LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

Select Committee on Foetal Alcohol Spectrum Disorder

Public Hearing Transcript

12.30 pm, Friday, 7 November 2014

Nhulunbuy Town Hall, Nhulunbuy

Members: The Hon Kezia Purick, MLA, Chair, Member for Goyder
Mr Gerry McCarthy, MLA, Member for Barkly
Ms Nicole Manison, MLA, Member for Wanguri (via telephone)
Mr Gerry Wood, MLA, Member for Nelson

Witnesses: Miwatj Health Aboriginal Corporation
Dr Lucas de Toca, Director of Public Heath
Mr Lucas tabled a submission from Miwatj Health.
Anglicare
Mr Kevin Bird, Facilitator, Communities for Children
The witness withdrew.
Nhulunbuy Alcohol and Other Drug rehabilitation Services
Mr Jason Laverack, Acting Manager
The following witnesses appeared before the Committee:
Djapirri Mununggirritj
Dhangal Gurruwiwi

MIWATJ HEALTH ABORIGINAL CORPORATION

Madam CHAIR: On behalf of the committee, welcome to this public hearing into foetal alcohol spectrum disorder, and to Dr Lucas de Toca from Miwatj Health Aboriginal Corporation. We appreciate your time. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use by the committee and may be put on the committee's website. If at any time during the hearing there is something you do not want to be made public we can go into a private session.

Did you want to make an opening statement then perhaps we can ask questions? I know you have tabled something.

Mr McCARTHY: Madam Chair, do we have the member for Wanguri?

Madam CHAIR: At 10.30 am. Nicole Manison is also on the committee. She is in Darwin and cannot get online until 10.30 am.

Dr de TOCA: Okay. I handed a short submission to the committee on our views on the subject matter. Also, I want to make sure it is understood the framework for the submission is in complete accordance and agreement with the submission the Aboriginal Peak Organisation for the NT submitted to this committee in June.

Apart from being members of APO NT through AMSANT, we have reviewed the submission and concluded the recommendations are aligned with our understanding of the subject matter, in particular recommendations seven to nine, which are the ones mostly directly related to our service provision.

In regard to FASD in this region, we are not dissimilar from other parts of the NT in that the overarching problem is diagnosis is hard. I am a numbers man myself, as a public health physician, and I find it difficult to feel confident about any number for the prevalence rate of FASD in this region. We have our own estimates from our clinic data, but we are aware of the difficulties of collecting those numbers and we separate the potential suspected cases of FASD based on whether we have monitoring of the pregnancy in our records. If it is in someone older we do not know what occurred during pregnancy, and that changes the way we approach the prevalence estimates.

The actual numbers are on the submission. I can go over them if you want?

Madam CHAIR: What does gravid mean?

Dr de TOCA: Pregnant.

Mr WOOD: I am glad you asked that.

Madam CHAIR: A special medical word I thought.

Dr de TOCA: I tried to keep it to a minimum, but I might have slipped on some of them. To us the main focus - because I have discussed these issues with some of our senior clinicians, particularly the mental health and child maternal health coordinators who have a lot to do with these spectrum disorders, and a common thread consistent with the nature as our community controlled service, is the key to recognising this issue properly lies with Aboriginal health practitioners from the community. Our experience is that the inclusion of a local AHP in the team managing the pregnancy leads to more factual and more actual disclosure of habits during pregnancy be it smoking, kava, marijuana or other drugs. If it is just in a sterile clinic environment with no local input, chances are we will be under-reporting drinking during pregnancy.

Mr WOOD: Is availability of alcohol in Nhulunbuy restricted?

Dr de TOCA: Yes. Nhulunbuy has three or four licensed premises, but takeaway alcohol is under a permit system. You cannot purchase if you have not registered for a permit, and the availability of alcohol within the permit system is dependent on residence. Nhulunbuy residents who apply normally for a permit have full rights, but due to alcohol management plans and the decisions of community leaders in the surrounding communities – Yirrkala and Gunyangara on the peninsula – they have restrictions to the amount of alcohol you can take away. If your place of residency when you apply for your permit is Yirrkala or Gunyangara you have limited …

Madam CHAIR: You will not be able to buy as much.

Dr de TOCA: Yes.

Mr WOOD: Do you have to show ID?

Dr de TOCA: Yes.

Mr WOOD: Can permission be taken away?

Dr de TOCA: By the community, yes. I do not think it applies to Nhulunbuy, but in Yirrkala there is a liquor alcohol permit committee and they can take that permit away from Yirrkala and Gunyangara residents.

Mr WOOD: If an Aboriginal person from Yirrkala went to Nhulunbuy, could they get takeaway alcohol?

Dr de TOCA: Yes, if they have a valid permit. You cannot purchase alcohol in Yirrkala or Gunyangara.

Mr WOOD: If there was a belief in this community that drinking while pregnant should not happen, could the pregnant person not be able to buy alcohol? They could still go to the bar, I suppose?

Dr de TOCA: Since this is something we have not discussed at an organisation level I can only express personal views. In line with professional practice, my personal views, andnot the views of Miwatj Health. I have some concerns regarding punitive action to specific sections of the population; however, the evidence shows a successful policy was the pre-existing policy of identifying and removing alcohol purchasing rights from people who had alcohol-related offences.

Mr WOOD: If it did not apply to just one group of people you would not have a problem? If it applied to one …

Dr de TOCA: I would not have a problem if it related to previous alcohol offenders. I would have a problem with a blanket pregnant women rule. Again, that is my personal view and not something we have discussed.

Madam CHAIR: Anecdotally, would it be fair to say the potential problem is in much younger women - teenagers and 20s versus a woman in her 40s or 50s? Is it a group of young women?

Dr de TOCA: I do not have solid evidence to back that, but that is my impression and it is consistent with smoking during pregnancy. There is also anecdotal correlation between mothers suspected of having FASD themselves and the more risky behaviour, intergenerational transition and high risk of alcohol consumption during pregnancy subsequently.

In fact, I mentioned in my submission a very small cohort of pregnancies treated by the Nhulunbuy and (inaudible) Gunyangara clinics in the last two-and-a-half years - out of the 63 pregnancies nine were suspected FASD and two had FASD themselves and had the children removed. It tends to be a spiralling disorder.

Mr McCARTHY: I am interested in two issues. The first is the isolation of northeast Arnhem Land and its correlation to the availability of alcohol, and also any cultural practices or protocols around pregnancy that are still used for good, healthy development and protection of the child. I like your comment in the letter about having Aboriginal involvement in the clinical environment to do that.

Do you think the isolation of northeast Arnhem Land provides any protection around alcohol abuse?

Dr de TOCA: Yes and no. It does initially. When we monitor the population in the homelands, on all accounts but particularly with alcohol-related problems, it is much lower because availability is lower. In fact, many of the community-allowed initiatives to manage a problem drinker go with reconnecting to land, ceremony and sending them to the homeland where availability is scarce. That is definitely the case.

However, Nhulunbuy changes things completely. That stark division between self-imposed dry communities – Yirrkala was dry before the NTER by choice. The difference between self-imposed dry communities and this township where alcohol is not only free flowing - there is a permit system, but there are several licensed premises and also a high drinking culture, as is typical of communities with a high proportion of fly-in fly-out workers and high levels of disposable income. That deepens the problem, and it is all ingrained with the big divide in advantage and disadvantage Nhulunbuy contributes to the surrounding region.

East Arnhem, as a statistical local area as per the 2011 Census, is 89% Indigenous population. It is the second most disadvantaged in the Northern Territory compared to the other SLAs. Nhulunbuy, in contrast, is the least Indigenous SLA in the Northern Territory with 67% of the population, and is second last in our level of advantage. We have highly disadvantaged communities with alcohol management plans and strict regulation and, 12 km up the road, several licensed premises with loads of disposal income and a steep divide in advantage.

That makes matters much worse than in more remote communities such as Galiwinku, which is also served by Miwatj, on Elcho Island, and Milingimbi as well, which is at the moment a Department of Health clinic. Alcohol is restricted to grog runs which are not that frequent, and the police are partnering with health services and the community to prevent that and home brewing. Those are isolated incidents compared to the availability on this peninsula.

Mr McCARTHY: I am keen to talk to a general practitioner from Nhulunbuy about the non-Indigenous examples. You mentioned mental health and youth and the possible link to FASD. Can you give us your thoughts on mental health issues and youth?

Dr de TOCA: Yes, it is related in a directional way. On one hand, having a disorder within the spectrum of foetal alcohol predisposes an individual to further mental problems. We would like to be able to quantify how much of our - we have a high level of mental health issues, not only depression and anxiety, but also psychotic disorders so we would like to characterise how. I am always referring to the Indigenous

population because they are our client base. Sarah will be able to comment on the non-Indigenous aspect, but in the Indigenous population that is definitely making an impact but we do not know to what extent.

There is the other side, which is misdiagnosis of conditions we might perceive as isolated or organic psychotic disorders we treat as specific mental health issues without acknowledging the potential cognitive delay or the potential effects of FASD in an already neuro-developmentally damaged brain through the influx of alcohol in pregnancy. If we add the potential stressor of neuroactive drugs there is not much evidence on the outcome, but we are a bit hesitant on the impact. We have had patients who have been routinely treated with an organic psychotic disorder or schizophrenia then later on, thanks to the involvement of aboriginal health practitioners going to the community and knowing this mum was here during her pregnancy and was drinking or not drinking, been able to track that back to FASD and been able to reconsider the treatment plan for that person.

Mr McCARTHY: In a clinical environment, how active is the conversation around foetal alcohol syndrome and foetal alcohol spectrum disorder among the Aboriginal practitioners?

Dr de TOCA: It is at the forefront. I think our communities are very aware of alcohol and its effect. In our clinics pregnant ladies are routinely asked about consumption of substances during pregnancy. That includes alcohol, kava, cigarettes and other drugs, and that is not a one-off event on the first visit; it is constantly updated because their status can change. Again, the value of that assessment relies enormously on trust, and that is why we are pretty confident on the results when they come from permanent midwives living with the community who have a longstanding relationship with the pregnant woman who discloses these issues to Aboriginal practitioners. That is problematic when we have recruitment problems and we rely on agency staff as short-term replacements. That is when the validity of the data is a little more questionable.

