works on their plan during their stay with us for when they leave our centre. That occurs frequently in the lead-up to their departure. So there is a mapped out plan. Then we work as best we can with continued contact with them. Now many of our clients come from all around Australia—some from New Zealand and other locations—and the way in which we can continue to work with them varies. We have representatives in some other markets. For example, we have a lady who flies up from Sydney who would have been an important part of their journey here in the local area. They might continue to work with her in group and individual sessions down there. We are trying to build that out into other capital cities, but otherwise it can be as simple as phone calls and, as the gentleman before us mentioned, text messages and just that regularity of contact.

**The Hon. BRONNIE TAYLOR:** If I am a client coming to you from Sydney, then this other person who is a counsellor—what is her profession?

**Mr THOMAS:** She is a family therapist in this case who provides individual counselling.

**The Hon. BRONNIE TAYLOR:** You will fly her up to meet me while I am there. She will make that contact and then she will follow me up in Sydney?

**Mr THOMAS:** Kylie, do you want to answer that?

**Ms BEATTIE:** We have a family therapist and a family systemic constellation therapist who we fly from Sydney while they are in treatment with us to run an intensive program. So they all have that relationship with the family therapist, along with their family members, and then when they return to Sydney they may continue their therapy with her there. We fly two particular therapists from Sydney, which sort of flows on to discussions on limitations to—

**The Hon. BRONNIE TAYLOR:** I think that is absolutely brilliant. You have got the continuity of one of your clients, guests or whatever who has made contact with someone at their most vulnerable time and then they are able to follow-up with that person, if they are from Sydney. That is pretty innovative stuff.

**Ms BEATTIE:** We also allow all clients to come back for free every month for three days to take part in a sort of outpatient follow-on therapeutic program and some of those—and we have had a few—who came years ago, still fly back and call me. They will stay locally in the area, connect back in with the community, and come and tell their stories at the centre and are able to work on issues that arise once they get back into functioning in their lives. Obviously issues continue on throughout people's lives. They are able to touch back in with us and have that support. I just had a message from someone who went through our program. They can contact the clinical director on the weekends, the family can contact us. We just have more resources to be able to support clients, pre-care, during care and post-care. We have quite a high level of engagement with them throughout and after their stay because we have the resources to be able to do that.

**The Hon. BRONNIE TAYLOR:** Can you tell me a little bit more about what you just said about the family. One of the complaints that you hear when you speak to people that are affected by a family member who has an addiction problem is their frustration that they will go into the system but no-one will talk to the parents. You might have a 17-year-old, but they are considered an adult. There is consideration of confidentiality—goodness, gracious if we share some information about our child who we have raised for the last 17 years! Sorry for the cynicism. That is pretty powerful. You involve the family so that they feel part of this. Can you elaborate a little bit. What you said really clicked with me, then.

**Ms BEATTIE:** I really believe it is quite limiting to address the issue on an individual level. It is clearly a social issue. It is a systemic issue. I have read in some other submissions and transcripts that we have generations of people presenting for treatment. It is not unusual to see in literature today that it is generated through childhood experiences. Including the family—not so much in a blame exercise—in that process means that you are sending

people back into an environment where everybody has an understanding of the issue and everybody has the support that they need. We put some of the family in contact with a therapist prior to their loved one arriving so that they are continuing to do their own work while their loved one is in treatment. Then we bring them all together in order for them all to find a better way forward. Afterwards they can all continue on with a family therapist or another therapist that we have engaged and set them up with post treatment. It is a community issue. It is a social issue. It is a systemic issue. It would be very limiting to think that we are just treating an individual client.

**The Hon. BRONNIE TAYLOR:** Do you refer on to NGOs and other government organisations? If someone is not going back to Sydney, they are going back to Cooma or somewhere, how do you support them?

**Ms BEATTIE:** We have just supported someone through our program into The Buttery program. We held them there until they were able to enter a long-term program. It was clear that they needed a long-term program, and also that they were willing to enter a long-term program, which is a key element. Not everybody wants to do more than four to six weeks. There are lots of people in different circumstances. So, where we can, we refer those people who are willing and engaged and motivated to attend other long-term programs or complementary programs.

What really resonates with some people, or what is really going to support them physically, emotionally and spiritually, is a range of different community initiatives in their area. We need to find those initiatives and engage with them. We will often call the people before they leave, and have them set up with sessions—whether it is yoga, going back and engaging in study or whatever it is that the person needs in order to step into their life in a good way.

**The Hon. BRONNIE TAYLOR:** It is a very personalised referral rather than saying, "I'll just refer. I've done it."

**Ms BEATTIE:** I field a lot of calls. Having built the centre and having been on call 24 hours a day, seven days a week for many years, I know that we have a real responsibility to refer people into programs that suit them. We cannot support a large demographic of people. A lot of people do not have funding for our particular centre. So where we can, we put people through our program for free. We have done so since the beginning, and we have done so for many people. That is part of our social responsibility, but we always refer people and make extensive efforts to refer people to a program that is going to best suit them.

**The Hon. Dr PETER PHELPS:** What sort of occupancy rates do you have for your beds?

**The Hon. COURTNEY HOUSSOS:** How many beds do you have?

**Mr THOMAS:** Twelve.

**Mr BEATTIE:** We did not always have 12. We were approved for five initially, and then we had to resubmit to council. We have been approved for 12 for about—

**Mr THOMAS:** In the last four months, if you average it, we would have nine or 10 of those beds full. Just to explain the complexity: it varies, of course. When one bed vacates you do not always have someone ready at just that moment to come in. As we mentioned before, the need for immediacy is so great. We do our best to fully utilise the beds, and spread the service where we can.

**The Hon. PAUL GREEN:** Is that because there is not a central pooling system that acknowledges all the residential opportunities throughout New South Wales? There are about 700 beds and, as you say, it is quite a fluid situation. You might have someone leave. There are 100 people waiting for beds across New South Wales, but how do they find out that there is an available bed in one of those 31 residences across New South Wales? Does anything like that exist?

**Mr THOMAS:** I do not believe there is.

**The Hon. PAUL GREEN:** It is something we could do.

**Mr THOMAS:** As Dr Faruqi mentioned before, there is this Dr Google approach to where the facilities are.

**The Hon. PAUL GREEN:** That is right, but we could do so much better in this day of technology, with apps and everything else, to see the availability of beds across New South Wales. How that gets processed would be up to the facilities.

**Mr THOMAS:** It is essentially a matter of researching who is out there—in our case, private providers and so on. One of the concerns that one might have—I am not sure if you are mindful of the development of this industry in the US—is that the unscrupulous may manage placement services, attracting large fees for finding beds and putting people into those beds, regardless of whether it is a quality operator and regardless of whether



they complete the journey in that facility. We would be well instructed to ensure that we do not replicate that in Australia.

**The Hon. PAUL GREEN:** Evil knows no bounds, my friend. I do not think we should knock a good idea on the head based on that. It is something to be aware of. Corruption never ceases, does it? The Government could very well do something that would be very helpful in that space.

**Mr THOMAS:** Absolutely.

**The Hon. PAUL GREEN:** I understand what you are saying, sadly.

**The Hon. COURTNEY HOUSSOS:** Thank you very much for your time today. How long have you been in operation?

**Mr THOMAS:** It is our fifth year, this year.

**The Hon. COURTNEY HOUSSOS:** We received a submission earlier about success payments and started to discuss the idea of success. Do you guys have an idea of what success looks like for Byron Private Holistic Treatment Centre?

**Mr THOMAS:** For the individuals who attend our service?

**The Hon. COURTNEY HOUSSOS:** Yes.

**The CHAIR:** Is it a term you use?

**The Hon. COURTNEY HOUSSOS:** That is probably a better question.

**Mr BEATTIE:** I really liked the way that somebody—I think it was We Help Ourselves in their submission—worded it. Success is not necessarily abstinence. There are some people who are not even looking for abstinence. Success may be some sort of harm minimisation approach for that person. Success, I feel, is that that person is able to step into connecting to a way of living that was not possible before—increased connections with their community and their family, being able to function in their everyday lives, having the ability to look after themselves. We have people who are really high functioning who come into our centre. Success for them can mean different things. I think it is a little bit of a grey area and it would be limiting to measure outcomes by abstinence.

**The Hon. PAUL GREEN:** We can talk about success being the knocking over of the addiction, but it is not just that; it is about putting tools in their bag so that next time they have an issue they have some tools so that they can at least do something differently—something they probably could not have done before because they had nothing there.

**Ms BEATTIE:** They also have a connection with people who are there and have an interest in the life that they want to live. When some people face troubles and difficulties they do not always have good people in their corner or the resources to do that. So we are trying to connect the person with the opportunities to connect with the resources and to be able to contact those people in a crisis. We all struggle throughout our whole lives. Obviously they might get out of an immediate crisis—they are about to lose their family or their marriage is breaking down or whatever it is—but they are able to function through life difficulties. Learning that there is another way of operating and responding to difficulties is most important.

**The Hon. COURTNEY HOUSSOS:** One of you mentioned that you do regular follow-ups. My colleagues teased out your very comprehensive after-care program. Do you keep data on how often people come back? You mentioned that there have been a couple of people who have returned.

**Ms BEATTIE:** People can come back for free. So it is just part of an outpatient program that we have where they can come and connect in with us, not necessarily readmit to do a complete six-week program. Yes, we do have some readmissions. I think that I would probably have to ask David, the clinical director, to respond to that question.

**Mr THOMAS:** We have the data. We have not committed that figure to memory but we could get that for certain.

**The Hon. COURTNEY HOUSSOS:** We are not talking about success as being people coming in, they leave and then they never come back. I am more interested in what you provide afterwards, in addition. Obviously you have got a counsellor, you provide outpatient service and do you stay in contact with everybody who comes through your service?

**Mr THOMAS:** Try to. In some cases that may not be feasible but for the vast majority it certainly is. I think that fostering of the continuing connection is a vital part of what we are all about.

**Mr BEATTIE:** In addition to what Kylie said before about after-care, we try to connect clients when they exit with therapists in their area to continue doing therapy, or some clients continue to do ongoing therapy with our therapists via Skype if they are not in the local area and maintain that kind of connection. Kylie and other staff in the centre maintain contact with residents. The revisits that Kylie was talking about, so we run the family program. A therapist comes to do the family program. We also run a systemic constellation program as part of the six-week program and clients are welcome come back for free to do that workshop and sit with other residents and participate in that workshop.

**The Hon. COURTNEY HOUSSOS:** Will you explain systemic constellation?

**Mr BEATTIE:** I will let Kylie explain that.

**Ms BEATTIE:** It is hard to explain it. They use it a lot in Europe, especially in treatment centres. It is quite a profound and deep way to look at generational trauma and entanglements in family systems. We often have people presenting and it is not so much their addiction—that person has an addiction to drugs, but they are often carrying incredible generation trauma that is entangled in their systems. Yes, there can be a range of issues that are not just a symptom, I suppose, in what they are presenting with. It just allows them quite a profound and quite a quick way of seeing the system that they are in, finding a better way of envisaging how they can move forward and learning to carry their burdens with integrity.

We have men who have served in Afghanistan and we cannot heal them of those traumas. It is about them learning to carry that trauma with integrity and being able to see the system and the trauma that they have come from, and being able to move forward in their lives in a good way. It does not carry forward that trauma to obviously the next generation in their family. It is certainly something that I think could be utilised more. I know that a few of the psychiatric hospitals in Sydney engage the therapist that we fly from Sydney to facilitate these workshops for communities of 60 or 70 people. It is quite an incredible therapy. I have done years of training in it and I really believe in it.

**The Hon. PAUL GREEN:** If ever there were evidence of such a thing it is domestic violence. The child learns from the father, in most cases but not all, and then has a relationship that is quite violent because of the trauma in which they have been brought up. The only way to stop it is to go back to those kids and say "That is not the way to go in life."

**Ms BEATTIE:** Yes, and allow them to re-vision a story for themselves moving forward.

**The Hon. PAUL GREEN:** And not pass it on to the next generation, which is so important.

**Ms BEATTIE:** Yes, definitely.

**The Hon. COURTNEY HOUSSOS:** Obviously you offer a wide range of support. The Committee has consistently heard that drugs are often the symptom, not necessarily the problem that needs to be addressed. I am aware that you offer supports for a range of different therapies. Will you provide the Committee with a breakdown of dealing with alcohol, ice and cocaine, for example?

**Ms BEATTIE:** I was speaking to our program manager yesterday to get a clearer picture of what presentations she sees. She said that 20 years ago before she did her training when she herself had those programs, the main presentation was heroin and alcohol but now what we are seeing is definitely alcohol and methamphetamines, cocaine and some cannabis. Not so much heroin presenting in our particular facility.

**The Hon. COURTNEY HOUSSOS:** That is very useful feedback.

**Dr MEHREEN FARUQI:** Ms Beattie, you spoke about what you believe is your success which really struck a chord with me. How do you involve families? I think stigma is a big part of why young people especially have quite a negative stigma with drug use. Do families being there help them have a better understanding and it is all right because people have always used drugs, but obviously addiction impairs what they can do in life. Is the presence of families helpful?

**Ms BEATTIE:** I think it gets families engaged in becoming a part of a solution. There is a lot of stigma and shame. The way that we view addiction is very different in the Western World. People who struggle in other cultures are not treated the way that we treat people who struggle. It is not necessarily that it is right or wrong, it just has consequences because of that. Sometimes it is just re-educating families, bringing families together. Our family therapist says there are all shades of light and dark. There is addiction everywhere. We are a very addicted society. Parents can then relate that they themselves probably have some level of addiction. We all have some level of dysfunction.

**The Hon. PAUL GREEN:** To keep our pains away.

**Ms BEATTIE:** And adaptations.

**The Hon. BRONNIE TAYLOR:** You should come to Parliament.

**Mr THOMAS:** I just want to share a quick experience. I once walked out on the lawns of our grounds and saw two adults hugging a clinical director and crying profusely. They had just come out of a family workshop. I thought, "Something has gone terribly wrong. This is not good. What have we got here?" When he managed to ply himself away from them after quite some time, they said, "We haven't actually spoken with our son in 15 years. He got into a gang. He fell into the wrong side of things, went to jail, committed significant crimes," et cetera. What I observed from that was that they specifically said it was the external impetus on this family system that was being explored with this lovely lady that comes up from Sydney, whom we have mentioned, that created that environment that got them into that situation. I think that is where this tremendous work occurs and without that this poor young guy stood no chance. With that I think he has got a chance.

**Ms BEATTIE:** It does allow our clients to feel that they are not the problem and that the whole family is a system and that they are all equally responsible for their part in how they respond to that problem. That then enables the person with the addiction to feel so much less burdened from that shame and feeling that there is something inherently wrong with them, and being able to see that they are actually part of a greater system and that it may not be so in your face as someone with heroin or a severe alcohol problem. But everyone is contributing to that system and everyone has a responsibility. It can be extremely freeing for that person that comes to our centre who feels that shame and that sense that there is nothing wrong with them. They are often the gift for the family system really. They are the person that is representing what often is wrong—not wrong—but often where the difficulties are in that system.

**The CHAIR:** Manifested, yes.

**Ms BEATTIE:** Yes. I think that they are doing a wonderful job for the whole system.

**Dr MEHREEN FARUQI:** You said you have been operating for five years. In the past 12 months on average how many clients have come through your facility?

**Mr THOMAS:** I can give you a very rough number.

**Dr MEHREEN FARUQI:** Just average—just a rough number, and you can take that on notice.

**Mr THOMAS:** It would be in the region of 100, 12 beds treating four to six weeks, pretty well occupied. It would not be too far off the mark.

**Dr MEHREEN FARUQI:** Could you give us an idea of who those clients are in the sense that are they mostly from Sydney? What gender are they? What age group?

**Mr THOMAS:** Sure. In order of priority, the first market would be Sydney, the second would be Melbourne, the third would be Brisbane, the fourth would be a dichotomy of rural, regional, other States and New Zealand. Men or women—that is fairly split down the middle. The age group would be a tremendous range as well. We take only 18 plus up to seventies, I believe, recently. Ms Beattie will correct me if I am wrong, but they are clustered, I would say, in the late twenties or early thirties—that would be the top of the bell curve.

**Dr MEHREEN FARUQI:** What is the average stay for your clients?

**Mr THOMAS:** Around six weeks.

**Dr MEHREEN FARUQI:** What is the cost per week? Could you remind us of that?

**Mr THOMAS:** In our submission it mentioned \$950 per day.

**Dr MEHREEN FARUQI:** That is more expensive than we heard from the last operator, which was \$250 a day.

**Mr THOMAS:** Yes, but in the private market there is a range. We sit at the middle to higher part. There is massively higher and there is lower. We try to provide as much service as we can within that economic bracket.

**Dr MEHREEN FARUQI:** We have heard throughout the inquiry that there are quite big gaps for facilities, specifically for women or specifically for under 18s. The previous operator, Gunnebah, said that they would like to expand, and maybe that is something that they would look at. Is that something that is on your radar?

**Mr THOMAS:** It is a question we ask ourselves similarly. I think if we had the confidence to know that we could do so sensibly financially, we will probably go forward with that. It is a very significant financial undertaking to get to where we are. I have come to the party somewhat later. I have a different—legal—background to Ms Beattie and Mr Beattie, who have built this from the ground up. They put every cent they have

as a family into the creation of the centre. It would require other people doing similar to do another one. It is millions of dollars to get to where we are and it is just really very challenging.

**Dr MEHREEN FARUQI:** What could you recommend to us in terms of improving rehabilitation services? What could this Committee recommend to make the situation better for the community? Is it more harm reduction or more harm minimisation? Is it at that end? Is it increasing detoxification or having beds for rehabilitation? Is there anything that you think it is really critical for us to change? There are many things, of course but, given your experience, perhaps you could suggest your top two priorities.

**Mr BEATTIE:** I would really like to answer this question, if for no other reason than I have not answered one.

**The CHAIR:** Mr Beattie, you have a whole eight minutes. You have still got plenty of time.

**Mr BEATTIE:** We have had a little bit to do with The Buttery, and I have had some meetings with the chief executive officer there. Just from that and reading the submissions, I think The Buttery has undergone a change in their direction. I think a lot of that is to do with the insecurity of ongoing funding. I think that is a massive issue for our society and for government. It is not really an issue for us. We are here today to try and offer and contribute what we can to this important issue and also to place in your mind the importance of private treatment services. I read in some of the submissions that a for-profit enterprise is bad. For profit is in all aspects of health: dentists are for profit; and doctors are not working for free most of the time. There is for profit everywhere in health and I do not think it should be any different in private.

