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 Macquarie Room, Parliament House, Sydney, on Tuesday 3 July 2018

The Committee met at 9.15 a.m.

PRESENT

The Hon. Greg Donnelly (Chair)

Dr Mehreen Faruqi
The Hon. Paul Green
The Hon. Courtney Houssos
Mr Scot MacDonald
The Hon. Dr Peter Phelps
The Hon. Bronnie Taylor

The CHAIR: I welcome everyone to the eighth hearing of the inquiry being conducted by Portfolio Committee No. 2 into the provision of drug rehabilitation services in regional, rural and remote New South Wales. I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respects to elders past and present of the Eora nation and extend that respect to other Aboriginals present or who may be watching today on the internet. As this inquiry has a strong regional focus, the Committee has conducted hearings in Nowra, Batemans Bay, Dubbo, Broken Hill, Grafton and Lismore. This is the Committee's final hearing and it will be hearing from a range of organisations, including the Department of Justice, NSW Health, Laughing Mind, and the Calvary Drug and Alcohol Centre.

Before we commence, I will make some brief comments about the procedures for today's hearing. The hearing is open to the public and is being broadcast via the Parliament's website. 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 they must take responsibility for what they publish about the Committee's proceedings.

It is important to remember that parliamentary privilege does not apply to what witnesses may say outside their evidence at the hearing. I urge witnesses to be careful about any comments they may make to the media or to others after completion of their 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 witnesses could answer only if they had more time or with certain documents at hand. In those circumstances, witnesses are advised that they can take questions on notice and provide answers within five days of receiving them.

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, I ask everyone to turn their mobile phones to silent mode for the duration of the hearing.

FILIZ EMINOV, Executive Officer and Registrar, Drug Court of New South Wales, affirmed and examined

JASON HAINSWORTH, Acting Assistant Commissioner, Community Corrections, affirmed and examined

HEATHER JACKSON, Acting Director, State-wide Operations, Community Corrections, affirmed and examined

The CHAIR: I invite you to make an opening statement. The Committee has the submission from the New South Wales Government, which is marked as submission No. 34. Therefore, you need not specifically quote from it. We will move from that opening statement to questions from members. We have members from the Liberal Party, The Nationals, the Opposition, the Christian Democratic Party and The Greens.

Ms EMINOV: The Drug Court of New South Wales commenced in February 1999, and expanded in 2011 to the Hunter and in 2013 to Sydney. The Drug Court sits full time at Parramatta, six days a week at Toronto in the Hunter region, and one day a week at the Downing Centre in Sydney. The court takes a whole-of-government approach with many government agencies working collectively to deliver its program and to achieve its objectives as set out in the Drug Court Act; that is, to reduce the dependency of eligible persons to promote their reintegration into the community and to reduce the need to resort to criminal activity to support their dependencies.

The Drug Court strives to achieve sustained behaviour change. The Drug Court sets external controls in the delivery of its program and assists in building a person's internal controls to maintain recovery from drug dependence. The three Drug Courts in New South Wales cater for up to 280 participants. Approximately 40 per cent of those participants utilise rehabilitation centres during the course of their programs. The rehabilitation centres operate independently of the Drug Court but have a strong working relationship with the Drug Court. The Drug Court relies on the availability of rehabilitation facilities as an option to place participants for treatment for their needs.

The Drug Court is not involved in the establishment of facilities or their general operation. The Drug Court relies on Justice Health to assess Drug Court participants and determine if a rehabilitation centre is the best treatment option for that individual. The Legal Aid's Drug Court team represents all participants all the way through their program, and the Drug Court has a sanction system whereby participants not complying with their program are placed in custody for non-compliance. Therefore, if a participant is not complying in a rehabilitation centre, the Drug Court can place them in custody for several weeks and readmit them, if appropriate.

I am aware that communities in the Illawarra, Dubbo, Lismore and the Central Coast areas have at different times sought expansion of the Drug Court. However, I am not involved in the decision processes of Government to determine any expansion of the Drug Court. The Drug Court has been evaluated by the New South Wales Bureau of Crime Statistics and Research which found that when compared to a comparison group people who had been treated through a Drug Court program were 37 per cent less likely to be convicted of an offence; 65 per cent less likely to be convicted of an offence against a person; 35 per cent less likely to be convicted of a property offence; and 58 per cent less likely to be re-convicted of a drug offence. A further evaluation by the Bureau of Crime Statistics and Research in 2008 also found the Drug Court is more cost effective than prison in reducing the rate of reoffending among offenders whose crime is drug-related.

The CHAIR: Thank you. That has set the scene nicely. As you are aware, the material that has come in regarding the Drug Court is part of submission 34 and is incorporated in the whole-of-government submission. You are aware of that, are you not?

Ms EMINOV: Yes.

The CHAIR: It is embedded within the whole-of-government submission.

The Hon. COURTNEY HOUSSOS: This question is for both Community Corrections and the Drug Court. You obviously rely on drug rehabilitation positions for the Drug Court to be able to place people in there. Do you keep a comprehensive list of drug rehabilitation beds in New South Wales?

Ms EMINOV: We do not, as such. However, our partner agency, Justice Health, which formulates the treatment plans, has all that information. It is aware of bed availability and waiting lists, et cetera, and it provides that information to the Drug Court.

The Hon. COURTNEY HOUSSOS: That is external to your operations?

Ms EMINOV: Yes.

The Hon. COURTNEY HOUSSOS: Do you keep a list at all?

Mr HAINSWORTH: Community Corrections does not. Our access to rehabilitation is generally managed through local arrangements. We also are dealing with not just rehabilitation services but general community-based drug treatments in outpatient types of services as well. But we do not have a centralised repository for that information.

The Hon. COURTNEY HOUSSOS: When you say "local arrangements", what does that mean?

Mr HAINSWORTH: Our local officers work closely with the rehabilitation centres in their area or with treatment providers in their area, so government or non-government private providers—whatever they have got—in that local area.

The Hon. COURTNEY HOUSSOS: When you say it is local, does that mean like each individual officer operates at that level or is it a local health district? At what level is it happening?

Mr HAINSWORTH: We have 60 locations around the State. Each has a manager and then we have unit leaders of Community Corrections officers within that. It is more at that manager level. They are broken into seven districts and 60 locations. Most of those arrangements around access to services are at that local level. When you are talking about larger organisations—say, Health, for instance, or other government agencies—then it is a little higher level. But in those local services it is mostly at the manager level.

The Hon. COURTNEY HOUSSOS: Okay. So those 60 locations, they are the ones that manage it?

Mr HAINSWORTH: That is correct, yes.

The Hon. COURTNEY HOUSSOS: Ms Eminov, you noted that you do not have the role of making a decision about an expansion for the Drug Court, but have you made any preparations for expansion of the Drug Court to new locations?

Ms EMINOV: No preparations as such, but we have expanded, as I mentioned, in 2011 and 2013 to other locations. We have experience in expanding. I think we are pretty well equipped to expand, if needed.

The Hon. COURTNEY HOUSSOS: But you have not made preparations? We particularly heard from the community in Dubbo about the need for a Drug Court out there. You have not made any preparations for that?

Ms EMINOV: No.

The Hon. COURTNEY HOUSSOS: In regard to the Drug Court, do you keep a breakdown of the drugs used by people appearing for offences?

Ms EMINOV: No. Again, Justice Health does that. The Drug Court registry or administration does not do that.

The Hon. COURTNEY HOUSSOS: They are more interested in the offences themselves rather than necessarily the drugs.

Ms EMINOV: Correct, and Justice Health has all that information though, however.

The Hon. COURTNEY HOUSSOS: We have been hearing very good things about the work of the Drug Court.

Ms EMINOV: That is nice to hear. Thank you.

The Hon. COURTNEY HOUSSOS: The only question is that they just want to expand it further across the State.

The Hon. Dr PETER PHELPS: You mentioned that 40 per cent seek rehabilitation. What do the other 60 per cent seek?

Ms EMINOV: They are normally treated in the community and they do have a treatment plan devised, again, by Justice Health. The area health services will be providing that treatment. The pharmacotherapy, counselling, and drug and alcohol programs would be administered by the area health services in the community as opposed to being in a residential rehab.

The Hon. Dr PETER PHELPS: You also mentioned non-compliance. What proportion of people before you fall back into non-compliance with what they are required to do? Do you have rates of non-compliance?

Ms EMINOV: I do not have the statistics.

The Hon. Dr PETER PHELPS: Could you get those for me on notice?

Ms EMINOV: What exactly do you mean by non-compliance?

The Hon. Dr PETER PHELPS: What do you mean by compliance? You say there are instances of non-compliance.

Ms EMINOV: Yes.

The Hon. Dr PETER PHELPS: Presumably you would have some metric to indicate that non-compliance has happened?

Ms EMINOV: Yes, non-compliance is many and varied. It could be not picking up their pharmacotherapy. It could be not attending drug testing. It could be having a positive urine test. It could be not attending counselling. It could be not being home for curfew. It could be many things.

The Hon. Dr PETER PHELPS: Would you have figures on non-compliance by people who appear before the court?

Ms EMINOV: I would have to take that on notice and check.

Mr HAINSWORTH: I can comment in respect of the final outcome. We keep data in relation to completion or non-completion, but in respect of specific instances of non-compliance, because there is a varied range, you may have someone who is generally compliant and there is the odd instance—they miss an appointment or they fail a drug test. Corrections does not have detailed data on that, but we can provide information on program outcomes in respect of compliance or non-compliance to the extent that the offender is successful in the program or not.

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

Mr HAINSWORTH: They reach the end of the program without having breached—without having to be removed from the program.

The Hon. Dr PETER PHELPS: They could have gone through the program with multiple instances of non-compliance but as long as they have completed the program, that will be treated as a success?

Mr HAINSWORTH: Yes. As you would be aware, an important part of dealing with addiction is dealing with lapses. It is as much how the offender responds to those instances of non-compliance. If they have a negative drug test, do they then engage in some kind of activity to manage that lapse, or do they continue on using? It is not about any individual instance of behaviour; it is about the ongoing pattern and are the offenders willing to address their issue overall and engage in treatment, or are they just going back to drug use?

Ms EMINOV: The Drug Court defines success by those who finish the program without a jail sentence, so bearing in mind that everybody who starts the Drug Court program is facing a term of imprisonment as part of the eligibility criteria. If persons finish the program without a custodial sentence, we classify that as a success in the statistics. Whereas if people finish the program and go back to jail, they may have had a long term in treatment so they may have better health outcomes and lots of intangibles that are not counted in the statistics.

The Hon. Dr PETER PHELPS: There are a series of Bureau of Crime Statistics and Research [BOCSAR] statistics that you gave in relation to people going through the Drug Court as being less likely to do certain things in the future. Less likely than what—the general population?

Ms EMINOV: The comparison cohort.

The Hon. Dr PETER PHELPS: Would that be because the people who go to Drug Court have a proclivity towards reforming their activities as opposed to those who have just decided that they are going to wear the conviction?

Ms EMINOV: I am not able to answer that.

The Hon. Dr PETER PHELPS: This is the key point. We have been asked to expand the Drug Court on the basis of its performance or its outcomes and if the outcomes are not based on the existence of the court but in respect of the self-selection of the people who go to the Drug Court, then why would not that same cohort going through the normal legal system have comparable outcomes?

Ms EMINOV: Could you rephrase question?

The CHAIR: It does not need to be rephrased. Ask it again. I understand what you are saying.

The Hon. Dr PETER PHELPS: You claim high levels of success than going through the normal court system. How do you know that those are simply not people who self-select through the court system to take the Drug Court option and who, if they went through the normal court system, would not be predisposed towards reformation anyway?

Ms EMINOV: I understand what you are saying.

The Hon. Dr PETER PHELPS: I will go a little further. You will probably be aware that about 10 years ago BOCSAR did an assessment into circle sentencing in Aboriginal courts and found that recidivism rates for those were virtually identical to the Aboriginals who went through the normal justice system. That is 10 years ago and processes may have changed. The problem that I have to deal with, and we all have to deal with in making recommendations, is if the Drug Court has a material effect on outcomes in respect of lower recidivism rates we should be recommending it. If it has no material effect because the people who go to the Drug Court are self-selectors towards reformed behaviours anyway, we are simply replicating at a more expensive level what would already happen in the normal criminal justice system.

Ms EMINOV: I think your question is an important one and I would like to take it on notice to answer it correctly.

The CHAIR: To be clear, do not take that as an attack or that we are seeking to undermine the position of the Drug Court. We are trying to evaluate the outcome.

The Hon. Dr PETER PHELPS: How do we spend our money wisely? Would we be better off having expanded systems within the existing magistracy or the existing District Court as opposed to having a separate court created?

Ms EMINOV: I understand your question. There was an evaluation about 10 years ago about the cost effectiveness. Although the Drug Court costs money, it worked out to be cheaper than sending a person to jail.

Mr HAINSWORTH: That is a valid point, and it is certainly acknowledged within those BOCSAR evaluations. There are differences. If you look at the outcomes for the Drug Court or for any other program in respect of completers versus offenders referred, the total impact of the program is less when you look at everyone who is referred as opposed to everyone who has completed. The other point to make is that although the Drug Court has positive outcomes, you have to look at the research in its entirety, not just the Drug Court, but also similar intervention programs. What consistently shows up is positive impacts in community-based treatment and treatment that is focused on intervening and trying to change behaviour as opposed to more punitive measures. Although the Drug Court may not necessarily be the magical solution per se, it is taking an approach that is well supported through a lot of literature, not just within New South Wales but also internationally.

The Hon. BRONNIE TAYLOR: I will not be quite as cerebral as Dr Phelps is able to be. Congratulations on what you do. I do not mean to sound cynical, but do you think there is any legitimacy in the comment that people know if they do complete the program they do not have to go to jail? Of those who complete the program, do you see a high rate of recurrence? I completely appreciate what you said. I think it is important that you said that there will be relapses; that is just part of the process. Do you think there it is a question of, "If I hang in there, it does not matter how many times I relapse. I am still not going to go to jail if I complete the program"?

Mr HAINSWORTH: If you have ever worked with offenders, one of the biggest problems is the impulsive inner lack of thinking. There is no foresight that, "If I offend, I will go to jail." That is part of the problem. The idea of deterrence and this thing hanging over their head is more of a myth than anything that is supported by evidence. I am not saying it is completely out of the question, but does it change behaviour? A lot of people will talk about jail as being a determinant factor, but when you look at how they behave, unless there is absolute certainty that they will get caught, it does not shift behaviour. What we see certainly in the Drug Court is an overall high-risk profile of offender, which you see similarly with our parole cohorts.

The CHAIR: What does high-risk offender mean?

Mr HAINSWORTH: We do assessments on our offender population to determine the probability of someone returning to custody or committing further offences. Not all offenders are equal. We use a tool called the Level of Service Inventory – Revised [LSI–R]. There are a number of other tools. BOCSAR has developed a GRAM, which is a Group Risk Assessment Model that estimates what is the likelihood of someone offending or not offending. That is really important. If you are looking at a program evaluation and you have low-risk offenders coming through, it means they have a low probability of offending and you get better outcomes—at least you appear to get better outcomes because you have low rates of offending, but that is more to do with that selection bias. If you put low-risk offenders into a program you are going to have low rates of reoffending. If you put high-risk offenders into a program you have high rates of reoffending. In the Drug Court's case the overall risk profile tends to be high. They are one of our highest risk groups and yet we still see those positive outcomes.

The Hon. Dr PETER PHELPS: On that point, I go back to Ms Eminov. Did you say there was a 37 per cent or 57 per cent less likely rate of reappearance for drug offences?

Ms EMINOV: Fifty-eight per cent.

The Hon. Dr PETER PHELPS: On that basis it is probably worthwhile.

Mr HAINSWORTH: That is the program completion rate. That is for the completers.

Ms EMINOV: Yes.

The Hon. Dr PETER PHELPS: That is the completion rate?

Mr HAINSWORTH: Yes.

The Hon. Dr PETER PHELPS: Do you have statistics on subsequent reappearance for drug offences?

Ms EMINOV: No.

The Hon. Dr PETER PHELPS: Would there be that record?

Mr HAINSWORTH: The overall rate is 17 per cent for general offending. I do not know what the rate is—

Ms EMINOV: No, I am not aware whether or not there are those statistics.

Mr HAINSWORTH: It is in the evaluation report, but if you look at everybody that goes in, as opposed to just the completers, it is a 17 per cent reduction in general offending. The drug figure is in there, but I do not recall it off the top of my head.

Dr MEHREEN FARUQI: I am interested in the operation of the Drug Courts. Is there a backlog or a waiting list for people to be heard in the three Drug Courts? How does it work?

Ms EMINOV: There is not a waiting list as such. However, we do have a ballot system. There is a certain amount of space on each Drug Court program and we get referrals from the Local Courts on a weekly basis and we determine on a weekly basis how many places we have. For example, we may have 10 places that week, but we may have 20 applicants at that court. We do a ballot system so that everybody has an equal chance of getting on the program. Ten people are selected. Those 10 come on program and the other 10 who have applied will get dealt with by the referring courts through the conventional court system.

Dr MEHREEN FARUQI: There are many more people looking to get into Drug Courts than there is room for?

Ms EMINOV: Correct.

Dr MEHREEN FARUQI: You said the Sydney Drug Court was the last to be established out of the three?

Ms EMINOV: Yes.

Dr MEHREEN FARUQI: And that only operates one day per week?

Ms EMINOV: It operates one day per week.

Dr MEHREEN FARUQI: If there is a need is that a cost issue?