To address not only this but also many pregnancy-related issues, and consistent with the focus we have on early childhood and prenatal to three years development as one of the most powerful markers in future success, we have put a bid in for the Australian Nurse Family Partnership which, at the moment, operates in Congress and a couple of other locations outside the NT. They are expanding next year and that is a targeted program focusing on a clinical group with midwives and Aboriginal practitioners to develop that relationship with the woman and the family and accompany them from early pregnancy to early childhood. We think an initiative that takes into account the pregnant woman and the family holistically and establishes a trust relationship might have an impact on these conditions.

Mr McCARTHY: In that realm, are you aware of any cultural practices or protocols which support nurturing in utero development?

Dr de TOCA: I am not the right person to talk about this because I am not Yolngu. If I were Yolngu I could not because that is women's business.

Mr McCARTHY: A couple of women are appearing later and I am hoping Madam Chair will ask those questions.

Madam CHAIR: Yes, I will ask them.

Dr de TOCA: From a clinical point of view my experience is, as with any culture, protection of the pregnant woman, the concept of motherhood and nurturing the baby is present and very strong. When that does not happen there is a very strong link with disadvantage and social breakdown. Young mothers who have had traumatic events - that is when more risk taking behaviour during pregnancy is seen. It is not that the Yolngu culture does not consider pregnant women or does not nurture babies. There is a lot of cultural practice around pregnancy precisely to protect that. It is the lack of sustaining that, homelessness, AOD problems, trauma and early pregnancy which triggers that type of behaviour.

Mr McCARTHY: In that respect, northeast Arnhem Land does not escape any of the pressures I live under and others in more populated areas?

Dr de TOCA: No.

Mr McCARTHY: The modern age. This is my personal interest with no reflection on the organisation. If a person who lives in prescribed area or a remote community travels to Nhulunbuy to purchase takeaway alcohol, where do they expect they will drink that alcohol? Do they drink it on the beach, in the bush or anywhere?

Dr de TOCA: I assume that is the expectation or justification behind the policy. The reality is we have - not frequent - alcohol binges in dry communities and that is alcohol purchased, yes.

Mr McCARTHY: Where I live a new policy has implemented a temporary beat location so you are assessed to a number of criteria before you are allowed to purchase takeaway alcohol. One is you have to prove where you reside. If you reside in a prescribed area you are restricted from buying takeaway alcohol. I was interested, when you opened the discussion with Mr Wood, that Nhulunbuy seems a bit ad hoc with that legislation.

Dr de TOCA: Permit availability and the type of permit you can have it is based on location. If you live in a prescribed area thenthe permit you get has a limited amount - there are different degrees of permit the liquor licensing committee can award to people. I am not entirely sure about this, but I think if you live in Gunyangara and first apply for a permit all you have is a six pack of light beer. That is the maximum you can purchase for a period of time.

Madam CHAIR: At a time or per day?

Dr de TOCA: At a time or for a period of time, I am not sure about that. It can change. People can have permits revoked, they can have permits increased if there are years of no alcohol-related offences, but that is monitored by the permit committee which has strong community representation. It is community owned.

Madam CHAIR: Who issues the permits?

Dr de TOCA: Permits are issued by an NTG office here, but the recommendations on the permit for Indigenous communities are based on the permit committee, which is multidisciplinary collaboration with community leaders and government people.

Mr McCARTHY: In Miwatj, do you have proactive education and awareness programs around prevention of FASD?

Dr de TOCA: At the moment we do not have specific resources in culturally appropriate language to give out, but definitely alcohol during pregnancy, early detection then management and treatment of FASD is a big part of what we do. In regard to mother education, prevention and pregnancy support, that would be in the realm of the child maternal health teams because that is also culturally appropriate because of women's business. That is where programs like the Australian Nurse Family Partnership would play a big role.

In early childhood into adolescent years, the responsibility of picking up potentially undiagnosed FASD and supporting the person with diagnosed FASD is done by the child and health team and the mental health team. For older patients who might have been undiagnosed but could be suspected, that is limited to the mental health team that operates. The mental health team is all Yolngu except for a very experienced psych nurse who helps them, but it is coordinated by a very senior Yolngu AHP.

Mr McCARTHY: When dealing with more traditional groups that represent the patriarchal and matriarchal lineage, do men also feature in this education and awareness?

Dr de TOCA: Following also the kinship system under way –the (inaudible) of society happens. Most of our education and support programs target families not individuals. As such we talk not just about FASD, but general pregnancy and healthy childhood education with both genders. Some material is delivered to the family as a whole, some material specifically about the biology of pregnancy is delivered to woman, but we have our Strong Fathers program which focuses on young fathers as a role model and the responsibility towards the family and the children. There are also discussions on healthy pregnancy, healthy childhood and early childhood development. That is all within our public health unit.

The purely clinical aspect is the child/maternal health pregnancy follow-up, which includes education, but within the public health unit we have an array of social and emotional wellbeing programs that follow a two-way approach called Raypirri Rom discipline and law. They have a varied representation from respected community members from the region, and conduct a lot of preventative and also ongoing support with a family focus on AOD and other substance use, mental health stuff and harm and family violence. It is normally targeted holistically in a keeping family strong approach.

Mr McCARTHY: Do you buy those services? Are there NTG services that will do AOD work?

Dr de TOCA: No, we work closely with NT AOD. We work closely with service delivery aspects (inaudible) under a visiting AOD specialist, and we worked closely with the rehabilitation residential centre. Since the loss of that service we are working with the ongoing, ever-changing rehab day program they are developing. We have put a bid in to minister Lambley to contest the service into community service control. We think with a majority Yolngu workforce and knowledge of the community we are in a better place to deliver an effective day program than the government is. We are in an ongoing discussion but always within a partnership approach. We sit at the table with them, but we deliver the service ourselves except for the clinical psychologist we have on a visiting basis.

Mr McCARTHY: With regard to that program delivery, does Miwatj do anything outside the square? Do you use performing arts in any of the education and awareness?

Dr de TOCA: We use film and art to a degree. Art theory is part of the activity Raypirri Rom does. There has been an interest, and some of our men's teams are designing, performing and role playing family situations as a component of one of the men's camps we are organising. Starting this month we are taking - completely Yolngu-led initiative, no Balandas, no non-Indigenous staff members are going to the camp.

We are organising three- or four-day camps with young men, particularly young fathers and those who have been deemed at risk, to go to one of the homelands, connect with culture, with country, talk about men's law, and what it means to be a man and the roles and responsibilities, and also receive education from visiting providers. We might have a session on tobacco, another session on FASD, a session on alcohol control, and the visiting service providers will come to the camp, deliver their education and leave because we want the majority of the camp in a Yolngu context and driven by Yolngu value and culture. Some of the men involved in that who acted in health promotion clips and films before expressed an interest into doing the role playing and performance of situations. That is something we are currently exploring.

Mr McCARTHY: Yes, very good. Are you were aware of any involvement with Skinnyfish and their AV productions?

Dr de TOCA: We have commissioned videos with Skinnyfish before. We have some tobacco and sugar control videos with Skinnyfish.

Mr McCARTHY: Have you seen them.

Dr De TOCA: We commissioned them.

Mr McCARTHY: Yes, they are brilliant.

Dr De TOCA: Sugar Man is one of the workers organising the camps - the main lead is *Sugar Man*. I recommend we put in a documentary a bit different to the health promotion videos recently, the *Tobacco Story of Arnhem Land*. It is a 45-minute feature which explores tobacco use in the region but from its historical and cultural aspects of how it came from the Macassans. We are trying to differentiate - cultural use was restricted to elders for ceremonial purposes, and with current use everywhere - young people, in front of children and while pregnant. We are trying to tackle it in Yolngu terms. The 'don't smoke' punitive approach does not work. That was a bit off topic, sorry.

Madam CHAIR: If a pregnant woman smokes heavily, does that deliver the same type of potential problems in a baby as alcohol or are they different?

Dr de TOCA: There are different problems. It delivers problems but they are more related to delayed growth. Generally, babies of heavy smokers are smaller and there are some growth-related aspects. Some of the developmental issues can be associated, but is not such a brain-targeted aspect as alcohol is. They carry problems, but a different set of problems.

One area we do not know - and there is scant general evidence - is with kava.

Madam CHAIR: What does it do?

Dr de TOCA: I have no idea.

Mr WOOD: Are you still getting kava in the area? Kava is banned …

Dr de TOCA: Yes.

Mr WOOD: Is some still coming though?

Dr de TOCA: We have not had any kava-related issues recently, and according to the latest report from the police there has not been any seizure of kava in the last few months. We have a community safety action committee where Health, Education, the township corporation, police and all the service providers meet. It is a great forum to share updates. Neither our records nor police records show any problematic - they have not seized any kava and we have not seen any problems over the years.

Madam CHAIR: It generally hits the news if there is an apprehension.

Mr WOOD: You spoke strongly about Yolngu people running their own health education services. If a mother who - even though the community is told about the hazards of drinking etcetera - continues to drink, do you see a role for the community where that woman is isolated from drinking using the community as a supported base? The government does it; it is similar to mandatory alcohol rehabilitation. Do you think something like that could, with the support of the community, work?

Dr de TOCA: The permit committee has the capacity to restrict or ban buying takeaway alcohol. That is not only for unlawful offenders, it is also being done on community recommendation for people considered to be at risk.

Mr WOOD: That would not stop them going to the bar and drinking would it?

Dr de TOCA: No.

Mr WOOD: The person could be an alcoholic and no matter how hard you try they will not stop drinking. The issue the government has is if that person continues to drink - they might even have FASD now and be worse if they keep drinking. One of the notions put forward is whether the government takes a role and removes that person until they have had the baby. If there was a better way of doing that, which was community-based and supported rather than …

Dr de TOCA: That would certainly be a better way. Again, I cannot speak for the community. Whether they would support it or not - I think any punitive approach is way more effective if it comes from the community rather than the government. The Yirrkala alcohol restrictions worked, only to some extent thanks to Nhulunbuy, but the amount of success they had was based on the fact it was a self-imposed restriction not an intervention restriction. Yes, if the community is willing to take such measures I think that would be far more effective than government imposition.

Madam CHAIR: Thank you for coming along and sharing with us. We will send you a copy of the *Hansard* to make sure we have it right. Thank you for your time, it is appreciated.

