LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

13th Assembly

SELECT COMMITTEE ON A NORTHERN TERRITORY HARM REDUCTION STRATEGY FOR ADDICTIVE BEHAVIOURS

Public Hearing Transcript

2.00 – 5.00 pm, Tuesday, 6 November 2018

Andy McNeill Room, Alice Springs Council Chambers, 93 Todd Street, Alice Springs

Members: Mr Jeff Collins MLA, Member for Fong Lim
Mr Paul Kirby MLA, Member for Port Darwin
Hon Kezia Purick MLA, Member for Goyder

Witnesses: Dr Jeff Brownscombe – Central Australia Health Service
Dr Bernard Hickey – Central Australia Health Service
Dr John-Paul Caciolo – Central Australia Aboriginal Congress
Will MacGregor – BushMob Aboriginal Corporation
Carole Taylor – Drug and Alcohol Services Association
Andrew Scholz – Remote Alcohol and Other Drugs Workforce Program
Merrilee Cox – Mental Health Association of Central Australia

The committee commenced at 2pm

Alice Springs Public HEARING
Central Australian health service

Mr CHAIR: Welcome to the public hearing of the Select Committee. I am Jeff Collins, Member for Fong Lim, the Chair of the committee. Paul Kirby, Member for Port Darwin; Kezia Purick, Member for Goyder and the Speaker of the Legislative Assembly. We may have Sandra Nelson join us. Sandra is the Member for Katherine. She will phone in if she can.

On behalf the committee I would like to welcome you to this hearing into reducing harms from addictive behaviours. In particular, I welcome to the table Bernard Hickey and Jeff Brownscombe. Thank you both for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you both today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and it is being recorded. A transcript will be made available for use of the committee and it may be placed on the committee's website. If at any time during the hearing you think that something that you say should not be made public you can ask the committee go into closed session and we can take your evidence in private.

That being said, could you please each state your name for the recording and the capacity in which you are appearing.

Mr HICKEY: Bernard Hickey, Psychiatrist, appearing for Central Australian Health Service.

Mr BROWNSCOMBE: Jeff Brownscombe, Director of Medical Services for CAHS primary health care. I am also a board member of CAAAPU, Central Australian Aboriginal Alcohol Program Unit. It runs the residential rehab in town.

Mr CHAIR: We have some questions that we will get around to asking you but would you like to make an opening statement?

Mr HICKEY: I am a psychiatrist fellow of the Royal Australian New Zealand College of Psychiatrists and I am an accredited member of the Faculty of Addiction Psychiatry of that college. It is a newish thing that has been around for about three years.

I work in the Alcohol and Other Drugs in-patients unit at Alice Springs Hospital and have done for nearly three years doing some part-time work just one day a week on most weeks in the in-patient unit as the consultant.

I also do some out-patient work at ADSCA, the Alcohol and Drugs Services Central Australia and I am also the Barkly mental health team psychiatrist. I have been doing that for the last two years. I have spent three to five days there every month with the team.

I am appearing here on behalf of the Central Australian Health Service. I have asked my college policy unit to prepare a brief for me, which I have tabled. I will not speak directly to that but it is a background in terms of reference document and refers to a number of other position statements that the college has on addictive disorders.

I have been in Alice Springs for three and a half years. I have worked in Tennant Creek in the 90s for five years and I have worked in addiction work for the last 10 years, recently intensively, and I have worked in rehabilitation services in Melbourne.

I have been involved with the treating services of the Victorian Doctors Health Program that has an addiction component to their program.

On my briefing sheet that I will speak to—it is brief and I can send in a more detailed submission. Just a note about Central Australia which everyone would know in a way but in terms of the terms of reference of the hearing it is a unique and rich and diverse area geologically, botanically, zoologically and culturally, and on a particular note a lot of the three fifths of the population is in Alice Springs.

There is a significant remote population and about 60%, is my understanding, of the whole region population is Aboriginal and the majority of those have English as a second language, so there is the remoteness, cultural diversity and language and cultural factors to take in to account.

There are high rates of poverty, unemployment and crime, particularly in the Aboriginal community. The incarceration rates for Aboriginal males is probably off the scale for anywhere in the world, I suspect, in percentages. A lot of those are particularly alcohol and other substance-related crimes.

To talk about addictive behaviours generally, for me it colours the whole view and the way they sit in our society and culture and the effect they have. There has been lots of work done on this, especially in the last decade or two, with the ability to do functional MRI imaging and see what is actually happening in the brain—what is lighting up and what is not in particular conditions.

They have found that there is an overriding of the brain reward circuitry by chemical or behavioural habits, which is the addictive behaviour—that is the correlation in the brain. By its definition really, the addictive behaviours are a loss of control, often leading to breaking of social rules and crime. So, as an illness, unlike diabetes where you cannot be put in gaol for your behaviour related to your diabetes, for addiction you can. The brain damage is measurable.

Recovery is possible but it takes time and effort and repetition to grow those new brain circuits to override the habitual ones, to learn new skills and override that hard-wired addiction circuitry. Addiction usually develops over a number of years, depending on the drug.

It is classified as a disease. It is not completed, because there are not many diseases like this, both in medical and psychiatric classifications. There is a crossover there. There is a strong evidence base biologically with the brain circuitry and there are genetic-related and environmental vulnerabilities which can increase the risk predisposition.

I will refer, as I have, to the US Surgeon General's report *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs and Health*, from 2016, which is a real overview of the current—or at least it was then and it is still quite new—of the whole area of addiction, cause of the biology and the strategies to prevent and treat it.

It flourishes in situations where there is lack of access to rewards for constructive behaviours, such as in poverty, stress and trauma where, similarly, a person's brain is in a dysfunctional or damaged state—again from the functional MRI imaging. It is a condition, I suppose, a bit like eating disorders and diabetes. It has some commonalities with that disorder. It can be commercially exploited with gambling and liquor.

I was just down at the Todd Tavern. Drug-dealing and pharmaceutical companies can exploit it. They have had to make Codeine just prescription. There is a huge opiate epidemic in the states, started really by pharmaceutical companies encouraging doctors to prescribe. New psychoactive substances also—the synthetic cannabinoids and catecholamines —they are cocaine-like substances. If you are needing a fix you can just go out the door here and see the Happy Herb shop across the street.

Reducing addiction-related harms requires action at all stages. There is prevention—I have gone wide here—reduced poverty and promote the gainful external activity. It is addressing the issues that lead to the vulnerability. Also, reduce trauma and treat it when it is there and reduce and regulate access.

The NT has done some useful things with the Banned Drinker Register and the liquor restrictions in Halls Creek and Fitzroy Crossing, which are older than the recent Tennant Creek ones, which are looking like they are really having a beneficial effect from anecdotal reports from the hospital, doctors, pharmacy and the women's refuge in Tennant Creek. I presume the police statistics would be similar.

In other jurisdictions, they have had blanket bans on the new psychoactive substances; the UK, WA and Victoria. It is unclear at this stage how beneficial the effect of those is going to be. Some of the substances I see in my work here are

showing really dangerous effects and there are reports in the literature of the toxicity causing comas and death and serious mental illness.

Prevention and early intervention, which is in primary care and community drug and alcohol work. Jeff will speak to that. Then, in recovery, this is an area that I have worked in quite a bit particularly at the serious end of the spectrum so it is quite hard work and a lot of changes need to be made to the person's life as a lot of people end up in the justice system.

The NT has justice diversion programs and from my reading of the literature, wherever there are diversion programs, they have always been effective. I have not read of one that has been a failure. The NT COMMIT program, based on the Hawaiian HOPE program, has so far been a success. I do not think they have great numbers on it yet but there are not bad numbers. The Hawaiian HOPE program has been a success, from its evaluations.

It serves as a form of mandatory treatment and mandatory treatment is one of the issues that you might address. There is a history of Alcohol Mandatory Treatment in the Territory which I have found was a bit awkward and felt a bit discriminatory to a lot of people.

I think there is a small group of people where a health professional could say this person has lost their capacity to control this illness, their insight, and they need time for their brain to repair, to get the toxicity out of their body and they need support to have a fair chance at recovery. I think there is room for that.

With the diversion programs, to me it is really important that as far as possible, the offences are decriminalised particularly in use quantities so there is that way back for people to become contributing citizens of the community. Otherwise there is no way back and you might as well just keep using. There is no motivation; you need a carrot and a stick. More carrots than sticks.

There is a need for appropriately trained and qualified staffing. I mentioned the physician health programs, which work on combining a lot of treatment support and sanctions, you lose your licence or you lose your ability to practice or fly in the air if you turn in a failed urine drug test so there is immediate sanction and you have to stop. They have an 80% success rate long-term. The models are there for how to get recovery. It needs to be pretty intensive and it needs to be abstinence based for people in the severe category.

What happens with people, we have the loss of control of use and amounts, and that predisposes to severe relapses. If you are a pilot or a surgeon, then you cannot afford to be in that situation where your risks of severe relapse are elevated and you might be going to surgery in the morning or flying. Abstinence is the aim for the severe end of the addiction spectrum and is well supported by evidence.