To really support non-government organisations, I think that there needs to be real clarity of long-term funding so that they can deliver a model that best suits their clients and not be in fear of losing that funding or planning short term for services. I think that is a really important aspect ongoing. For private, we probably need some forward visibility of what that regulation will look like because it is an inherent risk for us in investment. As Mr Thomas said, we have all invested a lot of our own personal money to develop Byron Private. We were quite passionate about that and, in hindsight, probably quite courageous. That has been successful and it is delivering successful outcomes. We would probably be inclined to invest further but we would just like real clarity on the framework that we will be operating in.

At the moment you have the private healthcare facilities and private hospitals. Private health funding will fund only for organisations that are operating as private healthcare facilities. The private healthcare model is underpinned by the Australasian Healthcare Facility guidelines, which is really around a hospital environment. There is just no relationship between a treatment centre and a hospital environment. There is a massive disconnect there. We wrote some stuff about that in our submission. I just see a benefit in the private Australasian Healthcare Facility guidelines for private treatments. As you know, we are in a quite picturesque rural-residential setting that is absolutely perfect for recovery. I go there and feel relaxed. I work in Sydney and I go there to relax. A lot of our clients just come and give a big sigh, and they just melt into it. It is quite conducive to recovery as opposed to a clinical hospital setting.

**The Hon. PAUL GREEN:** The Hon. Courtney Houssos brought up the website and I said I will probably go there after the next election for a bit of a break.

**Mr BEATTIE:** You would be welcome to come and have a look to see what a private treatment centre looks and feels like.

**The Hon. PAUL GREEN:** I might take you up on that. We are up there shortly on another inquiry.

**The Hon. Dr PETER PHELPS:** You do make one further suggestion in your submission and that is in relation to registration and accreditation under a modified form of the Private Health Facilities Act, which is a State Act. I am not sure what you are trying to achieve through this. I will tell you what my concern is. My concern is that I would like to have some assurance that you are not trying to exclude people from the market by forcing them into a mandatory system of registration and accreditation for substance use disorder treatment.

**Mr BEATTIE:** I will answer that first bit.

**Mr THOMAS:** You did great last time.

**Mr BEATTIE:** First, I would say that we have no intent to exclude anyone from the provision of services in this market. We are not trying to monopolise the market or do any such thing.

**The Hon. Dr PETER PHELPS:** What benefit would that grant your facility to have registration and accreditation under the Private Health Facilities Act?

**Mr THOMAS:** In hindsight, we have discussed that that was actually a disingenuous suggestion. Where we were coming from there is our lamenting at the time that people were unable to access their private health funds to come to our facility. We were merely coming from the perspective of, if we were registered as a private health facility and they could access those funds, we would be able to serve so many people that just cannot afford to come to our facility. In hindsight, that was not very clever because in reality the whole Private Health Facilities Act and regulations would be so difficult to manipulate into properly supporting a therapeutic-focus facility like ours, as Mr Beattie was explaining.

**The Hon. Dr PETER PHELPS:** That is fine. We can cross that off our list.

**Mr THOMAS:** It is probably a different legislative framework that would make sense.

**The Hon. Dr PETER PHELPS:** That is okay. No problem.

**Dr MEHREEN FARUQI:** But I think you did say that there should be some level of accreditation and some level of oversight to make sure that there is a basic minimum.

**The Hon. Dr PETER PHELPS:** No-one just hangs out their shingle.

**Mr THOMAS:** I think a quality framework and perhaps—

**The Hon. PAUL GREEN:** Yes, that is good. That is what we want. I would ask for that anyway.

**The Hon. Dr PETER PHELPS:** The previous speaker suggested there be a requirement for a medical practitioner or psychologist and then an independent government medical or psychologist to overview the program provided. Is that a model that you think you could live with?

**Mr THOMAS:** Certainly.

**The Hon. Dr PETER PHELPS:** Would you think it should be imposed on others? You could say yes. Or you could say no.

**The CHAIR:** Or you could take it on notice.

**Mr THOMAS:** Personally, yes.

**Dr MEHREEN FARUQI:** There could be other models as well.

**Mr THOMAS:** We think that each of those individuals mentioned have an important role to play in ensuring the success of outcomes. Whilst we are very much focused on the therapeutic journey that clients undertake with us, these are vulnerable people that need to have the protections provided by the aforementioned professionals.

**The Hon. PAUL GREEN:** My question is about your ISO 9000:2015. What did it take to get that and what does it look like?

**Mr BEATTIE:** It takes the documentation of policies and processes to a standard, and then a third-party certification order to ensure that those policies and procedures are in place, that people understand them and there has been training, and that there are regular audits of that system.

**Ms BEATTIE:** Also that we comply with the law and that we engage clients.

**Mr BEATTIE:** Some of the aspects of that are, "Does your organisation meet its legal obligations? What regulations are relevant? How do you track regulations?"

**The Hon. PAUL GREEN:** That is not an unreasonable base to have over a residential business, is it?

**Mr THOMAS:** It is actually a good commonsense quality framework.

**The Hon. PAUL GREEN:** Mr Thomas, you nailed it when you said that you are getting very vulnerable people. Someone has to look out for their interest above the facility and the organisation itself.

**The Hon. BRONNIE TAYLOR:** By the same token, also when you talked about a quality framework and some flexibility, we need to acknowledge that different facilities need to offer different things because there is no one size fits all. What we are doing at the moment is not working—I am not saying your facility, but generally. What if we gave you an overarching quality framework which then would make sure you did not have people hanging out their shingle but also allow people a flexibility to provide a practice and a program and people can choose which one suits them?

**Ms BEATTIE:** I think that is really important. I have been in private facilities—a private hospital—when I was younger. I have been in a government-funded halfway house. I paid for my stay in that hospital—

I did not have health cover. Then I went on to privately paying for my therapy, all my treatment and all of my training for the last 20 years. I have invested so much money in getting well and being able to now bring that forward and to give something back to the community. I think that there is a place for all of those organisations. We are quite empowered to be dynamic with our employees. They can make suggestions, we can engage our clients with therapies that we feel really work. We are not having to have a whole lot of meetings where we have to draw in key people and need to then have them agree, to them agree and to them agree. That can become really disenfranchising. You can feel quite flat with that. There is a real energy to our centre and people are engaged in our treatments and what we do. I think we need to be a little bit careful around having other people govern too much.

**The Hon. PAUL GREEN:** You made a really good comment then. You said it was not a cost, it was an investment. And that is what it is, is not it? It is an investment to getting well; it is not a cost.

**Ms BEATTIE:** I think when people pay for their treatment, half of their work is sometimes done. People can pay. There are people who can pay and there is a place for those people. There is nothing wrong with that.

**The Hon. COURTNEY HOUSSOS:** You have just touched on a point that has come across many of the valuable submissions that we have received, which is the role of lived experience. One of the things that we are grappling with is how important that is but how unquantifiable that is. Is there any suggestion that you might be able to provide to us about how we can quantify that?

**Ms BEATTIE:** I just did a six-year degree. Whilst it was helpful, I feel that my ability to meet people and to meet them on a level that brings about some sort of connection and change has not come from reading those textbooks. I think you have got a system set up where people get a certain amount of sessions with a psychologist. I have never seen a psychologist. The therapist that I sought out cost me \$160 an hour and I saw her every week. I spent probably half my pay packet on that because she had lived experience, she had a breadth of qualifications in a range of areas. I sought that out because she really strengthened me. I do not know if I have much to say on how you can overcome that, but just to say that it is not so much in the letters after someone's name that brings about real change for people. But also I am qualified, our clinical director is a psychologist and there is merit in having that training. People do need to go through those processes, but all of the people in our centre have lived experience. All of our therapists have some form of lived experience. There is not one that does not.

**The CHAIR:** Thank you for appearing before the Committee. It has been a treat to have a private perspective on drug rehabilitation, which the Committee did not have until this point. It has been most informative. Good luck with your ongoing endeavours. Thank you

**(The witnesses withdrew)**

**(Short adjournment)**

**DIAN EDWARDS**, Manager, Namatjira Haven Drug and Alcohol Healing Centre, sworn and examined

**The CHAIR:** Thank for making yourself available to give evidence at the hearing in Lismore. I thank the people from Lismore who have joined us in the public gallery. It is great to have interest from the local community, it is appreciated. This is the sixth and final public hearing outside of Sydney. We have been to Nowra, Batemans Bay, Dubbo, Broken Hill, Grafton, Lismore today and we have one more in Sydney next week. It has been very instructive and we appreciate the community's support in providing evidence from those communities, particularly non-government organisations [NGOs]. Ms Edwards, I invite to you make an opening statement to set the scene and then we will open to questions from Committee members.

**Ms EDWARDS:** Our perspective is as an Aboriginal service. Our service is a member of NSW Aboriginal Residential Healing Drug & Alcohol Network, which is all of the Aboriginal residential rehab services in New South Wales. Part of where I come from and my evidence is a collective voice relating to NARHDAN as well. Most of it is regional, so this is about our New South Wales service today. We gave evidence in Dubbo as well. Where we come from is more of a healing model. Our focus is that the drug is not the problem, it is all of the other underlying issues and social determinates that are causing such misuse of substances in our populations. A lot of that type of use is self-medicating, and the previous policies and worldwide policies that criminalised and stigmatised the use of drugs and alcohol caused more issues rather than helped it.

Part of my statement is I feel if we are looking at making real change that it has to co-occur with drug law reform. That is a strong sense of what we feel. Aboriginal community control is based on self determination. Our clients, residents, families and communities are the drivers of what they need for what is called treatment. Even though we rely on evidence based therapeutic interventions that have been developed by mainstream services, because we lack the capacity to be able to formulate and have an evidence base of our own therapies, we rely on a lot of that, but we have to modify it.

A lot of what we do is purely culturally based. It is not something that can be written down and put in a manual or in a workbook. That is an important part of our services. One of the main things that we believe is that we have a strong feeling towards not mandating people into so-called treatment, it has to be a voluntary perspective in making change. It has to come from someone's desire to make change, we cannot force that. In saying that we recognise that some people that are forced might have a light bulb moment and change. There is not one solution for all. We base our services very much on voluntary beds and having a health focus rather than a justice focus.

**The CHAIR:** How many beds in the facility?

**Ms EDWARDS:** Our beds are 14, we are funded for 14.

**The CHAIR:** That is by NSW Health?

**Ms EDWARDS:** We have only a small amount of money from NSW Health and that is for two Magistrates Early Referral Into Treatment [MERIT] beds. They are diversion beds. We have two diversion beds which we try and make sure that they are local people only so the wraparound services are there for them. We find it very hard to really work well with people not from our local area because you cannot get those pathways happening very well so it is not very successful. We do recognise that some people do need to get away from their own local areas to create change.

**The CHAIR:** What about the difference in the funding?

**Ms EDWARDS:** We have three beds that are funded by New South Wales Corrections and they are for parolees. They are called transition beds and they are for men that have been in custody that are either out on parole and not able to fulfil the requirements of their parole by being abstinent, so they are forced back into treatment. They can come via a custodial facility where they are released on parole to us if they have had a drug and alcohol problem. Again, no-one really assesses people's drug and alcohol needs for rehab so they are often forced as part of their parole to do a rehab even though they might not necessarily have a drug and alcohol addiction. The other nine beds are funded through the Commonwealth, that is through the Department of Health Primary Health Network (PHN) and Prime Minister and Cabinet. Most of our funding is Federal. The only NSW Health funding is MERIT, which is two beds.

**The Hon. Dr PETER PHELPS:** I would like to ask you a few questions about that funding. One of the things we are looking at is compulsory treatment. I think it is clear from the evidence that compulsion does not work. How does that fit in with the MERIT system, which is effectively a sort of compulsion that if you do not undertake it you will go to jail? What is the success of that? To what extent are they sincerely interested in rehabilitation or simply taking an easy option? Rehabilitation is not an easy option but an easier option than prison. What is your success rate, however so defined, with MERIT beds?

**Ms EDWARDS:** Probably the length of stay is usually pretty consistent with MERIT beds because of that stick at the end if they leave. The success rate really for someone finishing and doing well and wanting change is really based on the assessment of that person. If that person really does have a genuine desire to change and they do have an actual dependency or addiction then they will have a fairly high level of committing themselves to change. They are only mandated or coerced or diverted for three months. Then they go back to the magistrate, the magistrate says, "Aren't you a good boy, you have done that. You have been abstinent for three months. We will give you a bond". Then there is nothing. They are off the program, there is no-one supporting them, they are back to their community and the likelihood of them having reoccurring issues is fairly high.

**The Hon. Dr PETER PHELPS:** Do you have a post-release follow-up program with people going through your program?

**Ms EDWARDS:** Yes. All our caseworkers work in what is called transition, but that relies on the resident being active in that they have to be contactable or they have to make contact themselves. We have a weekly meeting that they can attend. It is an ex-resident meeting where they support each other as well, but it is a very low rate. Where we are is probably an issue for a lot of our clients; they do not have vehicles and licences, and we are off the beaten track. What we try to do is link into services in Lismore with Rekindling The Spirit so that we have that pathway to their workers back in the community a little bit and work that way.

Often our clients might have a mobile phone, but within a day or two of them leaving they are either disconnected or they have given them away to family. It is very hard to keep in touch with people in that active follow-up unless you have got community-based services, and one of our biggest issues is there are not enough community-based drug and alcohol workers in our region. Rekindling The Spirit is a nine-to-five service four and a half days a week, and that is it. I would see most active follow-up as being available more than just that and in all towns.

**The Hon. BRONNIE TAYLOR:** In terms of the people, I think you said it was in MERIT that they know they have to stay because they are on that thing from the magistrate. Why does that not extend to post-care?

**Ms EDWARDS:** In MERIT they only get three months, that is it.

**The Hon. BRONNIE TAYLOR:** I suppose I am asking for maybe another solution or a recommendation. You have said that because they know of the consequences if they do not complete the program, they stay. That is a positive outcome in the fact that they are not in jail but they are staying in your—

**Ms EDWARDS:** Yes.

**The Hon. BRONNIE TAYLOR:** What about extending that to say that you've done your three-month program, your bond extends for 12 months, and in that 12 months—I hate to use the word "parole"—as part of your requirement to not have the consequence because of the original action for which you were brought before a magistrates court, you have to participate in an after-care program for 12 months?

**Ms EDWARDS:** In the community?

**The Hon. BRONNIE TAYLOR:** Yes.

**Ms EDWARDS:** Yes, there could be. MERIT has good relationships with our clients that are working with them locally. I would love to see the pathway go back to MERIT after they left because they might have started with them and been doing groups and counselling with them. It would be an ideal scenario for them to go back to that referrer to follow on.

**The Hon. BRONNIE TAYLOR:** All the evidence says that to stop it after three months is a set-up to—

**Ms EDWARDS:** Sometimes it is young people. I am very big on advocating to not mandate length of stay for young people. MERIT clients, if they are young, we will only try and work with them for six weeks; after that we find it is detrimental. A lot of young ones that are coming in are being labelled as having an addiction when they probably do not have an addiction and they end up feeling that they are diseased and have this lifelong addiction when really a lot of those clients were just suffering from the normal chaos of youth and getting into trouble. They do not necessarily have an addiction. By forcing people that do not have an addiction into treatment when they are young, we feel, is detrimental. We will do a six-week education and support type—

**The Hon. BRONNIE TAYLOR:** It is a frightening scenario if people are being mandatorily expected to go into a rehab facility when they do not have a clinical diagnosis of an addiction.

**Ms EDWARDS:** I know.

**The Hon. BRONNIE TAYLOR:** I do not understand how that could possibly happen, but you are saying that it does.



**Ms EDWARDS:** It does happen, yes.

**The Hon. BRONNIE TAYLOR:** Who assesses that person?

**Ms EDWARDS:** The magistrate will say that this person needs a drug and alcohol assessment. MERIT are quite good at that, but if they go to prison on remand and the magistrate said they need to be assessed for treatment—obviously this person is coming before the court because they may have been caught with a little plastic bag—they get assessed for rehab and then they can come back to the court if they can get a rehab bed. We get calls from custodial centres constantly saying, "The magistrate says this person needs to be assessed for drug and alcohol treatment." They used to have drug and alcohol workers in the prisons that used to do those assessments; they do not have them anymore. They ring up our service and say, "Can you do an assessment on this person?" Well, no. We cannot do an assessment on someone in jail; that is not part of our service. There is a whole suite of assessments that you have to do with someone in jail.

**The Hon. BRONNIE TAYLOR:** Who does the assessment?

**Ms EDWARDS:** Nobody.

**The Hon. BRONNIE TAYLOR:** They are just sent to a facility like yours without a proper diagnosis or assessment?

**Ms EDWARDS:** That is right. We have got a fellow at the moment that was sent to us for three months. He has not used for 18 months. It is crazy, I know.

**The Hon. Dr PETER PHELPS:** So it is a diversion facility in some instances where that sort of diversion is not needed—in fact, a halfway house would be better.

**Ms EDWARDS:** A lot of our services are being used for halfway houses, yes. It is not appropriate.

**The Hon. Dr PETER PHELPS:** I want to ask you something that is a little bit off topic because you are part of the network. Do you know why Bennelong Haven shut down? Was it because it lost government funding? It was an interesting model in that it was a large facility and it involved families.

**Ms EDWARDS:** It was the only service we had for families.

**The Hon. Dr PETER PHELPS:** And it was the only service for women as well.

**Ms EDWARDS:** Some of our services have women, but not with children—single women.

**The Hon. Dr PETER PHELPS:** Was it a lack of funding or was it internal politics, if I can use that euphemism?

**Ms EDWARDS:** We were not given the heads up that it was going to be closed. We made some submissions and we have not had any replies as to why the network was not notified if that service was in trouble, governance-wise or funding-wise or reporting-wise. All we have been given is that there were some incidents at that centre and it was closed down.