Dr de TOCA: Thank you.

The committee suspended.

ANGLICARE

Madam CHAIR: Good morning and thank you for coming. I welcome you to the public hearing into foetal alcohol spectrum disorder. Kevin is from Anglicare, and we appreciate you taking the time to be with us today. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time you think what you want to say should not be made public we can go into a closed session.

Do you have an opening statement?

Mr BIRD: First, I apologise on behalf of my colleague, Karen, who is also my wife. She is at funeral business today and sends her apologises. Some aspects of the space Karen works in with Anglicare I can comment on if you like.

Madam CHAIR: Yes, thank you.

Mr BIRD: Welcome to East Arnhem. Anglicare is, as you would know, a church-based organisation. We are probably the only NGO community-based organisation in East Arnhem working directly within the community across a raft of different programs and services from disability to young carers, old carers, the Hack program, communities for children and a raft of new service programs. I will concentrate on the latter of those, communities for children, which Karen runs targeted to Yolngu communities - the 0-12 children's capacity and young mums. The programs I sit across are preventative programs, homelessness programs, AOD programs and youth diversion programs. The package I look after is from 12 to under-18 male and female, and 95% of our business is out on community.

Madam CHAIR: Not in Nhulunbuy?

Mr BIRD: No, when I say out I mean Yirrkala, the two communities south, town-based, and we are venturing into some of the closer homeland communities. The way we are developing and putting the programs in place is on a preventative model. Clearly our skills are not towards interventions; there are enough agencies in that space with the medical and clinical background to deal with that. Our focus is very

much building resilience, awareness and preventative activity for young people. That is the context I will talk to.

One of the areas we believe in, and are working through in the space, is preventative awareness, and preventative knowledge for this is in the school system based on it being a critical mass. Young people today in the communities are very exposed to social media - the good and the bad of it - and that has been an interesting tool. I will give you an example. We have issues in Yirrkala at the moment of self-harming or the choking game, which has been around a long time. It is about cutting off the supply of blood to the brain, letting go and getting a rush. There are kids as young as eight, who probably are the result of parents drinking alcohol in the past.

You can go on YouTube and different websites - there are 74 sites around the world showing you how to do it. You dig in to find how to unwrap that in a preventative model. It has happened in universities, sporting teams and is seen as a fun party thing to do. The kids pick that up and go, 'I'll have a shot at that', kids from eight to 12.

Awareness of abuse - be it male, female, substance, alcohol and drugs - we believe needs to start at school. That is where the consistency of discipline and a learning environment is - not necessarily in a non-cultural sense - and then broaden it out with other agencies like Miwatj, AOD or whatever to parents and the community at large. A raft of programs have all moved that way - we have concentrated on the 12 to 18 category.

With the communities with children concept, quite often our prevention has come too late because it is dealing with that birth to eight. It is preparation of the mothers to deal with issues of the young children - the behavioural issues, the slow learning, the low body weight and the things that are a direct result. That is like a helping hand process for those that are too late, then trying to build for the 12 to 18 group, targeting young girls and young boys, on a whole raft of negative outcomes of abuse.

It needs to be seen and built as an issue for men. Quite often the women are drinking with their partner or the males in the community. The cultural issue is the men here would probably not acknowledge their role in that. There needs to be, through the men's group, introduction of their responsibility or role on the effects of alcohol on their partners and their children. To my knowledge that is not so here. The men would not acknowledge or be aware of the long-term result. That interaction needs to occur.

Clinical practitioners and organisations like Anglicare develop a different relationship. I will give you an example where, in partnership with the school running Dhimurru and Miyalk sessions - girls and boys - each term we have covered different topics ranging from consent with boys - about sexual behaviour, alcohol, drugs, self-harm, and the girls have been doing similar work around sexual behaviour, prevention and how to say no. Of course, over that is the AOD and other substance abuse activity the whole time.

Madam CHAIR: Thank you.

Ms MANISON: I cannot hear clearly. I might go offline and chat to Russell. I will hang up because I cannot hear very well.

Madam CHAIR: No, just wait, Nicole. Try that.

Mr BIRD: Good morning.

Ms MANISON: I can hear Kevin clearly now so I might keep listening. Thank you.

Mr WOOD: Anglicare has programs on sexuality, behaviour and AOD. Is there a Yolngu way of doing that?

Mr BIRD: Yes, the awareness of wrong by Yolngu to young people - we would see working hand-in-hand and we do that. We normally have a cultural advisor or Yolngu school or community staff with us the whole time. An example is we take a group of girls camping at Ramo the first week in December who have been part of the girls group. The idea of that is their development, going away and those things, but underpinning it is the whole thing about self-awareness, self-development the subtleties of messaging on behaviour - as we lead into the long break over Christmas it always gets fragile here. Accompanying us the whole time are Yolngu staff.

Mr WOOD: Underneath that - maybe it is taught a lot earlier - they all know their skin group and are aware of the cultural things as well.

Mr BIRD: Yes.

Mr WOOD: Relationships and things like that, they know those automatically.

Mr BIRD: Automatically. It comes naturally.

Mr WOOD: Is that intertwined with some of the issues you deal with?

Mr BIRD: Absolutely.

Mr WOOD: Sometimes those issues are not within their own rules.

Mr BIRD: That is true, and that is the challenge in maintaining cultural integrity and cultural significance to young people when they are being influenced by so many other forms. What worries most people is social media - the good and bad of it. To the kids it is their reality, and overriding that are their cultural obligations and they keep washing away. The girls will mimic what they see on YouTube and the behaviours to a certain extent - the clothes on YouTube which are culturally inappropriate.

Mr WOOD: You said on YouTube there are 74 sites on how to strangle yourself. Would you see a role for YouTube being to promote educating young people, both men and woman, about the downside of drinking while pregnant? Can we use some of the …

Mr BIRD: Social media has a place in the education process, but the difficulty with things like YouTube is they are not sustainable because they move on. People look at something …

Madam CHAIR: It is a fad.

Mr BIRD: Yes, and then move on to the next thing that pops up. There has to be the same consistent, ongoing message and awareness raising rather than one-off events. Everyone pats themselves on the back. We have had a week long focus on what, and then they move on to something else. There is a place for it; there is also a place for monitoring what is accessible. Even though the school sites and other community sites have filters on what kids can and cannot watch these kids are experts in technology and get around it.

Mr WOOD: Do you think the danger of drinking when pregnant message is getting out there?

Mr BIRD: No. As a preventative measure the answer is no. As an intervention – in the time I have been in East Arnhem - I worked through East Arnhem Land for two years before I started working with Anglicare. The message was the antenatal side of it. The message in the prevention side is washed away in the broader alcohol management-type activity. It gets blurred. Try to send a message of alcohol abuse it so broad …

Mr WOOD: It is only part of it.

Mr BIRD: Yes. If you look back the issues are alcohol abuse, violence, community losing its will, money, malnutrition and stuff like that. Those types of things are what you have to focus on, whether that is right or wrong, but there is not a lot, as part of the package, I am aware of that deals with the issues we are talking about today. What happens is the focus then and the cost - obviously we are dealing with kids who are the result of that.

Madam CHAIR: From your knowledge, do you find teenagers are staying at high school? Do young Yolngu girls – we could probably get this from the Department of Education, but do you find they are staying at school? You suggested using the school system to get information to help people understand. Is there a drop out at 14 or so?

Mr BIRD: We all know the necessity of education and the focus within the school system. It is very much a work in progress. The girls are better attendees than the boys, but once they hit a certain age the number decreases dramatically. The number of Yolngu girls completing Year 11 or Year 12 - same with boys - shrinks. Whether focusing more on the school attendance-type activity will change it - when you have kids as young as eight smoking ganja or self-choking you cannot start too early to build the message of what this is all about.

Madam CHAIR: Eight is Year 2?

Mr BIRD: Yes, eight-year old boy - four, five, six.

Madam CHAIR: If they are not in the school system it is harder to get information to them.

Mr BIRD: That is when building the capacity of the community, and the health system that services the community, or NGOs in the community have to become the flag bearers and carriers of the preventative-type activity. I do not necessarily think you can treat this from a practitioner point of view. This is a single entity, a one-off activity we should address as part of the community capacity in health and wellbeing.

Mr WOOD: It is about health.

Mr BIRD: Absolutely.

Mr WOOD: Not only for the person, but in this case the child.

Mr BIRD: Yes.

Mr McCARTHY: Kevin, you mentioned your work. Have you been around this area a long time?

Mr BIRD: We came to the Territory for 18 months and have not quite made it back home. That was about five years ago. Our experience was in New South Wales. I also worked with Indigenous communities in rural and remote New South Wales, and my wife is a Yuin woman. Our background is that

area, and we have not been able to extract ourselves to go back to our grandkids. We are not quite ready to be grandparents, I think, is the problem.

Mr McCARTHY: You present a comfortable vibe talking about Aboriginal cultural issues so you obviously have a lot of knowledge of that area.

Is it strictly taboo to go into this area of education and awareness around pregnancy in Yolngu homelands today?

Mr BIRD: It needs to be introduced in a wrong context. It is women's business, but the building of a Yolngu workforce in community preventative health, as opposed to clinical preventative health, is a way to go. We have a way to go in breaking down cultural preventatives. In addressing these issues, you have young people in the school system and the community that are direct results of that. We are dealing with it anyway; it is there. It is getting a workforce that understands it and can blend it.

Part of our activity is talking to men. We check what we talk about with our cultural adviser in the school system, and we are taking thinks like the consent issue - what is consent? What is acceptable in partnership behaviours between young men and young boys under the age of 15 or 16? Traditionally there would have been cultural barriers, but we need to address those issues and that is happening.

Mr McCARTHY: What other influences do the under-25s have in this area? If I look at Darwin, for instance, I see a lot of homeless people generally in the older age bracket. Do young people from this area go in and out of Darwin frequently?

Mr BIRD: Darwin Show time - certain times of the year they will go with family. The issue of exposure - or on organised sporting trips or school trips, but as an individual drop in to or out of Darwin, I would say no. Moving to homeland or Gapuwiyak, Elcho or wherever - that is a constant turnaround within the cultural context. Some of the issues we have are - in one context it could be seen as homeless, but it is not because they are moving from house to house, to family, to relatives or to extended family. That creates its own issue because you never know the wellbeing or safety of the young child. Normally the older group, once they have that, the answer is yes.