Ms EMINOV: I think it is a cost issue. Initially there were funds available, from my recollection, for only a one day a week operation.

Dr MEHREEN FARUQI: Can you take this question on notice? I am trying to figure out what the costs of establishing a Drug Court might be for one day a week in a regional area, based on previous costs. Is that possible to take on notice?

Ms EMINOV: Yes, definitely.

Dr MEHREEN FARUQI: The Committee heard in many regional areas that people have heard about the success of the Drug Court program and how important it might be for their area. Earlier you gave us some Bureau of Crime Statistics and Research figures about the operation of Drug Courts. As far as I understand that was done 10 years ago?

Ms EMINOV: Correct.

Dr MEHREEN FARUQI: Is there a reason why it has not been evaluated again in the past 10 years?

Ms EMINOV: It has not been evaluated since there was a study in 2011, again by the Bureau of Crime Statistics and Research, into elements of the Drug Court program. We believe that it had been evaluated, and

evaluated as being a success. The Bureau of Crime Statistics and Research decided to look at why it is a success and elements of the success. It was a study into increased judicial supervision. It carried out a study in 2011 whereby half the Drug Court cohort appeared before the judge as per usual and the other half appeared double the amount, twice a week, instead of once a week. The outcome of that was that increased judicial supervision had much better outcomes. As a result, the Drug Court changed its program to increase the level of supervision or the appearances before the judge.

Dr MEHREEN FARUQI: That was 2011?

Ms EMINOV: That was 2011.

Dr MEHREEN FARUQI: Do you think there is need for another evaluation? The program may have become even more successful and lessons might have been learnt in the past seven years.

Ms EMINOV: I think it is important to look at elements like the 2011 study, but as to the program as a whole being a success, I think that has been evaluated and perhaps money could be spent on looking at other elements of why it works.

Dr MEHREEN FARUQI: One of the submissions to the Committee mentioned that there was a Youth Drug and Alcohol Court that was abolished in 2012. Do you know where it was and why it was abolished?

Ms EMINOV: It was at Parramatta and it was run through the Children's Court. It was abolished very quickly and quietly. I am not sure of the reasons why. I believe it had not been evaluated and perhaps did not have the evidence. Again, I am not sure because it is completely separate from the adult Drug Court.

Dr MEHREEN FARUQI: Do you know what the impact of closing that court might have been?

Ms EMINOV: No.

Dr MEHREEN FARUQI: In its submission Legal Aid calls for the reintroduction of the Youth Drug and Alcohol Court in New South Wales. The Committee has heard of the impact that drugs and alcohol have on young people and the services that are needed. If the Committee made a recommendation to that effect, given your experience with drug courts, would that be useful?

Ms EMINOV: I really have not had anything to do with youth Drug Courts, so I could not really comment.

Dr MEHREEN FARUQI: What about Community Corrections?

Mr HAINSWORTH: I think I would have to say the same in regard to the juvenile side of things. I could not comment.

Mr SCOT MacDONALD: I first put on the record that my wife works for Corrective Services.

The CHAIR: That is noted.

Mr SCOT MacDONALD: I made representations to the Premier about a drug court on the Central Coast.

The CHAIR: For the record, that is noted.

Mr SCOT MacDONALD: Everybody I talk to at the Drug Courts—and I visited about a month ago when Ms Eminov was there.

Mr HAINSWORTH: April.

Mr SCOT MacDONALD: Everybody I talk to says it works and the statistics seem to back that up. The resistance seems to be with the higher cost. How does the higher cost manifest itself?

Ms EMINOV: Higher cost?

Mr SCOT MacDONALD: The resistance to implementing the program elsewhere across the State. It is said that it works but it is a higher cost. I have never been able to drill down where that higher cost manifests itself.

Ms EMINOV: No, I have not either. I am not sure. I can only go by the cost-effectiveness study that was done in 2008, whereby the Drug Court was more cost effective.

Mr SCOT MacDONALD: In the outcomes. Is it higher administrative, managerial, staffing or resourcing costs? I do not know enough about it to compare what I saw in April with the regular processes. Do you have any insight at all as to why the costs are higher?

Ms EMINOV: I can quote the report.

The CHAIR: Which report is this?

Ms EMINOV: The cost-effectiveness report 2008 by the Centre for Health Economics Research and Evaluation [CHERE].

The CHAIR: If you could take that on notice. It is a very important question. The Committee is trying to understand this because we hear the argument anecdotally about the issue of the cost of the Drug Court appearing to have an impact on the consideration of whether it can be expanded. Having some sense of its value is important.

Ms EMINOV: That report says the economic analysis conducted showed that the total cost of the Drug Court program is $16.376 million per annum. That was in 2008. The report states:

> The largest drivers of this financial cost are the cost of final imprisonment (for those who do not complete the program successfully) and the cost of staffing and running the court.

It found:

> … however, that the estimated cost of dealing with the same offenders via conventional sanctions would have been slightly higher ($18.134 million per annum).

Mr SCOT MacDONALD: Every time we talk about magistrates and resourcing it comes back to the magistrates deciding when and where they sit. Is it the District Court judge or higher who decides what they do or do not want to back?

Ms EMINOV: No, it is a matter for government policy. If there are funds and a decision is made then it comes down to the judiciary as to where the courts can be reallocated, et cetera.

The CHAIR: Are there Drug Courts operating in other Australian jurisdictions?

Ms EMINOV: Yes, in Victoria and Western Australia.

The CHAIR: Do you have any dealings with them?

Ms EMINOV: We do have dealings in that they will come and have a look at how a drug court in New South Wales operates.

The CHAIR: Do you check out their courts?

Ms EMINOV: Yes, we have done.

The CHAIR: Do they operate on a similar basis?

Ms EMINOV: They are similar yet different. We are lucky in that we have a standalone Drug Court Act; I believe that no other State has that. We have dual jurisdiction, District Court and Local Court; I believe that no other State has that. The other Drug Courts are run slightly differently to the New South Wales Drug Courts.

The CHAIR: Are you aware whether they have been subject to evaluation by their States?

Ms EMINOV: I believe Victoria has and that they have got some additional funding to expand at the moment.

Mr SCOT MacDONALD: We really need strong evidence such as a review. Getting back to drug rehabilitation, is there any break on the efficacy of the Drug Court, such as the availability of drug rehabilitation?

Ms EMINOV: Yes, the Drug Court definitely needs rehabilitation services wherever it may be. It needs more beds, more services.

Mr SCOT MacDONALD: That might affect the options for the Drug Court, as stated by the judge at Parramatta who was mentioned before.

Ms EMINOV: Judge Dive.

Mr SCOT MacDONALD: Sometimes he is not able to direct someone to rehabilitation because of the lack of beds.

Ms EMINOV: That is correct. Judge Dive does not make those decisions; he is guided by the treatment plans formalised by Justice Health. If Justice Health says—

Mr SCOT MacDONALD: "We would like to do this, but it is not available."

Ms EMINOV: Correct, then they may deem that there is no highly suitable treatment plan, and that person may not be able to partake in the Drug Court program.

Mr SCOT MacDONALD: They could end up with a custodial sentence.

Ms EMINOV: Correct.

The CHAIR: Treatment would include the preliminary step of detoxification, or would that have already been completed?

Ms EMINOV: Yes, everybody that comes on the Drug Court program goes through a detoxification period in the Metropolitan Remand Centre. There is a dedicated Drug Court unit there.

The CHAIR: Where is that located?

Ms EMINOV: Silverwater.

The Hon. BRONNIE TAYLOR: How often would you find that it is not possible to find a bed for someone who has been offered the program, and so they have to go to jail?

Ms EMINOV: Not very often, because Justice Health is very good at juggling.

The Hon. BRONNIE TAYLOR: Do you have data on that?

Ms EMINOV: I will take that on notice and check with Justice Health. A lot of the time they will keep them in custody for an extra week or so.

The Hon. Dr PETER PHELPS: They will be kept on remand until a bed is available.

Ms EMINOV: Correct.

The Hon. BRONNIE TAYLOR: That is not ideal.

Mr HAINSWORTH: I can add to that. We have similar issues at the back end of the process, getting people out of custody onto parole. For some offenders it might be the difference between being granted parole and not granted parole, or when they can be released or how quickly they get revoked.

The Hon. BRONNIE TAYLOR: Please explain that.

Mr HAINSWORTH: Because Community Corrections relies on the same services when we are managing offenders, whether they are on parole or other community-based sentences, we access rehabilitation services as well. If we are making a recommendation to the State Parole Authority for whether somebody should be released to parole and that person has significant drug and alcohol issues—

The Hon. BRONNIE TAYLOR: That they have had since they have been incarcerated?

Mr HAINSWORTH: Or that led them to being incarcerated in the first place. Those issues do not go away just because somebody is in custody.

The Hon. BRONNIE TAYLOR: I know, but I am accentuating the point because it is a pertinent point.

Mr HAINSWORTH: We would try to get some of those offenders into rehabilitation in order to make it acceptable for them to be released on parole. Obviously, that can present a challenge at times, and somebody could be retained in custody longer than they need to be because of lack of access.

Dr MEHREEN FARUQI: Because you cannot find rehabilitation services.

Mr HAINSWORTH: Yes.

The Hon. COURTNEY HOUSSOS: And it is up to local officers to find those services.

Mr HAINSWORTH: Yes, our parole units would work with our community locations to locate a suitable service. That can be particularly challenging where the offenders have, as some of them do, histories of violent offending, which can restrict the number of places that will accept them.

The Hon. Dr PETER PHELPS: Is that an argument for additional resources to be provided for detoxification and rehabilitation facilities in locations where there are existing correctional institutions, especially correctional institutions with a preponderance of people who are drug offenders?

Mr HAINSWORTH: Community Corrections has services throughout the entire State, so the logical conclusion would be everywhere.

The Hon. Dr PETER PHELPS: But, for example, you do not have detoxification and rehabilitation services in Cooma, Junee, Goulburn, Lithgow, Grafton.

Mr HAINSWORTH: Proximity of the correctional centre for offenders in custody is not necessary, because the location of the inmate is not necessarily where they will be released to or the area they have connections to; sometimes their placement in custody will be more related to what programs are available at a particular jail. For example, if they are a sex offender they will need to go to one of our programs at Cessnock or Long Bay, rather than where they need to be.

The Hon. COURTNEY HOUSSOS: Excuse my ignorance, but do people appear before the Drug Court for alcohol-related offences?

Ms EMINOV: It has to be an illicit substance.

The Hon. BRONNIE TAYLOR: We have had conversations about legal and illegal substances.

The Hon. COURTNEY HOUSSOS: Would that include abuse of pharmaceuticals?

The CHAIR: Prescription medicine.

The Hon. COURTNEY HOUSSOS: I am happy for you to take that question on notice.

Ms EMINOV: Yes, I will take that on notice.

The Hon. COURTNEY HOUSSOS: When we were in Broken Hill we heard powerful testimony about people released from the correctional facility and put onto a bus to rehab on the Central Coast at 3 o'clock in the morning, but they did not arrive there although it was a condition of their parole. What penalties are in place? Would they immediately go back into a correctional facility?

Mr HAINSWORTH: Every case is different. In some cases, yes, that would be the case, but not in every case. It depends on the circumstances in which they were given that direction, whether it is a direction by their officer or it was a condition imposed by the parole authority on their release. The risks presented by that offender, whether or not there are alternatives—for example, they did not make it to that rehabilitation service but they reported to a Community Corrections office and said they would do something else instead—are dependent on all those factors. It is not automatic, but yes, in some cases.

The Hon. PAUL GREEN: Can you tell us the cost for a person to be put through the Drug Court program?

Ms EMINOV: I do not have that information.

The Hon. PAUL GREEN: Can you take that on notice?

Ms EMINOV: Yes, I can.

The CHAIR: I am surprised that that information is not readily available, because I would assume that you have been asked that question.

Ms EMINOV: No, it is not easily accessible.

The Hon. PAUL GREEN: It is not difficult to ascertain the cost per bed per day for a person in a correctional centre, although I know it differs from centre to centre due to a bunch of factors. It would be handy to know what it costs us to put people through the Drug Court program. Where are Drug Court sessions held across New South Wales?

Ms EMINOV: Parramatta, Toronto Court House and Sydney Downing Centre.

The Hon. PAUL GREEN: Why Toronto and no further abroad in regional areas?

Ms EMINOV: Why no further abroad?

The Hon. PAUL GREEN: Toronto is pretty close to Sydney and there are opportunities for having one there.

Ms EMINOV: Toronto near Newcastle?

The Hon. PAUL GREEN: Yes, as opposed to Broken Hill, Dubbo, Broken Hill, Wagga Wagga or Tamworth?

Ms EMINOV: I do not know why.

The Hon. PAUL GREEN: I think it would be more helpful if the court were able to get a day out in certain areas to do the same job that you do down here?

Ms EMINOV: Sorry?

The Hon. PAUL GREEN: It would be reasonable to run the Drug Court in those regional areas and provide people in the Far West and in regional areas with access to the courts.

Ms EMINOV: Yes, provided the services were available and partner agencies were able to resource them out in the regional areas.

Dr MEHREEN FARUQI: Do people who attend the Sydney Drug Court and the Toronto Drug Court come from those regional areas?

Ms EMINOV: No, there is a geographical catchment area.

Dr MEHREEN FARUQI: People in regional areas outside the catchment area have no access to a Drug Court?

Ms EMINOV: That is right. If you are outside of the catchment area there is no access.

The Hon. PAUL GREEN: They do not get the chance to qualify to go to one?

Ms EMINOV: That is right. You have to live in a certain local government area to be able to access.

Dr MEHREEN FARUQI: The Committee heard that people who are referred from Drug Court rehabilitation services may access services in Lismore or in other places if they are available.

Ms EMINOV: Correct. If Justice Health formulated a treatment plan whereby from Parramatta Drug Court their best treatment option is rehabilitation in Coffs Harbour that can happen, but in order to access the Drug Court program in the first place that person must have lived in that catchment area.

The Hon. PAUL GREEN: What in your opinion could this Committee do better and tweak in a recommendation to the Government to achieve its objectives?

Ms EMINOV: Drug Courts address drug-related crime—the drug-crime cycle. Any location where there is a high level of drug-related crime would benefit from a Drug Court.

Mr HAINSWORTH: My view would be that it is not the specific program per se that makes the difference. It is not about whether it is the Drug Court or community supervision, like on an intensive correction order [ICO] or parole, because we know that all those things can be effective. I think working out how you can best deliver that service in whatever format, for each local area, and resourcing it is the key issue. We have good results with ICOs and we have Bureau of Crime Statistics and Research studies saying that it is up to a 31 per cent reduction. The solution is not just to put everyone on an ICO; it is to provide the right service.

The CHAIR: Putting everyone on what?

Mr HAINSWORTH: On an intensive correction order. The solution is not just to find that this program works and let us put it everywhere, which I think is sometimes what you hear. Some communities say, "We heard about this fantastic program and we want it here", but it is not the right fit. I think it is about recognising that there are a lot of different programs doing some really good work across Health, Corrections and all different areas and making sure that those are adequately resourced in the areas that they need to be. For me, I think leveraging off existing services, which is the approach we are taking in Corrections and which is in our submission that we have provided, is the best way to do that because it is more cost-effective than trying to transplant programs around the State.

The Hon. PAUL GREEN: Ms Jackson, do you have any comments?

Ms JACKSON: Mr Hainsworth has been very articulate.

The Hon. BRONNIE TAYLOR: The Committee has consistently heard across the State, no matter what inquiry it is conducting, that communication between the agencies is disappointing. How do you find communication between Justice, Health, Education and Family and Community Services when you are helping these people to achieve a good result?

Mr HAINSWORTH: I think it is challenging partly because of the different remits that we have. Our job is to reduce reoffending. Health's job is to improve health outcomes. Sometimes those things align and sometimes they do not. We are working at different points in time in the system. I agree that there is a lot of room for improvement but there is a fundamental flaw there. The example that I often give is if we are looking at trying

to get housing for an offender, which is something that is a real issue for people getting out of jail, we need somewhere to place them. But from a housing perspective you have to look after the whole community.

Having these different priorities means that although our offender has a need, that need has to be weighed up against the housing needs of, say, the next person who is not an offender. If we want to improve in this space I think it is more about having common goals. If the Government wants a reduction in reoffending that is a priority across each agency. Another good example is policing. We say that policing has objectives around increasing arrest rates. We have objectives around reducing reoffending and sometimes those things work directly in contradiction of each other. I think that strategic thinking around the priorities for government across all those—

The Hon. BRONNIE TAYLOR: Surely every department's priority should be the person, regardless of competing priorities. The priorities of Corrections, Health and the police should be to get that person to achieve his or her best. At some point departments have to take that on and take responsibility for it. That is just not happening.

Mr HAINSWORTH: Again it comes back to resourcing. We do not have the resources to look after every individual.

The Hon. BRONNIE TAYLOR: We do not have unlimited resources.

Mr HAINSWORTH: No. But that comes to a fundamental problem with the system. I do not know whether it is one that can be easily solved. It does not mean that we do not try.

The Hon. BRONNIE TAYLOR: A glass half full.

Mr HAINSWORTH: It does not mean that we do not try. I think we have that as the goal.

The CHAIR: Thank you for coming along and providing evidence. It has been very enlightening to hear details about the operation of the Drug Court and the work that it is doing. On behalf of the Committee, thank you for the great work you are doing for people who are seriously struggling with addictions. The work that you are doing hopefully will help people come to terms with that addiction and then ultimately move on and function well in society. There have been some questions on notice. The secretariat will liaise with you in regard to those questions.