Medication-assisted recovery needs to be available when necessary and that is available in Central Australia. It is fairly well done and better done than a lot of other places because it has ADSCA, where you can get counselling and case management support which is good.

The need to treat co-morbidity is coming up more and more with the ice epidemic, which is real, and the psychosis and abnormal mental states that it puts people into, as well as the new psychoactive substances too. I am all for reducing the harms in users with needle-syringe exchanges which is already here. I think overdose kits are available here, I am not sure.

An important thing is the measurement of epidemiology in what is happening, hospital stats and police stats so that we can measure what is there, what we need to do and what the intervention outcomes would be.

Mr CHAIR: It covers a lot of the areas that we are looking at and have had submissions on already. On HOPE and COMMIT I understand the process—the stick approach in terms of if you come back in to the court system you test positive for drugs then each time you do you get a slightly longer sentence and that encourages them not to use so they do not get that.

I also have a problem—you touched on it in your submission—about the Portuguese system and trying to keep them all out of the criminal justice system in the first place. I like their system where you do not go in to the criminal justice system at all you actually go in to a health base system.

There is still some stick approach in there. It is not mandatory treatment but there are some aspects of that scheme where if you throw in a pilot, a doctor or a lawyer or a heavy vehicle operator, one of the sanctions they can apply is to put a restriction on your licence so effectively impinges on your ability to earn your income until you go to have treatment. While they say it is all voluntary there is a mandatory sort of aspect to it.

Mr HICKEY: They are real world things that cannot be avoided—the community safety.

Mr CHAIR: Yes, that is right and makes perfect sense. I am still in two minds—I understand HOPE and COMMIT and the Hawaiian approach and I have seen that but it remains to be seen.

Mr HICKEY: The important difference for me with those is that since previously if someone was on a community program and they had to do a urine test and they failed the test for whatever reason the parole officer would then bring that to a court hearing two months later or something like that, which could be delayed even further whereas

the HOPE and COMMIT program is really immediate and the consequences are immediate. But they are not life threatening so to speak.

Mr CHAIR: It is highly appropriate in circumstances where you have other criminal activity that—it is not the sole reason that you are there it is the possession or use of the drug—so if it is associated with other criminal activity.

The US report, could you talk us through a bit of the surgeon general's report?

Mr HICKEY: It came about, from my understanding, from the severe opiates epidemic in the US. The genesis of that was really a pharmaceutical company that has manufactured oxycodone putting forward a paper saying that pain relief was the first responsibility of doctors.

The risk of addiction in that situation where you are treating pain was fairly low and there would not be so many problems, and they spruiked that with their agents so the rate of oxycodone prescriptions went up and up and found that there were very severe problems with dependence apart from the other substance use problems history that they have had for many years. That led to 30 000 deaths a year. Alcohol still takes 60 000 or something like that.

They pulled together the resources of the US health departments to present the latest in the epidemiology in the neurobiology understandings of addiction and the relationships of genetics and environments and then looked at all the evidence basis for the various interventions—primary intervention, community prevention, access and then tertiary interventional care. It is all there. It is very accessible for anyone on the internet.

I have given a two-page brief summary there on that. One of the things that emphasises is how valuable it is to follow this path of treating it as an illness that is very treatable. That message needs to go to services for government and the community to treat it as such. Treatment is effective. Doing that is so much healthier in outcomes and so much more economical in cost. There is a little cost blurb on the second page.

Mr CHAIR: All right.

Dr HICKEY: There is a Deloitte Access Economics study commissioned, I think, from 2013, on diversion of Aboriginal offenders into treatment programs which found a similar thing. The outcomes were three times better for a third of the cost.

Mr CHAIR: Yes, all right. Bearing that in mind, what do you consider the key elements of effectively treating those addictive behaviours?

Dr HICKEY: In the severe end of the spectrum, it needs to be intensive support and treatment. A lot of people need a residential treatment facility. In the severe end, they need to be aiming for abstinence. The things that are associated most with long-term abstinence in the literature—or the only thing that has really been able to be reported—is association with mutual, peer support programs.

To belong, basically, to AA or NA is associated with a good long-term outcome. People need to be directed towards some sort of peer support thing, either through the justice system or the rehab facility they are going to.

Then there can be the establishment of a long-term recovery community within the community that can support. That is the end-stage. In the primary phases, I really think for Alice Springs, interventions, like those which have occurred in Tennant Creek—particularly the restriction on how much a person can buy per day—is a key factor which could just make an enormous overnight difference to the degree of harms.

Mr CHAIR: For alcohol in particular?

Dr HICKEY: Yes, which is the main one for the harm.

Mr CHAIR: Yes, that is right.

Dr HICKEY: There is a lot of difficulty in bringing that in—politically, industrially and commercially. But from my view of a health professional treating substance use disorders, if anyone needs more than a bottle of spirits, a carton of beer or two bottles of wine a day, then they seriously need to see someone.

Mr CHAIR: Yes. okay. How are strategies and treatment services tailored to meet the different demographics here in Central Australia—Aboriginal and non-Aboriginal people?

Dr HICKEY: Yes. There needs to be a link-up. We try to link up with hospital with the rehabs and the outpatient services and try to get an integrated plan for the person when they come in. Having worked in the remote locations, it would be a real boon. Sometimes, they are not readily available. But that is a really important aspect.

A crucial thing is interpreters and translators and cultural liaison officers in that because, without them, the communication is really difficult. I can ask a person in hospital what is actually wrong, ‘Where is your liver or where are your kidneys?’ They really have no idea. It just has not been communicated well to them.

Mr CHAIR: You say in your work in the Barkly, you spend a week—five days a month roughly—travelling through Barkly.

Dr HICKEY: Yes, three days a month or five days every six weeks.

Mr CHAIR: Okay. Are there any communities that do well in providing peer support in their communities?

Dr HICKEY: I have to say no. What seems to happen is there is a rehab at BRADAAG, and with the rehabs here as well, a lot of people are there as a result of diversion or finishing off their sentence as a pre-release thing. But they think, 'Once I have finished here, I have my certificate and that is it and it is over'.

So, there is not anything beyond that. There is very little. They can see the drug and alcohol worker for an outpatient appointment, but there seems to be a tendency for people to drift off into a relapse and back into a high-risk group—not everyone.

A person can be linked up with family with support. It is really important to find an environment for them to live in that will support their recovery, and abstinence particularly. If a person does not have that, then they are just about doomed. That leads to a big treatment nihilism as well, both for the clients and the staff.

Mr CHAIR: Okay. We heard a lot yesterday in Tennant Creek about treatment. It came across that it is largely about dealing with the end of the problem. You are putting band-aids on the situation. Do you have any ideas about how we can move that and shift it to the other end? What can we do in communities to deal with these problems before they …

Dr HICKEY: Beforehand? Yes. As I have spoken to here, the conditions that lead to such a high prevalence of this availability—there is also poverty, overcrowding, trauma and exposure to that method of dealing with those things. So, if a person starts using substances significantly when they are 14-years-old—I am sure there will be people later on today who will be speaking to that—their risk of having a severe substance disorder from 25 years onwards skyrockets. That is a place to really intervene.

But how to intervene in that? I can only see a change in the family environment. One thing that could happen is if the courts look at their role with the diversion orders and put those conditions on for reporting for a longer period of time. Recovery from severe addiction really is a five-year proposition. After five years of recovery, the risk of relapse does not go up or down. It goes down like that. It is a bit like cancer or something.

Mr CHAIR: Okay.

Dr HICKEY: Once you get there, then they are okay. You are looking at a five-year long follow-up. That is where the mutual support programs are so valuable, because they do not cost anything. It gives people self-efficacy and they are assisting the people who come in. Whether it is an AA, NA or other type of support program, I do not think you can reasonably teach someone who has been through a severe alcohol

withdrawal and has probably a bit of brain damage—which we are seeing all the time at the hospital, in rehab.

For them to come out and drink light beers, then have a glass of water, then have dinner at 7 pm and then stop drinking because they have had enough—it would not be good to drink anymore, it is not feasible. The idea of recovery equals abstinence needs to be up there and support networks for that.

Mr CHAIR: Okay.

Mr KIRBY: You are saying five years is about the time for relapsing and behaviour change. We were listening yesterday to the Tennant Creek people and overcrowding and not putting people back into that environment was one of the main problems that they raised. No matter people's good intentions, once they get back into that environment, it is very difficult.

Mr HICKEY: For sure. Recovery housing would be great. There is a model called the Oxford House model that is freely available on the internet and you can download the manual and their guidelines. The basic thing is that people are in there, it is a shared house and it can be all male or all female. Obviously it can be supervised or assisted and facilitated a bit.

The rule is that you have to be abstinent to be in there. If you become non-abstinent, then you have to leave immediately. That is the one immutable rule. The residents of the house decide in a group meeting whether you have used. It is not based on a drug test, it is just from your behaviour and what they think and how long you need to go out for, whether that be a month or permanently. Recovery housing, support housing, is really crucial.