**The Hon. COURTNEY HOUSSOS:** There is no service for Aboriginal women and families?

**Ms EDWARDS:** With children, no.

**The Hon. COURTNEY HOUSSOS:** Now in New South Wales?

**Ms EDWARDS:** No, nothing.

**Dr MEHREEN FARUQI:** Thank you so much for coming in. Did you just say that Namatjira Haven is for men and women?

**Ms EDWARDS:** No, men only.

**Dr MEHREEN FARUQI:** It is for Aboriginal men. How long have you been operating?

**Ms EDWARDS:** We are coming up to 40 years.

**Dr MEHREEN FARUQI:** How many men come through the facility on average in 12 months?

**Ms EDWARDS:** In 12 months the average is probably between 55 and 60.

**Dr MEHREEN FARUQI:** Is there a waiting list?

**Ms EDWARDS:** Yes, we have a waiting list. That is quite a complex thing to answer because we prioritise health referrals that are self-referrals. Anyone that is coming from a custodial situation or has current court matters may have to wait longer than self-referrals.

**Dr MEHREEN FARUQI:** What is the waiting list for self-referrals?

**Ms EDWARDS:** Self-referrals if we do our own detox at our service for methamphetamine and cannabis, but not alcohol. The long-term, heavy alcohol user we have to send through hospital. We can usually have people in within a week.

**The Hon. Dr PETER PHELPS:** Is that because alcohol detox is the most dangerous detox you can do?

**Ms EDWARDS:** It can be, yes.

**Dr MEHREEN FARUQI:** With the people that come to your service, is there a way of knowing what substances are being misused in the main? Can you quantify in percentages what would be the majority?

**Ms EDWARDS:** Most of the problems that we have in our communities up here that are significant as far as health and wellbeing are still alcohol. But a high percentage of our clients, at least 80 per cent, will use multiple substances. They will be using methamphetamine as well, cannabis, heroin, OxyContin, everything that they can get.

**Dr MEHREEN FARUQI:** Is prescription medication use on the rise? The Committee has heard from many people that it is.

**Ms EDWARDS:** We do not find that our clients use prescription medicine as far as they have got a legal script, but certainly illicit prescription drugs, yes, such as OxyContin and fentanyl. We have had a lot of deaths with fentanyl in the last few years. I feel that that could have been avoided if we had had a needle exchange service in this area.

**Dr MEHREEN FARUQI:** There is no needle exchange service in this area?

**Ms EDWARDS:** No, not an injecting room. We have got needle exchange, but not an injecting room.

**Dr MEHREEN FARUQI:** You said earlier in your statement that rehabilitation has to go hand in hand with drug law reform. Could you expand on that?

**Ms EDWARDS:** We are talking about Justice Reinvestment and that is what I was saying by that. When we are really looking at what is needed as far as services, we need to bring that into the mix.

**Dr MEHREEN FARUQI:** Could you explain the healing model you said you use?

**Ms EDWARDS:** Our NSW Aboriginal Residential Healing Drug and Alcohol Network has a model of care. That is our overarching framework for all of our services and it is based on that our services have to be Aboriginal community controlled, that the land that we are on has to be Aboriginal community-controlled land and that it is viewed as a spiritual safe place. That is the number one part of our services that we believe is the most important part for the healing, having that safe place. The other part of it is that we have to have that kinship connection and know that we are safe through kinship as well. All of our residents, upon entry they actually make connection with someone within that first entry. A lot of our local residents have been brought up disconnected from culture, brought up in missions which are Christian based. We have sometimes some conflict between our cultural-based practices versus communities that are Christian based. But on a whole it is about that safety and having the Aboriginal staff and that land that people feel is theirs.

**Dr MEHREEN FARUQI:** How many staff do you have at the moment?

**Ms EDWARDS:** At the moment we have 16 staff, they are not all full-time, probably about 11 full-time equivalent staff.

**Dr MEHREEN FARUQI:** They are all Aboriginal?

**Ms EDWARDS:** No, 70 per cent of our staff are Aboriginal. We have some non-Aboriginal staff as well.

**Dr MEHREEN FARUQI:** Is there a program to train Aboriginal people to increase the number of Aboriginal staff who can provide these services?

**Ms EDWARDS:** We are not a registered training organisation, if that is what you mean.

**Dr MEHREEN FARUQI:** No, but there could be an internship program, for example?

**Ms EDWARDS:** Yes. It is much needed in this area. We have just had a situation where we have had six months without two staff members because we could not recruit people with enough experience. Non-government organisations have quite low pay rates. Our funders stipulate what pay rate you pay people and it is very hard to attract people with qualifications. They usually get snaffled up by Health.

**The Hon. Dr PETER PHELPS:** The Committee has heard that once or twice.

**Ms EDWARDS:** Yes, and other NGOs, surprisingly enough. We had a situation where, we have just recruited recently, and two of those staff have been working with NGOs that were mainstream NGOs and were paid huge amounts of hourly rate, I could not believe it.

**Dr MEHREEN FARUQI:** That was coming from State or Federal government funding?

**Ms EDWARDS:** They were NGOs, so I do not know where their funding was coming from, whether they were a part of large organisations such as UnitingCare—big, huge organisations. They are paying Aboriginal people without qualifications high hourly rates just purely because they are Aboriginal people, not necessarily because they had the skills and qualifications for the job. We are battling against that as well. We have to try to offer something that is a little bit different in our services.

**Dr MEHREEN FARUQI:** The Committee has heard evidence in many hearings that large NGOs can crowd out the smaller, specialist service providers.

**Ms EDWARDS:** Yes.

**Dr MEHREEN FARUQI:** You said there were four different sources of funding for your facility.

**Ms EDWARDS:** We have the primary health network [PHN] as well, I forgot that. That is fairly new in the mix. That is Federal, comes across from the Commonwealth.

**Dr MEHREEN FARUQI:** So five different kinds of funding?

**Ms EDWARDS:** Yes, and they fund two projects. There are six different reporting requirements and funding streams.

**Dr MEHREEN FARUQI:** The Committee has heard that that can be very onerous, you have only a small staff. What would you change about the funding model for it to be more sustainable and less onerous on staff, because the staff are there to provide the services and not be overly involved in the administration of funds?

**Ms EDWARDS:** This is like the ultimate?

**Dr MEHREEN FARUQI:** The ideal.

**Ms EDWARDS:** I think that services such as ours and drug and alcohol services, a lot of services that are coming from a health and healing model, should be treated exactly the same as a hospital is; this area needs so many beds, it needs so many services, they are funded. That is it, they are funded. The money has to come and it has to be funded. Of course, the governance has to be in place, key performance indicators have to be met, just like a hospital. But the idea of our services being sustainable and being able to keep going like this, when we have got all different funding sources, and then we never know whether they are actually going to be ongoing, they are never ongoing. We have just been told by the Commonwealth, "We are just about to give you two years." You just cannot keep doing that. Our funding is always based on the current hype. The last few years it has all been about methamphetamine. The goalposts keep changing, the funding keeps changing, our reporting has to keep changing. Even now with our new Commonwealth funding we have been told that the goalposts have changed again and all the KPIs have changed again.

**Dr MEHREEN FARUQI:** It cannot be reactionary.

**Ms EDWARDS:** It is always reactionary. I think it should be that we need to look at what services are in the community, what the community needs and it needs to be treated just like it would be a hospital or a school. The community needs X, and it gets funded.

**Dr MEHREEN FARUQI:** What is your view on providing a drug court and a Koori court in this area? The Committee has received many submissions that talk about that. Would that be helpful?

**Ms EDWARDS:** We used to have Circle Sentencing, and that was always quite successful and very few people actually got the opportunity to go through it, but for those that did it was a good process. We committed ourselves to assisting in that process. I have met with people down on the Central Coast, the Drug Court down there at one of our services, The Glen Centre. They came and visited while we were there and they were explaining how it worked down there and what success rates they were having with people actually really being engaged with the process ongoing. I think the key thing is engaging people. If you can keep people engaged in services afterwards that is a big thing.

Our thing up here is that with our clients we do not have jobs, we do not have housing, we have so many social issues that we always have to provide a revolving door and that is a lot of things our funders do not recognise. They do not recognise that a lot of our services are actually providing respite; it is not just about you

are going to do a program and at the end of it you are going to have this level of completion or this success rate. A lot of it is about, "You are coming in again for another few months because you need some health care and you need a bed and you need to have some food and build up your weight," knowing that that person is just going to go straight back out at the end of it and their only social connections are at the riverbank. So we know that that happens. We have this revolving door for people, especially as men get older—alcohol actually keeps people alive, to the point that we often believe that if something suddenly happens spontaneously with people and they will make a decision to stop. If we can keep people alive long enough for that, which is what our services do a lot. But it is not recognised with funding bodies so much that that is what our service has to provide, and keeping men and families away from each other for awhile so that women and children can get back on track as well so people can think about consequences and reflect. It is not just about substances.

**The CHAIR:** The Committee has received evidence from various witnesses in regional and rural New South Wales about the issue of detoxification followed by rehabilitation. Many have said there is very little follow-up beyond that. On the other hand, it is well known that follow-up hopefully encourages people to stay on track, so to speak. What are your thoughts about mandating as part of a key performance indicator that the organisation seeking funding must be able to demonstrate that the service offered also provides follow-up care for its clients?

**Ms EDWARDS:** I think that might work in mainstream but very different for Aboriginal services.

**The CHAIR:** In other words, a strict requirement that that has to be part of what they offer?

**Ms EDWARDS:** I think that is possible especially in mainstream services where you have got a lot of people who have got quite secure housing to go back to, or families, or they might be going back to a job. But when we are talking about Aboriginal people it is very difficult to do that from a service perspective unless you are in the communities. We have tried all different types of aftercare. We have tried lots of different ways of doing that. Part of that has been trying to visit people ongoing in homes and communities and that.

It is very hard to get people to keep engaged with your service, especially if they have been mandated. It is like they have finished, that is it, they are out of there. They do not want anything to do with you. They will not answer your phone calls. It needs to be community-based stuff with a lot of men, somebody who is already in the community, someone in that role in the community, someone who is the referrer into the service so that they are already engaged with that service, then their pathway back to that service to keep engaged. That is what we find works best with our client base but there is not enough of that in the community. There is virtually nothing.

**The Hon. COURTNEY HOUSSOS:** Perhaps you could tell the Committee about the effectiveness of Rekindling The Spirit? I have heard testimony from them in previous inquiries but not in the current inquiry.

**Ms EDWARDS:** That is one of our pathways. They are one of our referrers and then we refer back to them. They have gained quite a bit of funding through the PHN and put on a lot more staff, which took a lot of staff from us and other services, so Aboriginal staff went from those services to that service. Their model in running men's groups and women's groups, so working with family, is a good one. What we do now is, people who ring us who are local, we try and encourage them to go to Rekindle first. We encourage them to connect with that service first and then do a pathway into Namatjira Haven if it is needed, rather than it being the first call for people to go, "I have had enough. I want to come into Nama." It is trying to engage them with some community workers first so that they have got that on exit, rather than just walking out the door.

**The Hon. COURTNEY HOUSSOS:** Having a partnership with organisations working as a continuing service is important.

**Ms EDWARDS:** It needs to be expanded. Nobody likes to work shiftwork on weekends, I know, but we need services, especially for youth, afterhours and on weekends. An expanded model of that would be really good and in a lot more areas.

**The Hon. COURTNEY HOUSSOS:** My next question concerns intergenerational drug use. You only cater for over 18s, is that correct?

**Ms EDWARDS:** Over 18, yes.

**The Hon. COURTNEY HOUSSOS:** With the younger people at Namatjira Haven do you see evidence of a previous generation of drug and alcohol abuse?

**Ms EDWARDS:** Yes. A lot of our clients have often been brought up by other family members because their own families have been in and out of jail and have had unmanageable use of alcohol. A lot of our clients will start being introduced to drugs and alcohol at a very young age. There is evidence there that the younger people

are introduced on a regular level, the more likely they will be dependent and form an addiction. Young people are really at risk in our communities.

**The Hon. COURTNEY HOUSSOS:** What proportion of your clients would you say have seen drug and alcohol abuse within their own families?

**Ms EDWARDS:** It would be up to 90 per cent I would say. I am just doing that as a rough figure off the top of my head. It is very rare that we get a client who says they had a wonderful upbringing with no drugs and alcohol. It could be that they have had an early childhood where there has been domestic violence and alcohol and stuff like that and then the families have ceased that. They could have had an early exposure and then come in and say, "No, my family does not touch drugs and alcohol." But when you go into it, they could have been early on as well.

**The Hon. COURTNEY HOUSSOS:** The figure of 90 per cent is shocking.

**Ms EDWARDS:** Yes.

**The Hon. COURTNEY HOUSSOS:** You spoke about your funding through the PHN. Was that funding part of the \$300 million ice package?

**Ms EDWARDS:** And then it got morphed into something else. We have a small project, which is finishing in December, for suicide prevention—so mental health. In that project we were training up local Aboriginal people to facilitate Aboriginal mental health first aid in our communities and also for our clients. That was in partnership with Rekindling The Spirit. The idea was to train two of our staff and two of their staff but, unfortunately, they all ended up at Rekindle, so we have to start again with our staff.

**The CHAIR:** It says something about the quality of the progeny from your organisation that they are being headhunted and taken away.

**Ms EDWARDS:** Yes, we get headhunted. Drug and alcohol is frigging hard—I am sorry. People work in our service and they get offered something and they say, "It is nine to five," or, "It is four and a half days a week," or, "I only have to see someone maybe for an hour." That is a breeze. Even though people might think that is obviously still hard, but compared to what we do that is a breeze. We are living with our men. They are part of our family and we develop relationships with them. No matter how many professional boundaries, you cannot help but form a relationship with people who are living with you for three months or more. We have a fellow who is leaving today who has been there 12 months. You cannot help them forming a very strong attachment to you as a member of their support family. It is very easy for people to be head hunted. On a daily basis you can be screamed at, yelled at and threatened. You may not get a lunch break. You could be there after hours trying to help someone through a huge trauma that has just happened. It is very taxing. It is not paid well enough. The burn-out or attrition rate is really high.

**The Hon. COURTNEY HOUSSOS:** That is something we have heard about consistently from some of the most important services who are doing outreach work. The remuneration may not necessarily be there but the value is so important. The entire Committee is definitely aware of the important work that organisations within your network do and that perhaps the remuneration may not be there, but the value of what you do is very important. We certainly recognise that.

**The Hon. PAUL GREEN:** Hear, hear!

**Ms EDWARDS:** One of the things we are trying to do this year is to get some help in forming some sort of enterprise agreement where our frontline workers get paid for a full workload but are moved to a four-day week, to try and get some sort of balance and rest. That is something we are trying to do.

**The Hon. BRONNIE TAYLOR:** The previous witnesses said that they were doing—

**Ms EDWARDS:** Something like that?

**The Hon. BRONNIE TAYLOR:** Yes, work flexibility. I often say that in the jobs I was doing before I entered Parliament, to the bosses who gave me flexibility, it was worth more than the money. I had young children and I wanted to do both. It is definitely a way to help out.

**The Hon. PAUL GREEN:** I have a quick question on mandatory treatment or detox. You said that you probably were not necessarily for it. How else do you get someone who is not in their right mind to a place where they are in their right mind?

**Ms EDWARDS:** There are cases where I think there should be a mandatory drying out to try and help someone be sober or straight long enough to say, "Oh my God, maybe I need to talk to someone." I have mothers

crying out to me for their kids, saying, "I need to take him somewhere. Can't you take him?" I say, "But does he want to come?" They say, "No."

It is a really difficult thing and I certainly think that there needs to be something, but I do not know about forcing someone into a situation where they are locked inside a facility. I can only talk about our experience in our residence. For young ones we have often said that we need somewhere where we can take fellas out bush. Out there, there is an ability to have medical attention on hand if it is necessary. Taking people out bush would be far more beneficial and easier to do, and easier to have someone actually engage in, than locking them in a room and leaving them to their own devices. That is why we do a lot of our detox at our service. A lot of our men will not even go to hospital detox. They just will not stay there. After two days they are ringing me up and screaming, wanting to get out of there.

**The CHAIR:** We have had evidence like that before. Down the South Coast we heard about the incongruity of being inside a facility or a hospital without any Indigenous identification, people and support staff. It is very hard.

**Ms EDWARDS:** We know that people with mental health issues smoke tobacco a lot more. To take that away from someone with a mental health issue is very distressing. That is another reason why people refuse to go to detox. We have a lot of mental health issues in our community.

**The CHAIR:** On that note, thank you so much for coming along and being so frank and open with us. It has been very helpful. I support the Hon. Courtney Houssos's comment that we are most grateful for the work your organisation does and for your personal work over a long period. It has obviously made a difference in a lot of people's lives. May you continue to do that.

**Ms EDWARDS:** It is certainly a well sought after service.

**(The witness withdrew)**

**TRENT REES**, Residential Programs Manager, The Buttery, sworn and examined

**JENNY MCGEE**, Clinical Manager, The Buttery Private, sworn and examined

**The CHAIR:** We have heard a lot about The Buttery; we are waiting with great anticipation. The bar has been set high. We have heard nothing but very favourable comments and reflections on The Buttery, so we are looking forward to hearing from you both. I thank you both for coming along and taking the time. I know you are both very busy with the important work you do. I invite you, singly or together, to make an opening statement. We have this valuable background information that you have given us but you may make an opening statement to set the scene and then we will open it up to questioning from the members.

**Mr REES:** The Buttery is one of the longest-serving residential rehabs in Australia. It was established in 1973. We Help Ourselves [WHOS] in Sydney and Odyssey House were established in 1974 or 1975—at around the same time. We have been operating in this area for 45 or so years. In that time we have developed from the therapeutic community program into outreach services. We operate several programs which are mentioned in your handout.

We are operating in the social enterprise sector now as well, with The Buttery Private program. More recently we have been funded for some after-care programs that are providing supports to participants at our programs. We are looking to work with this Committee in some respects, to look at where the gaps are in service provision and also hope to provide some insight into our objectives around what we would like to see happening with service provision and a continuum of care and opportunity for clients. We will, no doubt, talk about some of the potential gaps as we go through—youth service availability, particularly residential services and women's services. I think other witnesses have talked about those. We are very keen to receive your questions and offer any insight we can into our services and how we operate, and where we would like to progress to.