(The witnesses withdrew)

KERRY CHANT, Chief Health Officer, NSW Health, on former oath

GARY FORREST, Chief Executive Officer, Justice Health and Forensic Mental Health Network, affirmed and examined

DANIEL MADEDDU, Director, Alcohol and Other Drugs, Centre for Population Health, on former oath:

MICHELLE CRETIKOS, Director, Population Health Clinical Quality and Safety Centre for Population Health, on former oath

NICHOLAS LINTZERIS, Director, Drug and Alcohol Services, South East Sydney Local Health District; and Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney, sworn and examined

The CHAIR: As I am sure you are all aware, the government—I use that term in the holistic sense—provided evidence at the Committee's first hearing of this inquiry on 12 March 2018 here at Parliament House. That hearing provided members with an opportunity to ask a number of questions about the Government submission, which is submission No. 34. Following that hearing in Sydney, the Committee has been on extensive and enlightening visits around the State, in particular to regional towns and cities, to examine the provision of drug rehabilitation services in rural, regional and remote areas. I suspect that some or all of you may have read the transcripts of those hearings.

However, to recap, on the first leg the Committee went to Nowra and Batemans Bay, on the second leg it went to Dubbo and Broken Hill, and most recently it has been to Grafton and Lismore. A number of witnesses from a wide range of domains of experience and involvement in drug rehabilitation appeared at those hearings. The Committee heard from non-government organisations, individuals, members of the Indigenous community and others within those communities who made submissions to the inquiry. The Committee thought that because of their contributions it would be worth hearing from them. It has been an interesting exercise for the Committee. This is the last public hearing of this inquiry and it provides us with the opportunity to reflect on what we have seen and, importantly, perhaps for witnesses to respond to some of the evidence. Dr Chant, we are happy to be guided by you. If you would like to make an opening statement, please do so. Otherwise, we can go straight to questions.

Dr CHANT: It would probably be most useful to the Committee if we were to go straight to questions. Representatives of our local health districts were often present at those hearings.

The CHAIR: Yes, they were, and that was very helpful.

Dr CHANT: I think that shows the strong engagement of our local health districts with drug and alcohol issues and the great people we have on the front line.

The CHAIR: Yes, and the Committee appreciates your facilitating their appearance and encouraging them to make very helpful contributions. I thank our two new witnesses for appearing today. They bring particular expertise that I am sure will be of interest to members.

The Hon. Dr PETER PHELPS: I have one question that relates to the evidence the Committee received in the Illawarra about how Victoria delivers its drug rehabilitation programs. The Committee was told that 67 per cent of detoxification and rehabilitation services provided in this State are delivered by NSW Health, but 0 per cent are provided by the Victorian Department of Health and Human Services in that State. Do any of you have any experience in relation to that? Those were the numbers the Committee was given. What does Victoria do differently from New South Wales?

Dr CHANT: Professor Lintzeris can talk about that. However, the whole structure of the delivery of drug and alcohol services differs greatly between New South Wales and Victoria. I suspect this is part of that situation. We have a much more mixed non-government organisation and local health district [LHD] system and strong drug and alcohol service provision in the public sector.

Professor LINTZERIS: I worked in Victoria in the alcohol and drug sector from 1990 until 2002. I was part of the Victorian restructuring in the Jeff Kennett years, when we saw a big shift in the way services were provided from what was historically a government-dominant model. The Kennett reforms in the mid-1990s involved a big push to commissioning services through non-government organisations. It is fair to say that Victoria places a greater emphasis on commissioned services, and non-government organisations are often the lead providers. But by no means is it exclusively the case that it is only non-government service providers.

Indeed, in the most recent iteration of the Victorian treatment system, many of the acute services, such as withdrawal programs, occur in an acute hospital system, as one would expect. They are then not necessarily

captured in the standard drug treatment data monitoring systems. If a patient undergoes a withdrawal episode in a general hospital, in many cases that will not show up in the drug treatment statistics because they report to different lines. A lot of work is going on in the government sector in Victoria that is not necessarily captured in what are traditionally called the national minimum data sets, which define the characteristics of drug and alcohol treatment.

There is a greater emphasis in New South Wales on having more integrated community-based services provided by local health districts rather than having all of them moved out to non-government providers. When we are talking about residential rehabilitation services, the model is similar in Victoria and New South Wales. Those services are predominantly delivered by the non-government sector. However, there is a substantial private sector in both States, and that includes general practitioners, medical specialists, psychologists, and allied health providers who work on a Medicare funding model or in the private system. We have a greater emphasis on the government sector when we are talking about our inpatient short-term acute admissions. More of that is done in the government sector in New South Wales. More of our community counselling and community outpatient services are provided by the government sector in New South Wales than in Victoria. However, there is a mix of those services in both jurisdictions. It also varies by local health district.

The Hon. Dr PETER PHELPS: That is interesting. Has any analysis been done of the cost and outcomes? That is what I am trying to establish. It is not unnatural for people to understand that I strongly support privatisation. Has any analysis been done of the efficacy of the Victorian system as compared to the New South Wales system? Has any comparison been done of the cost to government of the respective systems? For example, if it is cheaper in Victoria and it has better outcomes, why would we not move to that model? If it is more expensive in Victoria but it has more effective outcomes, there is an argument for moving to that model. However, if it is both more expensive and less effective then obviously we would not move to that model. Has any analysis been done of the respective costs and outcomes in Victoria and New South Wales, and can any meaningful evaluation be made of the two systems?

Dr CHANT: Before I defer to Professor Lintzeris given his more intimate knowledge of the two structures, I point out that measuring outcomes is a strong focus of our new approach to drug and alcohol services. It is important to note that many of the evaluations have been done at points in time and we understand that drug and alcohol issues are relapsing a chronic disease in many cases. We are developing programmatic evaluations that follow people in the long term to understand about their intersections with the criminal justice system, with education systems, and developing some outcome measures.

While there is a number of programs that have been evaluated, to some extent there has been a dearth of long-term evaluations of different models. What we need to understand in drug and alcohol is there are often co-dependencies. I will ask Professor Lintzeris to pick up on this issue. We might do a residential rehab but that alone will not address the issues. We are likely to need a sustained intervention. We may need to address any underlying mental health issues. We may need to address any underlying social issues around housing. We need complex interventions; therefore, we need much better analysis and complex evaluations to truly pick up what is the best buy, or what services we need to provide in sequence or collectively to actually get the optimum outcome. A service may have a great outcome but it often has co-dependencies about the provision of other services to see that outcome.

Professor LINTZERIS: I think Dr Chant has summed up some of the key issues quite succinctly. We have no robust outcomes framework at a national level in Australia. We do have the Australian Institute of Health and Welfare [AIHW], which does collect minimum data outcomes, but they are very gross outcome frameworks that do not really allow us to compare outcomes from one treatment system to another. We do not have a shared outcomes framework. Individual independent evaluations may have looked at particular episodes of care or specifically looked at the cost of providing counselling in one service compared to another. There has been no robust evaluation of service costs across Australian jurisdictions.

I just really want to pick up the point that Dr Chant just highlighted from earlier—the issue around coordination and continuity. Our understanding about what addiction is as a clinical condition and how it affects the lives of individuals is that increasingly we are now framing this as a chronic health problem, so it is a chronic disease if you want to use the disease language. Our understanding about how we evaluate and value services or organise services for people with addiction problems has changed very much from, say, 15 to 20 years ago when we may well have put a lot of emphasis on let us look at a standalone residential rehab, or a standalone methadone episode, or a standalone detox and measured that and evaluated it.

Now we are starting to realise that on its own that is not a robust way to look at the journey that individual people go through over a lifetime. If addiction generally affects people over a 10 to 20 year course, often starting in the early twenties and usually starting to sort of burn out by the time our patients reach their forties and fifties,

often we are looking at a 15 to 20 year period of people needing ongoing contact with services. Often it is quite complex in terms of the range of services that they require. Many people will develop physical health problems, such as hepatitis C, chronic pain problems with opiate use disorders, mental health problems, especially with alcohol and methamphetamine problems. There are all these comorbidities.

Then there are the issues of continuity of care. The issue around how we network our services means that it is actually very difficult to isolate what does the drug treatment cost. Really, if we are talking about the health and wellbeing and the services for an individual, it is not just what did the detox cost but also how do we integrate that with mental health for the patient. Who provides that mental health service? How do we integrate this with physical health? It is really looking at the broader responses. The exercise of trying to look at what is the bottom line for delivering of detox, the cost of the detox in Melbourne or Sydney or Dubbo or Geelong is a limited approach in terms of it will tell you the cost of a component of care, but it does not really tell us adequately about the broader range of services that individuals need in order for them to be able to meet the goals of a broader rehabilitation program.

The Hon. Dr PETER PHELPS: Nevertheless, if that component of care can be delivered as effectively but at a cheaper rate through outsourcing to private providers or non-government organisations—

Professor LINTZERIS: Absolutely, but there is no evidence.

The Hon. Dr PETER PHELPS: But the trouble is that essentially you are saying that there is no evidence available to make a valid evaluation as to whether this is proper expenditure of the taxpayers' funds.

Dr CHANT: No. Can we just dissect those two things? There is provision of the physical rehab service and the cost structures, and we have no evidence that there is a substantive difference between private sector and public sector. But we will look at the data. We can provide you with some data around our contracted services—what we get for bed utility—and we are happy to provide some data from Victoria and search for some comparisons. We are happy to provide that. I think your second part of the question really was about a focus on outcomes. What we are really talking about is that it depends on how you define the outcome. But whether they stayed in a residential rehab is no longer an adequate indicator of the outcome because what we would say is that whether they re-presented to emergency departments within 28 days, whether they had an acute mental health episode, whether they had a suicide attempt, whether they had a self-harm episode and whether they injured themselves, these are more realistic indications if we want to optimise. What we are trying to do for that individual who has attended the rehab is optimise their health outcomes. We are saying that we believe we would need to have a follow-up.

The residential rehab may be fantastic, but if you actually do not put in the other connected services, then you will not see the outcome for that patient. We are saying that we realise that we are investing in New South Wales significant resources and also supporting the NGO sector in evaluations because many of these evaluations in the NGO sector have not been formally evaluated. As part of the $75 million drug package, there were some innovation funds and some funds set aside to actually support these evaluations. We have got data linkage capacity in New South Wales and we have access to cross-agency data, which will allow us to do a more rich understanding of the nature of the services we need to put to get the optimum outcome from our investment, notwithstanding—I take your point—that we have to be careful about looking at the cost of what a drug rehab service does. I will provide you with whatever information we have got to that effect.

The Hon. COURTNEY HOUSSOS: I just want to lead on from where you ended there. You said there will be more data available. The existing provision of particularly rehab beds is something that we have been quite concerned about. I am interested to see whether there has been any strategic planning. There is some in Cowra, there is some in Brewarrina, but there is none in Dubbo, which is a major centre. Is that a hangover from previous funding approaches? Do you have a current planning program that says we do not have one in Dubbo and that is something that we need? Clearly, the council is interested in it and has put some money behind it. What is the process that you have?

Dr CHANT: The process is that local health districts every year go through a scoping of what are the issues confronting the local health district in terms of service gaps or where they are recognising that there may be new approaches that they want to adopt. We are working in the Ministry with the local health districts to identify what are the gaps. Do we need more assertive case management? Do we need more residential rehab beds? Then, within their purchasing framework, districts get increased allocations. There is an algorithm around population activity projections that go to the funding model. We would then be proposing that that would be additional purchase services that the Ministry would request of the districts that we would be purchasing. We are going through that process now.

We recognise that there are gaps and there does need to be a broader range of drug and alcohol services. We have a particular focus on connections with emergency departments and better support for our court diversion programs. We see strong value in a range of court diversion programs. Also, as I said, we see the emergency department as a critical point where there is potentially better ways of providing care to individuals who present to ED as it almost is presenting an opportunity for early intervention.

The Hon. COURTNEY HOUSSOS: In the last 12 months, how many new residential beds did NSW Health purchase?

Mr Madeddu: Sorry, I have to get my notes because I do not remember from the top of my head. It was the $8 million from the allocated drug package and that provided beds at three residential facilities. I have to refer to my notes. Excuse me.

The Hon. COURTNEY HOUSSOS: From the $75 million, $8 million of that was to provide residential beds?

Mr Madeddu: Correct.

The Hon. COURTNEY HOUSSOS: Are you able to tell us where, or you are trying to find it?

Mr Madeddu: Yes. Perhaps I can come back to that.

The Hon. COURTNEY HOUSSOS: Professor Lintzeris, following on what you said earlier in respect to what happens in Victoria, detox happens in general hospital beds, it does not have specialised—

Professor LINTZERIS: In Victoria, there is a range of detox services. Some of them occur in acute hospitals. Some of them occur in what they call community residential units. That will often be a standalone residential—like a ward, near a hospital, often collocated—

The Hon. COURTNEY HOUSSOS: Like Riverlands in Lismore?

Professor LINTZERIS: Exactly. Good example. It is sort of part of the hospital but not really part of the hospital, so it is in close proximity. Should there be any acute emergency, patients can easily be taken to an emergency unit. Victoria also has, I would say, a stronger tradition of community-based withdrawal services, so ambulatory withdrawal, home-based withdrawal services, where it is more about withdrawal being provided in community settings for patients rather than residential settings. They have a robust approach to withdrawal. In New South Wales, it is probably more variable from one part of New South Wales to the next. In New South Wales we more or less see the same range of services of acute hospitals and community residential services. There are some ambulatory in-home withdrawal services spread out across New South Wales.

Dr CHANT: It might be useful for Professor Lintzeris to describe the risk-factors associated with withdrawal and how it varies across drug type.

The Hon. COURTNEY HOUSSOS: We have covered that in previous testimony.

Mr Madeddu: Apologies for the time. For that $8 million, that went to three different services. One was a new residential service in Orange. It was for women with dependent children. That is a 10-bed facility and it can accommodate up to 15 children at any one time.

The Hon. COURTNEY HOUSSOS: Is that one open?

Mr Madeddu: Yes, it is open and operating now.

The Hon. BRONNIE TAYLOR: We have been told there are not any.

The Hon. COURTNEY HOUSSOS: The next one was?

Mr Madeddu: Lives Lived Well is the organisation that is running it. There is a service called Kamira on the Central Coast. That was for an additional four beds. There was a third organisation that received funding, but that was more to build up its detox capacity for the women who used that service.

The Hon. COURTNEY HOUSSOS: What service was that?

Mr Madeddu: Jarrah House. There is another one, which is a youth service, a youth detox facility called David Martin Place. I do not know the number of beds from the top of my head. That is for young people 10 years old to 19 years old.

The Hon. COURTNEY HOUSSOS: If you can provide that number of beds on notice, that would be useful. I want to come back to Dr Chant, because the point that the Hon. Bronnie Taylor made is an important one. We have received lots of advice that people do not know whether there is any support for women with

children, for example. Do you have a comprehensive list of all the drug rehabilitation beds that are available in New South Wales at the moment?

Dr CRETIKOS: We have a list of all the services, but we do not necessarily count all the beds because we are not the only funder in some cases. We do not count beds; we count which services we are funding.

The Hon. COURTNEY HOUSSOS: Even within Justice Health you do not have—I appreciate, Mr Forrest, that you were here earlier and heard my questions of the Community Corrections and the Drug Court representatives. Do you maintain a comprehensive list?

Mr FORREST: We do not maintain a list of the beds for the residential rehab. Justice Health staff who are involved in the Drug Court program will work closely with the local health district to determine bed availability. Some of the patients who are enrolled in the Drug Court program do not necessarily need to transit into residential rehab; they can go to community-based placement. That is a discussion in relation to their parole conditions and which area they may be released to and what type of accommodation support they need.

Dr CHANT: We did pick up on the concerns that you raised at our first inquiry, and we are looking into how we make the bed availability more visible, be that through the Network of Alcohol and Other Drugs Agencies [NADA] or what mechanism, we are still scoping that. We agree with you, there should be easier access for service providers or people interested in accessing rehab to understand what availability is present.

Professor LINTZERIS: There is also, for example, private hospital providers. It is very difficult to identify one body that is responsible for all these services. However, we also do have ADIS, the Alcohol Drug Information Service, which is a 24/7 telephone service predominantly funded by NSW Health. That provides a telephone service for people in the community to ring up and have a confidential and anonymous discussion with a counsellor over the telephone about services that are available and what might be best suited to that individual, and ADIS maintains a database. It is run out of St Vincent's Hospital in Darlinghurst.

Dr CHANT: NSW Health funds that for this service.

The Hon. PAUL GREEN: I have some questions in light of this. Byron Private put in a submission. It States on its first page that in 2005 the Department of Health identified 31 residential services in New South Wales providing approximately 700 beds, but you seem to have lost that. You do not know how many beds you have got in New South Wales, yet in 2005 you had a system where you were auditing how many beds and residential areas you had?

Dr CHANT: We know what facilities we provide funding to, so we are happy to provide that detail and the range of services. I am not sure we have done a recent audit of the beds that may have been in the private sector or others. I am happy to look at what was known in 2005 and what they were referring to.

The Hon. COURTNEY HOUSSOS: In respect of that breakdown, if you can please provide that to us by LHD whether the services are for males, women and children, ages, and whether is it a detox bed or a long-term rehab bed and what is being provided and when was the last time you did a comprehensive audit.