Mr McCARTHY: You do not need to go to the big city to access alcohol and other drugs?

Mr BIRD: No. The big difference from working in remote communities and here is that it is accessible. I would hazard to suggest community wellbeing and health in remote communities is better than the health situation here. They all share similar health issues with overall health - the young kids are better from my observation.

Mr McCARTHY: You said you do not think young men are very aware of issues around pregnancy and the in utero development of children.

Mr BIRD: No, I think that is part of the cultural thing. I think they are well versed in creation, but not necessarily maintenance of what is being created or some of the negative issues.

Mr McCARTHY: Did you have those conversations?

Mr BIRD: With the boys?

Mr McCARTHY: Yes.

Mr BIRD: The model we are building on is about the subtlety of messaging and behaviours. We try to lock it in to respectful behaviour to community and to women. It has been interesting talking to boys about consent, what yes means and what no means. It took them some time to feel comfortable talking about that, or demonstrate what they perceive as yes or no – whether it is a right – it is not talked about.

Mr McCARTHY: That is the behaviour sense. We just heard a doctor talking about programs. I am more interested in the pathology of those issues. In your work do you deal with that level of education awareness where you talk about …

Mr BIRD: Where we are trying to head with this is it is a partnership model bringing in the other agencies with carriage of the intervention and building on that so everyone is on the same page. The difficulty of single agencies, whether they are NGO or government-based, still confounds communities. Who is turning up today? We are working with AOD, BSA, the NT and mental health. They come with us. If we are identifying behavioural issues or results of abuse issues, whatever they may be, we pass them on. To me, that is a good way to operate.

Mr McCARTHY: You come in contact with a lot of young people, and there has been a debate around this inquiry about diagnosis and diagnostic tools. Are you seeing what you consider to be foetal alcohol-affected youth?

Mr BIRD: An increase?

Mr McCARTHY: Anything.

Mr BIRD: Some kids are victims of previous abuse by parents - substance abuse, both alcohol and drug in full motion during pregnancy. That is without a doubt and the numbers are increasing.

Mr McCARTHY: What are the behaviours you identify with if you are thinking like that?

Mr BIRD: With young people?

Mr McCARTHY: Yes.

Mr BIRD: Body weight, development, learning difficulties, behaviour, concentration levels and self-care.

Madam CHAIR: Is there much self-harm? Forget the choking game.

Mr BIRD: They are all candidates. That is part of the reason I suggest. We all know the impact of petrol or glue.

Madam CHAIR: Paint?

Mr BIRD: Paint, the solvents. What worries many of us is the issue of ice in this community.

Mr McCARTHY: Ice?

Mr BIRD: Ice.

Mr McCARTHY: Methamphetamines?

Madam CHAIR: Drugs. Is it getting in?

Mr BIRD: It has always been here as a controlled substance within the Balanda community. It washes down so quick there is a gap in the market. There is a potential market I suggest here. Yolngu would not know or have used ice, but there is a worry ice is now starting to move around.

Mr McCARTHY: Ice is a lot easier to smuggle than a pound of grass.

Mr BIRD: Yes, that is right.

Mr McCARTHY: When you talked about …

Mr BIRD: The anecdotal advice we are getting is the unit price of ice is cheaper here at the moment than in Darwin. Logic tells me what is trying to happen, perhaps, is growing a market.

Mr McCARTHY: Yes, that is the way narcotics is grown - starter packs. I come from Sydney; I was born and bred in Sydney. The starter pack is a real issue, so look out for it.

You were talking about physical and cognitive aspects of youth you can identify and have concerns about. How does a significant Indigenous adult define that? Do they talk about it? Where I come from people will generally use a general comment of (inaudible) or (inaudible), which means mad. Is there any more defined conversation going on?

Mr BIRD: No, not to my knowledge. Perhaps within the family context there is, but my observation is there is not. People who talk about or interact with FAS are basically non-Yolngu practitioners one way or another.

Ms MANISON: Kevin, it has been a bit difficult for me to follow the questioning so I apologise if you have covered this ground already. In the region it sounds as if there are some very strong cultural links and cultural ways you need to respect when working with Yolngu. Do you feel people want to know more about FASD, and if culturally appropriate information was rolled out people would want to know about the risks of drinking during pregnancy and what happens if they drink during pregnancy?

Mr BIRD: I think you cannot ignore the issue. It needs to be done in language obviously, and subtlety needs to be used in the message regarding results. There is enough culturally acceptable stuff on ganja, kava and the broader based alcohol issue. This issue is crossing into a boundary of the cultural men's and woman's type separation. Perhaps what needs to be worked through is several sets of information, one targeted to woman, one targeted to young people and one targeted to men. Perhaps that would be a culturally safer way.

Ms MANISON: You mentioned earlier the importance of having local people deliver those messages.

Mr BIRD: Correct.

Ms MANISON: Do you think that is a more specific way to run campaigns around awareness out there?

Mr BIRD: Yes. The way I look at it is - working as an NGO and the background I had in community health with Miwatj - we are really custodians of funding. It is not our money; it ends up being community

money and that is how we dispense it. Utilising and developing a Yolngu workforce will ultimately have a far greater impact and footprint than we could ever provide. That is a no brainer from my point of view.

Ms MANISON: Thank you, Kevin.

Madam CHAIR: Thank you, Kevin. I am conscious of the time. Thank you very much for coming in today. We will send you a draft copy of the *Hansard* so you can make sure we have everything factually correct. I forgot to tell Dr de Toca we are hoping to have this report presented to parliament by the end of the year. We will make sure everyone gets a copy or knows where to access it on the Internet.

The committee suspended.

NHULUNBUY ALCOHOL AND OTHER DRUGS REHABILITATION SERVICE

Madam CHAIR: Good morning. Thank you for attending this public hearing into foetal alcohol spectrum disorder. We appreciate you taking the time. This a formal proceeding of the committee and the protection of parliamentary privilege and an obligation not to mislead the committee apply. A transcript will made for use by the committee and may be put on the committee's website. If at any time during the hearing you are concerned what you may say should not be made public we can go into a private session.

Do you want to make an opening statement?

Mr LAVERACK: No, I am just happy to introduce myself. My name is Jason Laverack and my current role is manager of Nhulunbuy Alcohol and Other Drug Services. Until 1 July 2014 I was manager of Nhulunbuy Alcohol and Other Drugs Residential Rehabilitation Services, which no longer exists. Forging ahead with community-based rehabilitation, we are in the throes of developing programs to cater for the needs of the community. I have lived in Nhulunbuy for 10 years or thereabouts. I arrived in 2003 and have had various roles in Nhulunbuy, first at the hospital as a registered nurse and then a short stint with YBE, the Indigenous mining company you could say, and then some remote nursing stints at Milingimbi, Yirrkala and as far as Belyuen. For the last three years I have been working in the alcohol and other drugs sector in Nhulunbuy.

Mr WOOD: Who funds you?

Mr LAVERACK: The Northern Territory government.

Mr WOOD: Are you a Northern Territory government employee or an NGO?

Mr LAVERACK: No, we are Northern Territory government – the Department of Health.

Mr WOOD: I need to work out how I ask questions.

Mr LAVERACK: Yes, Department of Health.

Mr McCARTHY: In your previous role with the residential facility, were you an NGO?

Mr LAVERACK: No, Northern Territory government. Prior to December 2009 the residential services were run by Mission Australia, but it was seen as not viable and the Northern Territory government took it over in December 2009. It was a bit before my time - I came on board in 2011 in another role - but through people leaving and being the next in line I am now manager of AOD services in Nhulunbuy.

Mr McCARTHY: I found your comment about the difference between having a residential facility to operate alcohol and other drugs services to community-based interesting. You are basically dealing with the same clients but they are living at home.

Mr LAVERACK: Yes, and we are trying to make that work. It has its challenges, but we are working towards a day program where people can come in and out of a 12-week program module. They might start at a point and go to the end, then come back to the start and then finish in the middle, if that makes sense.

One of the main challenges for us has been finding suitable premises to operate from. Having lost the special care centre as a place to operate from meant we are in a transition stage, and the Northern Territory government is pushing forward its processes to find us somewhere suitable to operate from. The facility they have earmarked is the old wet mess ironically, across from NORFORCE - I do not know if you know the building, but it could be suitable for a good day program for the region.

Mr McCARTHY: Are there restrictions on clients enrolled in your programs to purchase or consume alcohol in town?

Mr LAVERACK: We work from a harm minimisation model. Whilst we ran a residential rehabilitation program we were able to enforce certain rules and regulations around consuming alcohol. This is part of the rules of staying in a program and something you would see in any mainstream residential rehabilitation program. Community-based is a little more difficult. We know people probably drink, but to come into a day

program they would need to do things like have a breath test to make sure they are sober before engaging. That is one of the rules and regulations of a day program.

Mr McCARTHY: Did you have court ordered referrals …

Mr LAVERACK: Yes.

Mr McCARTHY: … in the residential component?

Mr LAVERACK: Yes, court ordered but they still had to be rated as suitable. We work with the courts and Corrections around taking clients into the service. They have to be contemplative. It is no good necessarily taking someone who does not want to change and try to work with them. Sometimes you can work with people over a period of time and they might see change would be good, but generally you would be looking for someone who is contemplative and ready to make a change in their life.

Mr McCARTHY: Male and female?

Mr LAVERACK: Yes.

Mr McCARTHY: Indigenous and non-Indigenous?

Mr LAVERACK: Yes.

Mr McCARTHY: Many non-Indigenous?

Mr LAVERACK: Not many but some, yes. During the time I was there I think you could count on one hand - four or five came through the service. We had mainly male Indigenous clients. A big referral source was the Corrections system or the justice system.

Mr McCARTHY: Is Nhulunbuy town a big consumer of alcohol?

Mr LAVERACK: Yes. In the non-Indigenous population that is the case, and in the Indigenous population I would say there are high levels of alcohol use.

Mr WOOD: Two people on the plane today were Thirsty Camel reps so there is a market here.

Mr LAVERACK: Yes, there is. There are three outlets where you can buy takeaway, and then probably another three licensed premises on top of that.