**The CHAIR:** Ms McGee do you want to augment that statement?

**Ms MCGEE:** Yes, just to probably add to that having listened to other witnesses this morning, it is really being able to emphasise the need for continuous pathways of care. We are trying at The Buttery to broaden our services, and we have over the past five years, to provide different services so people have that community contact and engagement, a referral either from our outreach services or from other community organisations and services into—they might be doing individual counselling out in the community first and then they might come into one of our residential programs of which we have three different residential programs. Two of those programs can be funded by an individual on their Centrelink portion of income. We have a new fee-paying service called The Buttery Private which is a one-month residential.

Our outreach services also are able to provide services for people in the community with dual diagnosis problems of mental health and drug and alcohol addiction and they do that through groups, individual counselling. And also continuous care pathways now in terms of having a case manager who might follow someone through from community referral into residential care and then back out into community and following that after-care gap that we have heard is so sorely needed and making sure that people are not falling through the gaps. We have partnerships with Riverlands in terms of detoxification. We do not offer detoxification services in our program. It is something that we would probably like to move to but that is another ball game. I think that is all we do.

**The CHAIR:** It sounds as though it is a fair bit even though it has been summarised.

**Ms MCGEE:** We also have youth programs but they are not residential. They only exist in our outreach services, in our two counselling services in group services called Intra and Be Well. Speaking to another community member and psychologist just this morning who used to work with The Buttery reminded me how a huge gap in service provision in this area in remote and rural is youth residential and women's services and family services. We also have a family inclusive counsellor but we would love to move into providing more family inclusive groups and counselling in the community.

**The CHAIR:** That has set the scene very nicely. Where is the site of The Buttery or does it have multiple sites?

**Mr REES:** Not at the moment. The main campus is at Binna Burra just near Bangalow. That is where our community programs operate and our maintenance and abstinence program. We have our The Buttery Private program operating just outside of Murwillumbah in Nobbys Creek.

**Ms MCGEE:** Down the road from Gunnebah.

**Mr REES:** That is right, just down the road in the same street. Our outreach services have offices at the moment in Lismore, Tweed Heads, Byron Bay and we move a little bit around in terms of Kyogle, Casino, Ballina, to meet some of the needs we have with group sessions.

**Ms McGEE:** We have just been successful in a couple of tenders in providing continuous after-care and caseworker services. Those regions we will be covering will be down to Port Macquarie, Kempsey, so we are going further in the Northern Rivers. Previously, we could cover from Tweed Heads, Casino, Ballina, Coffs Harbour and Northern Rivers.

**Mr REES:** We are now mapping a bit more to, I guess, what is essentially the primary health network in this area.

**The Hon. PAUL GREEN:** How many staff do you have?

**Mr REES:** Currently 71. We are about to add another five with the next program that we have just received funding for. I think there are about five. We have around about 55, 56 full-time equivalents, I think. We have some part-time workers.

**The Hon. PAUL GREEN:** That is beyond what we have heard about in evidence.

**Ms McGEE:** In terms of number of staff and the expansion in our services in the past five years, this inability to predict the ongoing funding and where it is coming from, and the multiple sources, as it has been indicated, you either expand, become bigger and provide a whole lot of services under one umbrella, or else you will be taken over by some of the other larger service providers. Different governments only want to provide funding to large players, not the whole myriad of small player services which becomes problematic in remote and rural areas where you have a lot of small providers.

**The Hon. PAUL GREEN:** That is a good point. That was done with women refugees. Why did you start The Buttery Private program?

**Ms McGEE:** We saw the need to do more early intervention having worked in The Buttery therapeutic long-term program, which is a 7½ month program for people with really severe addiction issues who need that time out and space within a therapeutic environment, which is safe, to learn how to reconnect with themselves and other people and instigate life skills. What can we do to teach and provide the elements of The Buttery long-term program earlier for people with less severe mental health issues and self-medicating issues, substance misuse abuse rather than dependence? That was the primary motivator. Then we also thought how will we continue to do the work that we do without broadening our income sources? We thought we could devise this self fee-paying service, with the elements of The Buttery and do it as a social enterprise and all the money goes back into funding our free services. All our outreach services are free.

**The Hon. PAUL GREEN:** Phase one is three months. How long is phase two?

**Mr REES:** That is for the long-term residential rehabilitation. Phase one is three months, phase two is three months, the transition phase is around six weeks and then if a participant completes that program they have the opportunity to access our halfway house, which is up to another three months of supported accommodation.

**The Hon. PAUL GREEN:** You also cover gambling. Will you provide the Committee with a snapshot of what that looks like for a person coming in? Do they have substance abuse as well as gambling?

**Ms McGEE:** In terms of our funding criteria for the long-term program the criteria they must meet are at least a two-year substance dependence criteria to come in for a long-term residential in our long-term program. A lot of the time people come in with substance and gambling issues. We also have the Northern Rivers Gambling Service, which provides outreach counselling in groups for people with gambling issues. There are very few residential services, which are just for gambling. What we are finding at The Buttery Private is that we are actually having people coming in that might have some substance misuse but they are primarily coming in for a residential service for their gambling. Now they are coming in for gaming, internet addiction, especially younger males, gambling, online sports betting, addiction to pornography and the plethora of misuse of digital devices.

**Mr REES:** Part of the intake process for a participant, particularly in the long-term program or our shorter term maintenance abstinence program, which is three-months, there is a screen and one of those screens is gambling addiction. If a participant identifies gambling as a concern that triggers a counselling session, a referral to our gambling service. They will do at least an initial assessment with that participant and if required do some follow-ups. We have also tried not to be all things for all people but recognise what areas cross over when someone is in treatment. The fact that they are actually there for potentially a longer period of time, we can do a bit more work in that space. Gambling is one of those areas that we could provide some support with.



**The Hon. PAUL GREEN:** There is no doubt if they go back out in the community and they have a gambling problem after you have resolved their substance abuse they are still not going to be able to afford their rent because they will gamble.

**Mr REES:** That is right. An adjunct we have there is our financial counselling as well. We provide a support mechanism for clients who identify that they have financial needs and we can provide some training and education in that area as well.

**The Hon. BRONNIE TAYLOR:** Everyone has been saying such great things about The Buttery so it is really great to finally meet you.

**Mr REES:** It has been lovely, thank you.

**The Hon. BRONNIE TAYLOR:** As I say, take the compliments while you can. Ms McGee, in your opening statement you said that you wanted to look at going into detox. I am assuming that is a continuity thing for you? Why did you say that?

**Ms McGEE:** I think one of the Committee members mentioned earlier the window of opportunity of someone wanting to engage with any sort of service or facility. They need to be detoxed before they come into any of our residential services and there is that window when they are on the waitlist. There are not many detox centres around so how can we streamline services so that we can get them in, we have the place for them and then the after-care counselling?

**The Hon. BRONNIE TAYLOR:** The Committee has constantly heard this throughout its inquiry. One question is if there is any merit in a resolution that offers detox and rehab in a centre as a stepped process to ensure continuity of a bed.

**Ms McGEE:** Quite possibly. I know that there are already existing services in Queensland that offer detox as part of their residential services. We are unable to do it. We do not have the infrastructure.

**The Hon. BRONNIE TAYLOR:** It seems to be such a waste of money that we can detox people and get them started and then we are setting them up to fail if they cannot have a rehab bed.

**Mr REES:** We do try to work with our clients to some extent. As Ms McGee has talked about, we have a waitlist for our long-term program. We do try to manage that waitlist in order to try and help facilitate access to detox services as well. Being in this area we have Riverlands accessible to us, so we are working with them to some extent to say, "Okay, we have got a participant who is coming in. We can offer them a bed in a month's time." Their waitlist is usually around two to three weeks, so we can try and marry that up to some extent.

**The Hon. BRONNIE TAYLOR:** It is really evident that you are all trying to do that but it is obviously not working in a lot of places.

**Mr REES:** If someone is out of area it is very difficult.

**The Hon. BRONNIE TAYLOR:** I was really interested to hear you talk about family inclusiveness. I personally have had the experience where people just do not want to involve the family for reasons of confidentiality or whatever. The private providers talked about that earlier really highly. When I spoke to them afterwards they said perhaps because they are not in a hospital where there are a lot of regulations about who you speak to, they are able to sit above that. For instance, if my daughter was in rehab there is a facility at some of those places for me to ring the medical director and say, "I am really worried. What is going on?" I have come from the public system and it does not have that accessibility.

**Ms McGEE:** That is true but I think it is changing. Even in my time at The Buttery in the long-term program we have instigated a program called the Family Single Session. The idea is not so much family therapies, which I heard some of the other private rehab providers say they offer, but it is a great model to involve and include the family members. You engage with them before their loved one comes into the program, then you do maybe one or two sessions with them and the person in the program, and then you can do a follow-up as well. People's confidentiality is maintained around the process because it is mainly supported by the individual, not by their therapist or psychologist giving information away.

**The Hon. BRONNIE TAYLOR:** It might like sound like a stupid question but it is really important that we get this information on the record so that we can form our recommendations. In your extensive experience would you say that by including the family and in doing programs such as the Family Single Session that clients are benefitting in their long-term outcomes?

**Ms McGEE:** Absolutely, because the reality is that even if you do offer after-care follow-up counselling people are going back to their families, their partners and their communities. If they can be involved in that process then successful outcomes are much greater.

**The CHAIR:** To take that argument further, what do you think is the efficacy and value of funding detox and rehabilitation ongoing support programs that do not contain the element that you have just been talking about? In other words, you understand the important stark reality in the work that you do, which has been successful. On the flipside, if that is not being done elsewhere is that a wise expenditure of money?

**Ms McGEE:** Absolutely, in terms of increased efficacy—

**The CHAIR:** Sorry, absolutely it is not wise to spend money in that area?

**Ms McGEE:** It is absolutely needed. It already exists in programs in the health system that have family multi-systemic, multi-disciplinary groups—I do not know what the acronym is. I know there is a group consisting of a psychologist, a mental health nurse, a social worker, doctors and psychiatrists. They work as a group with at-risk families and young children at early intervention. They try and get to children under three sometimes. So they are going straight to the families, to the origin. In our communities our relationships are families and that is where the dysfunction of self-medicating comes from.

**The Hon. BRONNIE TAYLOR:** You talked about youth residential. The Committee has heard loud and clear about under 18s.

**Ms McGEE:** And women.

**The Hon. BRONNIE TAYLOR:** I want to focus on youth at the moment. Is there a great need for specific youth detox and rehab?

**Ms McGEE:** Yes, with family inclusion.

**The Hon. Dr PETER PHELPS:** I have had a look through your submission. I would like to go into your funding model a little more. Is there a contribution from your clients themselves that you are treating? If so, how does that work?

**Mr REES:** I should specify too that our residential programs are funded through the State Government and our outreach programs are pretty much funded federally.

**The Hon. Dr PETER PHELPS:** Basically I am just talking about the alcohol and drugs program.

**Mr REES:** For the residential, our participants will actually contribute equivalent to 80 per cent of the Centrelink benefit. That is to essentially cover the cost of the service delivery.

**The Hon. Dr PETER PHELPS:** That is comparable to every other centre across the State that the Committee has heard from.

**Mr REES:** Pretty much. We run 24 beds and two Magistrates Early Referral Into Treatment [MERIT] beds. Around about 55 per cent of that is covered by the funding received, so the rest of that comes from our contribution.

**The Hon. Dr PETER PHELPS:** Are there variegated levels or is it just that fixed amount?

**Ms McGEE:** It is 80 per cent if you are on disability and 80 per cent if you are on Newstart.

**The Hon. Dr PETER PHELPS:** What happens if you are a functioning stockbroker with an addiction?

**Ms McGEE:** You can self-fund.

**Mr REES:** That is an equivalent of around about \$670 per fortnight to cover that. It is essentially what the equivalent to Newstart would be.

**Ms McGEE:** Just on that, increasingly you see people who are married and they are not eligible for a Centrelink payment of some sort. It is very difficult for them to fund their stay in a residential service.

**The Hon. Dr PETER PHELPS:** Can you give me a breakdown of what the addiction to alcohol, methamphetamine and OxyContin is looking like at the current time?

**Mr REES:** The last financial year figures have still got alcohol as our number one—it is about 52 per cent of our client base; methamphetamine has come in as number two.

**The Hon. Dr PETER PHELPS:** Is that specifically because you are being funded for it?

**Mr REES:** No. That is actually client profile. That is what they report on their observations. This is primary drug of choice as well. This has essentially been a fair change for us. That is at 25 per cent or a quarter of our clients who are currently reporting. Twelve months before that it was 13 per cent. It has managed to overtake heroin, which was primarily our number two spot. Then we move into cannabis, other amphetamines and diazepines for our area.

**The Hon. Dr PETER PHELPS:** The prescription opioids, like oxy?

**Mr REES:** They are on there, but not still as high as yet. In fact, for us, we will probably see that later. Being a long-term residential, we tend to find that we tail into those sorts of areas. If something becomes a trend, we will see it 12 to 18 months later, because that is when people start to hit recovery.

**Ms McGEE:** As previous witnesses said too, people are polydrug users. With methamphetamines, quite often they have alcohol or cannabis issues before they start using the meth. Then meth, because it becomes so unmanageable so quickly, is what might trigger them to come into residential treatment.

**The Hon. Dr PETER PHELPS:** First, one of my concerns is raised from previous testimony about the gap between detox entry. Is there an argument for saying that people should not be allowed into detox unless they have some sort of guarantee placed at the end of it? If not, why does that not represent simply a waste of money going through detox without appropriate rehab?

**Mr REES:** I think it is the lack of follow-up or response. Detox in itself is very useful for getting time out and getting clean. But what we often see is that there is then nothing else for a person, whether it be a long-term residential rehab or a short-term program or even one-to-one counselling. Invariably, there is not a follow-up to that. Someone will go to detox because their family says to go or whatever else, but they do not do anything around that.

**The Hon. Dr PETER PHELPS:** But whose responsibility is that? Are you saying that the detox facilities should be a bit more proactive in seeking spaces for their clients or, alternatively, alternate mechanisms, if spaces are not available in residential rehab?

**Mr REES:** Ideally, alternate mechanisms. I do not know that you can necessarily say it is the detox's responsibility to have to do all that unless, again, you are funding for it. We all operate under the framework of what we can actually afford to do. We would love to provide a greater service—after-care, for example—for our residential clients. But our funding only goes so far. We have to make the most of what we have got. The perfect world scenario is to provide a package that actually supports individuals all the way through. The Buttery itself is looking to try to create a framework that will meet participants where they are at; not where we think they should be. Our outreach programs, our harm minimisation primarily and our residential programs work on an abstinence basis. That is because our clients come from different walks of life, they come from different stages in their own personal lives and in their recovery spheres. Some of the previous witnesses mentioned this as well. Not everyone is looking for an abstinence recovery and they might not need that either. It is about learning how to function.

**The Hon. Dr PETER PHELPS:** Would it be fair to say that The Buttery's successful residential rehab program is the only residential rehab program which has made it into the key turning point of a top 20 song?

**Mr REES:** That I am aware of, yes, I think so. Again, that has come with exposure and time, realistically, and the songwriter himself being quite involved in the industry to some extent.

**Ms McGEE:** What it does point to is the value of connections and relationships that are made in residential rehabs, which focus on the therapeutic part of it. At The Buttery, it is based on a model called the communities method. That is why it is called a therapeutic community. Not only do the individuals have an individual caseworker and treatment plan, they are in intensive psychological groups, 24/7, because they have 30 other peers giving them feedback around their behaviours and their attitudes. That is the real value of the therapeutic community and how it ends up in songs.

**The Hon. COURTNEY HOUSSOS:** Thank you very much for your time and your testimony today. It is valuable for us. We heard great things and that have been reinforced by what we have heard today. Apologies if some of my questions are covered in your submissions. We will endeavour to read that after this. What are the waiting periods for your residential services?

**Mr REES:** At the moment, we are at a bit of a long wait. I have to qualify this. When we state a waiting time, we are talking about all current participants in our program completing the program, and then everyone who is there following thereafter going through. Right now, we are having to quote roughly a six to seven month waitlist for men and round about four to five months for women. We also aggregate based on localities. We have a requirement to provide beds for local clients.

**Ms McGEE:** Can I say something about the waitlist? Other people have said that it is complex. That is actually an engagement with a person. They may still be using, and they are ringing once a week and you are saying, "What's going on"? It is like that they have not exactly a counsellor, but they are engaging with someone about what is happening, what they need to do, what is the next step or, "Have you tried this?" Some people's level of readiness—

[*Interruption*]

**The CHAIR:** Excuse me, the witness needs to be able to continue. Ms McGee, that is okay. Just gather your thoughts.

**Ms McGEE:** The idea is that, with any waitlist, or even if they are engaging with a service in the community, there is some engagement going on.

**Mr REES:** I also need to specify that the onus is very much on the person themselves making contact. Again, for our service, we ask participants or potential participants to contact us on a weekly basis. We keep a track of that to an extent. If there is a long enough period where someone has not made contact, then they fall off our waitlist as well. At the moment, before I walked in here this morning, we had 74 people who are on our list right now. That is where we are at.

**The Hon. COURTNEY HOUSSOS:** And those 74 people are calling you every week?

**Mr REES:** Yes. We update that each week. What occurs is that we will complete roughly five or six assessments each week for new participants and there are probably four or five that will fall off through lack of contact as well. It is staying around that number at this stage.

**The Hon. COURTNEY HOUSSOS:** But it is an interesting idea. It is not just a list of people; these people are actually being forced to engage in a proactive way constantly to show that they are ready for rehabilitation.

**Mr REES:** Absolutely, and still that is not to the extent that we would like it to be. Realistically, we would like to be more proactive in that contact as well. Again, it is just about our capacity from a service provider to be able to about make follow-up calls. I will delineate between our long-term residential and our Maintenance to Abstinence program, which is a program for clients who are on maintenance medication and looking to reduce off that medication. We also run a waitlist for that program. The staff there are a bit more engaged with the clients waiting because we have to communicate with prescribers who are going to transfer clients over to our program when they come to us. That connection of where they are up to, what they are doing and where they are up to with their transfer of medication as well creates a greater engagement. There is a little bit more scope in that program than the long-term residential as well. But that would be the perfect world: a lot more front-end engagement from our side of things as well.

**The Hon. COURTNEY HOUSSOS:** It is not just that someone turns up at detox and says, "I want a rehab place", but they are actually being forced to consider what this actually will be, because it is a significant investment. I think it is really interesting.