The Hon. PAUL GREEN: For your information, the information came from a New South Wales costing study on alcohol and drug residential rehabilitation, which was prepared by Health Policy Analysis Pty Limited in 2005. It showed that the majority are being provided by the non-government sector. My second point is that we talk about what is available and when taking evidence it has become clear that no-one knows what is available in New South Wales. Given the fact that the Government is not providing the majority of the service, would it not be feasible that, given the advances in technology, Airbnb and the way the bike system works electronically, people across New South Wales should know what is available on a daily basis?

Dr CHANT: We totally agree.

The Hon. PAUL GREEN: Why has nothing happened?

Dr CHANT: I indicated in my previous response that we are looking at whether we use ADIS or what website we put it on. We are working with NADA, which is the peak body. We are progressing this. I agree with you, we need to make it visual.

The CHAIR: Dr Chant, can I give you this example. At the end of the Lismore hearing, out of utter frustration an Aboriginal gentleman came to see me with a solicitor from Legal Aid. I will not provide his name at this stage. He had two children who had a methamphetamine addiction. He was almost on his knees begging me how to find out how he could get his two adult children into rehabilitation and where there was a program, because try as he might have for weeks and weeks going into months, with the assistance and general guidance of his solicitor, he could not establish where rehabilitation could be found for his two adult children who had a methamphetamine addiction.

I had never met this gentleman in my life before, it was not something that had been set up. This was a man, a father pleading with me, "How can I find out where there might be a capacity to have my adult children somehow across the State placed into some type of rehabilitation program?" Those searing examples were found by us everywhere we travelled around the State. Adults and parents were absolutely desperate to find out how. I am amping it up a bit, but it is a very emotional issue. These people are trying to find out where they can get information, basic access, guidance, and hopefully direction to assist them to deal with these very serious drug addictions. The Committee understands that it takes time to put systems in place, but these are not new issues. It is not a question of a conservative government versus a Labor government.

Dr CHANT: No.

The CHAIR: These issues have been around for some years. I find it quite extraordinary that it is not possible in 2018 for anyone in this State who has a child in a most desperate position to be able to relatively easily go to a central source and find some very basic information and direction about where they could possibly go to get information about the provision of drug rehabilitation for their child with an addiction. It does not seem to me to be a particularly big ask.

Dr CHANT: I totally understand, and what we would say is, it would be the ADIS line that would be providing that at the moment. But I think you are challenging us to present that information in multiple ways for people.

The CHAIR: With the greatest of respect, it is the community of New South Wales, it is not Greg Donnelly, MLC. These are people all around the State.

Dr CHANT: I understand, Mr Donnelly. We will take seriously the feedback that you have had that people are finding it really hard to navigate the system.

The CHAIR: But you know that.

Dr CHANT: I understand, but what I want to do is work with the Committee to improve that. I genuinely can understand the trauma that the family might be experiencing at this time. Could I also offer the Committee the opportunity to provide in confidence any of the patients that did have difficulty navigating it, because there also is a role for the local health districts. My guidance would be that residential rehab may not be the most appropriate care model in all of the cases. What is important is that they are engaged in care with our mental health services and that they are accessible so we can actually develop a treatment modality. I do not know if you want to add to that, Professor Lintzeris? I would be saying that they need to contact our local health services.

The Hon. PAUL GREEN: No doubt there are lines of people our there. Because they cannot get the access to rehab beds there are lines of people. My point is that we are in the twenty-first century, it is 2018 where you can get an app. Secondary to that app would be the information. My next point concerns accreditation across the government and non-government organisations. Is there a basic accreditation system? I would think as part of an accreditation scheme there would be a reporting system where—because they are so vulnerable, someone might last a day or seven days to detox—almost 50 per cent of those beds are vacated before the rehabilitation is finished. Surely that means, with reporting to a single database, we would be up to date across the State of who has affordable, accessible beds available regularly.

At the moment no-one knows what the next person is doing. They are doing their best to put people from their large lists through their system, and there could be beds empty somewhere in New South Wales that people, such as this gentleman in his desperation with his two children, could access. We are not saying it is perfect, we all know the system is packed with desperate parents trying to get their loved ones into care. Is it not fair to say that through accreditation they could be reporting daily into a system? We know the water flows and the electricity flows of New South Wales on a daily basis. Surely we could know the data flow of what rehab or detox beds are available in New South Wales on a daily basis?

Dr CHANT: I have asked the team to prioritise this, and we will get this done. I am also very conscious that people understand that we also want the patients who are going to most benefit from a residential rehab program, going into residential rehab. We also do not want to create a situation where someone tries to ring up a residential rehab, or thinks that is the pathway. We would really support that people are assessed and linked into care and that is why I am concerned that, whilst providing the information, the most important point is that we navigate who is going to be their care provider to actually provide that holistic care. I am really concerned that we understand the evidence base associated with residential rehab and how it provides care. Professor Lintzeris, could you comment on that, because I think it is really important.

Professor LINTZERIS: And really highlights on this issue around what is our understanding and how we create a treatment framework for people with chronic addiction problems. The challenges are often that

individuals in the community, general practitioners and emergency department workers are confronted with a patient with an acute problem in front of them and the temptation is for the kneejerk reaction to that acute problem in front of them. That is completely understandable—as a service provider, as someone who works with patients and families you see this all the time. It is an acute presentation at that moment in time. But we are often talking about a 10- to 20-year journey. The challenge is how do we make sure that acute emergency services are available when they are needed, that residential rehabilitation services—which, let us be really clear, are a very important component of treatment and rehabilitation for a minority of individuals—are available when required. But resi rehab is not an acute emergency response.

The CHAIR: We understand that.

Professor LINTZERIS: It is about how do we get information available to the community, to potential patients, also to the acute services. The acute services are really important. We are often talking about police, emergency departments, the criminal justice system and mental health services. They are often the front line where they will have someone in front of them with a drug and alcohol problem. The presentation is not necessarily someone saying "I want rehab" or "I want my addiction cured". The presentation is often following either a criminal justice issue, a mental health problem or an ED presentation. We need to make sure that we have pathways from those acute services into planned, integrated treatment pathways, better connection between services, the networking—we actually have a lot of drug and alcohol treatment services but historically they have not been well networked, well communicated.

The Hon. PAUL GREEN: They do not know what the person next to them is doing.

Professor LINTZERIS: Welcome to Australian health care. There are potential solutions to this that we are starting to see with all chronic disease management. Better electronic records allow us to communicate from one service to another.

The Hon. BRONNIE TAYLOR: They have worked well! I find this quite staggering. The Committee is constantly told that we need pathways, integration and service coordination. I used to be a health worker myself, so I get it. But the reality is, it is not working. At some point as providers we have to take responsibility for that. We have heard evidence on the North Coast from a community-based NGO that provides services to drug and alcohol that there is nowhere for a woman to go with her children. The only place is in Queensland, and they were looking at its model. This is evidence given by an NGO that takes referrals from government agencies, whether Health or Justice. The facility in Orange sounds fantastic, but this NGO does not know what other services exist. I find that reprehensible. We need to look at solutions, because we know there are obvious problems. Professor Lintzeris, you know more than I do about drug rehabilitation, but we cannot keep talking about pathways. It is obvious there is no coordination of services and there is no follow-up care, although drug addiction could last for 10, 15 or even 20 years. What are we doing about it?

Dr CHANT: We agree there are many issues and we are working very hard to make sure that we change the model of care provided by the NGOs and our services to embed more of the recognition that this is a chronic relapsing condition. We need to have much more assertive follow-up and engagement with these in the long term. We need to reflect back to the services the outcomes, because we cannot see success as just having completed a program without addressing the fundamental issues. We recognise these issues, and we are working as hard as we can. We can do simple things, such as looking at the availability of the Alcohol and Drug Information Service call line. We can get additional numbers on rehabilitation spaces and better messaging about what services to contact in our local health districts for care navigation. I am very concerned that general practitioners are not aware of the local drug and alcohol services and how to get expert advice locally.

The Hon. BRONNIE TAYLOR: Maybe the message is that we need to look at funding NGOs to run these programs, perhaps for a 12 months or two years to set up the program and do the follow-up. We have no accreditation system for our NGOs, although I know there is work going on for that with the Social Innovation Council despite a lot of pushback from departments. We could do something like that and accredit those NGOs that do the right thing and fund them for, perhaps, five years. We might even get a cross-party agreement to ensure that NGOs that are accredited are funded for five years. We need to start thinking outside the box, because we cannot keep funding NGOs for short periods and then they are gone, meaning people go back to substance abuse.

Dr CHANT: We see NGOs as a key part of the service system. We reward NGOs that are able to provide good quality care.

The Hon. BRONNIE TAYLOR: How are they rewarded?

Dr CHANT: By having three-year funding agreements. We are also developing a lot more key performance indicators. We have embedded some standardised KPIs so we can benchmark—

The Hon. BRONNIE TAYLOR: How can three years be enough? Professor Lintzeris said you are looking at a 15- or 20-year trajectory.

The Hon. PAUL GREEN: Another point is that you can do all those wonderful things, but if services remain in silos then we have not established a network of services across New South Wales. Surely part of the accreditation should be a requirement for an annual conference of the NGOs for cross-pollination of services to learn about other services. At the moment desperate women with kids are not told about the available services in the area. We were in Dubbo and were told that they did not know about the services in Orange; that is crazy.

Dr CHANT: I would like to acknowledge the work of Network of Alcohol and Other Drug Services. I had the pleasure of attending the NADA conference to which all the NGOs across the State were invited. The auditorium was packed with, I would say, 300 to 400 people—we can provide the number of delegates. Evidence was presented and there were opportunities to present on the contemporary issues in drug and alcohol treatment. There were expert speakers, including interstate speakers for the very purpose highlighted.

The Hon. PAUL GREEN: This is a good start.

Dr CHANT: Dr Cretikos can talk about the work we are doing around quality and safety. We encourage NGOs to be part of the service system. They need to be integrated and connected as part of the service system.

The CHAIR: I do not want you to think that we are making the department a punching bag, although it may seem that way. In this last hearing we are driving home the point that we have heard evidence about systemic issues.

The Hon. COURTNEY HOUSSOS: You said that the only planning for new beds occurred at a local health district level. Is that correct?

Dr CHANT: We have a statewide remit and we are looking at data to see the patterns of presentations and hospitalisation in our overall understanding of drug-use patterns. We are working for local health districts to see what that would mean in terms of the types of services required. We have started that work and we are broadening the data to inform decisions. Our first report was on crystal methamphetamine and we are looking at a broader range of drug and alcohol measures to use that data in the service model with local health districts. We hope to get better visibility of the Commonwealth investment. Professor Lintzeris mentioned fragmentation and we know the Commonwealth is investing in drug and alcohol treatment. We will do much better if we work collectively on a commissioning framework for new drug and alcohol services by sharing data and intelligence in this regard.

The Hon. COURTNEY HOUSSOS: The Federal Government has put in $300 million and New South Wales has put in $75 million, yet we have heard consistent evidence that there has been no effect from this additional funding, although obviously more residential beds have been provided. Do you sit down with your Federal counterparts to work out where to invest the additional funding within the existing framework?

Dr CHANT: To be clear, the $75 million was part of the election commitment. Within the growth funds of local health districts there have been some enhancements to drug and alcohol services outside the $75 million. We need to work collaboratively with the Commonwealth, which is what the community expects us to do in the best interests for the outcomes of patients.

The Hon. COURTNEY HOUSSOS: I am happy for you to take this question on notice. Can you provide us with a breakdown of where the $75 million has been allocated?

Dr CHANT: Yes, we certainly can.

The Hon. COURTNEY HOUSSOS: You do not have a central register for the waiting times for drug rehabilitation services. Can you give a person seeking drug rehabilitation services a waiting time for access to services?

Dr CHANT: We can assess the person to check the nature of the person's condition and what services are required. We can provide advice about residential rehabilitation if that is the suitable service model for that person. We can ring around the services we are aware of and have them link that person into a service. We do not have real-time, current reporting of bed vacancies, but we have a requirement to ring around and get a person into these services.

The Hon. COURTNEY HOUSSOS: Who would you ring?

Dr CHANT: ADIS.

The Hon. COURTNEY HOUSSOS: We have heard from public and private so I am familiar with this. Does ADIS have a list of public and private, or is it referring only to publicly funded beds?

Professor LINTZERIS: They will have data available for all health services that provide drug and alcohol specialist services. Of course, they do not necessarily have databases on general practitioners with a special interest or private psychologists. But if we are talking about private drug and alcohol services they are on the ADIS books, all the non-government agency services that are funded to deliver drug and alcohol, and all the public sector services. So in regard to all the main players, yes. Now, of course, there probably are private specialists in the community that are not on the ADIS list—the psychologists with a special interest—but when we are talking about all the big services, ADIS would be.

If a patient or a carer contacts us and asks, "I need to find a treatment service. Who do I call?", ADIS is the central referral point. ADIS will then have a brief discussion, "What kinds of problems do you have? What kinds of services are you interested in?" Then it will be able to direct that individual to the range of services for that person to contact. There is mechanism for ADIS. But I think what we are also reflecting is that this is not just a problem of fragmentation between services, which obviously is an issue with all chronic disease management. I also think it has to be openly acknowledged across all of Australia that we have an underfunding of drug and alcohol treatment spots. Drug and alcohol contributes significantly to health problems

The Hon. COURTNEY HOUSSOS: I think you have a receptive audience when you say that.

Professor LINTZERIS: Whilst we are only funding about one in four treatment spots that are required—and a number of independent reviews have come up with approximately those kinds of estimates—there is no way that we can meet demand when only a minority of treatment services are available in the community.

The CHAIR: I accept as a general statement that what you say is right. But if you take the matter of where the money is being spent, there is the $75 million from New South Wales that was referred to and how much was from the Commonwealth? Was it $300 million?

Professor LINTZERIS: They are enhancements. I think they actually spend much more.

The CHAIR: I am talking about the aggregate of money. Was the most recent campaign $300 million from the Commonwealth?

The Hon. COURTNEY HOUSSOS: That is right.

The CHAIR: If you take New South Wales as one-third of the Commonwealth, this State picked up one-third of the $300 million, that is, $100 million. I do not know whether that came to New South Wales. In rough figures, if you took that $100 million or thereabouts and the $75 million from New South Wales, it is a total of $175 million. This Committee has travelled around this State. This evidence was not drawn out of people through questioning but rather essentially through them volunteering. Referring to this huge amount of money—let us call it $175 million in round figures—what manifestation have you seen of that huge amount of money in your area for drug rehabilitation? More often than not, in fact, virtually on every occasion, we got a blank look. Where has the $175 million gone? It is rhetorical question but it is part of a structural melee. If that amount of money came into New South Wales and worked its way through, as presumably it has—and no-one is suggesting for a moment that there has been corruption, fraud or anything like that—when this Committee travelled around the State it was met with blank faces. Something is seriously wrong.

Dr CHANT: I think it probably reflects the level of unmet need in drug and alcohol.

The CHAIR: But these people did not know where this money had gone. They were familiar with the Commonwealth commitment and they were aware of the New South Wales commitment, but when they were asked whether they knew what programs had been funded by it, or whether extra beds had been provided there were blank faces.

Dr CHANT: I acknowledge that.

The Hon. COURTNEY HOUSSOS: Are you aware of the Bennelong Haven closure in Kempsey?

Dr CHANT: Yes.

The Hon. COURTNEY HOUSSOS: Has any attempt been made to reopen that facility?

Mr Madeddu: Benelong's Haven was funded by the Commonwealth primarily. NSW Health has some funding for Magistrates Early Referral Into Treatment [MERIT] beds but it was funded by Prime Minister and Cabinet. We know verbally that they are doing a selective tender right now within the same geographical area for a similar service, particularly for Aboriginal people.

Dr CHANT: We will follow up with the Commonwealth.

The Hon. COURTNEY HOUSSOS: What happens to these MERIT beds?

Mr Madeddu: They have been relocated to other services within that district. So the local health district made sure that the same beds were being made available for Aboriginal people. I do not know the service off the top of my head but there are between two and three services.

The Hon. BRONNIE TAYLOR: The same number of beds still exists.

Mr Madeddu: Correct.

The Hon. COURTNEY HOUSSOS: But none of those would be available for Aboriginal women with children?

Dr CRETIKOS: I do not think Bennelong Haven was a dedicated women and children facility.

The Hon. Dr PETER PHELPS: No, but it allowed for women and children to go there as part of an integrated response with family members available.

Dr CHANT: We would be happy to provide outside a written response to the issues around Bennelong Haven. We would also be happy to provide details of where the services were relocated. We are very keen that accessible services are established and we will also chase up with the Commonwealth about the tender that it is running and just make it specifically clear that there is a need to address women specifically.

The Hon. Dr PETER PHELPS: Did Bennelong Haven fall over because Federal funding came to an end without any additional funding? No-one has been able to tell me how Bennelong Haven came to an end.

Dr CHANT: I think it would be better that we provide a written response.

The Hon. COURTNEY HOUSSOS: Take that question on notice and come back to us.

The CHAIR: We are not trying to ambush you; we just want to understand.

Dr CHANT: No, I think it would be more appropriate because there is—

The Hon. Dr PETER PHELPS: If it came to end because the funding was cut off and there was no additional funding that is one issue, but if it came to end because of internal Aboriginal politics that is an entirely matter. We need to know exactly how it came to end.

Dr CHANT: I think it would be better if we provided a response in writing.

The Hon. COURTNEY HOUSSOS: And you can provide that on a confidential basis. That is fine; we are happy for you to do that. Do you engage with other States and Territories to find out what they are doing and what is working and what is not working and how do you do that?