Mr McCARTHY: With your background as a RN, would you consider foetal alcohol spectrum disorder to be a big issue for the non-Indigenous population in Nhulunbuy?

Mr LAVERACK: With non-Indigenous I do not see it because we are not engaging with non-Indigenous as much as with Indigenous clients. That is possibly the reason. I know the rate of drinking amongst pregnant non-Indigenous woman is up to 80% in some cases in mainstream

Madam CHAIR: Just because they are drinking?

Mr LAVERACK: That is right.

Madam CHAIR: As would be slightly older men and …

Mr LAVERACK: That is right, and perhaps not drinking - there is no safe level of drinking when you are pregnant. Whether that is a glass of wine once a week or once a month I am not sure, but the rates are still fairly high amongst non-Indigenous people generally.

Madam CHAIR: That is pretty much across the board.

Mr LAVERACK: Yes.

Mr WOOD: You had a mandatory alcohol rehabilitation centre here, is that correct?

Mr LAVERACK: Yes, we had Nhulunbuy Residential Rehabilitation Services with 14 beds for the mainstream AOD program, and 10 beds on top of that were designated for alcohol mandatory treatment. There was a low uptake of the alcohol mandatory treatment beds largely because of the mechanisms in place in town and …

Mr WOOD: Was there the clientele to fill those beds …

Mr LAVERACK: Yes.

Mr WOOD: … or the mechanism did not catch up with what was needed?

Mr LAVERACK: The mechanism meant people were not landing into protective custody. For example, the police preference is to make sure people get home first and foremost. If they cannot do that they would access the sobering-up shelter, and if that could not be accessed they would take them into protective custody which, of course, is the trigger for mandatory treatment. We saw a low uptake of those 10 beds, but I reckon if you were to lose the town patrol that would have a significant impact on people getting home and police having to do extra work to perhaps pick people up and take them home or take them into protective custody.

Mr WOOD: This is why I asked who you worked for. Do you think there is still a need for the mandatory alcohol rehabilitation centre to exist?

Mr LAVERACK: Yes, I think so. Some people are drinking unsafe levels of alcohol over a period of time. Recently, two beds were gazetted at Gove District Hospital to recommence the assessment phase for mandatory treatment.

Mr WOOD: It has been removed but it looks like it might be coming back in a small way?

Mr LAVERACK: In a smaller way to reflect the small numbers that went through Nhulunbuy rehab centre.

Mr WOOD: Would most people in mandatory alcohol rehab be Aboriginal people?

Mr LAVERACK: Yes, 100%. In regard to mandatory treatment?

Mr WOOD: Yes.

Mr LAVERACK: 100%.

Mr WOOD: I spoke to Dr Peter …

Mr LAVERACK: Peter Chilcott.

Mr WOOD: Yes - … about the possibility government could intervene if a woman keeps drinking even though she has been told not to, but instead of government intervening in that process if the community could intervene and whether, in the case of mandatory alcohol rehab, you could have a Yolngu approach to it, which is out bush somewhere or in a culturally appropriate area rather than the hospital. Do you think there is more potential for that to be successful rather than putting people into a non-Yolngu situation?

Mr LAVERACK: If you were to make it compulsory for pregnant women to go to a place like that you could potentially have a situation where pregnant women are reluctant to …

Madam CHAIR: Tell you.

Mr LAVERACK: … tell people and engage with the midwife. They would probably be reluctant to engage with their midwife if they knew there was a chance they could be – this is speculation, but in my experience the key players in antenatal care are midwives and maternal child health nurses. If you disturb that relationship you will not necessarily have great outcomes. You are already dealing with a population that is high risk in regard to pregnancies. Engaging them is challenging enough, without other bits and pieces having influence over whether or not they talk to their midwife.

Mr WOOD: Obviously this would be a last resort. It is probably more if someone had been told if they kept doing it what would happen. The government has an issue about whether it should allow it to happen, because even from a moral or economic point of view, you have someone who will cost society a lot of money to look after.

Mr LAVERACK: Yes.

Mr WOOD: We are looking at the role of government, but also moving away from government, which is more like big brother, to a traditional outlook where you would have the community-based approach where that person would be encouraged and helped by the community but still be told they have to stop drinking. Could we have process that might replace the government and be done in a more traditionally cultural way, because you said 80% of women - is that correct?

Mr LAVERACK: Non-Indigenous. Those are the figures I am talking about.

Mr WOOD: I think we have some lower figures for Indigenous.

Mr LAVERACK: It depends on whether it is reported or not. I do not think there is a great deal of – it depends on the situation. I am not certain high numbers of pregnant Indigenous women are drinking - as long as they are getting good antenatal care and are engaged with their midwife or maternal child health nurse, which potentially has a big influence on whether or not people drink. It is not just their midwife, but

strong women in the community as well. If they have those good links in the community they are probably less likely to drink.

Mr WOOD: Are you saying a higher percentage of non-Indigenous women are probably drinking when pregnant than Indigenous women?

Mr LAVERACK: Potentially.

Mr WOOD: That is percentage, of course, which could be dangerous in what that means in actual figures.

Mr LAVERACK: When I say drinking, I am not talking about an entrenched alcohol misuse problem. I mean they might be drinking one glass of wine per month perhaps, which to someone who is not pregnant is not an unsafe level, but to someone who is pregnant it is technically unsafe because there is no safe level of drinking when pregnant.

Mr WOOD: Have you seen non-Indigenous children with FASD characteristics? We keep talking about Indigenous problems.

Mr LAVERACK: Yes, and I have dealt with people I would say are on the spectrum somewhere, some further along than others. There is no diagnosis in the Northern Territory around FASD for whatever reason. There has never been a diagnosis or a label that that person is FASD, had learning difficulties or would struggle with learning new stuff - capable of learning new things.

We worked with them as best we could and got some reasonable outcomes. If anything, we had abstinence for a period of three months and were able to link them back into their primary healthcare service. We had an engaged group of people who had really good service from Miwatj, for example. They would manage their primary healthcare needs over that three-month period and we would look at linking them into employment where we could. It has its challenges, but we definitely saw people who probably have FASD.

Mr WOOD: Would many non-Indigenous people have a real knowledge of FASD? Is it widespread knowledge that you should not drink when pregnant? In Alice Springs we were told a male should not have sex if he is drinking because it can affect the sperm.

Madam CHAIR: Researchers told us that.

Mr WOOD: Do people know this?

Mr LAVERACK: Non-Indigenous people?

Madam CHAIR: Anyone.

Mr WOOD: Both if you want, yes.

Mr LAVERACK: Yes, I think the population here knows drinking is not good. At some point people would have engaged with, you would assume, their - the trouble with pregnant Indigenous women here is they might not engage with a service until perhaps the second trimester. That is sometimes the case.

Madam CHAIR: The damage has probably been done by then.

Mr LAVERACK: Possibly.

Madam CHAIR: If they had been drinking.

Mr LAVERACK: If they had been drinking. It is important to make sure they are getting antenatal care as soon as possible. That would probably be a reasonable thing to do.

Madam CHAIR: The question then is, and it might sound silly, but in your experience and knowledge is there an understanding by young girls more than the young boys that unprotected sex will result in a baby?

Mr LAVERACK: Can you ask that again?

Madam CHAIR: Is there an understanding by the young women that if they have unprotected sex - not using condoms - that will result in a baby and if they want to drink …

Mr LAVERACK: They can put the foetus at risk.

Madam CHAIR: Yes.

Mr LAVERACK: Yes, I think so. I think that ...

Madam CHAIR: I am probably asking about their educational knowledge levels.

Mr LAVERACK: Yes, as long as there is education in the school and as long as they are going to school.

Madam CHAIR: Yes, that is true; you have sex education in schools.

Mr WOOD: Anglicare mentioned that.

Mr LAVERACK: There are some good programs from Victoria which have been implemented here. I have done the training. It is Core of Life. I am not sure if you have heard of Core of Life. It was set up on the Mornington Peninsula to target high school students and was a way of introducing education in a role play type format. It makes it a bit more fun to engage in and kids are more likely to look at it. It is sex education essentially - what happens if you get pregnant and what reality looks like when you are a teenage mother and father. That program is from Victoria and has been introduced into Northern Territory Department of Health remote clinics particularly. A number of people in and around Nhulunbuy have been trained in Core of Life.

Mr WOOD: Whilst those programs are good, you have the underlying Yolngu culture which has a lot of other values that are automatic in their society, whether it is skin relationships and the inter-relationship, and behaviour from a cultural point of view. I wonder about programs from Mornington Peninsula because it is a far distance from this part of the world.

Mr LAVERACK: I somewhat agree, but teenagers are teenagers, and the guys here are in tune with the latest trends and latest fashions. They are kids like other kids.

Madam CHAIR: Any other child.

Mr LAVERACK: To a certain extent, but they also have cultural obligations.

Mr WOOD: Is a clash there? I regard this part of the world as having very strong culture.

Mr LAVERACK: It does, and language.

Mr WOOD: You see another culture come in. Do they mesh, are they contradictory or are they improper in that they do not fit this culture? I do not know how that works.

Mr LAVERACK: From what I have seen it fits. The Core of Life program has been well accepted here. A lot of consultation occurred before Core of Life was introduced into East Arnhem communities. A lot of discussion occurred with senior people within communities, and they trod carefully when coming in because they knew there were sensitivities around what could and could not be said. The consensus was to get the program in because teenage pregnancies were happening and that was not ideal - girls as young as 12. That happens nationally. I would be inclined to say teenagers are engaging in sexual activity in the Gove Peninsula and Arnhem Land. Girls as young as 12 or 13 are having Implanon inserted their arms.

Madam CHAIR: That is the contraceptive device?

Mr LAVERACK: That is right, yes. That is a slow release contraception device and it is not there to do anything else other than prevent pregnancy.

Mr WOOD: Does there need to be more education about the effect of alcohol on the foetus?

Mr LAVERACK: I do not know. As long as you have people who can deliver the education, and I think pre-conception teens are your best target audience. If you have good integrated maternal child health services - if you look at the Victorian model, you have childcare centres with maternal child health services on site. They are somewhat integrated and they see people through the early childhood years up until they are 15. They visit schools, undertake immunisations and whatever else. Pre-conception teens are the ones to target for that type of education.