There is an organisation called SHARC who run the Oxford Houses in Melbourne. Trying to get housing is a tricky thing. I know that Aranda House has a number of houses and they have facilities for various types of programs. I am not so sure about CAAAPUs capacity out there. I know they have some halfway living perhaps out there. It is a progressive and ongoing thing and if there is not safe recovery support out there in the person's basic living circumstances then they are doomed.

Mr CHAIR: Do you want to tell us something about your stuff Jeff?

Mr BROWNSCOMBE: No worries. I thank the committee for taking a look at this issue. It is very complex and I think the best you can do is be informed and take ideas from all different directions. The media likes to come up with simplistic solutions but it is a complex area, it really is. Thank you for that and thank you for the invitation to come and talk.

My broad framework of harm minimisation, which is what we are trying to achieve here, is a balance between supply reduction, demand reduction and harm reduction. They are all relevant and they all have a place. What we are doing is deciding on the balance. As part of my introductory remarks, I will make some comments on each and you may wish to discuss certain things.

On the issue of supply reduction, I favour diversionary programs ahead of a punitive approach. Obviously that has to have an end point. Our prisons are already above capacity and they are not particularly rehabilitative places. In younger people with shorter histories, that is a preferred approach.

On the decriminalisation of cannabis, that is something that should be looked at. It is getting examined and various models are being tried around the world. I do not think it is appropriate to see someone have the criminal justice system come down too hard on them for possessing enough marijuana for personal use. Mind you, I think we have to be serious about people who deal and engage in destructive behaviours like sly grogging and that sort of thing. Those behaviours should be reined in.

At a local level, one of the best supply reduction measures is when communities come up with their own alcohol management program. Having been around during the days of the intervention, there are good and bad approaches. The most effective ones are those where there has been community consultation and community ownership of the program.

Whereas top-down approaches might deliver some benefits, ultimately they are quite disempowering, create a different set of problems and are not as sustainable. Those are my comments on those.

On demand reduction, I would like to state my case that I do not agree with mandatory treatment. Having said that, there are degrees of mandatory treatment. To some degree, there will always be elements in that treatment in our alcohol and drug treatment system. The reality is unless people have restrictions on them in access to their family or pending gaol time, they would not have the motivation to change sometimes and recognise how imminent the situation is.

There is certainly need for these kinds of processes. But the political side of things aside, I look at it just from a clinician's point of view. The evidence establishes very clearly that the people who benefit most from alcohol and drug intervention are the people who are motivated to change. There is a cycle of change in addiction where you are at. It is a level of insight and motivation to change. People who are at the point where they are wishing to change are the ones who gain the most from intervention.

I make the point that we already have scarce resources in the alcohol and drug sector. Let us use them for the people who will most likely benefit clinically, is my view.

Education is very important. You could say a lot on that. One point I make is we should have a very strong focus on pregnancy, because foetal alcohol syndrome and its variants is a major issue in the NT in learning and behaviour issues and criminal behaviour. We are becoming more aware of it, but there is more work to be done in that space.

In alcohol and drug services, there is a need for a broad range of services. Bernard has mentioned the abstinence model. There are a lot of different agencies and they offer slightly different things. Diversity is a good thing. We need more services, not less. Alcohol and drugs and mental health need to be integrated, as well as government sectors in the health service and beyond.

There should be some consideration given to the fact that a lot of people who run alcohol and drug services are Certificate III and IV level people. Essentially, in a lot of these NGO services we have, people come in and do a certificate and get their skills up, but if you compare it to other health sectors, there is probably relatively fewer, more qualified personnel. Qualifications are not everything. Empathy, good intent and a range of other personal qualities which they can bring are important.

I guess we are dealing with very complex clients who often have concurrent mental health issues and some significant emotional issues. There is certainly a place for more people with the kinds of qualifications and skills that can sort through them clinically.

In service gaps, it would be good if there were more services for employed people. We wait for it to get to the severe end of the spectrum before treating sometimes. If you could have some more services for families. For instance, in CAAPU, they go in as individuals. They go through a rehab program. They certainly learn some valuable lessons.

You made the point earlier about going back into the old environment. In some ways, if they could practice those skills in the family environment, and learn to work through not just the triggers for drinking, but triggers for getting angry with their partner or losing patience with their children—having that supported environment to build those skills would be a useful addition to our treatment services.

Primary healthcare is a place where most of our early intervention happens. It is the most cost-effective way to achieve lasting effects for people. It is interesting. The evidence base in alcohol and drugs is a complex discussion. But interestingly, a brief intervention from a professional in primary care has very strong evidence for impact compared to other more expensive interventions.

It is good to look at treatment—tertiary services—but it is also good to keep renewing our focus on primary care. It is where most people interface with the health system.

We have better opportunities to intervene earlier with a large number of people. Doing that is about expanding our specialist AOD workforce within primary health care.

You are going to hear from Andrew Scholz who is involved in the remote alcohol and drug workforce that operates out of Alice Springs but is Territory-wide. I was involved in the early days of the establishment of that service, upskilling primary health care staff in understanding and dealing with alcohol and drug issues.

I remember 10-15 years ago, often primary care staff did not want to touch mental health, because that was not their thing. Over time, we have reinforced key messages, built confidence, built capacity in the sector and we do risk assessments really well in mental health.

It would be great if in five or 10 years' time, we are looking back and saying people actually have a really good framework for assessment and management of alcohol and drug problems presenting in primary care; people who still might be at a good level of function and have a lot to gain from early intervention.

The final point I make is about orientating our models of care or treatment to being aware of the trauma that people have experienced. I mean trauma more in an emotional sense but there is a broad range and it sounds like you have touched on that in your time in Tennant Creek and no doubt elsewhere.

I am thinking more about Aboriginal people here but it applies to non-Aboriginal culture as well. There is a lot of embedded pain that crosses generations and is very complex and difficult to work through and that in a lot of ways lies at the root of the drug and alcohol issues that we have. We can start to make inroads into addressing that in a more proximal sort of way.

It sounds corny to talk about healing camps and group therapy but I actually think it has merit. It has to be done in a really mindful way but if we started talking in those terms and I suppose, bringing an awareness of that being the root of the issue, in a lot of instances, to our work would be beneficial. It might take a little bit off the judgemental route that we can sometimes find ourselves on. It might help us to find compassionate spaces. It is not a criticism of people out there working in the field. It is difficult for everyone.

Mr KIRBY: It is more a societal issue, a judgemental issue that you are speaking about. You are right, there were people yesterday that spoke about the generation and if that has had …

Mr CHAIR: That intergenerational trauma that you are talking about.

Mr KIRBY: And if that has led to the generation of people that have got the drug and alcohol problems. There was some conversation yesterday about if we can fix one

without addressing the other. I think we are in the space where we have to attack them both at the same time now because we will just lose another generation otherwise.

Mr CHAIR: The other thing is, we are not going to fix everybody's problem but we need to get started on those sorts of things.

Mr HICKEY: I have a left of field suggestion.

Mr CHAIR: I love left field.

Mr KIRBY: It is why we are here.

Mr HICKEY: Any prisoners with a substance use related disorder, which is often associated with family violence, instead of working at the tip or somewhere every day, they come one day a week, they go to their house and spend a day there cleaning up the house and the garden in front of their family and kids. Just as a way of creating benefits in all sorts of ways.

One of the things I have noticed about Tennant Creek is the main street is always very clean and tidy.

Mr CHAIR: Because they are always working.

Mr HICKEY: Because the work camps go through there every morning. I think that keeps them belonging to the community a bit and contributing.

Mr CHAIR: We heard a bit about coordination yesterday as well; a lack of coordination amongst service providers. Are there any suggestions on improvement for that?

Mr BROWNSCOMBE: It keeps going around this discussion. There used to be a regular monthly inter-agency meeting. Is that still happening?

Mr HICKEY: I am not sure.

Mr BROWNSCOMBE: I do not think it does. It is difficult. One definite improvement could be follow up after people have attended rehab facilities. People tend to get put out there and not necessarily follow it up through primary care as effectively as they could. There is a need for increased inter-agency coordination. That is true.

Better interfaces with the AOD sector and other sectors in health as well and beyond obviously—police and justice.

Mr HICKEY: It is about the disease model that is a chronic problem for a person and they are going to need support and appropriate interventions for a long time, especially if they are more severe and of the spectrum. It is good for them to have a link. The

primary care is follow-up and maybe that is a thing we miss out a little or we just do not think is there if we are seeing someone who is from a community and they are going back out.

Around town there are a lot of different services that we link up with and we have a person who does the linkages and from the hospital that seems to work reasonably well. Post rehab could be more difficult. I presume that Central Australia Aboriginal Congress has a lot of follow up and we certainly refer back and forward and have a weekly meeting with them and with the psychiatry department in the hospital to talk about common patients.