Dr CHANT: I think the answer to that is that we work with other States and Territories and we also engage internationally. We have a program council which meets with the non-government organisation sector and the drug and alcohol leaders in each of the districts and we are always looking at novel models of care. I am proud to say that a number of our drug and alcohol clinicians are strong researchers who are always embracing new models. We are currently in the process of rolling out a new trial within the Corrections setting with an injectable form of long-acting buprenorphine and that will obviously increase the capacity, if successful, for Justice to manage many more patients with opioid addiction within that setting. It will also potentially provide a better transition out externally on discharge. We are also embracing new models of care in relation to youth services and, as I mentioned, the Innovation Fund. So we very much are outwardly looking. Professor Lintzeris might want to add something.

Professor LINTZERIS: There is a lot of collaboration across Australia, at least amongst the health professionals. There is close collaboration with many of the key services. I think it is fair to say that some of the coordination at a Commonwealth level probably is not as strong as it was a decade or so ago. Some of those Commonwealth government structures are not as robust as they were a decade or so ago. Nevertheless, there is a lot of collaboration and cooperation between jurisdictions—at least at a professional level.

Dr MEHREEN FARUQI: I would like to revisit the question of detoxification units. We had a chat about this last time and also today. I think we all agree that there are very few designated detoxification units in the public system. Would I be right in saying that?

Professor LINTZERIS: In New South Wales the majority of detoxification occurs in the public health system—in hospitals.

Dr MEHREEN FARUQI: But not necessarily a separate unit? I recall that there used to be detoxification units but now they are just detoxification beds?

Professor LINTZERIS: Some of that reflects the changes in activity-based funding that has been introduced over the past few years. Once upon a time a ward may have been called a standalone detoxification ward. Now, because of the way ABF operates, that standalone detoxification ward will now be considered part of the hospital. An example is Gorman House.

Dr MEHREEN FARUQI: But is it still a standalone detox ward, or are their other people in that ward as well?

Professor LINTZERIS: They tend to operate as standalone services. However, in emergency periods—for example, in winter when there are flu epidemics—patients may well be decanted from extremely busy emergency departments to spend a night or two in a hospital bed that was once called a detox bed. I am not aware that we have seen a dilution across New South Wales from standalone detox services to integrated services. That has happened in a number of local health districts, but on the whole most that run withdrawal units fundamentally have not changed their model, although they may have reclassified them. Lismore has the Riverlands Drug and Alcohol Centre and Newcastle hospital still has its standalone unit. There have been no major restructures in metropolitan Sydney.

Dr MEHREEN FARUQI: How many designated detox units are there in the public system in New South Wales and how many beds are there? You can take that question on notice.

Professor LINTZERIS: In terms of ICD-10 presentations, the vast majority of withdrawal admissions in the hospital system occur in the mental health system. If we look at where most people in the New South Wales hospital system are being detoxed, it is within mental health services.

Dr MEHREEN FARUQI: That is still the public health system.

Dr CHANT: We will be careful about the terminology we use in our answer. We are highlighting that these are mental health beds because people are presenting with mental health issues and are then detoxing.

Dr CRETIKOS: There is a very large number of health facilities across New South Wales—I think it is more than 200—and we have a number of designated withdrawal centres in a small number of hospitals. However, many hospitals routinely handle withdrawals but in a non-designated bed because it not feasible to have a designated ward in every hospital across the State. What they need is the capacity to handle withdrawal in every facility. The important point is that a large number of withdrawal episodes occur across New South Wales but they are not treated in a designated withdrawal bed, and that is appropriate.

Dr MEHREEN FARUQI: The important point I was raising is that the number has not been reduced. The Committee heard evidence that there used to be dedicated detox beds in the public system but they no longer exist. That is the important point I want to make; not that we treat people who need to be treated. Is that the case? I would appreciate receiving some numbers.

Dr CHANT: We might also provide data about the number of detox episodes and whether they have increased or decreased across the system.

Dr MEHREEN FARUQI: That would be good. I think the Royal Australasian College of Physicians submission expressed concerns about the increasing merging of drug and alcohol services with mental health services. We understand there is comorbidity in areas like that, but is that because there is a loss of standalone drug and alcohol services? Could you comment on that?

Dr CHANT: We must again put the patient at the centre of what we are trying to achieve. People do not come—

The Hon. PAUL GREEN: People are complex.

Dr CHANT: Yes. They are simply badged as drug and alcohol patients. It may take many months to get to the basis of whether it is a pre-existing predominant mental health issue exacerbated by drug and alcohol or an addiction issue. People are incredibly complex. We want to ensure that the service system is such that a broad range a clinicians are managing drug and alcohol presentations in the right way, be that in emergency departments, which often see people at particular points. One of the challenges is that we must not be siloed in our response and that mental health services continue to see a large proportion of patients. We need to have drug and alcohol services and mental health services working collaboratively.

Dr MEHREEN FARUQI: I understand that, but you must provide services in response to that and increase services, not make do with the same level of services.

Professor LINTZERIS: The issue is drug and alcohol services being overtaken by mental health services. That is reflected more in some of the smaller local health districts—the rural and regional local health

districts—where we have a much smaller drug and alcohol workforce. Within those districts the drug and alcohol service system ends up being managed within a local health district under the mental health director. That often simply reflects the size of the drug and alcohol program. For example, in some rural and regional local health districts there may be only 20 drug and alcohol staff. That is too small to be a standalone organisation. Someone needs to manage them, and often that will be the mental health director. That trend has happened over the past decade, especially in rural and regional local health districts—that is, some of the organisational governance of the drug and alcohol services were incorporated into mental health services.

Clinically, we work collaboratively with our mental health colleagues with a range of integrated and emergency departments and the general health and welfare system. We need to work collaboratively. How we organise ourselves and who the manager reports to within the government system varies from local health district to local health district. There has been over the past 10 years or 15 years a tendency to integrate that organisational governance into the same teams.

Dr MEHREEN FARUQI: I want to be assured that the services are not being depleted. We know there is a lack of mental health services as well. That is the key point.

Dr CHANT: As was mentioned at the last hearing, NSW Health has moved administrative responsibility from drug and alcohol and split it from mental health. I think that is to ensure that, while we recognise the close synergies, it is important that we have a strong focus on them separately and individually as well. However, I am very much committed to integration and collaboration across the disciplines because the patient must be at the centre.

Dr MEHREEN FARUQI: You mentioned staffing arrangements. The Committee has heard again and again that there is an inadequate number of addiction medicine specialists in New South Wales. That could partly relate to the way we teach in universities. Is NSW Health doing anything in collaboration with universities to increase the number of specialists?

Professor LINTZERIS: I am the president-elect of the Australasian Chapter of Addiction Medicine and I am very familiar with what is happening in addiction medicine specialist training. New South Wales has trained the vast majority of addiction medicine specialists. At the moment we have seven or eight addiction medicine trainees and at least that number of addiction psychiatry trainees. New South Wales at least has a functional training system. In comparison, Victoria has only one addiction medicine trainee and Queensland has one or two.

Dr MEHREEN FARUQI: Comparison is not enough if we do not have sufficient people.

Professor LINTZERIS: Yes, absolutely. There are some barriers in terms of training pathways into addiction medicine that need to be addressed at the college level. We must also look at how we enhance training of general practitioners and non-addiction specialists. How do we ensure that our psychiatrists, emergency department doctors, gynaecologists and pain doctors have a better understanding of addiction issues?

Dr MEHREEN FARUQI: How is NSW Health doing that?

Professor LINTZERIS: NSW Health has supported addiction medicine through funding registrar positions. At the end of the day, that is what it is about: If we want training positions, we need registrar positions. That is why New South Wales has trainees. Those training positions do not exist in some of the other jurisdictions.

Dr MEHREEN FARUQI: Is there a plan to increase the number of those positions?

Dr CHANT: As part of the $75 million, we have identified support for youth and we have grown a youth and adolescent specialist. That is a particular gap we have identified. We are also funding training programs for general practice. That has been contracted out to the University of Sydney group to be undertaking that work. But we recognise there needs to be enhanced training and we are particularly committed to supporting our ED specialists and the other groups that Professor Lintzeris mentioned that we really need to support. We are very keen to work collaboratively with our mental health colleagues.

Dr MEHREEN FARUQI: Dr Chant, earlier you mentioned changing the framework of evaluation because it is complex; there are so many elements to people's addiction and complexities such as housing. We heard that transport was a real issue in regional areas. We have come across quite often an issue of people losing public housing if they go into residential programs and women having to leave children with foster carers with the risk of children being taken away from them as well. I am wondering if Health has spoken to Family and Community Services [FACS] about this at any time, or do you have a plan to talk to those sorts of services to make things easier for people and remove those barriers? How do we deal with that issue?

Dr CHANT: We have ongoing relationships with FACS where we raise program issues. It is challenging because as I think the speakers before us highlighted, FACS is challenged with housing demand and prioritisation. I think it goes to the evidence that probably Health has provided and that Professor Lintzeris as a clinician can speak about. It is that residential rehab is not suited for all circumstances for all those variety of reasons—you know, dislocating people from other family support structures, which may not be in the best interests of the patient. But it may be that we need to actually increase the range of options for the person. What are the other support services we can put in place?

Some of the things that we are conscious of is our supported home visiting programs and our other programs that, combined with that managing drug and alcohol issues, might actually stabilise the family and the woman in a better way than dislocating them for residential rehab. I think it is complex. We have to do more. Obviously, people in this situation are experiencing high degrees of vulnerability. But we need a complex interaction.

Dr MEHREEN FARUQI: Do you have resources to be able to do that?

The CHAIR: We need to raise that and we will come back again.

Dr CHANT: As an example to understand the co-dependencies, as part of the $75 million there was support for the substance use in pregnancy program. In receiving that additional money for the substance use in pregnancy, we required that the districts then support home visiting programs for those mothers and the families for two years. The indicator that we are actually using is that those children are engaged in early childhood learning by the age of three. That gives you an example of where that is fundamentally a drug and alcohol intervention where we provided funding for substance use in pregnancy, but we knew that to enable the outcome we needed that additional support of sustained home visiting for that family, and then we are using an outcome indicator, which reflects the fact that the child has then got into an environment which will facilitate early childhood learning. That is where we want to get to in a much more complex ecosystem of the evaluations.

Mr SCOT MacDONALD: I will direct my questions to Dr Cretikos. I refer to paragraph (4) of the terms of reference. The Government's submission on page 18 talks about performance reviews. I guess I was just a bit surprised. We go to the South Coast and across the inquiry we have seen a range of what I would call almost community well-meaning nice people, which was a mix of professional people and volunteers, right up to the more professional people. How does that work in terms of performance reviews?

Dr CRETIKOS: Is it in relation to the non-government organisations that we fund?

Mr SCOT MacDONALD: The NGOs, yes.

Dr CRETIKOS: We have strengthened our review of performance management framework just recently. It has always been the case that it is a requirement for non-government organisations that we fund to be accredited. We have strengthened that to make sure that they are accredited against an appropriate set of standards for the delivery of drug and alcohol services. That is coming into place now in the new contracts that are being agreed. Similarly, we are requiring them to report on their minimum data whereas that has not always been the case; they are not always reporting. We are strengthening the approach to safety and quality across the board where we are looking at patient experience measures, discharge and transfer of care processes, which is a key point where outcomes can be poor if people have not been transferred carefully, as well as critical incident management processes to ensure that the appropriate mechanisms are in place to review incidents when they occur, and to strengthen the processes of the organisations.

Mr SCOT MacDONALD: Does that include the bricks and mortar, the infrastructure that is there? We seem to get a variety. I am not saying that is necessarily bad; in fact, it might be good. But there seems to be a wide variation. On the South Coast we saw next to the church the pastor's house converted over many years—you know, kitchen upgrades and room upgrades. Again, I am not saying it is bad, but it seemed to be a wide variety of infrastructure and resourcing and skills. We met people who are volunteers running this show, or who were helping to run the show. Again, I do not know that is bad. In regional areas, maybe that is all you can get in some cases.

Dr CRETIKOS: I think it is important to acknowledge that the non-government organisation sector is not the same everywhere you go. The capability is very different, depending on the organisation, so what we are trying to do is strengthen the basics of an approach to clinical governance.

Mr SCOT MacDONALD: Do you help them?

Dr CRETIKOS: We are working in support with NADA as a peak body as well as directly with some of the organisations we are funding to make sure that they can meet some of these minimum requirements around, particularly, accreditation. Accreditation is a broad approach to looking at the capability of that organisation. It

focuses on clinical as well as corporate aspects. We are particularly focusing on clinical at the moment because we think that is the place to start.

Mr SCOT MacDONALD: That is a priority, yes.

Dr CRETIKOS: As I mentioned, the focus is on quality and safety as the basics.

Mr SCOT MacDONALD: So you are proactive. Someone might go out there and have a look at them, meet them, and walk them through the building and walk them through their processes and administration—all that sort of thing.

Dr CRETIKOS: I think strengthening those relationships and understanding what the service model provides and what the capability is requires a direct relationship between the service that we are funding and somebody who is contract managing, or who is the service relationship manager, to better understand what the capability is and how they can be supported to provide the best possible service and make sure that they are meeting certain basic requirements.

Mr SCOT MacDONALD: I would not like to see people scared away, particularly in regional areas where some of the larger organisations might not want to go for scale and capacity reasons. In fact, it might be a very good role for some of those NGOs. But I did wonder. We went there and I think there were four or six to a room in one building. Again, I am not saying that is bad.

Dr CRETIKOS: I think that is why we are strengthening particularly this focus on accreditation as one of the minimums. That covers a whole range of the aspects of service delivery. We know that there are some services that are not accredited, or are not accredited against an appropriate set of standards. That is something that we are seeking to support them to achieve quite quickly.

Mr SCOT MacDONALD: I think this question is directed more to Dr Chant or to Professor Lintzeris. I am trying to understand what you are trying to say to us. There seem to be messages coming saying that we need more resi rehab. But if I understand what you are saying back to us, it is, "Don't get fixated on resi rehab. There's a lot more to it. Resi rehab has its role, potentially, but don't get fixated on the resi rehab part of the puzzle." Am I right? I think you have to be a little bit more blunt with us.

Dr CHANT: Yes. I think what we would be saying is that resi rehab is an important component but it is not the whole thing. We need probably more a range of things, like intensive day management options—you know, a whole different range of services. We have got to actually tailor it more to the person and their family situation and do it in a very holistic way. We also have got to work more effectively across government agencies to make sure we put those co-enablers in place. For us, that would be the message. We are also keen not to focus on a particular drug, that our services need to be flexible. The pattern of drug use is often polydrug use. I suppose we should not forget alcohol.

The CHAIR: That is like the big pig galloping in the room. We thought this was an inquiry into illicit substances.

The Hon. PAUL GREEN: We need to rename it a liquid drug so people understand it is still a drug.

Dr CHANT: Again, the services need to pick up alcohol and other drugs, which is why we have named it Alcohol and Other Drugs. We also need to recognise prescription drugs and the diversion of prescription drugs. I am saying that we need a strong evidence-based response to drug and alcohol. I recognise that we have a mixed complex structure of NGOs, the public sector, the private sector and the Commonwealth. We should not make excuses for that. We need to look at integration pieces. We are committed to improving and supporting the NGOs. We really have a good relationship with NADA to do that. There is work that needs to be done. We also need to strengthen the relationships between the NGOs and the local health districts to see the NGOs as part of the service system to ensure that we have chosen the NGOs to deliver the right services for the skill mix, size and capability. We also need to look at some of these very tiny NGOs. How does NADA—or whatever entity—support them with their human resources.

Mr SCOT MacDONALD: They are not Mission Australia, are they?

Dr CHANT: That is one of the challenges for us. We are having discussions with NADA. I do not want to underestimate the importance of the small NGOs.

Mr SCOT MacDONALD: Particularly in the regions.

Dr CHANT: Particularly in regional areas but we need to think of innovative ways to support them with some of that stuff.

Mr SCOT MacDONALD: Governance and skills.

Dr CHANT: Governance and skills.

The Hon. BRONNIE TAYLOR: The funding applications.

Dr CHANT: The funding applications, and how we can do that better. As I said, we are working closely with NADA. We see that a peak entity can provide some of this infrastructure support, and NADA does that with data collection and other things.

Mr SCOT MacDONALD: In respect of reference 12, current and potential threats to existing rehab services, I do not think I picked that up in the Government submission. Maybe I am wrong. Maybe I missed it. At any level, whether it be funding, skills, burn-out, safety, coordination, area health commitments, whatever—

Dr CRETIKOS: One thing that is across the board is workforce. Professor Lintzeris would talk about that more, particularly in regional areas. Even in our local health districts there are a number of places where it is very difficult to recruit properly skilled professionals across a range of different professional types. I think the non-government organisations find it even harder.

Mr SCOT MacDONALD: That is why we see volunteers.

Dr CRETIKOS: And to have the appropriate set of skilled people. If you are managing something risky, like withdrawal management, you need the appropriate range of health professionals available to recognise when people start to deteriorate, when mental health issues become a problem. To be able to pick that up and manage it requires an appropriately skilled person. Each organisation needs to have that skill available at all times, so that means more than one person.

The Hon. BRONNIE TAYLOR: Dr Cretikos, you talked about funding and the things that the NGOs have to do. Are you going to put service coordination and talking to other agencies as criteria for the New South Wales Government's funding?

Dr CRETIKOS: In the first round of what we are doing, we are trying to strengthen the relationships primarily—

The Hon. BRONNIE TAYLOR: Is it going to be a criteria of funding, yes or no?

Dr CRETIKOS: I cannot think that is in the contracts right now.