Mr WOOD: Your job is also the general aspects of alcohol and drugs. We had Kevin from Anglicare ...

Mr LAVERACK: Kevin Bird. KB I call him.

Mr WOOD: He said you cannot concentrate just on drinking and pregnancy; you have to look at the bigger picture because alcohol has many more effects - health issues, violence and all sorts of issues.

Mr LAVERACK: Yes, our remit is there are many problems with alcohol in the region, but there are also many problems with other drugs in the region as well. As you know, we look at a range of drugs and their effects and how that affects the public and individuals. We target our strategies towards ultimately reducing the rate of substance misuse and the harms associated with that across the region.

Mr WOOD: From an economic point of view, you get money and as members of parliament we need to see an outcome. How do we know the money spent is improving the lot of people here? Is there a way of showing your program is making a difference?

Mr LAVERACK: You need to look at KPIs. What do you want to see in particular?

Mr WOOD: It could be a reduction in people admitted to hospital. It could be an improvement in the health – which takes a long time - in life expectancy. It could be a reduction in the number of FASD people. It could be a reduction in domestic violence because it is a widespread drug, so many effects in different areas. We have a lot of people working in this area and a lot of money goes into it. Is it making a difference?

Mr LAVERACK: I think a combination of strategies is making a difference. A one-pronged approach does not work; there has to be many different angles to fix the problem. In Nhulunbuy we have a good strategy with the permit system which looks at supply and demand. You then complement that with strong permit committees in each region with community involvement and engagement. Then you need a good alcohol and other drugs service that can identify emerging issues and work out how to address them.

Mr WOOD: Do you have an alcohol management plan for the community?

Mr LAVERACK: Yes.

Mr WOOD: Is that run by a committee?

Mr LAVERACK: The Department of Business looks after the management plan.

Mr WOOD: Does that deal with health issues?

Mr LAVERACK: No, supply and demand.

Mr WOOD: That is all it is about?

Mr LAVERACK: Yes, pretty much.

Mr WOOD: Are permits part of its role?

Mr LAVERACK: Yes, that is right. Myself or a proxy sit on various committees in the region. There is one for Nhulunbuy, one for Ski Beach and one for Yirrkala.

Mr WOOD: That is an alcohol management committee for each one?

Mr LAVERACK: A permit committee essentially.

Mr WOOD: Was a broad committee set up as an accord?

Mr LAVERACK: There is a liquor accord for Nhulunbuy and I have read the document. A lot in it is not being adhered to by members of the liquor accord I have to say.

Mr WOOD: Can we get that accord?

Mr LAVERACK: I reckon you could. Is Brendan Muldoon on your schedule today?

Madam CHAIR: No. Who is he?

Mr LAVERACK: He is the officer in charge at the police.

Mr WOOD: What areas do you think are not being fulfilled or carried out in that accord?

Mr LAVERACK: Responsible service of alcohol.

Mr WOOD: You could ban someone from not getting takeaway - we mentioned before whether a pregnant woman might be banned from alcohol through the permit system but could still go to the bar.

Mr LAVERACK: Yes, there is merit in - it is a fine line, but there are ways around - I have seen pregnant women at the bar in Nhulunbuy.

Madam CHAIR: In Tennant Creek the hotels tend to have self-regulation. If they can see the woman is pregnant they will not serve her.

Mr LAVERACK: That is a great idea. However, a pregnant woman should be able to buy takeaway alcohol for her partner, for example. If my wife was pregnant and I was at home watching the footy - that sounds very chauvinistic - let me paint a picture for you so you know what I mean.

Mr WOOD: It has complications.

Mr LAVERACK: That is right. Just because you are pregnant does not mean you cannot …

Madam CHAIR: You will consume it.

Mr LAVERACK: … buy it. Consumption is a good word. Thank you, Kezia.

Madam CHAIR: The publican who has the Tennant Creek hotel …

Mr McCARTHY: He is the Chair of the accord in Tennant Creek.

That is a good comment about measurement. You could compare Nhulunbuy before the permit system and after. There was obviously a logical reason why a permit system was implemented in this town.

Mr LAVERACK: Yes.

Mr McCARTHY: We have seen empirical evidence in parliament that shows a reduction in what Gerry talks about - presentations to hospital, referral to your services and domestic violence.

Mr LAVERACK: I was a member of the public here 10 years ago - before the permit system - and there is a huge difference in public drunkenness around town.

Mr WOOD: What is the general perception? Do people not like it or accept it and think it is for the benefit of the community?

Mr LAVERACK: The permit system?

Mr WOOD: Yes.

Mr LAVERACK: I think people are agreeable to the system. Not too many people spit the dummy about having to get a permit. It is a pain in the butt when you do not get notification your permit has expired, you try to buy grog and they kindly inform you that you cannot, but that is another matter. My experience is most people are open to it and see it as a good thing.

Madam CHAIR: Do you have to get a permit?

Mr LAVERACK: Yes.

Madam CHAIR: Everyone has to get a permit?

Mr LAVERACK: Anyone who buys takeaway alcohol.

Madam CHAIR: Regardless of who they are?

Mr LAVERACK: Regardless.

Mr WOOD: We had it but you needed your licence. That was the BDR.

Mr LAVERACK: The only inconvenience is pulling out three cards if you use your Everyday Rewards card to get points. The only inconvenience is producing card after card after card.

Mr WOOD: You can get a Thirsty Camel card, and I bet people pull that out when they want the discount the next time they use it.

Mr LAVERACK: Yes, I chose not to have a Thirsty Camel card because I do not need any more encouragement.

Mr McCARTHY: If I lived in a prescribed area could I get a permit for takeaway alcohol?

Mr LAVERACK: If it is a dry community, no.

Mr McCARTHY: What is the difference between a prescribed area and a dry community?

Mr LAVERACK: My understanding is Yirrkala is a prescribed area; the alcohol management plan for that community allows people to purchase takeaway alcohol, but it is restricted. You cannot purchase whatever you want. In Nhulunbuy the system is open so we can purchase whatever we want. If you do something stupid and lose your permit you have to go on start-up conditions where you start with a small amount of alcohol and work up to an open system again if you prove you are not causing problems.

Mr McCARTHY: That clarifies it for me. I am a responsible person, I live in a prescribed area, I have a permit for takeaway alcohol and come into town and purchase it. Where do I drink it?

Mr LAVERACK: At home.

Mr McCARTHY: I can take it into the prescribed area?

Mr LAVERACK: Yes.

Mr McCARTHY: That is very interesting.

Madam CHAIR: If you fly to Darwin and bring back four cartons of wine, is that okay?

Mr LAVERACK: As long as I have a permit.

Madam CHAIR: An open permit. You have to have the permit.

Mr WOOD: Will that be checked when you get off the plane? Is it spot checked?

Mr LAVERACK: I think it is spot checked, yes.

Mr WOOD: Sniffer dogs?

Mr LAVERACK: They check it at Darwin, I believe.

Madam CHAIR: Before you leave?

Mr LAVERACK: Airnorth will. Yes, you have to have a permit to bring alcohol in. If you go to Bali - people expect to bring back duty free and that is okay.

Madam CHAIR: Nicole, do you have any questions?

Ms MANISON: Jason, I believe you said the number of pregnant women in the region who drank was relatively low, is that correct?

Mr LAVERACK: Yes, I would say so. I do not think there is a great deal of pregnant women drinking a lot of alcohol.

Ms MANISON: We have heard some fairly horrendous evidence about other parts of Australia where there is heavy drinking while pregnant. Why do you think you are fairly successful at keeping the number of pregnant women from drinking down?

Mr LAVERACK: It is a couple of things. It might not be the preferred drug of choice for pregnant women. I think there are higher rates of smoking and probably higher rates of ganja use amongst the Indigenous population of antenatal women. I think the drug of choice is not alcohol, and there are some really good antenatal services. For example, the hospital has a good antenatal service, as do the local community clinics in the region. As long as women are accessing those antenatal services and getting good education and strong support from the strong women in those communities they are less likely to drink.

The men, on the other hand, are the big drinkers as well as having polysubstance misuse. I know there are high rates of not only alcohol, but ganja. Ganja and nicotine are huge problems here for antenatal women. I do not think high numbers of antenatal women drink here.

Ms MANISON: Thank you, Jason.

Madam CHAIR: Thank you for your time today. We will send you a draft copy of *Hansard* so you can check it factually. The final report to parliament is due by the end of the year.

The committee suspended.

DJAPIRRI MUNUNGGIRRITJ and DHANGAL GURRUWIWI

Madam CHAIR: Welcome. On behalf of the committee, thank you for appearing before this public hearing into foetal alcohol spectrum disorder. We appreciate you taking the time to talk to us. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be make for the committee, and may be put on the committee's website. If at any time you think some things you want to say should not be on the public record we can go into private session.

Do you have any opening comments? You are an Indigenous engagement officer, correct? Perhaps you could explain what kind of community work you do.

Ms MUNUNGGIRRTJ: I have to go through the channel because I work for the federal government. I had to struggle a bit to get myself into this because of my work role in the community, but most of all my

work was more concerned about whether there were any media here because in my role - I would not speak when there was media here.

Madam CHAIR: Are you with the local newspaper?

Mr WOOD: That is the man from the newspaper. You cannot speak while he is here?

Ms MUNUNGGIRRTJ: No.

Madam CHAIR: That is okay.

Mr WOOD: You might want to come to the public forum.

Madam CHAIR: At 12 o'clock.

Ms MUNUNGGIRRTJ: It is just the regulation I need to play – the code of conduct.

Madam CHAIR: Yes, that is fair enough. The Northern Territory government has similar rules sometimes.

Mr WOOD: My daughter works for the federal government.

Madam CHAIR: He has gone now, so keep going.

Ms MUNUNGGIRRTJ: I have only been in this job now for 11 months now and I am the engagement officer for my community of Yirrkala.

Madam CHAIR: Is that funded by the Commonwealth government?

Ms MUNUNGGIRRTJ: Yes.

Mr WOOD: Which department.

Ms MUNUNGGIRRTJ: A network of PM & C now.

Mr WOOD: Nigel Scullion as well.

Ms MUNUNGGIRRTJ: Yes.

Mr McCARTHY: The GBM, now the government engagement officer, is contracted to local people to work in communities as an engagement officer?