But I only heard about Jeff last week. I do not know whether that is relevant to that but it could be better.

Mr CHAIR: We will bear that in mind. We need to move on but I just want to ask—we were talking about decriminalisation before—in terms of a barrier for people seeking treatment and coming forward and seeking voluntary treatment, do you think that the criminalisation of drugs is an impediment to those people?

The fact that at this point in time personal use of drugs is criminalised, do you think that is an impediment to people coming forward and seeking treatment?

Mr BROWNSCOMBE: I do not think it is the biggest impediment personally. It is probably not nothing but at the end of the day it is pretty clear health personnel are bound by confidentiality. I have never heard an anecdote of a doctor—a patient leaves a room and the doctors, the cops and says this bloke is smoking marijuana.

The health services seems a safe haven for people with those kinds of issues. I would hope so. People whose state of mind often is a little disordered can certainly have paranoid thoughts. That is certainly a mistrust in the mainstream services generally which is complex to pick apart.

Mr HICKEY: On the Portuguese model that they have decriminalised with the point of reducing the stigma associated with substance abuse, there may be levels at which we cannot account for the fact that the people are not coming forward because they want to keep it a bit hidden. You do not really want to admit that you have a problem.

Whether criminalisation has something to do with that, certainly for illicit drugs it possibly does—I want to keep my ice use quiet, and certainly for people in professional situations as well. It has come up in terms of mandatory reporting for impaired doctors. If I know a doctor, for example, is impaired by substances then I am mandated to report him to APRA.

There are questions about whether that is a good thing because a doctor will really try to keep it as secret as possible and will not be able to seek treatment for that condition.

Mr CHAIR: Thank you gentlemen. It has been a pleasure.

The committee suspended.

Central Australian Aboriginal Congress

Mr CHAIR: On behalf of the select committee, I welcome you to the public hearing into reducing harms from addictive behaviours. I understand you are Dr Jon-Paul Cacioli?

Dr CACIOLI: Yes, good work.

Mr CHAIR: I welcome you to the table to give evidence to the committee. Thank you for coming. We appreciate you taking the time to come and speak to us today and we look forward to hearing from you.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and is being recorded. A transcript will be made available for use of the committee and may be put on the committee's website.

If, at any time during the hearing, you are concerned that what you will say should not be made public, you can ask the committee to go into closed session and we will take your evidence in private.

Could you please state your name and the capacity in which you are appearing?

Dr CACIOLI: My name is Jon-Paul Cacioli. I am clinical psychologist and the Social and Emotional Wellbeing Manager for the Central Australian Aboriginal Congress.

Mr CHAIR: Thank you. We have a brief submission from the Congress. Would you like to make some opening comments?

Dr CACIOLI: I have some opening comments. The Central Australian Aboriginal Congress works in primary healthcare, providing services to some 13 000 Aboriginal people in Central Australia in Alice Springs, including some of the remote communities. We see alcohol as a significant issue for Aboriginal people in Central Australia. Congress has had a big involvement in attempting to address some of these issues.

As was mentioned before, primary healthcare is the level where a lot of people will interface with health professionals, so we see it as an important platform to offer comments across all areas of health and mental health.

Mr CHAIR: You say alcohol—we appreciate that. Government has implemented the Riley review and undertaken to implement the vast majority of the recommendations coming from that—without wanting to understate that. What other drugs are in your Aboriginal communities? Have you …

Dr CACIOLI: Alcohol is the primary. There is use of marijuana which occurs. Usually comorbidity with alcohol. Ice is present but there is a lack of data really of what the prevalence is. It is still our view that alcohol is the primary drug that causes damage to the community.

Mr CHAIR: We have heard of multidisciplinary non-residential treatment model for Aboriginal clients that was developed by Congress. Can you provide us with an overview of your model?

Dr CACIOLI: Yes. Congress uses a three-streams-of-care model where we view we have to treat the clients in a holistic way. That means medically, psychologically, socially and culturally. We know addiction has a biological basis. It is a chronic relapsing disease. We also know that it is largely a social and health issue and there is a high level of social factors which influence the onset of addictive behaviours, as well as perpetuate them.

If we are just treating one aspect, we will not have sustained change. We will not make a large amount of difference. It was talked about before—overcrowding with housing. We have financial issues, transgenerational and intergenerational trauma, historical traumas. We have co-morbidities in terms of mental health and chronic disease. We have a whole range of factors which really lead to addictive behaviours starting and continuing.

From our three streams of care model, we try to address all those areas so we have GPs and other allied health professionals, clinical psychologists, other psychologists and mental health social workers, and case managers who are at a minimum Certificate IV trained so they can provide intensive case management, address their social needs, see what we can do in regards to housing and finances, try to stabilise them there and at the same time look at their psychological health and treat their medical health.

That also includes pharmacotherapy for substance use as well. There are a range of drugs available to help treat addiction and in some cases they indicate it and they can be very useful in conjunction with other forms of treatment.

Mr CHAIR: How is your access to those?

Mr CACIOLI: They are fine. We have access to their medication and we do have GPs at Congress who can prescribe that medication. They are asked if there are any health conditions that might prevent different people from being suitable for that medication. It is one part of the picture. Having a multidisciplinary approach allows us to provide a holistic approach and give the client the best chance.

In addition to that, we are providing support to CAAAPU, one of the alcohol rehab programs. People go there for a two month program. We send in psychologists who provide the therapeutic one-on-one intervention as well as group programs, the CBT-based therapies. We are working with the rehabs while clients are there. We will follow them out into the community when they are discharged.

That breaks it down bit—Congress does service a number of remote communities but not all of them obviously. Sometimes people will be discharged and return home to a community where we are unable to provide support. Sometimes there may not be the resources needed in that community to continue therapy.

Mr CHAIR: What sort of communities are you talking about there?

Mr CACIOLI: There is a whole range of them like Utopia, Haasts Bluff—sorry my list is not mentally very good. Sometimes there are clinics that are based there that we can liaise with and sometimes remote AOD will have workers there that we can liaise with. That is really good but it is not always the case. Sometimes— I have spoken before—when people do finish rehab sometimes they feel they have their certificate and do not want ongoing therapy and they disengage at that point.

Mr CHAIR: And funding?

Mr CACIOLI: We are funded from various sources, federal and Territory. Most of this funding is in cycles. There are disadvantages to that because some of them are two year cycles, some of them are three year cycles, so we are continuously advocating for ongoing funding to provide a service.

There have been programs which have been funded in Central Australia and then de-funded and that obviously impacts the clients. There are a lot of examples like Night Patrol, which we do not handle, but they have been funded for periods and then de-funded and then re-funded. Sometimes no one is actually sure what services are currently running.

Mr CHAIR: I have heard the same thing up in Darwin.

Mr CACIOLI: That lack of consistency also makes it very hard in terms of long-term future planning, particularly when he have short-term funding cycles.

Mr CHAIR: What are the main barriers that you see to Aboriginal people accessing and completing treatment programs?

Dr CACIOLI: First, in some Aboriginal families there is a lot of chaos. It can be very difficult to attend regular appointments. Their situational crisis and other things take precedence over coming to address an AOD issue. AOD is often a coping mechanism for a range of other things which are occurring so we have to make sure that when we are addressing the alcohol use we are also providing the skills to deal with the things that the alcohol is helping support them through essentially.

Transport can be a barrier, education can be a barrier. We have to make sure services are flexible in terms of their delivery and have a trauma-informed approach—understanding a lot of the historical context. Dual diagnosis issues where previously people have had to go here for their AOD issue, there for their mental health issue, there for that appointment—it just becomes overwhelming for the individual to have so many different areas that they have to attend that they burn out.

Mr CHAIR: We heard a bit about poverty and hunger yesterday.

Dr CACIOLI: That is the other issue. If we do not address those core basic needs that people have with housing and hunger and poverty other things do not seem as important. No one is going to come and get their mental health needs addressed when they are trying to address what they are going to eat that day.

Aboriginal people are not a homogenous group, that is, different people and different circumstances but there are a lot of people in that situation.

Mr CHAIR: Another addictive behaviour is gambling. Do you have much to do with gambling?

Dr CACIOLI: We will treat people. We get referred people for gambling who have disclosed to their health practitioner. We will get a referral for that. We do not have any specific gambling programs. However, gambling can be treated much like any other addictive behaviour. It utilises the same brain pathways and very similar strategies can be used to treat gambling.

Gambling does have a significant impact on families. There is a high expenditure here and that obviously then eats into money that could be used for food and other things. There are various mechanisms that evidence for certain mechanism that can assist with that.

Obviously the restriction of how many poker machines and gambling avenues are available, but also things like being able to preselect an amount that you are willing to use before you start gambling, that is shown to have efficacy as well. It is a bit hard in the moment as you are losing or chasing to actually make rational decisions. But if you

preselect before going in to that behaviour there tends to be a better element of control.

One of congress's big areas is early childhood intervention. There is a lot of cycle of behaviours which is occurring and through addressing children through developing education and positive behaviours and parenting strategies in those early years we can prevent people from going down the pathway of addictive behaviours and other negative behaviours.