**Mr REES:** I think a number of submissions before were talking about motivation. It is a contributor and also part of the reason that when other services are talking about their participation rates most will talk about the long-term rehabs that have 30 per cent to 35 per cent completion rates. It is all the same. We are all at roughly that same sort of number. It has got a lot to do with people coming through services that are not suited to that service or that are not ready for long-term rehab.

**The Hon. COURTNEY HOUSSOS:** What is your completion rate?

**Mr REES:** Around about 35 per cent. For the long-term, we have about 65 per cent who complete phase one of our program. Each phase is a program in itself. About 65 per cent will complete the first phase, around about that again in the second phase. By the time they reach the completion to either halfway house or exit, it is around about 35 per cent, historically.

**The Hon. Dr PETER PHELPS:** Do you then assess those people who have left to say that they will be right? There might well be a situation where a person does not; they just need the trip wire and they are right after phase one. They go on to lead productive, if not necessarily abstinent, lives. Do you look at that and go, "Well that person is—", because that is an unrealistic assumption. If you get a dropout, that dropout might well become a perfectly functioning person, even if they have not completed the program.

**Mr REES:** I can speak to that. I could not provide the paperwork because it is an unpublished PhD at the moment but we have just done a small study. It is funded and supported by the University Centre for Rural Health. It looks at participants who exited our program early either through voluntary means or they were asked

to leave because they were noncompliant. They interviewed 13 participants for a qualitative study. Half had involuntarily left and half had voluntarily left, on average, two and a half years out of the program. Ten of those 13 were reporting abstinence at that stage and three had relapsed. The majority also reported that they had learnt enough from the program—they did not necessarily get it initially when they chose to leave or were asked to leave—that in hindsight they could go back and say "that is what they were getting at", and that had supported them. It is not absolutely about everyone having to go through from start to 12 months and therefore you are okay. I know research does indicate that the longer someone stays in a residential rehab the better the outcome but that also does not look at the fact that you have had two or three other attempts.

**The Hon. Dr PETER PHELPS:** I think it is great that you have made the effort to do that.

**The Hon. COURTNEY HOUSSOS:** What proportion of your clients are Aboriginal?

**Mr REES:** We do not have a very high proportion, historically around about 2 per cent. When I say historically, back to around 2010, about 2 per cent have identified. I have noted that we have had a couple of clients recently who have not identified and after the fact we have been made aware. We take that information from the get-go. If they have not let us know at the beginning, we sometimes miss that too.

**The Hon. COURTNEY HOUSSOS:** Is the halfway house on your site?

**Mr REES:** It is located in Byron Bay. We have two houses in Byron Bay.

**The Hon. COURTNEY HOUSSOS:** Do you mind telling us how much The Buttery Private costs?

**Ms McGEE:** No. It is \$19,800, which includes the one month residential and that is your food, counselling with psychologist, groups, the outings—everything—art, music, and then there are three months of follow-up after-care with either the psychologist or the counsellor that you have developed a relationship with during the month. We do that using Skype, or phone, or in person if they are in the local region, but quite a few of them come from out of region.

**The Hon. COURTNEY HOUSSOS:** What is your wait list?

**Ms McGEE:** We have only run four programs, which has been going not quite a year. We have run four programs and we will start to run them every five or six weeks. There is a five- or six-week wait list for that.

**The Hon. COURTNEY HOUSSOS:** If you can pay for it you can get into the next one?

**Ms McGEE:** We are different from other programs. Apart from being more early intervention, we are a closed group. It starts on a certain day and only six or eight people come through. They tend to bond very quickly together and you get that community as an element very quickly and they work through a set wellbeing program in that time. Whereas other people say, "How can you do that?" We are trying a different model to capture the therapeutic element of the closed group. We are getting really good outcomes in terms of mental health reductions in depression, anxiety, stress and abstinence.

**The Hon. COURTNEY HOUSSOS:** Thank you for sharing your insights today.

**Dr MEHREEN FARUQI:** Just on The Buttery Private, how many beds do you have on the program, how many can come into the program at one time?

**Ms McGEE:** Seven people.

**Dr MEHREEN FARUQI:** You said four to six weeks?

**Ms McGEE:** Yes, it is going to be a program running every five to six weeks and the residential component is one month—four weeks—and the three-month follow-up counselling after that. Also, if we have contact early enough that we do quite an extensive assessment before they come in so they have an individual treatment plan before they arrive.

**Dr MEHREEN FARUQI:** Where are the clients coming from for that particular program? We heard from other private places it is mainly from big cities that people come from. Is it the same in your case?

**Ms McGEE:** Everywhere. It is the same as our long-term program. They come from everywhere—rural, cities, all around Australia.

**Dr MEHREEN FARUQI:** There is no one specific demographic for that?

**Mr REES:** Not as yet, but again it is early days for us in that regard. We will look at that more over time. We have had four or five programs over that timeframe. It is not a huge client base as yet.

**Dr MEHREEN FARUQI:** What substances are they coming for? Is it the same as your other programs, mainly alcohol?

**Ms McGEE:** It is a real mixture. Some of it is gambling, some of the other behavioural addictions and there might be slight misuse of alcohol. We have had only 25 participants through so far but there is an increased abuse of pain medications, legal opioids. That is becoming a huge problem especially once they can no longer get those, they start using methamphetamine and other substances and fentanyl and things like that.

**Dr MEHREEN FARUQI:** Part of the profit from there goes back into funding your other services. What about funding from elsewhere? Do you get State and Federal funding?

**Mr REES:** Yes, we do receive State and Federal funding. Our residential programs are State-funded and our outreach programs are federally funded. We also have an element of our service where we look for philanthropic funding as well, donations and such. We have a fundraising manager who will put on events periodically and work with the local community to raise money for some of our programs and services as well. Our financial counselling, for example, is actually run purely on a philanthropic donation from a provider.

**Dr MEHREEN FARUQI:** Could you break that down into proportions? How much funding do you get from philanthropic, State and Federal?

**Mr REES:** I can take it on notice and provide that. I can give you rough numbers. At the moment residential is around about \$1.5 million or \$2 million, I think. We are a bit over \$6 million all up for the services we provide and the rest of that is outreach services.

**Dr MEHREEN FARUQI:** Could you take that on notice?

**Mr REES:** For sure.

**Dr MEHREEN FARUQI:** Where are the patients, clients being referred from? Is it mainly SeNT referral or do they come from a variety of other referrals as well?

**Ms McGEE:** Family members, work colleagues, other drug and alcohol services, doctors and social media. People do a lot of research for rehabs. They go to the internet and search there. There is the Rehab Reviews and increasingly people will access it. There is a lot on the web. Word of mouth, people hear someone has gone to a particular service and it has worked for them.

**Dr MEHREEN FARUQI:** Word of mouth for The Buttery is what we have heard. Well done on that. You said that 2 per cent of your patients might be Aboriginal identifying.

**Mr REES:** That's right.

**Dr MEHREEN FARUQI:** Do you have staff from Aboriginal backgrounds?

**Mr REES:** Not in our direct counsellors. We have a couple of workers in the residential programs who are Indigenous who work on our night staff, the after-hours care. I cannot speak for the outreach programs. I am not 100 per cent sure of the breakdown there. I can get back to you on that.

**Dr MEHREEN FARUQI:** That is important for Indigenous communities; it is absolutely vital. Can your facility provide training for health with Aboriginal people.

**Mr REES:** We are in the process, as Ms McGee mentioned, of Rekindling The Spirit. We are also in the process of Rekindling The Spirit to look at how we can better support our potential participants around reconnection with culture and providing a more culturally sensitive service. All of our staff have been through cultural competency training and certifications, but it is still not the same as having an Indigenous worker or people within the service who can provide that support. The hope is that Rekindling The Spirit can provide more of a connection for us and back into community as well.

**Dr MEHREEN FARUQI:** You do provide services for women as well, but do any of those include children?

**Ms McGEE:** No.

**Mr REES:** No.

**Ms McGEE:** We do not have any family services and we do not have any women only, it is a mixed gender population in all the residential programs.

**Dr MEHREEN FARUQI:** It is something that you are looking for? We have heard there is a real need for that.

**Ms McGEE:** We have looked at tenders providing those services and it was not financially viable to run those services.

**Mr REES:** I think the last one we saw was a tender that came through looking for a combination of participants who are on maintenance medications, with families, particularly women, and Indigenous focused. We did submit with a consortium a tender application but, in truth, we would have to consider whether we could have provided that as well because the funding that was on offer would have amounted to possibly one participant at a time being serviced. That also does not really fit the models we look at in terms of that inclusion in the therapeutic community framework and the community method model that we like to try and work with, particularly in those sort of settings.

**Dr MEHREEN FARUQI:** That funding is unrealistic?

**Mr REES:** That one was, yes.

**Ms McGEE:** There are places like Kamira Farm on the Central Coast, which offers a great women's and children's service.

**Mr REES:** Odyssey House in Sydney also do a great program for families. They have got a component of their service that they have the families come into and they can then separate out into the rehab as well, as necessary, and come back in. Those sorts of structures and programs are phenomenal and they have got some great successes, as I understand.

**Dr MEHREEN FARUQI:** They are very far from here.

**Mr REES:** They are very far from here, yes. There is nothing in this area, absolutely not.

**The Hon. Dr PETER PHELPS:** Have you started or are you planning to do some sort of longitudinal study on your early intervention program? I think everyone here would agree that if we can get early intervention to prevent a more expensive later intervention and it proves to be economically viable to do it, then that would be good, but we will need some sort of data to indicate the efficacy of early intervention. Are you planning with your clients some sort of longitudinal study to look at how it goes?

**Ms McGEE:** Yes, we are. We encounter the same problem with all the different residential services in maintaining contact with people, even if they go on to successfully go back to work and home.

**The Hon. Dr PETER PHELPS:** In fact, probably more likely if they successfully go back to work and home because that part of their life is done and dusted and why would they want to remain in contact?

**Ms McGEE:** At the moment we capture measures before they arrive, after one month and after three months. Over longer periods than that, we can try but I do not know how successful we would be. But we are collecting quite a considerable bit of data.

**The Hon. Dr PETER PHELPS:** And there is no way you would have readmissions, unless they were to your own facility—there is no way you would find readmissions at a subsequent period five or 10 years down the track from other facilities around the State, would you?

**Mr REES:** There is a method that could be occurring. We are participants and members of the Network of Alcohol and other Drugs Agencies [NADA], who I think has met with you previously as well, and a lot of the providers that input information into their system have the service linkage key identification number for participants. That is going to start to provide us with the ability to provide some follow-up information and get details around outcomes longitudinally as well. I am not sure where they are up to as far as that goes or how far we have gone back. We, as a provider, have not got to that stage yet; our systems are a little bit archaic in that regard. We are upgrading right now.

**The Hon. Dr PETER PHELPS:** But it is good that you are looking at that sort of thing.

**Mr REES:** Absolutely—it is essential.

**The Hon. Dr PETER PHELPS:** Even if people do lose people in that, in some sense that is good because if no-one is involved in the criminal justice system and they are not involved with detox or rehabilitation, that essentially tells me that they have become functioning members of society again, and that is a success.

**Mr REES:** It is the trade-off and it is the assumption. We can look at research as well, as there have been a lot of papers published over the years around rehabilitation and treatment programs, and the greater criticism is that the population we are speaking to is very small compared to those that have been through treatment, and the question is: Is it because they are unwell or because they are well? The truth is we do not know

the answer to that, and that is part of the problem. Hopefully, we will be able to capture enough information in the future that we still can get some semblance of responses around that, but it is an ongoing challenge.

**The Hon. Dr PETER PHELPS:** But that requires a bit of coordination and agreement between the various—

**Ms McGEE:** Research costs money too.

**The Hon. Dr PETER PHELPS:** But it is a valuable exercise. If you can find a less expensive way of early intervention which has material effects and long-term consequences—it is presumably cheaper and easier to treat with early intervention than it is to try and keep someone after a sustained period of addiction—then that is certainly worth spending the money on.

**Ms McGEE:** That goes to the youth programs as well. It is not only working with youth who have a diagnosed dependence or mental health issue. It is if you can engage youth and people earlier with their wellbeing issues before they have an ingrained mental health issue and dependence.

**The Hon. Dr PETER PHELPS:** Another argument for increased youth services.

**Ms McGEE:** Absolutely.

**Mr REES:** It takes us back even a step further to just education itself. We work a lot, particularly in our therapeutic community program, around communication—the fundamentals of communication, particularly compassionate communication and how an individual can protect themselves and can get their needs met—and a lot of that is just not taught as such; we do not really educate people in how to do that. We can look at society as it is now and say we are probably getting further and further away from that. The reality is, on our current trajectory, we are still going to be required. The services we provide and what we are talking about here now and the funding we are putting into this is going to continue; we are not going to be out of a job anytime soon. My perfect world would be that one day I come into work and I have got no-one to work with.

**The Hon. Dr PETER PHELPS:** But the problem is that the youth that we are looking at probably do not go to school, have not gone to school for a period of time, so they have not learnt resilience techniques. The problem is that you will always have a cohort which will require your services.

**Mr REES:** Absolutely, and there will always be a cohort because there is always going to be someone who will trial something or who will give something a go regardless of what is going on. It is about the rationale as to why you start doing these things as well.

**The CHAIR:** Most organisations, particularly non-government organisations, flourish over time if they have a set of underlying principles or a mandate or a mission—call it what you will—which are often started out by the founders but can be perpetuated over time because people coming into the organisation feel part of that and supported and sustained over time. With The Buttery, what is its essence in terms of the underlying mission or principles? This is not fluffy talk because it seems to be quite important because that brings in the people you want to work with you and sustain you over time. What was the start of it all?

**Ms McGEE:** It started as a drop-in centre when people came up to the Aquarius Festival in the seventies, and the Anglican diocese, I think, started as a drop-in centre and it later went on to develop into a residential community. But for the last 30 years it has been operating as a therapeutic community; it operates under the premise of community as method, where peer support and connection to others and respectful and safe interaction is a way of learning to be able to live in life engaged with themselves and other people. Without that environment of safety and trust and respectful communication and interaction, people are likely to not cope in life and end up self-medicating with drugs and alcohol.

**The CHAIR:** Thank you both for coming along—it has been very insightful, like all the evidence today—to give us some very specific perspective into an organisation that clearly is functioning well and producing results for people who ultimately are coming to you with an addiction of one form or another but then getting themselves on a track which is able to take them out of that over time. We appreciate the work you do.

**(The witnesses withdrew)**

**(Luncheon adjournment)**



**HUGH VAN DUGTEREN**, Solicitor in Charge, Legal Aid NSW, Lismore, affirmed and examined

**The CHAIR:** Welcome and thank you for coming along this afternoon. I acknowledge the presence of the member for Lismore, Mr Thomas George. The Committee has received your submission and it becomes part of this inquiry. You can take it as read. I invite you to make an opening statement. The questions the Committee asks will be drawn from points you make in your statement as well as from your submission.

**Mr van DUGTEREN:** First, I thank you all so very much for coming to Lismore. This is the type of inquiry that this area certainly needs and I know that other remote and rural parts of the State need it as well. Certainly, the issue of drug rehabilitation has been something on my mind ever since I commenced work at Legal Aid in 1988. I have been the solicitor in charge of Lismore Legal Aid since 1998. I spent some time in the city for about four years but the vast majority of my time with Legal Aid has been in Lismore. I am a solicitor, I am not a healthcare professional. My observations are from acting for clients, from seeing what has happened to clients in courts, in jail and in the community.

The Far North Coast has a population of approximately 250,000 people, that is from north of Grafton to Tweed Heads and west to, say Tabulam and taking in that catchment. For a population of 250,000 where there are clearly drug and alcohol issues there are really only two rehabilitation centres that clients of Legal Aid and the courts can access, that is Namatjira Haven—primarily Indigenous-focused rehabilitation at Alstonville—and The Buttery, which is just out of Bangalow. In the first 15 years that I worked at Legal Aid, alcohol and heroin were the two main drugs that gave rise to criminal offences. In that period of time trying to find a rehabilitation centre or obtaining drug treatment or alcohol abuse treatment for my clients was incredibly difficult and the work that I and other solicitors in my office did would often take on the role of a social worker.

The Magistrates Early Release Into Treatment [MERIT] program was then introduced. I was on the steering committee of the MERIT program and it was piloted on the Far North Coast of New South Wales. The MERIT program had a very good magistrate, Mr Lyndon, who was the first magistrate in New South Wales to administer the MERIT program. The advantage of having that magistrate was that he had a keen understanding of addiction and rehabilitation and had an approach where he was more interested in the rehabilitation of our clients, the defendants, as well as the safety of the community. He also understood the process of rehabilitation and that many people were not successful on their first occasion and would bust, rather than the situation that there was zero tolerance when people were granted bail and if they breached bail conditions they would usually be put back into custody. When people had breached their conditions of MERIT bail and the MERIT program stated that they were to go back to the rehabilitation program or go back to community-based treatment, the magistrate would allow that. The consequence of that was that far more people were leaving the criminal justice system and not coming back.

The difficulty is though that alcohol was not included in the MERIT program and people with alcohol abuse problems have real issues in obtaining appropriate treatment on the Far North Coast. Since then, in the last say 15 years, particularly in the last five years, heroin is no longer the major problem that it was on the Far North Coast. I would say that it is a combination of alcohol and methamphetamines. Throughout the first 15 years or so working at Legal Aid, people with issues related to amphetamines would come up occasionally but it would never present as a major problem. I do recall one or two clients who appeared to have very strange behaviour and we realised this because they had been addicted to amphetamines for some four or five years. But certainly they did not exhibit the type of behaviour that many of my clients do now that have problems with methamphetamine.

Notwithstanding the introduction of MERIT, my view is that the lack of rehabilitation opportunities on the Far North Coast has been and continues to be a grim situation. There has also been a fundamental change in young Indigenous offending in that it was rare to ever find Indigenous Koori clients who had heroin issues through the 1980s and 1990s. It is an unfortunate situation that there are a significant number of disaffected young Indigenous youth who are using ice and that is very much reflected in the type of offences that they are committing. When I commenced work as a criminal lawyer I could not understand when I read a fact sheet why someone's behaviour would change so dramatically from being in a situation that I might find myself in after leaving a hotel, and many of my friends. It was only until I realised that so many of my clients have a personality disorder or a mental illness that I realised their rather bizarre behaviour was a product of—sometimes without any alcohol or drugs—but a combination of their mental illness or their personality disorder in combination with alcohol—in particular alcohol back then—and sometimes heroin.