Ms MUNUNGGIRRTJ: No, the IEOs have to work with the GECs like they call that.

Mr McCARTHY: Yes, it is a good thing.

Ms MUNUNGGIRRTJ: Develop them in the field of administration, especially getting you to the level of one day taking over the work of the GEC, and the GEC moves elsewhere. It is a passion for me in this field; I guess I am more advanced than other IEOs in the community, where I can take my expertise into other communities and develop them.

Mr McCARTHY: They are good jobs.

Madam CHAIR: Engagement Officer.

Mr McCARTHY: Yes, it was a good policy.

Madam CHAIR: The kind of work you do, does it involve all community members - old people, middle-aged and young people?

Ms MUNUNGGIRRTJ: It is an engagement.

Madam CHAIR: Everyone.

Ms MUNUNGGIRRTJ: Yes, engagement with all stakeholders, community members and elders in the community.

Madam CHAIR: On issues of health and education?

Ms MUNUNGGIRRTJ: On everything - school, education, employment.

Mr WOOD: You multi-purpose?

Ms MUNUNGGIRRTJ: Yes.

Mr WOOD: You are the department of everything.

Ms MUNUNGGIRRTJ: You could call it that.

Mr WOOD: That is good. You know we are looking at FASD, foetal alcohol syndrome. Have you been engaged with communities in talking about this issue?

Ms MUNUNGGIRRTJ: Before I got this new job I have always been a participant in matters of alcohol, health especially, and in the ways policies are made and conducted in communities. I have always been the front person in my community as a leader, in a woman's leader role in making sure information on the ground is clear to people understanding the non-Yolngu language, which is English.

Mr WOOD: You try to turn that into your own language?

Ms MUNUNGGIRRTJ: Yes.

Mr WOOD: How effective is that? Do people understand FASD in a Yolngu way? Does it make sense to them?

Ms MUNUNGGIRRTJ: I think they do, but Yolngu people have always had a strategy of how we can implement policies to our way of thinking, of looking at them from Yolngu perspective. When I say that, that was passed down from the old people, and there are very few leaders like myself and a few others - probably a handful now - to continue with that straightening of the pathways of what comes into the community that influences outside our own culture.

Madam CHAIR: Like social media and Facebook and all those communication channels?

Ms MUNUNGGIRRITJ: Yes.

Mr WOOD: Do pregnant women understand the dangers? Is that knowledge widespread?

Ms MUNUNGGIRRITJ: To my perspective there is very little of it.

Madam CHAIR: Knowledge?

Ms MUNUNGGIRRITJ: Yes, very little knowledge of what alcohol does to each child inside the mother's womb. Because of the old ways - it is still there, but the younger generation has forgotten who to go to in our culture, where they think everything is okay without even realising what the parent takes affects the child inside. I think there should be more resources put into the community.

One of the good things I have seen is the antenatal program the Core of Life. The Core of Life is the central contact point in the community of Yirrkala. Because I was very much involved from the very beginning of when Core of Life came to this community, we enable the Yolngu people to train up in the field - also going to schools talking with those age groups from 19 down. Also, taking the program itself to the homelands and the school but connecting the culture - what we know and of the western world connected so they can marry and ...

Mr WOOD: You adapted it?

Ms MUNUNGGIRRITJ: Yes.

Mr WOOD: It came in and, according to Jason, it went to the elders to discuss.

Ms MUNUNGGIRRITJ: This is more like starting off with the women. We are just beginning to see men participate in the Core of Life.

Mr WOOD: You can tell us if we are not allowed to talk about something, but do men realise they have a role to play in helping pregnant women with the danger of drinking?

Ms MUNUNGGIRRITJ: Of course they would, but there are certain rules in our culture that ban them from not participating for cultural obligations.

Madam CHAIR: They are married, but there are things preventing them touching or talking to the woman?

Ms MUNUNGGIRRITJ: That has always been a women's thing.

Mr WOOD: They could encourage the woman not to drink, which is not talking about that side of it.

Ms MUNUNGGIRRITJ: Sure, they can encourage the woman not to drink.

Mr WOOD: Alcohol is not a cultural issue; it has been brought in. Reading the history of Maningrida it came from the Macassans before Europeans came.

Ms MUNUNGGIRRITJ: Yes, same here.
Mr WOOD: It is not a cultural thing as such so men could talk about the effects of alcohol?

Ms MUNUNGGIRRITJ: Of course, yes, in mens' meetings, as long as the two, male and female, are not in one room, but separate. There might be a brother and a sister there - it is inappropriate in Yolngu culture.

Madam CHAIR: Women being taught by women and young men being taught by old men?

Ms MUNUNGGIRRITJ: Yes, and old men.

Madam CHAIR: Does Yirrkala have a primary school and a high school?

Ms MUNUNGGIRRITJ: Just primary. The primary is also a bilingual school.

Madam CHAIR: Like any school, it would have health education.

Ms MUNUNGGIRRITJ: Yes!

Madam CHAIR: Do they do health education and sex education in primary school, Gerry, or are they a bit young?

Mr McCARTHY: In Years 5 and 6. It depends on the school and the school council.

Madam CHAIR: We heard from the previous gentleman that some of the young girls get the contraceptive you put in your arm to stop having babies.

Mr WOOD: Do you see many FASD children in the communities affected by mum's drinking?

Ms MUNUNGGIRRITJ: Yes.

Mr WOOD: How does the community feel about them? Are they pushed away because they are different or regarded as mad?

Ms MUNUNGGIRRITJ: It is the choice that person makes.

Madam CHAIR: The mother?

Ms MUNUNGGIRRITJ: The mother.

Madam CHAIR: The mother, but then the little baby ...

Ms MUNUNGGIRRITJ: Of course, the cause could be something else which leads the mother to - this habit of drinking could be so much of - within families of course, a crowded house can be another thing and depression and culture, you name it. That could lead a woman to drink too much.

Madam CHAIR: If she has the baby and it has FASD, do the old ladies and the aunties look after the baby because it is not learning properly?

Ms MUNUNGGIRRITJ: Yes, still look after it.

Mr WOOD: They do not forget about it.

Madam CHAIR: It is still family.

Ms MUNUNGGIRRITJ: No, it still goes under the care of the family. As the child grows older it is always passed onto the grandmothers.

Mr WOOD: One of the problems we have is if a mother keeps drinking, even though they have been told it is dangerous for the baby, generally speaking we know the baby will have FASD and the government, or someone, will have to pick up the cost of looking after that child.

Ms MUNUNGGIRRITJ: Yes. One of the good things with the Core of Life is we have been able to educate them long before it does happen.

Madam CHAIR: Before they have a friendship with a boy and get a baby.

Ms MUNUNGGIRRITJ: Yes.

Mr WOOD: How long has the Core of Life been going?

Ms MUNUNGGIRRITJ: Six years now.

Mr WOOD: Have you seen a change in attitudes?

Ms MUNUNGGIRRITJ: Yes, I have seen it with my own eyes being part of the Core of Life and seeing a difference. Those children, once they are born, even though the mother is not drinking - mums who have been drinking, where you see quite enormous interest now in how the children are brought up. Even though the mother has been drinking they finally realise, 'Hang on a moment, I have a child now'. They have been doing this during pregnancy but not really getting that inside message that drinking is not a good thing for a pregnant mother to be taking on because it affects the child.

Mr WOOD: If a mother kept drinking and was told to stop drinking, or knew if she kept drinking it would increase the damage to the baby, do you think the community could have a role in trying to stop that person drinking?

Ms MUNUNGGIRRITJ: Yes. In our culture often people carrying kids - women - are often taken away from this township to the homelands. Of course, we have 14 different homelands surrounding this region and the Laynhapuy homelands centres, but (inaudible) homelands also has its own health organisation within Laynha which services these homelands.

Mr WOOD: How does that work? Do they encourage that person to go out or do they give them a push along? Has it worked?

Ms MUNUNGGIRRITJ: Yes.

Mr WOOD: We were looking at whether the government had a role. It would be a lot better if the community took that responsibility rather than saying, 'We will force you not to drink by putting you in a house somewhere and you have to stay'. You say the community can do that now?

Ms MUNUNGGIRRITJ: The community can do that now.

Madam CHAIR: In somewhere like Yirrkala or Ski Beach, if young girls were sitting around with friends drinking and having fun, because you are a community engagement officer and she is pregnant, is it okay to say, 'You should not drink' and tip the alcohol out?

Ms MUNUNGGIRRITJ: No, but we can talk to the parents of that person.

Madam CHAIR: They could then take the alcohol?

Ms MUNUNGGIRRITJ: They could be the one. All I could say is, 'Look, do something about this child of yours. Take my advice or leave it.'

Madam CHAIR: The discipline or teaching would come from the parents?

Ms MUNUNGGIRRITJ: Yes.

Madam CHAIR: Not you telling them off. Okay, I am with you.

Ms MUNUNGGIRRITJ: That is going beyond the cultural boundary of my clan groups.

Madam CHAIR: Nicole, we have Dhangal with Djapirri. Do you have any questions?

Ms MANISON: No, I am fine. It is interesting to hear about the strong cultural ties and how you are working together as a community. It seems to be a really effective way of getting messages out to young women about drinking and the dangers during pregnancy. Thank you, ladies.

Madam CHAIR: You said there were 14 homelands; is there some order? Is it like those three are the important ones and that one is less important?

Ms MUNUNGGIRRITJ: No, it does not go like that.

Madam CHAIR: Depends on the family connections?

Mr WOOD: They are all beautiful. I have been there.

Madam CHAIR: I know that, if a young girl was in trouble – it would be the family connection?

Ms MUNUNGGIRRITJ: There are little clinics in the homelands which work as a network. Someone from Laynha goes out and through this they have meetings - women separate and men separate.

Mr WOOD: I visited about three years ago with my wife and was very impressed with some of the homelands. People living out there were healthy. Where they lived was beautiful; they had the crocodile there, and unfortunately the little boy was taken last year.

Ms MUNUNGGIRRITJ: I think I know which homeland you are talking about.

Mr WOOD: They used to feed it on the beach with some fish. I love the idea of helping these people by taking them out bush. I think that clears the brain - the bush, the country, the fresh air, the blue sky and going back to grassroots.

Ms MUNUNGGIRRITJ: That is a place of healing out there. Here there is so much attraction that leads to you.