Mr CHAIR: Have you developed any program specifically for young Aboriginal children?

Dr CACIOLI: Yes. Congress has the preschool readiness program which does assessments and intensive training to get young Aboriginal children ready for preschool. There are cultural Aboriginal children who are not at the right educational level to attend preschool.

Essentially when they start school they are already behind because they have not had the same experience of being read to and of the educational behaviours so this program helps get young children ready to enter preschool and then school and that has been shown to have some good outcomes.

We also have set up the neurodevelopmental assessment centre where we have some neuroscience OT speeches and working with the hospital paediatricians to identify neurodevelopment disorders such as ADHD, FASD, and a range of other learning issues, which will impact upon the child as they progress through school.

We know that in the forensic system there is a high number of people there who likely have a neurodevelopmental disorder, which impacts on their need to engage with some treatment and diversionary behaviours.

Mr CHAIR: Do you have that assessment tool going?

Dr CACIOLI: Yes. That has been set up for about a year and we are running at the moment.

Mr CHAIR: So, if you identify a child who has FASD or ADHD, what happens then?

Dr CACIOLI: We work with the hospital. They will get the diagnosis. We will be able to work out recommendations as to how the child will be supported. That can be used for the schools as well as for the parents. There is a lack of behavioural support programs after that.

There is no funding really set up for it. But NDIS has options for behavioural interventions. NDIS will not fund, it is a pay-per-service type system essentially.

Without idea of what the current prevalence is, we will not have services stepping into the area to provide those treatment elements.

Mr CHAIR: Do you have such providers who are ready and able to provide those services?

Dr CACIOLI: Not currently. These are intensive treatment programs and there is a need for them …

Mr CHAIR: You at least identify …
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Dr CACIOLI: We are identifying them. We are doing some intervention at our programs, but there needs to be more investment in them.

Mr CHAIR: Thanks. It is interesting. It is something, again, that came up yesterday.

Dr CACIOLI: It is a problem across the whole Territory. Again, it is still relatively new. Everyone knows it is an issue, but having actual assessment centre based in the Territory has not happened recently. We have had a lot of fly-in, fly-out professionals who have done assessments for various poor cases or educational needs.

Sometimes, these professionals are not always as educated with some of the context core elements that affect Central Australia, particularly in the assessment of Aboriginal people. A lot of the norms for the test—there are not any norms for Aboriginal people. They have all been done on generally Westernised populations. So, it needs careful interpretation.

Mr CHAIR: What about education? You mentioned before about alcohol and pregnancy and the like. Do you have any programs that …

Dr CACIOLI: Yes. Congress has the public health division, and as part of that, we do a lot of health promotion activities including FASD, AOD and mental health. We also have the tobacco program. We do a lot of educational activities, both here in the prisons as well out in the communities.

We are very strong believers of the need to educate. Then we have incidental education and brief interventions. As people engage with primary healthcare, they will be screened and will be given a brief intervention at that point, as well as a referral to SEWB for additional support.

Mr CHAIR: Okay. Anybody have any questions?

Mr KIRBY: With the transient nature of community people now, it is a lot easier for everyone to get around. Does that create some issues for treatment, for identifying, or for family groups?

Dr CACIOLI: It can create issues in that premium addiction is an ongoing process. People come and engage for a little while and leave. They may not always have the resources they need or the ongoing support—they are moving from place to place. Sometimes there is not that ability to hand over to another service to work with the person while they are out in community. It can cause barriers with people who will come directly for a while, then we do not know where they have gone.

They have disappeared after a while and they have gone back out bush. Sometimes though that is a good thing. Sometimes there is a lack of access to alcohol and other drugs where they go and that can be positive. Some people tend to engage in more of those drinking behaviours when they are in town as opposed to when they are out bush. Each individual is different.

Mr CHAIR: Overseas and in some Australian jurisdictions there is some evidence of a shift towards treating illicit substance abuse as a health issue rather than a criminal issue. What effect do you think decriminalisation of illicit drugs would have on substance abuse in Aboriginal communities?

Mr CACIOLI: I think it being viewed as a health issue and a social issue is very important. It being a criminal matter where people are sent to prison or have excessive punishments placed on the individual for their use does not support the individual in their recovery. There do need to be sanctions in place to some extent. However it should not be a criminal matter unless you are talking about stealing and other aspects but individual use should be viewed as a health issue and addressed as such.

Mr CHAIR: This is a slightly different one, taking a different step: equally there are other jurisdictions which are legalising the use of the cannabis. What effect do you think the legalisation of cannabis would have on substance abuse in Aboriginal communities?

Mr CACIOLI: I am not sure actually. I am not sure if I can comment on that. It would probably increase access in some cases where certain drugs are harder to access in some communities and legalisation would allow for easier access to those drugs. Anything around that needs to be coupled with education on the potential side effects of any drug use.

Mr CHAIR: Thank you for that. Anything else you would like to say?

Mr CACIOLI: I will just check my list.

Mr CHAIR: It is okay, I have been doing the same.

Mr CACIOLI: The big thing is holistically, the three streams of care, early childhood intervention is very important in addressing the social issues which underlie addiction in Aboriginal people including building up self-efficacy and dealing with racism.

Mr CHAIR: You have given us some great stuff. Thank you very much.

The committee suspended.

BushMob Aboriginal Corporation

Mr CHAIR: Welcome, I am Jeff Collins, the Chair of the Select Committee. We have Paul Kirby, Member for Port Darwin and Kezia Purick, Member for Goyder and Speaker of the Legislative Assembly.

On behalf of the committee, I welcome you to the public hearing of the select committee into harm reduction strategies for addictive behaviours. I welcome Will MacGregor from BushMob to the table to give evidence to the committee. Thanks for coming in and meeting with us. We appreciate you taking the time to speak to the committee and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee applies. This is a public hearing that is being recorded. A transcript will be made available for use by the committee and it may be put on the committee's website.

If at any time, you are concerned that what you will say should not be made public, you may ask the committee to go into closed session and take your evidence in private. Can you please state your name and the capacity in which you are appearing?

Mr MacGREGOR: Will MacGregor, CEO of BushMob Aboriginal Corporation.

Mr CHAIR: Thank you, Will. Would you like to make an opening statement?

Mr MacGREGOR: Yes, I would. I am really glad I have a hearing aid; that is one thing. The other thing was that I was looking at ABC News today and I was looking at a tsunami that is going to hit Darwin. Have you seen it?

Mr CHAIR: No I have not.

Mr MacGREGOR: Beautiful graphic. I work with young people affected by alcohol and other drugs including volatile substance abuse. I think that is the future in terms of young people coming through. They are going to have significant issues.

Mr CHAIR: As a result of the use or do you think their use is going to increase them?

Mr MacGREGOR: Inconsistent policy, short-term policy making that is not conducive to long-term, intergenerational issues. I would like to flag a program quite a while ago that was very effective and made some inroads and that was the Living with Alcohol program, using exercise, which is not allowed anymore.

Mr CHAIR: That was where it fell over unfortunately.

Mr MacGREGOR: The fundamental structure of that framework is sound. Obviously it needs to be adjusted to meet the times but from my own experience and other experience and readings, it was a coherent framework: whole-of-government, not-for-profits, whole of community, as far as is possible for an initiative like that.

In between then and now there have been short-term, consumerist policy decisions about alcohol based on public hysteria. Aboriginal people have been unfairly targeted throughout the process going way back to the 50s. Young people are part of that too. They run amok in Alice Springs, Darwin, Palmerston and Katherine and everywhere else.

In terms of the recommendation of the Riley report, there were not that many about youth apart from young people with acquired brain injury, special needs or suffering from Foetal Alcohol Spectrum Disorder should be in a secure care facility.

There was discussion about diversionary programs on site. There are not many. My organisation has tried some without any support.

Mr CHAIR: Okay.

Mr MacGREGOR: I am referring to Loves Creek Station, which was—I do not know—a con in my view …

Mr CHAIR: Okay.

Mr MacGREGOR: … set up to ameliorate the Royal Commission. We certainly had zero support from the Northern Territory government, which is why we gave the money back.

Ms PURICK: To the NT government or Commonwealth?

Mr MacGREGOR: I beg your pardon?

Ms PURICK: To the Northern Territory government or the Commonwealth?

Mr MacGREGOR: To Territory Families.

Ms PURICK: The Territory. Okay.

Mr MacGREGOR: It was all run out of Darwin.

Mr CHAIR: Okay.

Mr MacGREGOR: It was also run by traditional owners from that place.

Mr CHAIR: This is the one up Yuendumu, is it?

Mr MacGREGOR: Loves Creek near Ross River Homestead.

Mr CHAIR: Yes.

Ms PURICK: No, other side.

Mr CHAIR: Other side, is it?