What I find now is that in fact sheets, in briefs of evidence, I see the type of behaviour that I would have expected from someone with a borderline personality disorder, from people who have been using ice. I have my own personal views in relation to drug use and addiction and the like, but I really have not seen the type of bizarre behaviour ever exhibited as I do from clients who use methamphetamine. In the Legal Aid submission right at the

end there was a case study of a person called David. David was one of my clients. David was incredibly lucky that he had a supportive mother who spent so much time trying to get him into a rehabilitation centre and it was only because of the efforts of his mother that David was able to get into a rehabilitation centre and then essentially blossom in life. The local District Court judge was so impressed with his efforts at rehabilitation that he ended up getting—although it was a custodial sentence—an intensive corrections order, which meant he did not go back into custody.

I would compare David to Daniel, a recent client of mine, a young Indigenous man aged 23, who is not allowed back to his community because of some domestic violence issues. His behaviour became more and more erratic until he committed three different sets of offences. I found at the time of his arrest that his behaviour was bizarre. He was making nonsensical comments to the point where I could not comprehend why his behaviour continued as it did after he had been in custody for at least two weeks. When I spoke to a couple of the Magistrates Early Referral Into Treatment [MERIT] workers yesterday they indicated that there are problems—and I apologise that this is lengthy but I need to say this.

**The CHAIR:** Please continue.

**Mr van DUGTEREN:** Because so many rehabilitation services were set up in terms of alcohol or opiates, the detoxification program and the rehabilitation services have been structured in relation to those drugs—alcohol and opiates. Alcohol has a relatively short period of detoxification, heroin seven to 10 days, and methamphetamine 28 days. In terms of rehabilitation for people with heroin problems, say, six to nine months or maybe 12 months, and for people with methamphetamine problems 18 months. That is one of the issues. There are outpatient services—and I note in the Hon. Thomas George's submission that he talked about some of those services—but, unfortunately, in my view they are inadequate. They are certainly inadequate when it comes to people when they get to the criminal justice system. The MERIT program has to put a hold on referrals for periods of time because their books are full, they are not able to assist people in custody, they are not able to assist anyone in the district or supreme courts but certainly the District Court. So that limits opportunities.

There is no Drug Court in rural areas; there is no Drug Court here. There is a Drug Court available to people in the metropolitan area and in Newcastle. The Drug Court would be a really good program for any rural area. There are a number of other points but I am sure they relate to questions Committee members may well have. I really thank you. My concern is that there are not the facilities and that people in custody have limited opportunities. The Department of Corrective Services has a directive that rehabilitation assessment orders, where people in custody can access welfare officers to assist them in contacting rehabilitation programs, are only made in relation to people who plead guilty. There are still a limited number of welfare officers in jails who are able to assist those people in getting into rehab services.

**The CHAIR:** Thank you for a very considered and thoughtful opening statement. You have set the scene very comprehensively. Are you happy for the Committee members to share the questions around?

**Mr van DUGTEREN:** No problem at all. I am usually asking the questions so it is a nice opportunity.

**The Hon. COURTNEY HOUSSOS:** Can you elucidate your comments about the behaviour of people with a borderline personality disorder?

**Mr van DUGTEREN:** Expect the unexpected. Essentially, people getting angry at the drop of a hat. People reacting in a fashion that shows no consideration for their circumstances. When being confronted by five police officers it is like someone is so drunk that they have no idea what they are doing, yet they are not affected by a drug. There are things that make it impossible for them to distil the situation and understand what is required of them, as anyone sitting around this table would react. When I read my first couple of psychology reports and they talked of a borderline personality disorder I thought that could not be too bad because it was only borderline. In fact, a borderline personality disorder is one of the worst. It took me some time to sit down with a psychologist to find out about this. What I find is that our jails are full of people with personality disorders and mental illnesses.

**The Hon. COURTNEY HOUSSOS:** Excuse my ignorance, is there an Aboriginal Legal Service in Lismore?

**Mr van DUGTEREN:** There certainly is. They have been here probably longer than Legal Aid NSW, Lismore, although there was an Australian Legal Aid office here.

**The Hon. COURTNEY HOUSSOS:** What proportion of your clients are Aboriginal? You can take that question on notice if you would prefer.

**Mr van DUGTEREN:** In the criminal law section we would probably act for 20 per cent of our clients. If you go to a town like Casino, which has a 10 per cent Indigenous population, the court list is 80 per cent Indigenous. It is not the same at any other court on the Far North Coast, but certainly at Casino.

**The Hon. COURTNEY HOUSSOS:** What proportion of Legal Aid's clients have been charged either with offences related to drugs or as a result of those people having taken drugs?

**Mr van DUGTEREN:** I would say about 90 per cent, and that includes alcohol. There was going to be a hotel put into a small community—this was about 20 years ago, so it was at a time when heroin was more of a problem, not methamphetamine—and I can remember looking at all the local court cases for four months and working out that 65 per cent of those cases were alcohol related and about 25 per cent were other drugs. So 65 per cent were alcohol related at that time, and that included drink driving offences of course. What I find now is that offences of violence tend to be alcohol or alcohol and methamphetamine or methamphetamine—those combinations. It is rare that you get offences of violence without some form of either untreated mental illness, which is very tragic, or there is some combination of alcohol or some other drug.

**The Hon. COURTNEY HOUSSOS:** You said you have worked at Lismore for 30 years?

**Mr van DUGTEREN:** Yes.

**The Hon. COURTNEY HOUSSOS:** Do you think that the current drug problem is worse or similar to the use of heroin in the 1990s? In other words, can you provide the Committee with an historical context of how bad the current drug problem is?

**Mr van DUGTEREN:** I cannot say that there has been a dramatic increase in property theft or offences of violence. There has certainly been an increase in possession and supply of methamphetamine offences. What you will find is that back in the 1980s and 1990s—now many of the offences that I get, and a lot of my matters are in the District Court, people with an amphetamine problem are being charged with supplying methamphetamines. That is a very common situation. I have not looked at the Bureau of Statistics in recent times but I do know that generally crime figures have been going down in the last 20 years, not increasing, apart from the odd different type of offence. There have been many measures within the community that have worked in terms of reducing crime. There is certainly not the amount of break and enters that I can remember back in the 1980s and 1990s. There are not the young people going out and doing those things.

Also, it is much harder for people to break into a home and take things that they can hock. There are just not those things that would fall off the back of a truck, as there was 20 to 30 years ago. So the nature of property crime in court has changed too. But with the increase in methamphetamine what I have seen is the real breakdown in people's lives. When I talk to someone in the cells and I say to him, "Now look, you have had your children taken by FACS, you are living in your car, you do not have a driver licence and you are saying life is okay." He says, "It is great." He is a meth addict. I can remember seeing something in one of the submissions about that attitude; they just do not care. I can remember seeing in a psychological report from many years ago that a local psychologist said that this man takes heroin to remove the pain from his life.

I feel like I am a very lucky person. I was not abused when I was young. I had a really lovely family; I had doting parents. I went to a good school. I went to university. I never experienced some of the things that these people experience, whether it be domestic violence, sexual abuse, drug and alcohol abuse when they are young. I do not have this pain that these people have. Certainly heroin is like that and heroin will take away all pain—emotional pain, physical pain and the like. What surprises me is that I have a lot of clients now who used to be heroin addicts who are now using methamphetamine. They are completely different drugs; they have a completely different effect on the body, and yet they are more than happy to move from one to the other.

**The Hon. COURTNEY HOUSSOS:** You said there are a lot more methamphetamine users who are being charged for supply. Do you say that in comparison to heroin in the past?

**Mr van DUGTEREN:** No.

**The Hon. BRONNIE TAYLOR:** It is great that you are here. Thank you so much for your time today. I want to flesh the MERIT program out a bit more. I am really excited to hear that you were on the original steering committee for that. Do you know how long it has been since the MERIT program has been reviewed?

**Mr van DUGTEREN:** No, but I understand it is currently under review. I think that is the situation now. It was reviewed when it was a pilot program for expansion around the State.

**The Hon. BRONNIE TAYLOR:** Some of the evidence given before lunch was really interesting in that when people were on the MERIT program they tended to stay for the duration. I am not sure of the legal terms. The magistrate would say that they have to stay in this program and in this bed for X amount of time, and they tend to stay because of the consequences if they left.

**Mr van DUGTEREN:** Twelve weeks.

**The Hon. BRONNIE TAYLOR:** That is at least giving someone a chance. They are going to stay and they are not in jail and they are in this MERIT program, but then it ends and there is no requirement in the program for anything after that.

**Mr van DUGTEREN:** Most of the people who have been on the MERIT program, whether it be community-based treatment or in a rehabilitation program—those in a rehabilitation program tend to stay in the rehabilitation program beyond the 12 weeks; those in a community-based program, there will be the appropriate referrals on to assist them when they are no longer in the MERIT program. Also, part of MERIT was to refer people to the services that those people needed so they would make the contacts within the community and they would know where to go and how to stay out of trouble and how to access assistance once that program was finished.

**The Hon. BRONNIE TAYLOR:** But 12 weeks is not really going to be time to have long-term changed behaviour.

**Mr van DUGTEREN:** It does not go long enough.

**The Hon. BRONNIE TAYLOR:** Yes. Why would something like that that obviously has had some really great consequences—anything keeping young people out of jail is positive.

**Mr van DUGTEREN:** It is not just young people. There are a lot of mature-age people that are part of the MERIT program too.

**The Hon. BRONNIE TAYLOR:** Whoever, is it not great they are not in jail and they are in this program? What if we looked at extending that so that they have to successfully complete an inpatient requirement, and then for another six months they have to see other services, and they are home?

**Mr van DUGTEREN:** What would happen for many people, because they get a non-custodial penalty—and there are very few people who complete MERIT who get a custodial penalty—they will have been put on a section 9 bond.

**The Hon. BRONNIE TAYLOR:** That means no record?

**Mr van DUGTEREN:** Sometimes it is section 10 with no conviction recorded. They are placed on a good behaviour bond and placed under the supervision of Community Corrections, or a requirement that they can comply and complete other programs that they have engaged in through the MERIT program. Although MERIT will have finished, the people will have been linked up with other services and there will be requirements of their good behaviour—the court sanctions it. I have found that many of my clients who have accessed MERIT are not on the same recidivism treadmill as a lot of clients who have, because they have had access to other services once they are off the MERIT program.

**The Hon. BRONNIE TAYLOR:** What we were hearing was that they will not complete the MERIT program and then they will not complete the outreach. We can hear all the evidence, but we have got to try and come up with some good solutions for recommendations. I am just wondering if something like that should be considered by the Committee because then at least we know that we have helped them onto a three-month mark but that really we need them to stay engaged for the 12 months.

**Mr van DUGTEREN:** There was a program in Lismore called Life on Track; it lasted two to three years and then was replaced by another thing called the Elective Offender Management Scheme. I am afraid to say I think it was a very poor decision. Life on Track worked intimately with MERIT and it was a program that was run by Mission Australia. They accessed people through the courts through referrals by the magistrates, and I know that two of the magistrates who had access to the Life on Track program thought it was a fantastic program. It went longer than MERIT. They provided assistance after the court finished, and they were having so much success that they were able to—because many clients who have criminal offences will also have fun and games with the Department of Family and Community Services and have their children removed. People who had been refused contact with their children will have to negotiate with FACS and even for circumstances where they were able to get custody of their children again.

They were providing a very, very good service. It was quite broad-based. They worked well in combination with MERIT and I tend to find that these community-based programs—particularly when you see a brand-new jail being built in Grafton, a big jail on a new place would cost a lot of money. I appreciate why we have needs for new jails but, at the same time, there does not seem to be much of an investment in rehabilitation programs and there are other costs to a community like Grafton, even with a new jail. With jails you get families moving into those communities because their partners, their husbands, their wives are in custody there. There is a dearth of drug and alcohol services in Grafton and there may well be a crisis down there once the new jail opens because of that.

**The Hon. BRONNIE TAYLOR:** We heard evidence about that yesterday and we heard some really great stuff about prevention.

**Dr MEHREEN FARUQI:** Thanks for coming in this afternoon. Counsellor Lloyd's submission highlights that this region has the highest number of drug offences in New South Wales. In her submission she points out it is almost three times the average for New South Wales. In your experience, why do you think that is the case?

**Mr van DUGTEREN:** One reason is over-policing. We also have festivals here. Whenever there are festivals like the Byron Bay Blues Festival, and there are two other festivals down on the coast, there is a large police presence. There are reasons for that large police presence. They have to have special list days at Byron Bay after Splendour in the Grass and after the Blues Festival. The only offences that go to court after that are drug-related. I think when you have courts having to have special list days that spikes the numbers. There was one only yesterday at Byron Bay in relation to the Blues Festival, and there will be another one in August or September as a result of Splendour in the Grass.

I really do not think the Far North Coast is all that different to other parts of the State, but I tend to find that in country areas there is a much larger police presence in some places. In Byron Bay, with a population of 10,000, there is a permanent police station. There would be no suburb in Sydney that has 10,000 people with the number of police that are in Byron Bay, and there are various reasons for that, but there a lot more police per head of population in some places. There are things like the MardiGrass that Nimbin will attract. So there are certain reasons that those numbers increase.

**Dr MEHREEN FARUQI:** They would be because of those particular times in the year.

**Mr van DUGTEREN:** Those particular times. I am not being critical of the police, it is just police numbers. There is more police per head of population.

**Dr MEHREEN FARUQI:** I have been to MardiGrass a few times and I know exactly what you are saying. One of the submissions that we had from the Broken Hill working group raises a concern about people losing public housing when they go into residential programs. Even women who leave their children with foster carers risk having them taken away altogether. Do you find that there is a similar situation around here in your work? Is that a risk that would stop some people from seeking rehabilitation services?

**Mr van DUGTEREN:** No, people wouldn't not access the rehabilitation services because usually when they have got to that point it is going to be jail or the rehabilitation service quite often when we get to court. So if they are going to jail for any period of time they are going to lose their public housing. There are going to be issues with children. I do not think the threat of losing a home or children is something that will stop people doing rehabilitation. There are also excellent rehabilitation programs, if you can get in, where you can take the children.

**Dr MEHREEN FARUQI:** There are? We have heard there are very few.

**Mr van DUGTEREN:** Down in the metropolitan area.

**Dr MEHREEN FARUQI:** In the city not around here?

**Mr van DUGTEREN:** Not around here. I can remember in court only last week it was a committals day in Lismore. We had a client who, I think, was at John Morony which is out at Windsor. He had a rehabilitation assessment order made. He had been accepted into Odyssey House and had to be at a certain train station at nine o'clock the next morning. The biggest issue for the magistrate was to make sure he did not miss meeting that person there, and that really concerned the magistrate. It was not that he would run away instead of going to the rehabilitation centre but the physical nature of getting people into a rehabilitation program. They are the real problems. Also when I have had a mother with children client, there seems to be sometimes a greater effort made by other people to get them into a rehabilitation program that is suitable. There used to be one at Benelong's Haven at South West Rocks but that has only just closed, I understand.

**The CHAIR:** The Committee has heard a lot about that.

**Mr van DUGTEREN:** Unfortunately. That was a program where part families could go and everything. It is a great tragedy that that is no longer there.

**Dr MEHREEN FARUQI:** Do you think there is a need for something like that in this area?

**Mr van DUGTEREN:** There is most definitely a need for rehabilitation services for women especially with children and also for young people. The young client of one my solicitors in the office is actually on bail at 16 and said, "I need to go to rehabilitation," which is quite an amazing insight for a 16-year-old. But there is a lack of rehabilitation—I think I have had to have clients go from here out to Mac River at Dubbo to access them.

There have been programs at Coffs Harbour but really the only place he could get into from Tweed Heads was Dubbo.

**Dr MEHREEN FARUQI:** This Committee is reaching the end of its inquiry and we will start to think about the recommendations that we may make. Will you highlight what you think are the major issues in the way we treat people who use drugs? How do we change that?

**Mr van DUGTEREN:** It is interesting. Truly alcohol creates the most number of problems at court, and that is only from my own experience. I do know from the study I did of the last days—even though it is 20 years ago I do not think it has changed all that much—there is an acceptance within our community and, basically when people have an alcohol problem it is tragic but not enough people encourage them to go and get assistance. I think it is a lack of understanding within the community of what drug problems are and why people have them. I think programs such as Merit and the Drug Court are really good. Programs such as the Drug Court really need to be moved into rural and remote areas.

The problems on the Far North Coast are really different. I read a lot of the transcript of your hearings in Dubbo. The problems endemic out there are very different to the problems we have here because the remoteness out there creates added real problems. Here it is lack of services, a lack of beds for rehabilitation, a lack of appropriate—I think in communities such as Casino and those that feed into Casino there are major health issues for young Aboriginals. The number of young Aboriginal clients I have who leave school at 13, 14 or 15 years and essentially they have got hearing problems. I have got a significant number who are illiterate. The number of clients I have that are illiterate is just astonishing. I think you have got to understand we are dealing with a very different cohort of the type of people you would normally meet in your day-to-day life.

It is a question of providing services for these people. I think education programs at schools need to be better targeted to people. David in the case study in the Legal Aid program had a mother who loved him and cared for him. I know it sounds a bit old-fashioned but most of my clients do not have anyone who loves them. There is no-one to help them and one of the reasons is because of their behaviour. They really test your patience. We have to work out ways to either find those people when they are at school, and not let them leave school but give them a better break at school, and if they have major problems being able to divert them into other programs. As adults I think when you see the type of changes that befell David by sticking with rehabilitation they are the sort of outcomes we should be hoping for everyone.

**The Hon. Dr PETER PHELPS:** The submission of Legal Aid indicates a reluctance to support mandatory detoxification and rehabilitation of, in particular, methamphetamine users. Do you agree with that recommendation?

**Mr van DUGTEREN:** I would. I have read a little bit about the report from Northern Territory where it existed for a period of time. It would concern me how it was implemented but essentially people who are forced into a program generally when they get out do not get any form of insight and will go back to the type of behaviour they were engaged in. The closest I can recall is when I first started, I think it was the Intoxicated Persons Act that was in existence. People could be taken to a facility and made to be dried out. I can remember clients at court that were so drunk that a magistrate made that order and within a week or two weeks of their release they are back engaged in that same behaviour. When people go into custody, generally speaking, you would think they would be detoxed over a period of time.