Professor LINTZERIS: One of the new key performance indicators is that every patient, on leaving the service, must have a discharge summary completed. That does not sound like much, but without a discharge summary there is no record of what happened to that patient, who that patient is. When they go to the next service provider, there is no way of getting a summary. The general practitioner does not have a summary. No-one has a summary of what happened so you start the process from the beginning, "Hi, tell us your story." They say, "But I have told my story 50 times before." It does not sound like much, it is an administrative thing, but it is those little things. If we all agree that we have a shared document of what has transpired in treatment, that then allows us to pass that on to the next service provider, because no one NGO will follow up a patient for life. That is the issue about chronic disease. Chronic disease means you see one service provider this year, three months later you see someone else, six months later someone else.

The Hon. BRONNIE TAYLOR: Could that be a recommendation from this Committee to NGOs that they must clearly demonstrate their service coordination with other agencies that they have been through?

Professor LINTZERIS: Yes.

The Hon. BRONNIE TAYLOR: It is difficult today because a lot of this evidence that you are giving us is conflicting with what we have heard in the regions. You talked about eight training places that Dr Faruqi was asking you about. We heard evidence from a specialist who was based in the Northern Rivers who said it was virtually impossible for her to complete her training to become a specialist in drugs and alcohol. She had to fund it herself, she had to come to Sydney, there was no help, and she was the only regionally based—

Professor LINTZERIS: I think I know the doctor you are talking about. She was supported by a NSW Health grant for the whole training package.

The Hon. BRONNIE TAYLOR: There is a New South Wales grant available for doctors to take to increase their qualifications to become a specialist?

Professor LINTZERIS: When she did her training, there were standalone one-off fellowship grants that were additional and supplementary to existing training positions. In New South Wales, we have funded registrar training positions, which are linked to an addiction medicine training program. I have five registrar positions in my LHD, which is South Eastern Sydney.

The Hon. BRONNIE TAYLOR: In your LHD you have five registered training positions for people to become specialists in drugs and alcohol?

Professor LINTZERIS: Correct.

The Hon. BRONNIE TAYLOR: This is really important. The evidence that we have heard is that there are none, that NSW Health does not train them and it is almost insurmountable to do it.

Professor LINTZERIS: It is certainly difficult in regional and rural LHDs, there is no doubt about it. There is a range of issues. It is not only addiction medicine. It is even harder for addictions in rural and regional areas. The metropolitan LHDs and Hunter New England—I think Hunter is considered regional.

The Hon. BRONNIE TAYLOR: How many training spaces do we have across New South Wales in respect of registrar training positions for the specialty of drug and alcohol—

Professor LINTZERIS: Between 10 and 20.

The Hon. BRONNIE TAYLOR: How many more do we need?

Professor LINTZERIS: If the rest of Australia had comparable levels, we would be producing sufficient specialists. The challenges are not just in the training. The challenges are at the end of that; you need a job to go to. Training specialists is a complicated journey. We need registrars and we need—

The Hon. BRONNIE TAYLOR: We need registrars and we need positions for the registrars to go to?

Dr CHANT: We also need the dual trained drug and alcohol and adolescent mental health clinicians. We support that as well.

Dr CRETIKOS: It is not just addiction medicine specialists, it is the appropriately trained nurses and allied health professionals.

The Hon. BRONNIE TAYLOR: I understand that. I am trying to tackle one thing.

Dr CHANT: Would it help the Committee if we provided an overview of the training and the places?

The Hon. BRONNIE TAYLOR: That would be helpful. The evidence we have received is contradictory to what we are hearing today.

Professor LINTZERIS: It highlights how in New South Wales, which has invested more in the public hospital model, we have training positions. Other jurisdictions that have predicated an NGO system, there are no training positions because NGOs do not train specialists.

The Hon. Dr PETER PHELPS: If I were an undergraduate going through an MB BS or bachelor of nursing in Sydney, would I come across a core compulsory component dealing with alcohol and other drugs?

Professor LINTZERIS: Thank you.

The CHAIR: You were waiting for this one.

Professor LINTZERIS: It is a great Dorothy Dixer. Sydney University has the most robust training in addiction medicine. Sydney University also has nursing, pharmacy and a range of allied health, so, yes, you certainly would be exposed to drug and alcohol training in medicine.

The Hon. Dr PETER PHELPS: A compulsory element or an optional element?

Professor LINTZERIS: It is compulsory in some lectures; the placements are voluntary. Other universities are probably less robust in their training of the medical undergraduate workforce.

Dr CHANT: I think Professor Lintzeris probably cannot comment for other universities.

Professor LINTZERIS: I am familiar with the University of New South Wales and the University of Technology Sydney.

The Hon. Dr PETER PHELPS: The problem the Committee has heard is that people do not choose postgraduate work in alcohol and other drugs because they never get exposed to it as undergraduates.

Professor LINTZERIS: Yes, you are absolutely right. Indeed, those medical students who come and do placements, who do the voluntary drug and alcohol intensive placements, a large proportion of them come back to us.

The Hon. Dr PETER PHELPS: Dr Chant, I want to discuss something that the private providers talked about, and that is a missing middle. If you can afford $10,000 a week, you are fine. If you are on Centrelink

benefits and are provided with $670 a week, you are catered for—provided you get a spot and are prepared to wait for it. There is a missing middle for private providers who charge an amount which is out of reach for the person who is a functioning addict, but cannot afford the $10,000 a week treatment, and is unlikely to get into the $670 a week treatment. Is there an argument for expanding the system to allow for them or to provide additional funding for placements in private detox, rehab facilities for that missing middle? If so, how would we go about it?

Dr CHANT: To clarify your question, is your proposition some sort of co-pay where there would be designated beds for people—

The Hon. Dr PETER PHELPS: That was the suggestion that was put to us by the private provider.

Dr CHANT: With public funding?

The Hon. Dr PETER PHELPS: Yes.

Dr CHANT: We would have to see what the service model would be, because some elements are able to be funded under Medicare; for instance, if they were having psychologists attending the patients, and GPs and other things. It would depend on the nature of the service and whether they would be eligible for—

Professor LINTZERIS: The real challenge in the private health system is not so much about covering the inpatient admission. As we all know, private health does hospital admissions; it covers much of that. The real challenge again gets back to what is the nature of treatment for most people with drug and alcohol problems, and for most people stints of residential inpatient treatment may be required, but generally we are talking about community care over a long time. That is my understanding where a lot of the deficits in private health funding exist in private insurance. It is not what happens if you are in hospital; it is care in the community. A lot of those services are just not picked up by private health insurance.

The Hon. Dr PETER PHELPS: There is also a problem in those facilities which are not treated as hospitals as far as the Federal Government is concerned. They are still facilities for treatment but they are not treated as hospitals, thus they fall through the cracks that way.

Professor LINTZERIS: For some of the private rehabilitation centres that is my understanding—they are not in scope for private health cover. But again, I think that is case by case. Some private health providers of drug and alcohol services clearly are covered by private health insurance. Some of the main services in Sydney I know are covered through private health insurance and they operate a medical model.

The Hon. COURTNEY HOUSSOS: Is that because they are attached to a private hospital?

Professor LINTZERIS: Yes.

The Hon. PAUL GREEN: Mr Forrest, given that the Committee has seen that many addicted people end up in the Justice Health network, do you have some comments about what sorts of services are given and how you are balancing those issues? The Committee is aware there is more and more illegal drug use in prison.

Mr FORREST: Is your question around existing treatment services available and where we could extend services?

The Hon. PAUL GREEN: Give the Committee a snapshot as to how you are managing the current drug rehabilitation situation.

Mr FORREST: Justice Health has a role, not only within custody but also we have limited responsibility pre- and post-custody. In the pre- and post-custody space we operate out of some court locations, some local courts across New South Wales. The primary aim there is to divert appropriate people back into community-based treatment. If somebody presents before the court with a mental illness or drug and alcohol problem with low index offences, we have staff who are available to assess the patient and provide a treatment plan to the magistrate that might allow the patient to be diverted into appropriate community-based care. That is done in consultation with the local health districts and the relevant drug and alcohol mental health treatment providers.

Within custody, we have a role in the Drug Court program, as was previously discussed. We are present in the Parramatta Court and in the Downing Centre. We are present in Toronto. That is run by the Hunter New England Local Health District. That Drug Court program has been operating since 1999 and Justice Health has played a major role, predominantly in Parramatta but more recently in the Sydney-based court. We do not have a major role in the MERIT program. We certainly provide some advice but MERIT is a program that is run by the local health districts. It is not a custodial-based drug and alcohol program. We have a presence at the Parklea Compulsory Drug Treatment Correctional Centre. Again, that is a Justice-led program. It is for recidivist drug users who might have failed other sorts of treatment options, including the Drug Court program, that have compulsory or mandated enforced treatment by the compulsory drug treatment model.

Then in the post-custody space in our adult services there is a program called the Connections Program. The Connections Program is an assertive linkage program that assists people with drug and alcohol problems who need integration back into community-based care. It is an assertive linkage model that provides support for patients when they leave custody for anywhere between four weeks to three months post-release from custody. It helps patients navigate the complex issues around the health system, how to get appointments, how to get another script, making sure they pick up their opioid substitution therapy. We found with that assertive linkage model we have been able to demonstrate that patients who are linked into the Connections Program are sometimes more than three times less likely to reoffend and come back into custody. That gives you a bit of an idea about the structure.

The Hon. PAUL GREEN: How many beds are there in Parklea, and is there a waiting list?

Mr FORREST: There are 40 beds in Parklea. It is a separate part of the Parklea Correctional Centre. It is run completely separately to Parklea. There is not necessarily a waiting list because it is a mandated program and the way that the program is staged is that there will be some people who need to stay within the confines of the facility for a six-month period and then they progress to the next stage, which is some community-based access. They might go out into the community to do some work and they will return to the centre. The final stage is predominantly community-based placement. As part of that whole spectrum Justice Health will provide any necessary health treatment, whether it be withdrawal detoxification from medication, or providing opioid substitution treatment for patients who might need that.

The Hon. PAUL GREEN: Do you have some data on how successful it is?

Mr FORREST: I can certainly take that question on notice and provide some data.

The Hon. Dr PETER PHELPS: I ask a question on notice relating to that. Do you have any data relating to recidivism rates for those who have gone through Drug Courts, as opposed to those who have gone through the normal criminal justice system? And could you break that down into areas of recidivism?

The CHAIR: I appreciate the frankness with which all of you have addressed the questions directed to you this morning. I hope you do not think we have saved everything until the end of the inquiry process and we have been venting on you. The Committee has two members who were registered nurses who practised for decades before coming to this place, and other members have had extensive experience working in regional New South Wales. We are all concerned about services in regional New South Wales, which means we are anxious to produce a report containing pertinent recommendations. We know that as public servants your evidence is couched in particular ways, but we believe there needs to be blunt talk about some matters. We recognise there is myriad priorities in this area of health provision, and we are not commenting on the general provision of health services in New South Wales.

We understand the complexity of health services in this State. We are dealing with vexing problems of addiction, which in some instances goes back to when addicts were in their mother's womb with fetal exposure to alcohol. We thank you for the important work you do on behalf of the State and people of New South Wales.

(The witnesses withdrew)

BRIAN HILL, Chief Executive Officer, Laughing Mind, sworn and examined

The CHAIR: Welcome. The secretariat has circulated your document dated Monday 2 July 2018, which we will take as your opening statement. Would you like to make additional comments before we ask questions?

Mr HILL: I am the founder and director of Laughing Mind, a technology and healthcare consulting company. I thank the Committee for your interest in drug and alcohol rehabilitation and the services needed across regional, rural and remote New South Wales. I have spent formative years in the places you have visited, and I know how hard access to services can be in these areas. You visited Dubbo, and I lived in Bourke for about three years. It was a five-hour drive to our nearest shopping centre, and many small towns have simply no access to services. Secondly, as an entrepreneur I recognise a lot of work is occurring internationally in this sector.

The challenges of medtech innovation in Australia are manifold. We work in a market where access to capital can be tricky. We work in a regulated market where the Therapeutic Goods Administration does not necessarily have the same acceleration pathways as the Food and Drug Administration has in the United States. In the markets that do exist, when looking at it from an entrepreneurial sense, we cannot necessarily focus on just a primary health network or a State to develop platforms. We need to look at the total addressable market, which for us includes Australia, to develop tools that are potentially useful globally. I would be happy to explore any of those elements through the course of questioning.

Mr SCOT MacDONALD: We have heard evidence from representatives of New South Wales government agencies, including the Chief Health Officer. They are predominantly responsible for delivering drug rehabilitation services through funding, oversight, et cetera. They gave us details of the range of treatment and how it should be client focused. Your focus is digital platforms, which we have not heard much about during the course of this inquiry. When developing and delivering these digital platforms, do you approach NSW Health and say, "I have a great idea for digital delivery. Can you use it?"

Mr HILL: It is certainly something that we have explored. Part of the genesis for what we have been doing with Clean Mate arose from a Primary Health Network innovation challenge. We put forward a submission as part of that innovation challenge, but we were unsuccessful in that round. We have been continuing to do that. Organisations like State Health and the primary health networks represent excellent control sites where there is a potential pathway to innovation and exploring innovation paths.

Mr SCOT MacDONALD: Can you explain that?

Mr HILL: Last year, I was responsible for running Slingshot Accelerator's Accessible Cities. This was a New South Wales Government-sponsored incubator for five different start-ups exploring how they could bring accessibility technology into making the city more livable. That was effectively incubating an idea and taking it to the next stage of commercial trials. That happened for five different start-ups, each of them receiving about $150,000 of investment from the New South Wales Government. Those sorts of innovation partnering models can be quite useful. They provide early access to markets to pilot concepts, and I wish that we saw more of them.

Mr SCOT MacDONALD: How do you do that with health care and drug rehabilitation?

Mr HILL: Health is a harder one. When we are talking about trying to deliver a digital health intervention, we have to be mindful of responsibility and duty of care. To develop experiment protocols that provide you with the gold standard of a randomised controlled trial means we have to have some way of developing a control that is an alternative to a digital tool. That is a hard concept.

Mr SCOT MacDONALD: Do you go to NSW Health and say you are developing something that could fit in with Health's preferred clinical care and support?

Mr HILL: A straightforward innovation pathway is for us to have those discussions, yes. Our discussion so far have probably been a little more grassroots; we have been dealing with individual clinicians and rehabilitation centres and understanding the pathways into the treatment journey for them. We typically see that residential rehabilitation is a well-understood pathway; community-based out-treatment in the care of a general practitioner is another well-understood pathway.

We have been dealing with Hunter-based general practitioners who specialise in addiction medicine. They have been featured in the *Hunter News* over the past few months. Our focus is very much on what happens at the level of the grassroots individual care worker—the clinician, the consumer and, importantly, the carer. We know that the family support mechanisms that sit around people are a really important part of the relapse prevention journey for them. We are looking at how we are able to integrate each of those three different stakeholders' perspectives into what we are doing.

Mr SCOT MacDONALD: It may be a bit unfair to ask you but generally would you say that NSW Health is innovative and receptive enough to innovation and other means of support delivery? Let me rephrase my question. What could we do better?

Mr HILL: Let us phrase it that way. Any time we are dealing with a relatively large institution we know that there is inertia. It is just a function of scale. It is the same with Federal health, or any Federal agency.

Mr SCOT MacDONALD: Can you point to cost savings or better clinical outcomes?

Mr HILL: I can certainly point towards what we think would be better clinical outcomes. If we take the example of trying to deliver care to someone in a town of fewer than 1,000 or 2,000 people, we know that they might have a general practitioner. If they are lucky the general practitioner might have some skills and experience.

Mr SCOT MacDONALD: But he is really busy. I come from a very small town. They are doing work in the emergency department, their general practice, aged care and dementia, and you knock on the door and say, "I am here to help."

Mr HILL: For the general practitioners that we have been working with we have identified that there is a really large gap in the tools that they have available to use in supporting people with substance dependency. In the case of our local general practitioner in Newcastle, he specialises in this for about 95 per cent of his caseload and he wishes that he had better tools that were available to help him. We have been looking at what has been happening in the United States to take some reference points from that. We know that anytime you are trying to develop digital health tools for use in the health system you are dealing with large complex institutions. There is lots of privacy, lots of regulations and lots of confidentiality safeguards, all of which still apply in treatment.

Mr SCOT MacDONALD: And someone will say, "Prove it with trials and good research."

Mr HILL: That is right. Any time we are dealing with a health technology innovation there is a much larger barrier for entry compared to, say, a consumer-based platform.

Mr SCOT MacDONALD: Is that reasonable or unreasonable? It is tax dollars.

Mr HILL: I think it is quite reasonable. The issue is trying to find the trade off in providing enough exposure to early innovation. This is where the Food and Drug Administration [FDA] in the United States has been quite instrumental for us in looking at how you try to provide those safeguards and, at the same time, stimulate early stage innovation. They have something called an expedited access pathway and that is above what is being used by Australian companies to enter into the United States market.

Mr SCOT MacDONALD: But we do not have that at NSW Health?

Mr HILL: We do not have that in NSW Health that I am aware of. We do not have it within the Therapeutic Goods Administration [TGA].

Mr SCOT MacDONALD: Will you provide the Committee with a recommendation?

Mr HILL: If we could find a pattern matched to what we see in the FDA for expedited access pathways that support and stimulate that early stage medical technology innovation, I think that would be quite a good game changer.

Dr MEHREEN FARUQI: I would like some more information about your program Clean Mate. Will you provide the Committee with an example of one of the digital tool that is within the suite of tools that you have? You have highlighted the fact that it addresses clear areas of need. How does it address clear areas of need?