Mr MacGREGOR: This side. We have done cross-culture healing treks with Santa Teresa community—eight of those. It is very difficult to get funding for alcohol and whole-of-community initiatives. We operate as one of the few drug and alcohol agencies for young people. There is one in Darwin called CAAPS. Mount Theo is a brilliant program but the Warlpiri triangle mob have dealt with a lot of their petrol sniffing and particular issues.

We receive young people from all over the NT because there is nowhere else to go. There is CAAPS or us. There was a youth program at BRADAAG that was shut down.

Foetal alcohol—I remember the beginning of the discussion a couple of years ago. I do not know, nothing much seems to be happening. I estimate that at least 20% of our young people have spectrum …

Mr CHAIR: Disorder.

Mr MacGREGOR: Yes. When I assisted on programs and when I have trained in that area et cetera, one thing is security is a major issue. Any initiative needs significant time with evaluation from the outset—day one—and benchmarks. We have never been able to get that or do that.

We have been reviewed a number of times, but it is pretty ad hoc. Most of our data goes to the Commonwealth via the Territory Alcohol and Other Drugs mental health mob now. It does not actually capture what is happening. It is very mainstream.

The facilities for young people—ours is not suitable. It is the old Centre for Appropriate Technology training building and precinct. It is a bit like a rabbit warren. We would really like to work further with family—as in the whole family, as it is a whole-of-family issue. It is a lot better than the house we had at DASA—four-bedroom house. It is a lot better than the back of a troop carrier and swag, which we did for the first six years.

Mr CHAIR: Yes.

Mr MacGREGOR: I have been told that our funding will possibly be signed off on for five years next June. Who knows?

Ms PURICK: NT government funding?

Mr MacGREGOR: Yes. We are also funded by the Commonwealth. There seems to be not a coherent dialogue between the NT and the Commonwealth. A reflection of that is the Indigenous Advancement Strategy funding round where, if I was a big not-for-profit—one of the mega ones—I would probably have a good chance of getting some of that funding for discrete programs across the country, whereas places that really need it either get not much or miss out.

A lot of programs have been shut down over the years here that I am aware of—and Top End. Have to come back to youth all of the time. The main age group we are getting—say in the last year—12 to 16—a lot of that is dual poly drug use—if I cannot sniff petrol I am going to drink grog, if I cannot drink grog I am going to smoke ganja, if I cannot smoke ganja, whatever else.

It is also modelled in our whole community not just Aboriginal communities. We are all aware that a lot of problem drinkers, Aboriginal problem drinkers, are drinking out here because there is nowhere to go beginning with the intervention and the changes to where you could and could not drink and so on—and not being able to drink at 16 Mile Gate and get hit by a car.

The other part of our service is white kids and other—mainly seen by our outreach guys. Very rarely do they want to come in—so that is visits at home and talking to mum and dad—which has been quite effective.

Going back to diversionary, you do stuff like—one of the health bosses gave us $80 000 for 12 months to repatriate young people from say Yirrkala that have been through our program. They finish around the same time, you drive them home, you stop at Tennant Creek, Tea Tree, Katherine, Borroloola or wherever and you see young people that have already been in the program—parents, police, teachers and health workers and so on that are defunded after 12 months. We did 18 trips I think it was.

There are a lot of agencies that come up with good little programs but there is no cohesion around the planning, around the effectiveness of what is working and not working. That is why I was saying about 'Living with Alcohol', I do not care which government it was—I am apolitical—but it was a good framework.

Mr CHAIR: You will find that there are supporters of that program on both sides.

Mr MacGREGOR: It was bipartisan.

Mr CHAIR: It is just the funding model for it unfortunately …

Ms PURICK: 1992; 2002.

Mr CHAIR: Lost out in the High Court unfortunately and we are stuck as a Territory government.

Mr MacGREGOR: In terms of this discussion, harm reduction is not punishing—as in going after the baddies.

Mr CHAIR: No. That is right. It is about trying to find out what the programs are that do work. What you say about funding is a message that has come through from a number of people and that seems to be an incredible frustration that you must have to suffer.

Also the assessment of programs that start, do not get assessed properly, stop, get defunded—coming from somebody who does not work in the area it must be almost impossible to deal with.

Mr MacGREGOR: The other side to funding is we get requests from all over Australia every week for placement, ice or whatever. We are allowed to have a couple a year. It is not written anywhere. The department lets us do it because it keeps us in the black one day a year when we are in audit—$360 a day which is based on actually operating costs compared to $800 or whatever at the juvie and other states—so we could theoretically cut our funding reliance on NT and Commonwealth through that type if we were allowed to do that.

I have heard many times over the years we should be looking at a business model and we all have to come up with strategic plans and business models and it is bullshit—I beg your pardon.

Mr MacGREGOR: There are a lot of programs that could do that. There is another issue about young people. We have employed 60, 70 young people who have been through our program, who do not have Year 12 or any qualifications, but they would like to have a go.

We put them on as casual—the same rates as any casual under our EBA—and whatever training we do, they do, with a qualified staff member on their shift. It gives them something to put on a resume—a break—a look at what it is about and opportunities elsewhere.

Mr CHAIR: Absolutely.

Mr MacGREGOR: So, they have stayed from 10 minutes to two years—that type of thing.

Mr CHAIR: Okay, yes.

Mr MacGREGOR: There is no written contract to scare the hell out of them, apart from the casual one-page thing. It should be part of every NGO that is funded by the NT government outcome measures. It is creating a local workforce and you can imagine there are inherent—for people who are risk averse, it is hard. We do not get any support for that at all. We used to via the Commonwealth, briefly.

Mr CHAIR: When you talk about other individuals paying to be part of it, where do they come from?

Mr MacGREGOR: Hey?

Mr CHAIR: Where were those prior to that time?

Mr MacGREGOR: The young people from here?

Mr CHAIR: No, you were talking about the ones who came up. I think some from Western Australia or somewhere come up.

Mr MacGREGOR: Oh, yes. WA, South Australia, Victoria, Tasmania, Queensland …

Mr CHAIR: Are they the government …

Mr MacGREGOR: … Singapore.

Mr CHAIR: Are they correctional facilities referring them to you, or are …

Mr MacGREGOR: Correctional, youth justice, other, welfare …

Mr CHAIR: Okay.

Mr MacGREGOR: … large organisations interstate. Obviously no family can pay that.

Mr CHAIR: No.

Mr MacGREGOR: We do one or two freebies a year, provided the person can get here and back. That is for people who do not have support from any of those large agencies.

We had a contract with WA Alcohol and Other Drugs for $100 000 just for placements for a year. But we are not really allowed to do it because we are an NT service.

Mr CHAIR: Yes.

Mr MacGREGOR: The demand is not just here, it is all over.

Mr CHAIR: How many staff do you have?

Mr MacGREGOR: Thirty-two.

Mr CHAIR: Thirty-two. And how many placements do you do a year?

Mr MacGREGOR: That varies. The last 12 months was 102. That is in our facility. Right? Sixteen weeks they are there. They are aged 12 to 25—young men and young women. The majority—60%—are 12 to 16. There are other yearly 19 to 20. Someone older is usually quite damaged.

In the outreach community education part, we get requests from support link, police and whoever else—1069 …

Mr CHAIR: Placements?

Mr MacGREGOR: That is visits at home, visits wherever, come on bush trips, go horse riding and that stuff.

Mr CHAIR: Yes, okay. Is that …

Mr MacGREGOR: That is a year.

Mr CHAIR: Yes. And what is your impediment? Is it your contract with the Northern Territory government that precludes you from taking on these other …

Mr MacGREGOR: Interstate.

Mr CHAIR: Yes.

Mr MacGREGOR: Yes, I do not trust them, because it is not written.

Mr CHAIR: Right.

Mr MacGREGOR: They have said it is okay and it has been okayed for …

Mr CHAIR: That is our mob?

Mr MacGREGOR: Yes.

Mr CHAIR: The NT government.

Mr MacGREGOR: And the one before.

Mr CHAIR: Yes, I am sorry …

Mr MacGREGOR: And the one before the one before.

Mr CHAIR: … I am just talking about the NT government broadly, not politically.

Mr MacGREGOR: It is a hard problem, times are tough. There is a capacity to lessen reliance on state Territory funding and pinch someone else's. Why not?

Mr CHAIR: Yes. And build your own …

Mr MacGREGOR: It is also good for young people, quite often, that mix.

Mr CHAIR: Oh, yes, but it also builds your own capacity …

Mr MacGREGOR: Yes.

Mr CHAIR: …and provides more employment opportunities.

Mr MacGREGOR: Drug and alcohol is across everything. The Royal Commission for example, there is bugger all about therapeutic treatment. They are looking at programs from Spain and somewhere else to import. It is a serious issue. We are getting kids of kids now. I have been there 21 years—kids of kids of kids.

We see a lot because it is multiple entry and exit. You might come when you are 12, you might come when 15 or you might come when you are 18—we tend not to say no. It is not a lock up. It is a choice thing. Ownership is the other thing by the consumer, by the user

Mr CHAIR: Can you provide an overview of the services that you do provide at Bush Mob?