**The Hon. Dr PETER PHELPS:** That is not what the Committee has heard. The Committee heard testimony from a person who said that the only place you can be guaranteed of getting drugs in New South Wales is in the prison system.

**Mr van DUGTEREN:** I was saying that theoretically. I would like to think that just like at Parklea where they have got that special program that when people go into custody they have dry cells. They have cells where they think people are liable to commit suicide and they put them in these special cells. They do all sorts of things. What would be really good is if when people are on the intake that they be assessed for their drug usage and if they have a problem with methamphetamine that they get taken to a certain type of facility so that they can detox properly.

Something I will say, even with the mandatory coercive programs, the thing about the MERIT program is it is a pre-plea program. Most of these clients always say, "I am not guilty. I am not guilty." And after they have been in the program for six to eight weeks they end up pleading guilty. They gain insight. So going back where we have the coercive programs like the Drug Court or even MERIT to an extent, they would learn, they get insight whereas people who are subjected to a mandatory program do not seem to get insight for some reason or another—and I am more than happy to bow to the experts.

**The Hon. Dr PETER PHELPS:** I spoke to a solicitor on the South Coast who said that there is a growing number females who, because of their association with amphetamine users, are subsequently being drawn into the criminal justice system as part of a dealer network. Have you noticed that here?

**Mr van DUGTEREN:** I think anyone who gets an addiction has the capacity to be part of the dealer network.

**The Hon. Dr PETER PHELPS:** But I have been told that there is an unusually large correlation between use and dealership with methamphetamine which you do not see in other drugs.

**Mr van DUGTEREN:** The only time I have ever seen that is in relation to cocaine on the North Coast and that was about two or three years ago when there seemed to be a lot of cocaine for one reason or another. There was a whole bunch of young women who had somehow got caught up. I could not say that I have noticed a large cohort of young women methamphetamine addicts getting caught up in that.

**The Hon. Dr PETER PHELPS:** Not so much addicts but in a relationship with addicts who then find themselves—

**Mr van DUGTEREN:** No, I could not say I have noticed that—

**The Hon. Dr PETER PHELPS:** It might be because of the geographical difference between them. Do you believe that stringent enforcement of drug laws results in demand reduction?

**Mr van DUGTEREN:** I really could not say. There has been a war on drugs for the whole time I have been a lawyer and I have not seen any reduction in the amount of drugs out there in terms of offenders.

**The Hon. Dr PETER PHELPS:** You indicate no.

**Mr van DUGTEREN:** Yes, no.

**The Hon. Dr PETER PHELPS:** Yes, no?

**Mr van DUGTEREN:** No, just a no. With heroin I think the reduction came about because it was harder to import for a period of time.

**The Hon. Dr PETER PHELPS:** And because there was a major war taking place—

**Mr van DUGTEREN:** There was a war taking place in Afghanistan which creates a much more difficult situation to get it out of Afghanistan and into Australia. But at the same time another drug took over.

**The Hon. Dr PETER PHELPS:** Is that one of the problems that we face—that is, it is now effectively cheaper to go out and get a significant hit of methamphetamine than it is to buy a slab of beer?

**Mr van DUGTEREN:** Yes, allegedly.

**The Hon. Dr PETER PHELPS:** No, the Committee has heard evidence from experts—

**Mr van DUGTEREN:** I spoke to the MERIT people yesterday. They reckon a point of methamphetamine on the far North Coast costs between \$20 and \$30.

**The Hon. Dr PETER PHELPS:** About \$30 is what we heard from witnesses from western New South Wales. That is, in fact, three-fifths of the price of a slab of beer.

**Mr van DUGTEREN:** Yes.

**The CHAIR:** It might be cheaper at Aldi.

**Mr van DUGTEREN:** It might be cheaper at Aldi. What I find astonishing is that people who use methamphetamine tend to just keep taking it. I have had clients that have been awake for 28 days. I cannot imagine being awake for 28 hours, let alone 28 days. And they have been drinking and taking methamphetamine. It is a really strange situation, I am afraid. I find it hard to relate to what this drug does.

**The CHAIR:** In relation to alcohol supply and availability, a theme that has arisen in the course of this inquiry and in our visits to regional areas is that, objectively speaking, looking at June 2018 the availability of alcohol, the price point at which some beers and wines are now available is much greater than was the case five, 10, 20 years ago. Is that feeding into the alcohol issues that communities are facing or are there other drivers leading to the impact of alcohol abuse? Do you have any sense about the availability of alcohol and the number of sites or retailers where it is available and the relatively reduced prices they are offering? Is it impacting on the supply?

**Mr van DUGTEREN:** I think the one impact I have noticed is I have more female clients who are at court as a result of alcohol-related offences. That is the way I have noticed the difference. One of the funniest comments I ever heard from a police officer was about 30 years ago. He said that the introduction of RBT changed the whole landscape. The death rate on roads was halved and offences at pubs when they closed multiplied. Before RBTs everyone went home, got drunk—more drunk—someone got killed on the way home and now everyone hangs around the pubs.

**The Hon. Dr PETER PHELPS:** They stay and in goes the biff.

**Mr van DUGTEREN:** Yes, in goes the biff, and if there is any methamphetamine around it really is a silly situation.

**The Hon. Dr PETER PHELPS:** The law of unintended consequences. The only law which is immutable in government.

**Mr van DUGTEREN:** Yes, I could not agree more.

**Mr SCOT MacDONALD:** The 2016 Corrective Services NSW transfer policy says that residential rehabilitation programs can now only be undertaken following a guilty plea to assist in identifying sentencing options. What has been the consequence of that?

**Mr van DUGTEREN:** It means any of my clients who are pleading not guilty, or have not entered a plea in relation to committal matters, in particular, but also in the Local Court cannot get a rehabilitation assessment order made which means a welfare officer at the jail will not facilitate the process of contacting rehabilitation programs for assessment.

**Mr SCOT MacDONALD:** I understand that. What in your view is the consequence?

**Mr van DUGTEREN:** It just means a lot of clients do not get access to rehabilitation. Sometimes the magistrate will make an order when they know it is a committal matter and there is positive negotiation going on between the defence and the Office of the Director of Public Prosecutions so that the matter will be resolved in some form of guilty plea.

**Mr SCOT MacDONALD:** Sort of like a Drug Court approach?

**Mr van DUGTEREN:** Yes.

**Mr SCOT MacDONALD:** Would your recommendation to this Committee be an assessment report, irrespective of a guilty or not guilty plea and where they are in the justice pipeline?

**Mr van DUGTEREN:** Yes. Also I refer to what I said about the MERIT program. It is quite interesting. When people get access to rehabilitation services the difference in the instructions you get from them after a period of time is dramatic.

**Mr SCOT MacDONALD:** What was the motivation behind that change in 2016? Was it to try to get more guilty pleas?

**Mr van DUGTEREN:** No. It would have been because the welfare officers do not have enough time to assist everyone.

**Mr SCOT MacDONALD:** Resourcing?

**Mr van DUGTEREN:** I would say it was resourcing more than anything. It certainly would not have been aimed at getting guilty pleas out of it.

**Mr SCOT MacDONALD:** Your next dot point is the reintroduction of dedicated alcohol and drug workers in prison. You say that has been wound t back a lot?

**Mr van DUGTEREN:** Yes, that has been wound back.

**The Hon. Dr PETER PHELPS:** A witness mentioned that earlier in her testimony.

**Mr SCOT MacDONALD:** Including in remand?

**Mr van DUGTEREN:** Most definitely in remand.

**The Hon. Dr PETER PHELPS:** That is the first point of contact. That is more important than anywhere else, surely. Would you agree?

**Mr van DUGTEREN:** It is, without a doubt, but they are not there.

**Mr SCOT MacDONALD:** Will you talk a bit more about its value?



**Mr van DUGTEREN:** Of drug and alcohol services in the jail?

**Mr SCOT MacDONALD:** In remand or in jail.

**Mr van DUGTEREN:** The advantage is that when people get into custody they are confused, they do not know what to do.

**Mr SCOT MacDONALD:** They are scared?

**Mr van DUGTEREN:** They are scared. They are absolutely terrified and they become hyper vigilant after a period of time. The advantage of having drug and alcohol workers at jail would be that they would be able to assess people, see whether they are the appropriate ones to go to rehabilitation programs and the like.

**Mr SCOT MacDONALD:** Not necessarily pushing everybody that way?

**Mr van DUGTEREN:** No. Because there are some people who just will not go to rehabilitation—they will be a failure.

**Mr SCOT MacDONALD:** Assessment is necessary?

**Mr van DUGTEREN:** Some form of assessment, assistance and detox is the important thing when they are in jail. My client Daniel, even three weeks later, is still not making sense. That is the effect of methamphetamine on the brain, and the type of psychosis it can create.

**Mr SCOT MacDONALD:** Do you say Legal Aid could have a role there?

**Mr van DUGTEREN:** Yes.

**Mr SCOT MacDONALD:** Within that assessment?

**Mr van DUGTEREN:** Yes.

**Mr SCOT MacDONALD:** Your last dot point refers to the establishment of a free call service to rehabilitation providers?

**Mr van DUGTEREN:** Yes. What happens is when I get a call from a client in jail I am on his telephone list so I am one of the people he or she can contact, like their wife, their husband, their child, their parent. If you are not on that telephone list you cannot make a phone call. That is why they need the assistance of a welfare officer to make those phone calls because they cannot make them themselves.

**Mr SCOT MacDONALD:** Are you talking about someone in custody?

**Mr van DUGTEREN:** Yes, who wants to contact a rehabilitation service.

**Mr SCOT MacDONALD:** For any reason?

**Mr van DUGTEREN:** To try to get an assessment done.

**Mr SCOT MacDONALD:** To get an assessment happening?

**Mr van DUGTEREN:** Yes. The assessment takes anywhere between half an hour and an hour on the telephone. After I have been on the phone for five or 10 minutes with my clients the bell starts going "ding, ding, ding", unless I have phoned them and I have got a registered audio visual link. They only get a limited amount of time and that is why they need these special phones to be able to call rehabilitation centres.

**The Hon. Dr PETER PHELPS:** I know this so well over recent times.

**The CHAIR:** Your evidence has been very insightful and interesting. I thank you for the amount of work you do on behalf of people needing legal advice in this community.

**Mr van DUGTEREN:** Thank you for having me along. I really appreciate it.

**(The witness withdrew)**

**EDWINA LLOYD**, Councillor, Lismore City Council, affirmed and examined

**The CHAIR:** Welcome. Thank you so much for coming along. We have a submission in your name, which is submission No. 36. You can take it as read—the Committee has had the opportunity to have a look at it. I invite you to make an opening statement, following on from parts of the submission but not in reference to it in detail because the Committee has read it but perhaps to set the scene more broadly and make some other salient points. Then Committee members will pose you questions. Are you okay with that?

**Ms LLOYD:** Sure. Have a couple of documents that I want to table and refer to.

**The CHAIR:** Thank you. Please begin.

**Ms LLOYD:** Lismore City Council would like to say thank you very much for this really important opportunity to address the inquiry. In regard to my role on council, I am also chair of a recently established social justice and crime prevention committee that has been tasked to explore the need and demand in our area for a drug court, youth and adult Koori court, further residential rehabilitation beds, and justice reinvestment initiatives. In addition to my role on council and as a criminal defence lawyer, I am also someone who has had a substance abuse disorder. I was arrested 12 years ago and was facing a gaol term. I was lucky enough to be afforded the opportunity to go to The Buttery residential rehab. I did that and I live to tell the tale. I have a few different hats in regard to the evidence I am going to give today.

Our area does have some pretty dubious statistics in regard to drug offending. I note what Mr van Dugteren has said about the over-policing or a lot of heavy policing in our area and the festivals that may contribute to some of those drug possession offences. I have had a good look at the Bureau of Crime Statistics and Research [BOCSAR] statistics for our area—not just this local government area but all of our surrounding LGAs. Indeed, for what I would characterise as drug-related offending, we are two to three times the State average. Those kinds of offences are break and enters, malicious damage, assaults and a lot of domestic violence, unfortunately, in our community. I add to that this is my own experience in court as well, that these are often drug- and alcohol-related offending.

We have got a significantly higher than State average proportion of Aboriginal persons in our community. BOCSAR released a report in 2017 that said that there has been a 25 per cent increase in New South Wales in Indigenous incarceration. There was a further report that in this area it was a 50 per cent increase. Alcohol and substance abuse are, unfortunately, very big problems in our Aboriginal community. I read this quote from Noel Pearson, who has argued:

Indigenous drug and alcohol abuse are far more important causes of Indigenous incarceration than economic and social disadvantage.

I think it is really important that we listen to that. If we are really, genuinely going to try to address the disproportionate amount of Aboriginal persons in custody. We need to address further access to rehabilitation services, both inside and outside the criminal justice system. One of those options that our committee is going to be looking at is perhaps a Koori court here, one that services the youth and adults. I know there is no formal evaluation done of the Koori court in Parramatta at the moment. The early reports have been very positive and positive enough that the Attorney General, Mr Speakman, has announced \$2.7 million funding to expand it into the Surry Hills Children's Court. That is good evidence, I would say, that they are working and really turning these young people's lives around.

I also do the list for Aboriginal Legal Service at Casino Local Court on the Wednesday. I can tell you that it is a full day of Aboriginal persons facing charges in court. Koori courts do work—they are much more culturally sensitive, they are much less intimidating than westernised courts, and they really intensively case-manage the people and put them in touch with all the necessary supports that they need to put their lives back on track. I can tell you anecdotally that working for Legal Aid duty work and Aboriginal Legal Service, I can count on one hand the number of people that I have represented in the last 12 months that have not had a substance abuse, drug or alcohol and/or mental health issue that I would say would be linked to their offending.

These clients are very complex clients and they have very complex needs. Despite the very best efforts of defence lawyers, prosecutors and the judiciary, we are struggling to find opportunities to funnel these people into treatment and recovery. That is because there are so many shortages. You have heard a lot about that in our area. You have heard a lot about the Magistrates Early Referral Into Treatment [MERIT]. I wanted to table a document but it has not been printed today. It was an article put online by the local *Northern Star* newspaper at about 12.00 a.m. so it has not made the print version. That is where our local magistrate, Magistrate Heilpern, was quoted. There was an offender before him—a female—who had been drink-driving a second time. She desperately needs treatment.

She had received a suspended sentence for a high-range drink-driving offence and she was back before the court yesterday for a mid-range drink-driving offence. MERIT was not available but it might have been something that might have reduced the risk of reoffending the second time but because she only had an alcohol problem you have heard evidence, it is not available. I know that MERIT in some areas have got alcohol, but for our clients here, it is only drugs—only if you have got drugs. That is a real gap. I understand that it is a resourcing as a result of MERIT not having the funds to service a lot of people, so they have to make these kinds of decisions.

They do not take people in custody. MERIT used to take people straight from custody but that has stopped now, again, as a result of resourcing issues. In regards to MERIT, I want to clarify because I heard another speaker speak about MERIT today—I think Mr van Dugteren addressed that. It is a voluntary program; it is not mandatory. It is often not the case that the client is facing gaol to go to a MERIT. It is not often that. Sometimes they may be facing gaol but there are a lot of people that do the MERIT program who are not facing gaol but genuinely want to do that program. What MERIT does is that they do link people up with Alcoholics Anonymous and Narcotics Anonymous. That is a fantastic after-care program that I still rely on today. A lot of these programs and rehabs will entrench people into that program and they will go on and become members of that fellowship for years to come.

We do not have a drug court. I think there is enough evidence that our area needs a drug court. A lot of regional areas need drug courts. They are better at reducing recidivism than incarceration. There have been a couple of studies done. I know that there has been evidence referring to them, so I will not go into that. We know that they work. Like Koori courts, they also provide intensive assistance to the participants in a holistic way, in all areas of their life. There is understanding and there is compassion that these people have a multitude of problems when they are before the courts, not just their substance abuse but complex housing, family, custody issues, and mental health problems.

There is a bit of postcode justice going on where if you are in Sydney and you live in the right catchment area and you are eligible for the drug court, you can participate. But if you are here, the option for you might just be gaol. Of course there is no point having a drug court unless we have the supporting infrastructure around it, detox facilities and residential rehabilitation centres with enough beds. We have got a huge gap in our detox sector here. I note the Hon. Thomas George has included that in his submission as well. It is not available for under 18s and that is a real problem for our area.

Another huge problem I would say is what people have given evidence about, there is no smooth transition from detox into residential rehab. It is very difficult—I can speak from personal experience—to find that small window of opportunity where you have that motivation and willingness to do something about your drug addiction. That point in detox when you have come off those drugs or alcohol for the first time is that moment. It is that moment that we need to seize and make sure that there is a smooth transition straight from detox into rehabilitation. But there are lots of waiting lists. When I did my submission, regarding The Buttery, that was their waiting list at that time and today we have heard it is seven months long. It is only increasing and getting worse.

The fact is that we have got these long waiting lists. I know it is not unique to this area. You have heard about the long waiting lists right across the State. That is really good objective evidence, I think, that the people who are suffering from substance abuse disorder are putting up their hands to do that mode of treatment. They are the ones, the 74 people that are ringing up every Thursday, 6687 1111. I still remember the number from 12 years ago. Every single Thursday I had to ring that service to make sure that I stayed on the waiting list. I think we really need to listen to that objective evidence and provide more beds for people because that is the kind of treatment that they are asking for.

The last thing I wanted to talk about is the idea of justice reinvestment, which is something that our committee is also looking at. In the 2016-17 budget there was \$3.8 billion allocated to increasing prison beds but only \$197 million to the whole drug and alcohol sector. Gaols are expensive and statistics reflect that they are not effective in rehabilitating or deterring people from reoffending and they are also not an appropriate setting, in my view, for people to get clean. When people are coming off the drugs and they really need to address the underlying issues of why they took the drugs they are going to be talking about trauma, about sexual abuse and physical abuse. A gaol setting is not an appropriate place to let your front down and to start getting vulnerable like that. It is a very dangerous place to do that.