Mr WOOD: My sisters-in-law are Aboriginal (inaudible) and live at the Daly River. They have always had a healing centre and they get people from here sometimes to go the other side of the Northern Territory.

Ms MUNUNGGIRRITJ: We have a healing centre here too.

Mr WOOD: Do you think healing centres should be expanded, not just for people who drink when they are pregnant - sometimes people have problems in the brain. Some people know they are dying and have gone away to get some peace and solitude for a whole range of reasons. Do you think we should look at expanding healing centres?

Ms MUNUNGGIRRITJ: Yes, very much. Yes.

Mr WOOD: You have one healing centre officially?

Ms MUNUNGGIRRITJ: One healing centre.

Mr WOOD: I thought there was money for healing centres or some program for …

Ms MUNUNGGIRRITJ: It only operated through the Garma Festival, but we want it to continue outside all year around, offering not only to women but men as well. Often a group of children goes out just to listen to a woman talk about healing.

Mr WOOD: I think my sisters-in-law would have it for men and women but separate. If there was a man there were no women; the men could go there, but at a different time to the women. Families could sometimes come.

Madam CHAIR: Does it have a structure like a health clinic, or is it just taking back to culture?

Ms MUNUNGGIRRTJ: Taking back to culture, the one I talk about.

Mr WOOD: All they wanted out there was a shelter with some toilets and showers. They did not want anything flash; they wanted some basic ...

Ms MUNUNGGIRRTJ: Yes, that is what we got at the festival.

Mr WOOD: Is it still being used?

Ms MUNUNGGIRRTJ: Yes.

Madam CHAIR: Gerry, do you have healing centres in Tennant Creek?

Mr McCARTHY: No, but the concept has value.

Madam CHAIR: Do the traditional owners or elders manage …

Ms MUNUNGGIRRTJ: Yes, and are passing that knowledge on to the young ones.

Madam CHAIR: Men for men and …

Mr WOOD: It is used for a range of things.

Ms MUNUNGGIRRTJ: There is not one for men, but women certainly have a healing place. We have always allowed that space for men to go and take that healing. One of the stuff that …

Ms GURRUWIWI: Besides that healing centre, there is a lady I know of who is wanting one to be set up at Yirrkala all year around.

Madam CHAIR: If you had the healing centre you have - some young women go there and stay for a period of time and then go away - can the men use the same centre?

Ms MUNUNGGIRRTJ: Yes, because the area they located for this healing centre to happen at Yirrkala is the healing space where the old tribes of men used to gather. If you ever come across a book called Arnhem Land something, it is a powerful book - *Healers of Arnhem Land*.

Mr WOOD: You had a mandatory alcohol rehabilitation centre at the hospital. If people were picked up three times by police they would have to go there. Do you think that would be better? I think they are starting it up again. Do you think that would be better out bush too? It would be like a healing centre but you would have to stay there.

Ms MUNUNGGIRRTJ: Yes, that is another strategy we are working on.

Mr WOOD: People with an alcohol problem who were given an order ...

Ms MUNUNGGIRRTJ: Not only those that are alcohol, but others as well - getting juveniles who are into mischief into that camp.

Mr WOOD: If you had a court order on someone they could have the option to go bush and would have to stay there dry instead of being at the hospital?

Ms MUNUNGGIRRTJ: Yes.

Madam CHAIR: It could work.

Ms MUNUNGGIRRTJ: It could be somewhere where they could do activities.

Madam CHAIR: That is right.

Mr WOOD: In the alcohol mandatory rehabilitation legislation there are two kinds. There is the one in Darwin which was at the hospital and is now at the old prison, there was community alcohol rehabilitation and they had one at Venndale, Katherine. Venndale is for alcohol, but it is bit too close to the highway and a number of people ran away. Here it is a bit harder, if you are out bush, to run away.

Madam CHAIR: Yes, that is right.

Ms MUNUNGGIRRTJ: But also having those five homelands - something like that in each of the homelands.

Mr WOOD: Yes, you take them back to the country.

Ms MUNUNGGIRRTJ: The traditional people of that land could be operating - often clan groups do not mix well.

Ms GURRUWIWI: Homelands have their own clan nation estate.

Mr WOOD: To some extent it says you take responsibility for some of those people …

Ms GURRUWIWI: The homeland would take responsibility for rehabilitating those people.

Mr McCARTHY: I am from Tennant Creek. I have been a teacher for many years and am now a member of parliament. We have been going to all the regions, and it is great to hear from Yolngu people and community members of Nhulunbuy town.

The government is concerned that the number of children affected by alcohol is increasing, and government is also concerned those numbers are increasing at a dramatic rate in the Aboriginal community. It is a Balanda problem and a Yolngu problem, but the government is concerned it is increasing at unacceptable rates in the Aboriginal community. I am interested to see if Yolngu people have something special they can offer government - this committee - because we have to report to the minister and tell him what we have researched and discovered. The government will then look at providing resources to support this project and help get better outcomes.

Is there anything special from Yolngu knowledge we should know about?

Ms MUNUNGGIRRITJ: I will not talk on that; I will let Dhangal talk on it.

Ms GURRUWIWI: No, especially when I walked in, hearing about the children having that disease; I have seen ads on TV that made me start thinking how we can prevent that. Coming here and listening to Djapirri talk about the healing – I am a person who looks widely, not just …

Ms MUNUNGGIRRITJ: Not just family.

Ms GURRUWIWI: … widely around the community and the issues I see. What came into my mind was young girls coming into maturity at the age of 13 to 14 - nurses from the hospital coming to parents to inform them of the possibilities for them to take contraception.

Madam CHAIR: Education.

Ms GURRUWIWI: Education for the parents and say what it is and how you want your child, especially the young ladies. We cannot predict what their lives will be in the next few teenage years. That is the parent's decision - and relatives close by in that family - to be informed about what we can do about this young lady if she wants to have that.

Mr McCARTHY: Yes, we have heard that from medical people.

Ms GURRUWIWI: This happened way back. When I had my daughter I did not even think about it. Her and her friends spent most of their time in a clinic talking with the nurse, helping her out with anything and finally the nurse came up with contraception. They had no one to turn to. They came home and with much excitement, 'Can you please say yes for us to get this?' Gladly I am going to sign the papers.

Mr WOOD: Tell me if I cannot ask the question, but are they also teaching boys to have respect?

Ms GURRUWIWI: That could happen.

Mr WOOD: That sometimes is not hammered home to boys.

Ms GURRUWIWI: It is the girls that (inaudible) because they are the ones who carry the life within them later on to be in that state. Boys can be educated.

Mr WOOD: Kevin from Anglicare spoke about the right to say no. He also spoke about the Core of Life. Kevin was talking about having respect as well - not just about contraception, but also about no.

Ms GURRUWIWI: It is for the parents, or the young girl herself, to make that decision - whether she wants it or not.

Mr WOOD: There are two people involved is what I was getting at. That person has to have respect for the other person.

Ms GURRUWIWI: Yes. I was thinking about the future of preventing more babies in that situation.

Madam CHAIR: More family education and more community or school education.

Ms GURRUWIWI: When it comes to drinking, that could happen at the community or even on the homelands.

Madam CHAIR: Are homelands meant to be dry? No alcohol?

Ms GURRUWIWI: Yes.

Ms MUNUNGGIRRITJ: Yes.

Madam CHAIR: By law?

Ms GURRUWIWI: By law.

Madam CHAIR: Nicole, Lynne has joined us.

Ms WALKER: Sorry, Nicole, it is Lynne. I was beckoned by Dhangal to sit next to her.

Madam CHAIR: I am conscious of the time. Do you have another question, Gerry?

Mr McCARTHY: That has been raised by medical professionals. It is a very strong point, thank you. Let us go to the next level. Mother and father welcoming children with the support of the family, how do we teach those young people about alcohol-affected children?

Ms GURRUWIWI: As I said, the advertisement I saw on TV is appropriate because I can understand it. It is up to parents or any family members aware of those issues to educate them at home. Children usually ask what that particular thing is - something they see on TV because that is what happens.

Madam CHAIR: Are there enough resources around like posters, booklets …

Ms GURRUWIWI: No, not at the moment.

Madam CHAIR: … in language and video clips?

Ms GURRUWIWI: I have only seen the ad on TV. I have not seen any flyers.

Madam CHAIR: There is lots of money put into do not smoke, quit smoking, ring up this line to help you stop smoking, smoking kills, bad for babies and there is very little for - we know too much alcohol is bad for all of us, but there is not a lot of public material to say no drinking when you are pregnant. There is no propaganda. There are no heroes, no champions.

Ms GURRUWIWI: There is nothing I know of. I have only seen that ad on TV and that is it.

Madam CHAIR: That would be Imparja probably.

Ms MUNUNGGIRRITJ: Speaking in language.

Ms GURRUWIWI: Not only posters, but it can be made into a DVD like the animated thing on TV now. There could be an animated DVD at every rehab centre or even in schools. That is where it starts.

Mr McCARTHY: Djapirri, you talked about cultural protocols. I have been a teacher for many years. How would a Balanda teacher or health worker get involved in teaching this important knowledge to boys and girls? In other words, does it have to be done separately? Do we need to engage …

Ms MUNUNGGIRRITJ: No, for the last two visits from Core of Life they have had a session at Yirrkala School that the men were involved in, but it would not be proper for a Yolngu woman to be talking to the Yolngu men, but with *Ngapaki* women, yes.

Mr McCARTHY: What is that word?

Ms MUNUNGGIRRITJ: White - the woman.

Mr McCARTHY: Whitefella.

Ms MUNUNGGIRRITJ: Whitefella woman, yes.

Mr WOOD: Us mob.

Madam CHAIR: I am conscious of time. Thank you for talking and sharing with us today; it is much appreciated. We will send you a copy of the *Hansard* to make sure we have it correct.

Mr WOOD: We will tell the federal government we have a very impressive Indigenous engagement officer.

Madam CHAIR: You have given me information on a book, and we heard about the Core of Life. We will try to get a copy of that. Thank you very much.

Ms MUNUNGGIRRITJ: We have been able to make DVDs out of the Core of Life program - birthing on country this is.

Madam CHAIR: We will have the public forum now if you want to stay.

The hearing concluded.