Mr HILL: I will talk about two of the prototypes that we have been working with. The first of those is a chatbot that sits behind Facebook Messenger where we can use that as a way to be able to provide an automated response system for people who are coming in on three different pathways—whether they are a carer, clinician or consumer. I am sure all members are aware of the extended press that has occurred around Facebook and the need for strong privacy and confidentiality safeguards. For us that has really just been a bench exploration. We have not exposed that to an audience to work out whether a chatbot like that can provide a responsive mechanism that is able to give someone a bit of hope.

Dr MEHREEN FARUQI: So it is chatting with a clinician or someone?

Mr HILL: No, it is an automated response system. It is an algorithm that is providing responses back to an individual. If we step away from Facebook as a platform we see that we can create more platform agnostic techniques where we can provide stronger confidentiality and privacy safeguards. We know from talking with individuals, particularly lived experienced advocates—people who have been through addiction and incarceration—that the first motivated moment when they want to reach out for help can be a very frustrating

experience. The opportunity window for doing so is very small. And for many people that might be a phone call to a rehabilitation centre and then they find themselves going into a wait period or they might find themselves looking at it and going, "There is no way I can go to that because it is off country; it is out of my area; it might be reliant on fees that I am unable to support." We have been exploring how to provide better support through what we call that pre-clinical stage. We are looking at three stages where these tools are potentially used: pre-clinical, clinical and post-clinical.

Dr MEHREEN FARUQI: Have you been trialling this?

Mr HILL: We have been doing paper-based prototyping initially. It is important when we are looking at potentially investing valuable capital that we try to address as much product design risk in the early stages as we can before we start touching a line of code. We try to do that with good prototyping techniques. That can be things as simple as providing a screen-based simulation on paper, walking someone through the flow of the experience. We have been doing that with both clinicians and our local rehabilitation service with some of the lived experience advocates who sit there.

Dr MEHREEN FARUQI: You said this has been used in other areas. Are there countries other than the United States where similar things have been used. Has an evaluation been conducted for its usefulness, effectiveness or otherwise?

Mr HILL: There is a constant series of research papers coming out. We have been using probably two key touch points in our research work. That is the Alan Turing Institute in the United Kingdom that is doing a lot of work around the ethics of AI and how you design an artificial intelligence system to be interrogatable so that you can understand the algorithms that are being used and understand the engineering safeguards that are being put in. The second touch point that we look at quite closely is the sort of digital psychiatry in the United States at Harvard Medical School. There is a good researcher there called Dr John Torous who has been exploring the value of virtual care models and how clinicians might potentially use aps like this, or platforms like this.

Dr MEHREEN FARUQI: So they have not been used? Is it just the potential for use at the moment?

Mr HILL: There have been initial limited trials but they do recognise that there is an ocean of complexity in trying to do this. We need to make sure that there are good, strong effective safeguards and protections for the consumer and the clinician.

Dr MEHREEN FARUQI: Have you involved medical specialists and addiction specialists in your research and development of the tools?

Mr HILL: We are having an expanding range of discussions. Keep in mind that Clean Mate has been a self-funded venture. This is something that I invest my spare time into and whatever margin we can create through our services consulting. There are effectively two arms to what we are doing. Clean Mate is a commercial exploration where we are identifying other tools and the platforms fit for purpose. Can they provide the level of fidelity that someone in a consumer, carer or clinician role might need? The second side is a research based PhD that I am undertaking with the University of Newcastle that is looking at whether the sector is ready for tools like that. What is the level of digital maturity in different rehabilitation centres and in different clinical practices and what might be the focus safeguards and barriers to entry for the use of those tools? We are trying to address it from both sides.

The CHAIR: Do the medical technology hubs in Australia that can support the work you are doing to create an environment of consideration of new ideas exist in New South Wales? Is it individual entrepreneurs, for the want of an explanation, who are trying different things and hoping that they will hit upon an idea that ultimately over time with work, input and maturity will come forth?

Mr HILL: We are seeing the marketplace emerge. A lot of medical technology innovation has been chiefly entrepreneur driven and led. When I started this a couple of years ago we could probably throw a bus between the gaps that existed in trying to find early stage incubators and accelerators that supported medical technology entrepreneurs in trying to bring these sorts of innovations to market.

I am pleased to report that we have seen an increase in the number of accelerators who are recognising that there are different technological challenges for people working in medtech innovation—the pathways are steeper and more complex—and there is a greater regulatory burden, as there should be. I could mention at least three accelerator programs, but the centres of gravity are typically Brisbane and Melbourne, and there are some in Sydney. Being regionally based, I am trying to grow some of that health technology in the Hunter. There are universities and institutions that have very strong digital technology streams and very strong health streams, but we know there is not a lot of cross-collaboration. We use hackathons as a fast-paced prototype environment to

address a challenge and to see what we can produce in 48 hours to respond to it. We have seen that used to good effect.

The CHAIR: What about private health providers who run private hospitals or healthcare facilities that may not have the same inflexibility? NSW Health is a large enterprise, but a smaller private enterprise might have greater flexibility to be able to engage with and to talk with entrepreneurs like yourself. Are you dealing with the private health sector?

Mr HILL: We are certainly having discussions. The challenge for anyone taking this sort of commercialisation journey is the conundrum of taking on investment without diluting equity. It is difficult to find investors for this sort of investment because they will look for the commercial return.

Mr SCOT MacDONALD: And they want all of it.

Mr HILL: Yes. We have been in the shortlisting process for one national medtech accelerator, but we would have had to give up 20 per cent of our equity in the early stages. Clearly, we want to protect that equity and at the same time build enough of an intellectual property moat to create value for the team behind what we are doing. The challenge is finding people who are willing to invest for a smaller portion of equity while recognising that it is sector where you do not necessarily want to be seen to be profiting from someone's misery. We need to find the right balance between philanthropic endeavour and philanthropic and family-based investments while developing something that has enough commercial value to attract investment. That is a real challenge. Pear Therapeutics Incorporated in the United States attracted a $30 million investment from Novartis, which is a major pharmaceutical company. Finding patent precedents in Australia is a much harder undertaking.

Mr SCOT MacDONALD: I would like to flesh out what you said about the innovation capability of NSW Health. What is the opportunity cost of not going down this path or not adopting some of this technology and getting on board some of the digital platforms? Did you put your mind to that?

Mr HILL: The opportunity cost is what we see now. There are unserved communities.

Mr SCOT MacDONALD: Is it a specific regional perspective?

Mr HILL: It is a hyper-regional perspective. It is about going to towns with 500 to 1,000 people where the general practitioner might be their only resource.

Mr SCOT MacDONALD: And we will not put a rehabilitation complex there.

Mr HILL: It would be unviable.

Mr SCOT MacDONALD: Or even much in the way of community.

Mr HILL: They are part of the very fabric of the communities we are trying to reach. We know that anonymity is difficult in those communities if someone has a substance dependency issue. Word of mouth spreads through small communities very quickly. We think that is a good sweet spot for digital services.

Mr SCOT MacDONALD: Do you think those communities are receptive? More and more people have a smartphone. Is there a willing audience?

Mr HILL: We know from talking with the Australian Digital Health Agency that there is a massive level of interest from consumers in finding consumer-facing health tools that address these needs. At the moment, most of the digital health development that occurs is in monolithic systems—that is, systems that serve large agencies. Our focus is far more on developing tools and platforms which sit in the hand of the consumer and which support them in their own care.

Mr SCOT MacDONALD: Can you point to anywhere in America where digital platforms are being used?

Mr HILL: I will take that question on notice to provide some good concrete examples. I was looking at our Twitter feed this morning from the schools of digital psychiatry. I could direct the Committee to a number of different references.

Mr SCOT MacDONALD: Can you provide a quick snapshot of someone with a psychological challenge who is serviced by such a platform?

Mr HILL: I have a visual on screen that I will circulate to the Committee that talks about how we use digital clinic staff embedded in a physical facility to provide an outreach service. As I have read the transcripts and submissions I have noticed—

Mr SCOT MacDONALD: I would like to drill down on that. Imagine I have a psychological problem and I walk into some sort of bricks-and-mortar facility in my small town. Is that what you are talking about—a general practitioner in my small town?

Mr HILL: You would start with the general practitioner, which is the most common healthcare experience for people. We are looking to be able to provide a tool which can sit on a consumer device and which that consumer could share with their clinician. That is what is emerging in the United States. There is a very strong demand from consumers to be able to go to see their clinician and to say, "I am tracking my own biodata and consumption. Can you help me to navigate through this recovery experience?" There is a very strong innovation wave to turn around the clinician experience. Rather than dealing with their own practice management tools, from which the patient is excluded, they are now thinking about how they can better support a person's individual recovery journey by using tools that sit in their hand.

Mr SCOT MacDONALD: At the University of Newcastle the Committee was told about someone who was a suicide risk and they picked up on blood pressure and anxiety somehow. Is that what you are talking about?

Mr HILL: Yes. I am wearing a smart watch that is tracking my biodata, including my heart rate and my activity. It will prompt me to stand shortly because I have been sitting down for while. It is that level of granularity of data that we can use to help shape the experience.

Mr SCOT MacDONALD: And that talks to a platform?

Mr HILL: Yes. The big data research is developing phenotypes, or a digital footprint of a person's healthcare status. We are starting to work out how to leverage that data to help them to follow healthier habits or to support their recovery pathways.

Mr SCOT MacDONALD: If your watch alerts you about your blood pressure because something bad is happening, will it send a text to someone to ring you or to text you to ask how you are feeling, or to ask you whether you have a craving for drugs or alcohol?

Mr HILL: That is a pathway we are actively exploring. We have been talking with another start-up called Soldier.ly, which is working with the same device and technology in the treatment of post-traumatic stress disorder. A range of biodata can be generated by the body, such as stress measures based on skin conductivity and heart rate, which could trigger an alert advising that this person has an escalating heart rate. Are they having a panic attack or are they climbing some stairs? They are already able to generate automatic protocols asking them whether they need to reach out to a friend. By monitoring some of that biodata, we can trigger next-step interactions, which might be to reach out to a peer or to connect with a trusted resource, whether that be a friend or a family member. Those are the sorts of things that we are actively exploring in the design stage at the moment down to the level of location tracking as well. So someone could potentially geo-fence an area and say, "I don't want to go there. I know that's an area where I've used substances in the past. Can you give me an alert to warn me if I'm tempted to go back into that space?" It all comes down to the level of permissions that a person is willing to use and the fidelity of data they are willing to use for that.

The CHAIR: Thank you very much for coming along and giving us those insights. We have not had any insights quite like this in our inquiry thus far, so it is in some sense great that we have been able to get you on the last day, so to speak, because what you are looking into is the future. Particularly for anyone who is born after 1992 or 1993 with the introduction of the internet, this connectivity with technology is all like the air they breathe. Obviously, its capacity to help to deal with these manifest problems will be very interesting to observe in the future. Thank you very much. Do you mind if we take your statement and incorporate it and consider it as a submission to the inquiry? Are you okay with that?

Mr HILL: You are welcome to.

The CHAIR: Good. We will do that in due course. Once again, thank you very much. We appreciate your contribution.

Mr HILL: Thank you so much for your interest.

(The witness withdrew)

BRENDAN McCORRY, Manager, Calvary Riverina Drug and Alcohol Services, Wagga Wagga, sworn and examined

The CHAIR: Thank you for making yourself available. Your attendance was a suggestion by the Deputy Chair, the Hon. Paul Green, who has had firsthand insight into the existence of the centre and the good work it has been able to do for people suffering addiction. If you wish, you may make an opening statement to set the scene. After that we will ask you questions. Do you wish to make an opening statement?

Mr McCORRY: No. I am happy with the terms of reference. I am pleased to come along and give my opinions and my experiences.

The CHAIR: That is great. Thank you very much.

The Hon. PAUL GREEN: Thank you, Mr McCorry, for coming up. Can you tell the Committee how many detox beds you have there, the initiative of how the Calvary detox-rehab unit got established, how many detox beds there are and how many rehab beds there are? Can you talk us through the P1, P2 and P3 system? Can you also give us an insight into the out-of-unit outreach that you do and then talk about the houses that you have out in the community that you progress people into? There is a bit of a snapshot. If you can take us through that, then we will ask questions.

Mr McCORRY: Calvary has been providing treatment for people with drug and alcohol problems since the 1970s. It operated originally from O'Connor House based at the hospital, which was initially an alcohol withdrawal unit, and then a three-week program after that. As time moved on it got funding and it then opened a residential treatment program for people with illicit drug problems, but it opened it on a separate site because the hospital did not have the capacity to have it on-site there. Then we got funding to open a day program, which we also did not have capacity to have on either site. When regional grants came around, infrastructure grants, the hospital applied for funding to build a multipurpose centre. What it received from the Commonwealth in funding it provided in the value of the land. It provided the land and the Government provided the money to build the unit. So we built our multipurpose centre where all the services were placed into one building.

Mr SCOT MacDONALD: So that is residential, day and outreach.

Mr McCORRY: Yes. The withdrawal program, the residential rehab and a space from which to run the outpatient day program. We did that because it made better use of resources. It also eliminated the need to constantly renovate old buildings to make them meet occupational health and safety standards. This was purpose-built and it has been a godsend to the centre. There are 32 beds all up in the residential units, and 10 are specifically dedicated to the withdrawal of people from alcohol or drugs. We offer both medicated and non-medicated withdrawal, depending on the severity of the person's withdrawal symptoms.

All of the withdrawal beds are single rooms because we want to create a stress-free environment to make it as calm as possible for people withdrawing from alcohol or drugs. Over on the next wing of the building there are 22 residential beds for ongoing treatment. We do an after-care program for 12 weeks. They do 12 weeks in the residential program and then they do 12 weeks in a cottage next door in a halfway transition house. Then there is the day program and it runs for 12 weeks. It is outpatients, Monday to Friday. It has also a cottage for people who are coming from out of town to attend the program, but also to support our stepped-care model where people can transition out of the residential program into the day program, if they feel that they do not need as much support as that provided by the intensive residential program.

Alternatively, people can transition from the day program into residential treatment if they cannot maintain their treatment goals with the level of support provided by the outpatient program. The senior residents—those who have been there for 12 weeks or longer—provide mentoring and support to the people in the day program. They go along and support them because they have had more experience and they are able to share their treatment journey and the knowledge they have gained from treatment with people who do not have as much support as they do.

Mr SCOT MacDONALD: So that is P2?

Mr McCORRY: That is P3, when they go over after 12 weeks when they have moved into the residential.

The CHAIR: For the sake of the record, what does "P" stand for?

Mr McCORRY: Phases.

The Hon. PAUL GREEN: Phase one is when they come in.

Mr McCORRY: What we provide is a stepped-care program. We found that originally, to graduate, you had to have completed the whole six months. People did not need six months. Not everyone needed six months. We divided it into stages of six weeks. At every six weeks, we review their progress and then we decide with the person whether they want to progress to the next level, whether they want to move onto the outpatient program, or whether they want to transition back to their home town or community. We offer a stepped-care program. People can come just for withdrawal and then they can have an assessment and decide, "Well, maybe I can manage on the day program, or I can go to outpatient counselling." If they cannot manage, we encourage them or provide them with support to transition to another level of intensity of treatment.

The CHAIR: Can you talk about how the whole thing is funded? Who funds what?

The Hon. Dr PETER PHELPS: That is what I was going to say, how do you pay for this service?

Mr McCORRY: The residential part of it is funded under the Commonwealth Government, as is the day program. We get a grant to provide the treatment. The withdrawal part is funded by the New South Wales Health department. We get grants from them. We are also running a number of outpatient programs from the centre as well. We have got the ambulatory or home withdrawal service. That is people who are withdrawing at home with support from the nurse and their general practitioner. By running it out of the centre, there are nurses on shift at the centre 24 hours a day. People who are withdrawing at home can ring up the centre at night, or their carers can, and say, "I am struggling, what can I do?" There is always a nurse on duty 24/7. That is a good support to that program.

We also run another outpatient program, the day program, which is a 12-week outpatient program that does group work and education, and also case management and individual counselling to the people on the program. We also have a contract with the local Murrumbidgee Primary Health Network to provide drug and alcohol counselling to young people at the headspace centre. We are doing that three to four days a week. We also have just been commissioned by the Murrumbidgee Primary Health Network to provide an area-wide service to provide support and counselling to pregnant women who are substance abusing and women who have substance abuse problems and who have young children. We have started one in Wagga. We are about to start the next stage of the program in Griffith and then we will move to Young and Deniliquin to open offices there.

The Hon. BRONNIE TAYLOR: Women and children?

Mr McCORRY: Yes, under five years old.

The Hon. BRONNIE TAYLOR: What is the capacity for women and children?

Mr McCORRY: It is all outpatient. We have only been operating since April. There is already 15 to 20 clients, pregnant women, at the last intake on the books. There are women waiting to come into treatment at Griffith as well. There is a lot of excitement in the health network about that program opening. It is run by a midwife to look after the medical needs of the pregnant women and there is also a drug and alcohol clinician who goes along and provides the counselling and support. That program also runs one of the initiatives coming out of Network of Alcohol and Other Drugs Agencies [NADA]. They run a support group for women who are drug users who have been involved in domestic violence relationships. They have started that program locally. It is booked out. As soon as it gets advertised it is booked out locally. It has had a huge response. The other thing that we are doing locally is we provide a family support worker two days a week to provide counselling and support to families who are looking after people with alcohol or drug use. The person who runs that also has a support group once a week. Her support group is going really well. They meet, get together and support each other that way.