There is a need for more drug and alcohol workers in gaol. I do know that there is Alcoholics Anonymous and Narcotics Anonymous that is run in some of the gaols, by the inmates themselves. I think that they really need to allow inmates on remand access to phones to contact rehabs to get on a waiting list and maintain themselves on there. My personal view, sharing with others before me that the war on drugs has failed, but importantly that is probably not going to change so my view is while we have the criminal justice system the way it is, we need to

ensure that we use that contact with the justice system that people have to funnel them into treatment. It is a great opportunity to get people into treatment. I think you need to be making the most of that. That is all I have got.

**The CHAIR:** That has been detailed and comprehensive. It augments nicely what was in your submission.

**The Hon. COURTNEY HOUSSOS:** Thank you so much Councillor Lloyd for your submission and testimony today and for sharing your story. As you heard me say earlier today, the lived experience is an unquantifiable factor in what we are talking about. I want to start with the final point that you made, which is that we should be using the interaction between individuals and the criminal justice system as a key point. We heard testimony yesterday that the new enormous Grafton gaol is going to have lots of opportunities for innovative rehabilitation programs. Is there any advice that we could possibly provide to ensure that has the best possible outcome?

**Ms LLOYD:** I will say I would not think that the gaols, the way they are, are an appropriate setting for people to address their drug and alcohol issues. I will say that I have read the studies done on the compulsory drug treatment correctional centre and whilst I do not support mandatory detoxification and things like that, people are going to gaol mandatorily, so while they are there—that program only has 70 beds. It has been really successful.

I will share with you a story of one of my clients I had many years ago. He was a repeat offender. He was 43. I tried to help him as much as I could. We managed to keep him out of gaol. He got an intensive corrections order that he broke with a break and enter and he was going to gaol. He was a heroin addict. He had never had any rehabilitation before, did not want it, did not care, loved his life, and had been using drugs since he was 11 years old.

I said to him, "You might be eligible for this compulsory drug treatment correction centre." He said, "I do not want anything to do with it. I do not want to do that. There is no way in the world". I said, "Well, you might actually get more time. This might actually be an opportunity for you to address these longstanding issues." He said, "I don't have a problem". Anyway, he ended up giving me instructions to be referred to that if that was an option for the court and it became an option. We referred him to that and about a year later I got a call saying that he was there and it was the best thing that ever happened to him and that he had turned his life around. He was clean for the first time and he wanted to now follow that path. As far as I am aware he is still clean today. That program worked for him.

The other point I want to make about that, whilst we have a need to address it, prevention is obviously better than anything, but we cannot forget the people out there that are maybe in their forties and fifties. They are just as valued and have just as much right to the treatment. Sometimes I hear that if they do not get it in their early twenties, it is too late, that they have made their choice now. It is important to remember that addiction is a very cunning and baffling disease and it can take a long time for people to want treatment and it can take many goes for people to actually find recovery.

**The Hon. COURTNEY HOUSSOS:** You mentioned earlier in your opening statement that almost all of the clients that you see are affected in some way by drugs, that their offences are in some way related to that. Can you give us a rough idea of how many clients you would be referring to? How many clients would you see in a year?

**Ms LLOYD:** So many.

**The Hon. COURTNEY HOUSSOS:** You can take it on notice.

**Ms LLOYD:** I do not know how to quantify it. If I am doing the list day for the Aboriginal Legal Service or Legal Aid I could see 20 clients a day, maybe two or three, maybe more, fresh custodies, which are people you need to run bail applications for who are sitting in the cells. All of them, and that may be two days a week of that kind of work, and then other clients I have on a private basis as well. So, a lot.

**The Hon. COURTNEY HOUSSOS:** I am trying to get an idea of the numbers. We have been around different parts of the State. Up here there are quite a few facilities between Riverlands to do detox and The Buttery, The Buttery Private, Namatjira Haven, and other private services, but you are saying there is still a need for additional beds in this region?

**Ms LLOYD:** The private ones are prohibitive for many of my clients who are from the most socially disadvantaged parts of our community. They rely on the public system. The waiting lists are just too long for those.

**The Hon. COURTNEY HOUSSOS:** Given the drugs that we are dealing with, do you think that there is more of a need for residential rehab rather than community outreach?

**Ms LLOYD:** I think there is probably a need for a diverse range of opportunities for people. As you have heard, everyone is different. Everyone has complex needs, individual needs. Something that works for one person may not work for another person. People have different commitments to life, children, family and work. Some people are managing their addiction. Maybe a community outreach program is appropriate for them. Others are not. There is definitely a gap for women, and women and children. There is a huge barrier for them to access treatment if they cannot take their children in there. Especially there is a gap for Aboriginal women and culturally sensitive rehabilitation centres.

**The Hon. COURTNEY HOUSSOS:** I think one thing we can all agree on is the need for a variety of services and supports. Have you seen any results up here—particularly in your local government area perhaps, and surrounding ones—for the various different ice packages that the Federal and State governments have had?

**Ms LLOYD:** I do not really know where the money went. All I can say is that there are lots of gaps and shortages. I had a look at the drug package from 2016 and 2017, and I do not think any of that dribbled down to our region—\$24 million to help young people, \$16 million for youth detox and increased access to MERIT. There was something about women in there, as well, but none of that came down to our region, unfortunately.

**The Hon. COURTNEY HOUSSOS:** What we are seeing around the State is that councils are taking more of a leadership role in this because it is becoming such an issue. It might not necessarily be directly within their responsibility. Thank you very much for your testimony and for your excellent submission.

**The Hon. BRONNIE TAYLOR:** Thank you very much, Councillor Lloyd, you have certainly opened up some issues. From googling you I found that you have made quite a commitment to telling your own story and advocating for other people. I really commend you for that. It is really brave; it takes a lot of courage. Just to clarify: is this your personal submission or is it the submission of the Lismore City Council?

**Ms LLOYD:** This is my submission. The committee formed after that submission was put in. I have to say that the committee is pretty consistent with the views that I have put in there.

**The Hon. BRONNIE TAYLOR:** I was just clarifying that. You spoke about the MERIT program. I have been quite fascinated by that today. Would you think that if we looked at extending that MERIT program to include people who are using alcohol as an addictive substance it would be helpful?

**Ms LLOYD:** Absolutely. I could not do the MERIT program because it was not available for me.

**The Hon. BRONNIE TAYLOR:** That is something we could do. Obviously it is a really good program. It has been done really well. It would be great if we could expand and extend it. You also spoke about private providers and the long waiting list at The Buttery. Another thing that was mentioned today by those private providers was looking at some sort of ability to fund that to a certain extent and open up the beds that already exist to everyone. Do you think that would be helpful?

**Ms LLOYD:** Do you mean private places—subsidising their beds for public people?

**The Hon. BRONNIE TAYLOR:** Yes.

**Ms LLOYD:** Yes, absolutely. There could be a multitude of ways of accessing more beds. That could be one.

**The Hon. BRONNIE TAYLOR:** The other thing I wanted to ask about came up before with Mr van Dugteren. He spoke about the arrest rates going up because of your festivals and things like that. Do you think that the area is over-policed?

**Ms LLOYD:** I can tell you one statistic. We came first in drug-driving offending in the Richmond area. That seems to suggest that there is a lot of targeting of that. You just have to have the presence of the drug in your system, but not necessarily be impaired. There is a lot of talk on social media and whatever about that targeting. What I will say—it is probably not so relevant to this inquiry—is that sometimes it can entrench social disadvantage for many clients who live outside of public transport zones and lose their licence because of drug-driving. Then they cannot continue being employed or attend Centrelink. It just makes life very difficult for them to access any services at all. I can see that there is a challenge for people who lose their licence in our area, because we do not have great public transport infrastructure.

**The Hon. Dr PETER PHELPS:** Councillor Lloyd, the Legal Aid submission in relation to mandatory detoxification is pretty clear:

Legal Aid NSW does not support mandatory detoxification programs. There are insufficient places for people who are motivated and ready to undergo detoxification. The efficacy of mandatory detoxification is not demonstrated.

Would that accord with your view of the situation?

**Ms LLOYD:** I have not really seen mandatory detoxification in action. I have not read a lot about it. I am not a fan of it. I think there has to be some willingness. If it is just a mandatory detoxification, then what? Are we talking about mandatory detoxification and then rehabilitation? As you have heard, detoxing is just one part of it. Then there is the psychosocial behaviour change that needs to happen. That can be undertaken in long-term residential—

**The Hon. Dr PETER PHELPS:** Can you mandatorily rehabilitate?

**Ms LLOYD:** My client was from the Compulsory Drug Treatment Correctional Centre. I do not think it is wise, no. I think for someone to get clean off drugs they need to have that inner willingness. But, as has been mentioned—and which was my experience that I will share with you—when I was arrested I did not want to enter a plea of guilty. No. I did not want to take responsibility. That is very common for someone who is in substance abuse. They are very selfish and self-obsessed. All you have done is push everything out of the way to the exclusion of you trying to get your drug or alcohol. You lose that responsibility. You do not care about anyone else. You certainly do not care about yourself. I did not want to plead guilty.

Honestly, I went to The Buttery rehab because I was sick and tired of reporting to bail every day. That is the truth. It was when I was in the rehab that I had that light bulb moment. I woke up and said, "I want this." Then I felt that genuine consciousness of guilt. Then I entered my plea of guilty. That is what is so fantastic about the MERIT program. It is a pre-plea. There is no forcing you to enter a plea of guilty. It is in the process of rehabilitation that the person starts to learn to take responsibility for themselves and what they have done.

**The Hon. Dr PETER PHELPS:** Isn't the nature of methamphetamine addiction fundamentally different, both in terms of length of detoxification and the effect on the individual? It is a stimulant and makes them hyper-aggressive. No-one punches a few cones and decides to go and beat up someone. Given its fundamentally different nature, is there an argument for mandatory detoxification?

**Ms LLOYD:** I think there is already that option for someone to be detained involuntarily at mental health hospitals if they are in some kind of psychotic episode. If they are at risk of harming themselves or other people there may be an argument for that, to alleviate that immediate harm. Sadly, with ice—methamphetamine—it does appear to lead to very violent behaviour. That is another problem. If we were going to get a drug court, the eligibility requirements need to be looked at. When the drug court started much more people who were eligible were heroin users. That has changed, so I think one of the eligibility requirements should be that you cannot have committed a violent offence. People who are taking methamphetamine are committing violent offences all the time.

**The Hon. Dr PETER PHELPS:** What about minors? We have heard about the failure to provide voluntary treatment services to youth. Do you think minors should be able to be mandatorily detained and subjected to mandatory detox and rehabilitation?

**Ms LLOYD:** Should minors be mandatorily detoxed? If there is an issue—if they are harming themselves or at risk of harming others—there could be some intervention for their own safety and for the safety of the community.

**The Hon. Dr PETER PHELPS:** With or without the approval of their parents?

**Ms LLOYD:** If they are at risk of harming themselves or someone else I do not know how you would get that approval from the parents in the moment, if it was something that was immediate.

**The Hon. Dr PETER PHELPS:** No, if you were forcing them into a program of mandatory detoxification and rehabilitation you would have plenty of time to seek the approval of their parents. Do you believe that minors should be mandatorily detained for mandatory detoxification and rehabilitation?

**Ms LLOYD:** No. I would say no.

**Dr MEHREEN FARUQI:** I join the other Committee members in thanking you for your very passionate submission, as well as the evidence that you have given. To me it comes straight from the heart. I especially thank you for sharing your own lived experience as well. In your submission you talk about the stigma attached to the drug and/or alcohol "problem", as you call it. You say, "The stigma was a barrier for me in accessing treatment." I want to hear from you about how we can remove that stigma? What do we do about that?

**Ms LLOYD:** End prohibition probably. I think punitive drug laws really have got something to answer for in entrenching that stigma. Whilst it is predominantly in the criminal sector, that stigma will remain and at the end of the day—I am sure you are all very aware—it is very much a health issue. It is not a choice. When I was a little girl I did not choose to grow up and drink three bottles of wine and then vomit everywhere and all over myself. I did not choose that life for myself. Sometimes you hear out in the community that, "When you took the

drug you chose to do it." It is a health issue. Like you do not choose to get cancer you do not choose to become an addict. I did feel a lot of stigma. I did not access treatment for my alcoholism, probably because it is so socially acceptable as well, and I hung out in that world where lots of people were drinking and I was really embarrassed. I was really ashamed of it.

**The Hon. Dr PETER PHELPS:** Going further than that, the problem with drug laws is not only are you ashamed but you are potentially liable to incarceration.

**Ms LLOYD:** Yes.

**The Hon. Dr PETER PHELPS:** Do we not face a similar situation to 1920s America and prohibition, and that is the proper response would be decriminalisation, regulation, taxation and treatment?

**Ms LLOYD:** Yes. Look at what Portugal is doing.

**Dr MEHREEN FARUQI:** Yes, and many States in America. Yesterday the Committee heard from the Clarence Valley Council, which is playing a big role in the initiative Our Healthy Clarence, which is not specifically related to drugs but to mental health issues. The council realised that a lot of people in the community did not know what the availability of services was. It is making a huge effort and the council is taking the initiative to connect people and provide lists of them all. In addition to the committee that Lismore City Council has, should it be playing more of a leadership role in drug rehabilitation? I am not necessarily saying it should run centres, but is there anything else that the council could do to improve the situation?

**Ms LLOYD:** They are the kinds of things that we are going to discuss on the committee at a later stage once we prioritise what we think the need is in our region. There may be a role for council to play in terms of land perhaps, or partnership. I am not sure but that may be something that we will look at. What was really good about our very first meeting was getting everyone in the one room. We have got members, Ms Edwards from Namatjira Haven. We have got The Buttery, Legal Aid, Rekindling The Spirit, Community Corrections. We have got barristers and lawyers. We have got our local police Inspector Connors. We have got the MERIT manager. We have got Mission Australia and representatives from the Department of Public Prosecutions and police prosecutors. It is a very bipartisan-wide committee. Hopefully we will have more information to give you when we meet. What was brought up in that meeting was that no-one really knew what everyone else was doing. That seemed to be maybe a result of there being so much competition between everyone for funding, that everyone kind of sticks in their own little corner and does not share information. That might be something that needs to be looked at.

**Dr MEHREEN FARUQI:** It could just be the siloisation.

**Ms LLOYD:** Yes, a lot of that.

**The Hon. BRONNIE TAYLOR:** What happened to responsibility?

**Ms LLOYD:** It is the individual who is suffering who is actually missing out on that lack of sharing of information.

**The Hon. BRONNIE TAYLOR:** Of which the funding is there to give to those people.

**Ms LLOYD:** Yes.

**The CHAIR:** I noted that NSW Health was not on that list.

**Ms LLOYD:** I did have someone from the mental health sector who was coming.

**The CHAIR:** I did not hear them mentioned in the list you read out.

**Dr MEHREEN FARUQI:** You have given the Committee a very comprehensive list of recommendations that we could make. If you could choose the top three things that would really change the situation in this area, what would they be?

**Ms LLOYD:** Drug Court, Koori court and further residential rehabilitation beds.

**The CHAIR:** Thank you for coming along.

**Ms LLOYD:** Can I add one thing?

**The CHAIR:** You certainly can.

**Ms LLOYD:** I wanted to refer to what I tabled. It was not put in my submission and I wanted to address it. It was what Mr van Dugteren began to talk about today in regards to the Life on Track program.

**The CHAIR:** There is only one copy for the Committee members. It will be circulated but we will note the reference you are making to the document.

**Ms LLOYD:** They are just pamphlets on the Life on Track program, and the replacement program, Extra Offender Management Service [EOMS]. We were all—when I say "we" I think I can say on behalf of lawyers, prosecutors and the judiciary—really, really liked the Life on Track program. We had these community members who were the employees that would come to court and I would refer to them as angels of the Local Court, because they were just incredible. This program worked. It was very, very flexible. They could be self-referred, it was early intervention, it targeted people who were just starting their criminal career and stopping them from becoming entrenched in the system. These Life on Track workers worked out of the box. Because we have such a wide regional area and people with complex needs, the staff—and I know the Life on Track in other areas did not work as well as this but I think we just had the right mix of staff here—would go out to people's houses at night-time and see them.

They would pick people up and bring them into psychological appointments. That is what is needed, especially someone who is suffering from a substance abuse disorder, and often there is mental health involved in that as well. They cannot just get out of bed and get on the bus, if there is even a bus available. They actually need someone in those early stages to help them put their lives back together. They would write these incredible reports that would just make you cry about the state of someone's life and all of their complex needs before they had contact with the program, and they would deal with accommodation. They would help people pay their fines, financial counselling, mental health support, suicide counselling, domestic violence, sexual assault support, drug and alcohol assistance, education, training, employment, disability help. There was nothing that they did not do. They really went into everyone's lives with a microscope and just holistically helped them with everything. Then that program stopped.

**The Hon. Dr PETER PHELPS:** Is EOMS essentially a re-insourcing by Corrective Services?

**Ms LLOYD:** Yes. It is more, I think that the targeting and assessment of who is eligible is done by Corrective Services, as before it was a Life on Track tool. EOMS now only targets people with medium risk of offending, so it does not target below.

**The Hon. Dr PETER PHELPS:** It is done by Corrective Services?

**Ms LLOYD:** No. There were eight staff with the Life on Track. Mission Australia is still running it. They ran that and so they got the contract for EOMS, but they have only got two or three staff members who are running EOMS now. It is still the Life on Track workers reduced to three and now they are only able to target people at medium risk of offending.

**The Hon. Dr PETER PHELPS:** Medium or high.

**Ms LLOYD:** Medium or high, and they are only allowed to address the criminogenic needs. They are not allowed to help with housing and all of those other things that Life on Track did. I just wanted to make the Committee aware of that.

**The CHAIR:** I am glad you have given the Committee some emphasis to that. Are there any other points you would like to make?

**Ms LLOYD:** When do we get our Drug Court?

**The CHAIR:** Once again, thank you for your submission and oral evidence today, and thank you for putting yourself forward in a most personal way. It is not easy to open yourself up, so to speak, to what is in effect public scrutiny and insight into a most difficult time in your life. The wonderful thing is that when people do that they create a great sense for others who see it. I am sure that is why you did it.

**Ms LLOYD:** That is why I did it.

**The CHAIR:** People can see that there can be ways out of what might appear to them to be an impossible situation. It is great that you, and indeed others as we have gone about this inquiry, have shared that with us and I am sure that has provided a great example to others in the community.

**(The witness withdrew)**

**(The Committee adjourned at 14.30 p.m.)**