Mr MacGREGOR: We have residential facility—20 beds. We have Bush Adventure Therapy, but they call it community education and outreach. There is a horse culture

healing program which came out of the horse treks. The horse program are running their own now. We have leased a bit of land off CAAP out at Desert Knowledge, we have horses there. A lot of people use that that are not bush mob as well as us.

There is a small one person media unit. It is full of second hand computers from Menzies and wherever else. We can actually start looking at numeracy and literacy as well as Facebook and all the normal stuff. They can make movies, they can do animation etcetera.

We were doing animation at the prison for a year and that got shut down as well because I said, look, can you help us out with some fuel and they went no.

We have a trauma-informed team. There are two social workers and a counsellor. We work with Paul with congress although that is quite difficult sometimes because if we are going to refer for a neuro-psych assessment—Bernard knows about this stuff—we have been told you have to be straight for three months and three months is the time that you are with us. Unless you have come straight out of Don Dale or somewhere.

It is pretty much 100% Indigenous young people. All of them have health conditions that have become chronic, whether they have been locked up or not. We have embedded ourselves in a primary health situation as far as possible. We had a volunteer GP and she just retired.

Bernard helped us out as a psychiatrist for a while. We have been talking to congress for a couple of years about access to the social emotional stuff. We have always done that anyway because the needs are not just drug and alcohol, it is whole of everything.

It is fundamental that the services are either turned up or moved in to a primary health care setting because it is the beginning of everything for us. If I am not running well—on top of the drug use, on top of whatever else, I am not going to be okay.

The other thing we are not set up for is ice. Preferably it would be nice to have a quieter space where someone coming in that is coming off can sit for eight to 10 days instead of in our main facility which is like chaos. Noise makes them aggressive sometimes.

It is very structured. Every young person that has ever been at Bush Mob when we have had a facility, goes to school. That is an issue. We can go to St Joseph's Alternative Learning and to Alice Outcomes Alternative Learning.

Because of the time limits on getting enrolments and all that stuff happening, they keep coming back and saying they have to have birth certificates. That is just about impossible. We have also had young people from all the local schools. Kids coming from Yirrkala, Nhulunbuy and wherever, when they are with us, if the school is open, we will go to one of those places. Similarly, with sport and all the rest of it.

Mr CHAIR: It sounds like a good program. What do you reckon the challenges are in trying to replicate your programs, say in the Top End or elsewhere?

Mr MacGREGOR: It would be quite manageable. It is a really simple program.

Mr CHAIR: Yes.

Mr MacGREGOR: And or Arnhem.

Mr CHAIR: Okay.

Mr MacGREGOR: We have spoken to some of the old people from Galiwinku and have visited. Even if they were talking about taking kids out bush to bush camps, it is not sustainable. There is no money in it with the old people with that. Whereas, maybe through Miwatj or one of those, they could set something up.

Mr CHAIR: Yes, okay.

Mr MacGREGOR: They could also take young people from all over at money.

Mr CHAIR: Yes. All right. I will certainly bear in mind what you have said about funding. Kezia?

Ms PURICK: No, all good.

Mr KIRBY: No, he put a really good wrap around it all, yes.

Mr CHAIR: Thank you very much.

Mr MacGREGOR: Thank you.

The committee suspended.

Drug and Alcohol Services Association

Mr CHAIR: Welcome. Jeff Collins. I am the Member for Fong Lim and the Chair of the select committee. Paul Kirby is the Member for Port Darwin and Kezia Purick is the Member for Goyder and the Speaker of the Legislative Assembly.

On behalf of the committee welcome to you for coming to this public hearing into Reducing Harms from Addictive Behaviours.

Carole, we welcome you to give evidence and thank you for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and it is being recorded. A transcript will be made available for the use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, just ask, the committee can go in to closed session and take your evidence in private.

For the recording could you please state your name and the capacity in which you are appearing?

Ms TAYLOR: Carole Taylor, I am the CEO of DASA which is Drug and Alcohol Services Australia.

Mr CHAIR: Thank you, Carole. Would you like to make an opening statement?

Ms TAYLOR: I have not prepared anything so it will have to be straight off the cuff because I have also been out of town.

Mr CHAIR: That is okay. Whatever you feel like saying.

Ms TAYLOR: I suppose my interest in appearing, even though you asked me to anyway, to this particular session is I suppose to emphasise the importance of non-alcoholic drugs that are permeating this town, which is the issue that we face mostly.

I am well aware that alcohol is a serious issue and a serious problem; it is right across the Territory and right across the nation. The issue that we face in our organisation at the moment, the most important issue, is the issue of methamphetamines in the town. The depth and breadth to which it has infiltrated Alice Springs and the amount of effort that we try to put into this particular drug and the people taking it and the people supporting those people is extraordinary.

There is very little support from government even from the ice taskforce that came through last year or the year before to which I gave evidence as well. I do not think people realise, they seem to think it is just a tradie drug that comes in with cashed up tradies every now and again and that is not the case in Alice Springs any more.

As an example, two years ago residential rehab owned a house, had probably 90% to 93% Aboriginal alcohol and ganja users in it, and that had been that way for many years. Today and for the last 12 months or so it is about 60 40 Aboriginal, non-Aboriginal and about 60% methamphetamine users.

Mr CHAIR: Across both?

Ms TAYLOR: The whole place has changed—the whole dynamic, the whole racial change. Everything has changed around the rehab. We have also introduced with the help from the primary health care network a methamphetamine team of two people to the outreach team. It was expected that they would do one on one case work with perhaps up to 20 or 25 clients. By the time the ink was dry on the first pamphlet they had 25 and that was before it was even—it was never advertised.

They are now up to 60 and I have just said you have to close the books. You just cannot go any further with this. It has become a really big problem. I have applied just today to put in a family support system around the meth users that we deal with because it is their men, their families that become part of the client base. I have no idea how that will go but it has just gone in today.

There is a very serious misunderstanding in this town that all the problems around here are caused by grog and they are not. There is a serious amount of young people being encouraged to commit crime for their older siblings to purchase this stuff.

We have first-hand information of kids being sent into houses to pinch saleable items and cash so that methamphetamines can be purchased. They are very easy to get here. They are not as cheap as Melbourne but they are not dear.

One of my meth workers said to me—why would you buy a slab of beer when for the same price you can buy a point of ice and be high for three days? That is the sort of thing we are dealing with—constantly.

We are the only organisation, Will, who was just here before, they have a few kids in with meth use, but we are the only people in town that deal with adult meth use at all and it is getting harder to do to be honest.

Mr CHAIR: Do you have a meth outreach program?

Ms TAYLOR: Yes.

Mr CHAIR: Can you provide an overview of what you do?

Ms TAYLOR: Yes. It started just over 18 months ago. What we anticipated doing was to get two—one of them was already working for us and one of them was a person we knew, so we had people earmarked already—people who had been users in the past, because, frankly, that makes a better system than a medical profession-type system that is around. Not that that is a poor system, it is not as openly attractive to the people on the streets.

They were street workers, in a sense. We put them out there to see if the users on the streets would come to them before we bothered to advertise through hospitals and various other places. They were inundated within weeks. They do a very intensive case-by-case management with these clients. They do all sorts of things. They take them to court, they represent them everywhere. As they say each client is so very different, they are all handled very differently. Their success rate has been quite high.

They also have one of the organisations in town that is prepared to take these young people—they are not all young—on as workers when they get to a certain stage of recovery. We have six or seven of them into full-time employment now, which is not bad in that period of time, given the fact that it takes that …

Mr KIRBY: Over what period of time, Carole, from when they first presented?

Ms TAYLOR: Eighteen months, which is pretty good, given the fact that you can be detoxing for a year on this drug. They have done very well. They have had a few failures—they always will. I do not know if they are failures yet. They come in and out and in and out until such time as they either succeed or they do not.

But that is the nature of our program. It is very intense. These guys are working 24/7. They should not be, but they keep responding to people who threaten suicide, or the parents plead with them to come and look after their kids or someone's children have been taken off them, can they come and do something and represent them. These guys are out all the time.

As I said to someone last week, two is not enough. We just cannot do it.

Mr CHAIR: Fair enough. Are you always dealing with the problematic users—obviously, the addicted users? Do you ever get to meth users who are casual meth users?

Ms TAYLOR: Yes, but the honest truth is most of our clients now are self-referred. Self-referred clients do not refer unless …

Mr CHAIR: When they are just casual.

Ms TAYLOR: … unless they are getting to the stage where it is getting tricky and they cannot handle it anymore. We know of a lot of siblings of users who are casual users. The guys try to counsel them before it gets out of control. But most of our users, as I said, are self-referred and most have hit rock bottom before they come to us.

We have even had a bloke move in from Brisbane because the program is funded in the Northern Territory. They were successfully counselled and got their son to the point of going to work. He was the person who got his son onto it in the first place who

started to move in from Brisbane and joined the program, as a Northern Territory resident.