The Hon. COURTNEY HOUSSOS: Going back to your fantastic centre in Wagga where you provide detox, rehab and outpatient, in respect of the detox and rehab beds, do you have a current waiting list?

Mr McCORRY: We do. There are about 15 people on the waiting list at the moment for entry, but it can fluctuate over a month with up to 30 on the waiting list. At the moment, the waiting time for men for admission is six to eight weeks and for women it is four weeks. We also take people from Corrective Services. However, the demand is high. There are 100-plus people on that waiting list for treatment and the time on wait is fairly extensive.

The Hon. COURTNEY HOUSSOS: You do not exclude people for violent offences?

Mr McCORRY: No. The only ones we consider too violent or that we cannot take because of children and women coming on to the site are sexual violence offenders.

The Hon. COURTNEY HOUSSOS: Do you have any special provision for women with families?

Mr McCORRY: We cannot take their children. However, we allow visiting once a week. If the children are young and, where possible, if the person looking after the baby while they are in treatment can bring the baby in, we allow visiting based on the needs of the child and the mother. Every Saturday we allow visiting so that they

can do that. We allow telephone contact once a week and they can ring out and their families can ring in. We allow them contact with social media, like emails, Skype, stuff like that so they can keep in contact that way.

After the first six weeks are completed, we encourage people to go home and start the work of family reintegration, where possible, and where it is safe to do so. After they move into the last stage or the aftercare part of the program, we encourage parents to spend more time with their children and families and partners, rather than just going home at the end and nobody has had a chance to adjust to the changes. We offer them family therapy and we invite families to celebrate their achievements. If they are having a graduation, we invite the families to come along to that.

The Hon. COURTNEY HOUSSOS: Do you charge a proportion of Centrelink benefits?

Mr McCORRY: Yes. I have the scale here.

The Hon. COURTNEY HOUSSOS: You can provide that to the Committee staff afterwards.

Mr McCORRY: It is about 85 per cent.

The Hon. COURTNEY HOUSSOS: Do you only cater for people within your local health district or do you provide priority to those people?

Mr McCORRY: We provide them with priority but we look at accepting people from anywhere.

The Hon. COURTNEY HOUSSOS: Do you have any lived experience in your workforce?

Mr McCORRY: We are looking at that. We went to the lived experience conference. That was mainly mental health but we liked the idea. It is from that perspective, so we have staff with lived experience, and we are employing them and encouraging them, because a lot of people finish a treatment program and then go on to study, and usually it is drug or alcohol or some human service type study.

The Hon. COURTNEY HOUSSOS: For your clients and your workers, what proportion are Aboriginal people?

Mr McCORRY: It fluctuates between 16 per cent and 18 per cent. We have developed a good relationship with the local Riverina Aboriginal medical and dental service. They see our clients on site. They are very good. They are very motivated. They took our last two clients on a cultural camp and that did the clients a world of good. They were so pleased to have gone on that.

The Hon. COURTNEY HOUSSOS: How long have you been in operation at your new site?

Mr McCORRY: For about five years at our new site.

The Hon. Dr PETER PHELPS: The 16 per cent to 18 per cent is clients?

Mr McCORRY: Yes.

The Hon. Dr PETER PHELPS: Are there any personnel within your unit who identify as Aboriginal?

Mr McCORRY: In treatment?

The Hon. Dr PETER PHELPS: Yes.

Mr McCORRY: It fluctuates. Roughly it is around that.

The Hon. Dr PETER PHELPS: We heard previously that there is a reticence among members of the Aboriginal community to come to a mainstream facility because of the absence of—for want of a better word—black faces. Is that something you have found?

Mr McCORRY: We have found it from time to time, and that is why we are building up our relationship with RivMed and we have always given the clients the option of going to culturally specific services where possible, and RivMed has always taken them on.

The Hon. Dr PETER PHELPS: You mentioned the Federal and State grants. Are those of a recurrent nature or are you going to reach a cliff at some stage where they might or might not be renewed?

Mr McCORRY: Every three years it reaches a point where they decide. All funding seems to be tied to a three-year cycle.

The Hon. Dr PETER PHELPS: Do you believe that is sufficient time for you to adequately plan for future employment and resourcing for your facility?

Mr McCORRY: It can be difficult, especially when it is—if I use the women's program for example—if the funding does not come back in three years, then those people are out of work across the district. It can be hard for people to first of all decide that they will apply for it, because you have to be up-front and tell them that you hope the funding is ongoing, but you cannot 100 per cent guarantee it.

The Hon. Dr PETER PHELPS: Presumably if you have been in business for five years, you would have gone through—

Mr McCORRY: Through a number of cycles.

The Hon. Dr PETER PHELPS: But you have never lost funding?

Mr McCORRY: No, we have never lost funding.

The Hon. Dr PETER PHELPS: The concern is not that you are going to fail to meet the criteria set for the programs; you do not know that the government funding for that particular program will be continued in the future?

Mr McCORRY: Yes, and what will change in government priorities.

The Hon. BRONNIE TAYLOR: You talk about phase one, phase two and phase three. Is there any home-based treatment, or does everyone come into your centre?

Mr McCORRY: The outpatient program?

The Hon. BRONNIE TAYLOR: Yes.

Mr McCORRY: They come into the centre. The women's program will visit people at home. The withdrawal program will see people at home. Most of ours is centre based at the moment.

The Hon. BRONNIE TAYLOR: You have capacity?

Mr McCORRY: Yes. We have a worker two days a week down at the local LikeMind centre. It is in the main street of Wagga Wagga, so people drop in and see them there as well.

Dr MEHREEN FARUQI: I am still not clear about the percentage of staff. You said 16 per cent to 18 per cent of the staff identify as Aboriginal?

Mr McCORRY: No. Sorry, I thought it was clients. We have never had any long-term Aboriginal workers. We have had Aboriginal employees before. They have stayed short term and gone on to other jobs.

Dr MEHREEN FARUQI: You are looking into that as well?

Mr McCORRY: We always are. That is why we are really grateful that the men from RivMed come over and see our clients on site. Sorry about that.

Dr MEHREEN FARUQI: How many staff do you have?

Mr McCORRY: We have 16 full-time equivalents.

Dr MEHREEN FARUQI: I want to understand a bit more about your patients. What sort of substances do you treat for? Could you give the Committee a breakdown of your patients?

Mr McCORRY: All of our clients are what you would call polydrug users. Most of them are using the following drugs constantly: alcohol, amphetamines, cannabis and nicotine. They are the most common drugs people are using to a level that is causing them to worry. People are asked to pick a primary drug of choice. Up until the past 12 months it was always—amphetamines were really high, they were the major drug, significantly more so than alcohol, as the leading cause of concern. In the past 12 months it has swung back to 50:50. It is a 50 per cent split between alcohol and amphetamines, with people reporting in equal numbers that these are the two drugs that are causing them the most problems.

Dr MEHREEN FARUQI: Do you see a trend in patients who are using or are addicted to prescription medication?

Mr McCORRY: The one drug that was of concern with prescription drugs was Seroquel. Everyone seemed to be on Seroquel for a long time and often without ever seeing a mental health professional to look at why they were on that drug. The other one that seems to be going up and down a little bit more in common use—and anecdotally people are saying it is because they are using it to get off the amphetamines—is opiate-based prescription drugs. People are taking them, they are saying they are using them to come down off the crash from amphetamines, to sleep, to unwind and perhaps to think about quitting or getting over the cravings of that drug.

Dr MEHREEN FARUQI: Do you provide services for under 18s?

Mr McCORRY: Yes, not residential treatment. We provide an outpatient service at headspace.

Dr MEHREEN FARUQI: The Committee has heard that is a service that is really lacking in regional areas.

Mr McCORRY: It is really needed.

Dr MEHREEN FARUQI: Given your vast experience, what do you think are the biggest barriers to people seeking treatment for drug abuse?

Mr McCORRY: It seems to be around a couple of factors. When amphetamines hit it became quite clear for a while that most treatment was based on an addiction model based on alcohol and heroin addiction. People had to use every day to qualify as having an addiction. Lots of amphetamine users did not, so they did not see themselves as addicted and did not seem to fit into that kind of treatment model. That was one. The other one seems to be the immediacy of the problem. If people ring up in a crisis and they cannot connect straightaway and cannot be taken into treatment straightaway, there is a high rate of drop out. They seem to be the biggest challenges, especially the further you get away from big population areas where there is not somewhere that can pick you up straightaway. That is part of another service. We have entered into a partnership with Directions Health Services who look after our clients pre-treatment and then pick them up post-treatment as well. That provides some support. But again, if you do not live near a big population area it is even hard to access that level of support.

Dr MEHREEN FARUQI: There is research that suggests that the stigma associated with drug use is negative, for young people especially. The Committee also heard that during the inquiry. In your experience what is the way to overcome that?

Mr McCORRY: I think the best way is to educate people, and to educate the clients as well, to encourage people to see it like other chronic medical health conditions, where people have developed an addiction or developed diabetes or developed some other chronic disease, but that it is manageable and it is treated and people do recover and get well. We encourage that kind of belief.

Dr MEHREEN FARUQI: Treating it like a health issue.

Mr McCORRY: A health issue.

Dr MEHREEN FARUQI: Do you think the illegality of drug use and the criminalised nature of it leads towards that stigma?

Mr McCORRY: It does and also then when people do get into trouble and they come to treatment, there are a lot of arguments around that they are coerced or mandated into treatment. It does add to the stigma. However, like all the research shows, whether you end up mandatory or voluntary within treatment has little impact on the final outcome.

Dr MEHREEN FARUQI: The Committee has heard both views on this, that mandatory often does not work and that people have to be ready to make that change and that is what works.

Mr McCORRY: There is no definitive research that says that mandatory does not work. We promote a view that it does not matter how you got into treatment, it is where you are going from there.

Dr MEHREEN FARUQI: Do you have any recommendations on the funding model? The Committee has heard about the short-term nature of funding, as you have suggested, you lose staff and cannot provide permanency. There is also the administrative burden of preparing those grants, which can be quite restrictive in what you can and cannot apply for. I would like to hear what recommendations you may have to improve it.

Mr McCORRY: What I find working for Calvary is that they have the infrastructure to do that. For organisations that do not have an existing infrastructure to do it, it would add to the burden of their administrative work. From a funding point of view, funding services, especially in rural and remote areas, has to happen to a level that ensures that the service can deliver what it is supposed to deliver to all of the population. If you set up the services, you need to have the infrastructure that supports them so that they can travel to do proper outreach and provide and maintain vehicles for staff. You need to make sure that the telehealth system is staffed by appropriate people and services are funded to a level that allow them to be maintained properly.

The CHAIR: Let us take as a given that you have done this work over a period of time and have been associated with the Calvary Hospital, which has shown its commitment over decades. You have seen that New South Wales spends money to deal with alcohol and drug addiction in rural and remote areas, with some programs working well and others working moderately well or even failing. What are the major impediments to

the replication of your model working in other parts of New South Wales? Is there a capacity to replicate a service that works to a reasonable standard in other parts of the State?

Mr McCORRY: To recreate what we are doing you would need to have a multipurpose centre to do that detoxification and residential care, and it needs to be well supported. The hospital does our finances, our telecommunications, our information technology and our occupational health and safety. It helps out with our accreditation process by joining us to the hospital system. It takes us on like another part of its service.

The CHAIR: It is like a wing of its service.

Mr McCORRY: We are a wing of its service. The CEO looks after us and we are looked after by the finance department and the human resources department. There is a good, robust clinical governance structure with a good accreditation system around it.

The CHAIR: You have not had to set up a payroll system to pay your 16 staff, for example.

Mr McCORRY: Yes, and that is the biggest support for us. It frees us up to do a lot of work.

The CHAIR: Would you say that is significant?

Mr McCORRY: I think it is significant. If it is not going to be provided by another body, an organisation setting up a multipurpose centre would need a high level of support to ensure it succeeds.

The CHAIR: Assuming that could be delivered, are there other impediments to the replication of this model? Calvary is a private hospital, not a public hospital, but I presume you have seen the work of public hospitals. Does anything stick out that suggests that model could not be replicated in a public hospital?

Mr McCORRY: I do not see why not if it is given the support and given the same consideration as all other departments of the hospital.

The Hon. Dr PETER PHELPS: After people have been through your programs, do you keep analysis of them re-presenting for addictions in the future?

Mr McCORRY: We can identify through our database people who come back and we do that.

The Hon. Dr PETER PHELPS: Do particular programs appear to be more successful in the sense that patients do not re-present?

Mr McCORRY: So far we are finding that there are roughly the same completion rates between inpatient and outpatient. One of the contradictions of the treatment is that one size does not fit all, so it is almost like matching people. If it is a very supportive program that provides case management, counselling, education, relapse prevention and things like that, we find that the first time through about one-third are successful. If you look at success as abstinence, one-third do not come back and we do not know what happens to them long term. In all of our research, which matches other research, there is a significant improvement in physical and mental health after about two to three weeks; there is a marked improvement in physical and mental health. We have done follow-up studies in post-treatment and have found that even when people have setbacks or relapses, only one person in all of those we have followed up went back to drug use and a lifestyle significantly the same as before they entered treatment. The rest continued to show improvement.

The Hon. Dr PETER PHELPS: Even if they are not abstinent, they are at least functioning.

Mr McCORRY: They function way better than when they came in. The level of severity of their dependence is much reduced. Their physical and mental health is much improved. Also, none of them had committed a criminal act in the follow-up period.

The Hon. Dr PETER PHELPS: What proportion goes on to regular employment and what proportion is still dependent on social security?

Mr McCORRY: Most of them that we know of at 12 months are still trying to find full-time employment. Some of the things that make a difference in employment are covered in our after-care program. In this program people do voluntary work in the community, and some of that includes doing workplace experience. One business in Wagga Wagga runs a bakery and employs them part-time after they finish, if they are interested. A lot of them find employment through their voluntary work. The local council is another place where people do voluntary work or they work with tradespeople and then get employed when they finish. We encourage them to look at their education and their employment and get them to do voluntary work or work experience if they want in those services. The community college comes to the centre and teaches them job-ready skills—numeracy, literacy and stuff like that.

The Hon. COURTNEY HOUSSOS: Because you are attached to a hospital, are your patients eligible to claim against private health insurance if they have it?

Mr McCORRY: Not at this stage.

The Hon. COURTNEY HOUSSOS: Is that something you are looking at?

Mr McCORRY: The hospital is looking at private health cover and building a mental health unit. They think they might be able to get them in through private health.

The Hon. COURTNEY HOUSSOS: You said you receive Federal funding for your rehabilitation beds and for your outpatients. Is that right?

Mr McCORRY: Yes.

The Hon. COURTNEY HOUSSOS: The State Government funding is for the detox beds?

Mr McCORRY: Yes.

The Hon. COURTNEY HOUSSOS: Does the Federal funding come through the PHN or the department?

Mr McCORRY: It is all going to come through the PHN because all of the Commonwealth money has moved to it.

Mr SCOT MacDONALD: When I asked NSW Health about reference 12, current and potential threats to existing rehabilitation services, they nominated that one thing that keeps them awake at night is workforce. Do you have any comments? It sounded to me as though your workforce was pretty solid.

Mr McCORRY: Yes. It can be difficult to recruit qualified staff to the centre. What we find is that we have staff who have worked for long periods of time, which is great. When they leave you feel it and then it becomes a problem for recruitment, yes.

Mr SCOT MacDONALD: What do you put that down to? Salary levels or availability of people?

Mr McCORRY: Yes, it can be to do with salary level. It can also be to do with competition for a small workforce. We have found that the number of applicants have fallen off because of the growing number of jobs made available through the National Disability Insurance Scheme, so there is more competition out in the marketplace for people who have got those sorts of skills. The other one seems to be to do with remuneration compared to public health. The other one seems to be a career path. If you come in, where do you go in a decade's time? Especially in a residential rehab, if you are not creating new programs which have new positions then sometimes there is not much further to go once you are in the door.

Dr MEHREEN FARUQI: But there is a problem in that we do not have enough Aboriginal staff members.

Mr McCORRY: Yes, definitely.

Mr SCOT MacDONALD: Have you put your mind to it either as Calvary or a wider industry?

Mr McCORRY: NADA was doing research into it—I think it is still ongoing—inquiring into the cost of providing services and it has done lots of workforce study issue matters. We are always interested in the outcomes of its study and attracting and maintaining staff. For us even for things like professional development, until quite recently they had to come to the city. So you have to pay for accommodation, pay for wages, pay for them to be away and then backfill the position. And then they might not want to be away from home for extended periods of time. We have combated that a bit by wherever possible getting the training delivered on site. Whilst it is costly at least it creates equity for everybody to attend the training, so that is really good.

Mr SCOT MacDONALD: If you had a magic wand, what would you do in this space?

Mr McCORRY: People come in with minimum qualifications sometimes but the clients present with lots of complex issues which they work to address or stabilise. There is lots of scope for different levels of clinical support that we could probably provide a career out of. That even includes attracting addiction specialists and treating psychiatrists.

The CHAIR: You have given us some rich insights into the great work that Calvary does. This Committee has travelled the State and has been very challenged by much of what we have seen in gaps in the provision of programs and initiatives that are working and helping people in great need. Clearly, the wonderful work that Calvary is doing is successful. I understand you were going to tender a document.

Mr McCORRY: You wanted the fee structure.

The CHAIR: Yes. The secretariat will liaise with you. If you consent, that document will be incorporated as part of the inquiry.

Mr McCORRY: Yes.

(The witness withdrew)

(The Committee adjourned at 1.04 p.m.)