It has to have something going for it if people are coming in from interstate.

Mr CHAIR: Yes, yes.

Mr KIRBY: Physically, what does the program entail, Carole?

Ms TAYLOR: Two people, two cars and two computers.

Mr KIRBY: Yes. No other infrastructure …

Ms TAYLOR: Nothing.

Mr KIRBY: … linking in with other programs?

Ms TAYLOR: Oh, they link in with everything. DASA is a very multifaceted organisation and we do not believe in reinventing the wheel. Anything we can use out there, we will. We are not a standalone empire. Any services that are out there and available to us that we can possibly use, we will.

The guys who run this program are also very closely now connected to the judiciary in town. The judges here think the program is fantastic so they refer to it a lot. But what we promised them when we started is that we would give them honest feedback so that if a person was charged with a certain crime and our people thought they had no hope of recovery for a period of time, they would say so. They would not say, as the lawyers do, you can get a get-out-of-gaol-free card and let them go and spend some time in rehab and they will be fine.

They do not dob people in, but given the fact that they have an honest record with the judiciary, they are very supportive of our program and actually refer people to us quite a lot—more than we can cope with.

Mr CHAIR: All right.

Mr KIRBY: So the people who come to you are obviously still living in their own homes?

Ms TAYLOR: Some of them will hit the streets. A lot of them are couch surfing. A lot of people's parents come—we had a discussion with the guys a few weeks ago and said, 'You cannot take as many clients, it is getting ridiculous'. Their argument to me is, 'What do you do when the parents are standing in your office crying their eyes out saying, "Take my son"?' Or daughter.

We have clients from 14 to 60, so it is right across the board. They are Aboriginal and non-Aboriginal. There is no real cohort now that you can put your finger on.

Mr KIRBY: Differing professions and …

Ms TAYLOR: Yes. It used to be non-Aboriginal males, 25 to 35 in the first six weeks. Then, all of a sudden, it has just gone everywhere.

Mr KIRBY: Do you think the success you have had is the ability to link in with other programs? Is it just the face-to-face contact that is a big part of the success?

Ms TAYLOR: The fact that guys, having had the background they have had, have a connection with these people and they trust them. Also, of course we link in with other programs. More so other programs link in with us, to be honest. As I said, we use whatever is available. We use counselling from the Congress and all sorts of services we can find.

Mr KIRBY: Apart from basic funding and resources to have more people on the ground, are there programs that are just glaringly deficient in Alice Springs that would help you out?

Ms TAYLOR: Some of the programs that—not really, to be honest. It is just a matter of making it big enough to take the group of people we have. We get on very well and work very closely with the hospital. We have a very good relationship with them and they are great. The I Was program out near the gaol—the detox is good. I would prefer it to take people for longer. That would be one of my requests, I suppose. They only take people for up to nine days and that is not long enough for a meth user.

Mr KIRBY: No, no.

Ms TAYLOR: We do our own detox at Aranda House beyond that. I would like to think I could train my staff a little better than they are trained. We give them every bit of training we can possibly find, but there is a limit to the amount of money it costs to train staff in Alice Springs, because you have to send them elsewhere normally.

Mr KIRBY: I was going to ask, is that all training that is available in town, or what? How do you …

Ms TAYLOR: There is not a great deal. I have four people at the APTA training in Darwin tomorrow. That is for eight days. I have six people at the NIDAC conference in Adelaide, which is also quite helpful. But specific training for this particular drug or series of drugs is quite important.

We are an organisation that does not lose staff. For some strange reason, whether staff are good or bad or not, they do not leave DASA. We must pay them too well.

Mr CHAIR: You cannot …

Mr KIRBY: You are not working them hard enough.

Mr CHAIR: Strike that from the record.

Ms TAYLOR: Whether it is as good place to work or not, I do not know. I believe it is. But we do not have a lot of transient workers like other people. Just now, we are getting to the stage where people are starting to get very tired. Some people are getting a bit nervous. Some people are a bit nervous of these clients because they do not detox the same as alcohol clients do …

Mr CHAIR: Right.

Ms TAYLOR: It takes them longer and they are often more needy. Their mood swings are greater …

Mr KIRBY: More aggressive at times?

Ms TAYLOR: At times, but it is normally more the freneticism. They are quite frenetic people in a lot of ways. Once people start to really come down, we put them through pretty heavy gymnastic sessions, rock climbing and all sorts of things. You have to get rid of their energy. Their energy tends to build up in these people.

It is not like it is on TV. Everybody is not a mad, stupid, aggressive ready to kill everybody. They are just not. That is just not the truth. But there is a level of aggression that is a bit higher than someone coming down from ganja or alcohol.

Mr KIRBY: Yes. I understand what you are saying. If somebody has been in that headspace and been addicted and has come out of that, then the ability to help other people come out of that would be an immensely rewarding …

Ms TAYLOR: It is amazingly rewarding, it is.

Mr KIRBY: Yes. It is probably …

Ms TAYLOR: It is also the issue that people on this drug have a higher, from what we can understand, have a higher suicide ideation than other people because coming off this stuff you are going through massive depression for a long time.

That is part of getting off this stuff because the pleasure receptors in your brain have been knocked out, sent to sleep, whatever you want to call it and it can take up to 18 month for those to start to regenerate back where you can feel normal pleasures in life. You are effectively depressed for quite some time.

Mr KIRBY: Do you know if that is a measurable effect—on the suicide rates around town or it is not something that you have studied?

Ms TAYLOR: We have not even in this program, I must confess, done a lot of terms in data. We have not had the time. I would like to have someone to do some work with us now that it is settling down a bit, to do some decent data collection to see how it is shaping up.

I know we had three suicide attempts last week. Whether they were serious enough to be—we take them all seriously—but whether they would have come to fruition, I do not know. It is a bit hard to tell really.

Mr CHAIR: It sounds like your program is quite specific.

Ms TAYLOR: We have lots of programs.

Mr CHAIR: No, but in terms of specific for meth users. Is there anything there you would use for other substances or do you have other programs?

Ms TAYLOR: Yes. They are basically heavy drug team. You do not call them heavy drugs anymore you are supposed to call them specific drugs. It is the latest …

Mr CHAIR: Okay. Specific gravity.

Ms TAYLOR: The latest terminology is specific drugs. In our rehab in the last eight, nine years there has been very little in the way of massive heroin use. Every now and again you get a bit of everything, and these guys are pretty much our experts, if you like. They deal with those sorts of drugs too. Most people that use this drug are probably drug users anyway. It is almost inevitable the person who smokes a lot of ice normally smokes a lot of ganja because they interchange.

Sometimes they use one to get off the other and all these sorts of things. It is very much a mixed bag.

Mr CHAIR: Any other questions?

Ms PURICK: Is your funding predominantly NT Government?

Ms TAYLOR: Not in this program. This program is entirely federal.

Ms PURICK: Federally funded.

Ms TAYLOR: We are roughly 60/40 Northern Territory Government for our overall funding, for our base funding which is the rehab and the sobering up shelter and the

core programs is Northern Territory funded. The rest are federally funded. Although, as I have said, put in today—I had a discussion with the Northern Territory Government who suggested I might put in today for an extension to this program with the Northern Territory Government.

That is not just to deal with clients it is to do with families and clients because one of the issues that we have, and most of the research says that one of the major reasons people take drugs is a lack of what they call interconnectedness, which is a stupid word really but that is the word they use.

In the family that is where the connectedness breaks down because they are the people that are normally affected adversely by a particular user. Their trust is broken and all of those things. In order for a user to get back on the road to recovery they need that family unit around them but they have burnt their bridges.

Our program is designed to rebuild those bridges, to rebuild the trust in the families. For instance, a family that you have promised 50 times that you are going to get off, you are going to do the right thing, everything is going to be okay—and you have broken that trust every time—they are not going to believe it when it really starts to happen.

So you have to start helping families to lose that judgemental view of their family—it is very hard to rebuild that. If they do not rebuild it the person is not going to go very far. It is a very difficult thing to rebuild but I think it is worth doing.

Mr KIRBY: You are right. Any success stories that I am aware of has come from that family unit …

Ms TAYLOR: That is exactly right.

Mr KIRBY: …leaving everything behind—I have a family that have just left the Territory to go to a safe place and thankfully has worked out well—but without that support would never have happened.

Ms TAYLOR: Yes, and when the user has gone that far that they have burnt all the bridges—the parents almost are at the stage where they cannot stand them anymore. Many are frightened of them or what have you—that is a very hard thing to rebuild. But I really think if we do not do that, we are doing half a job.

Mr KIRBY: Well, we have admitted defeat.

Ms TAYLOR: Yes.

Mr KIRBY: the drug has won if we do not have families that are prepared to do that …

Ms TAYLOR: Exactly.

Mr KIRBY: … because that …

Ms TAYLOR: We all need family for whatever reason, but more so if we are in trouble.

Mr KIRBY: Yes. Are there similar programs in the Top End of the Territory?

Ms TAYLOR: I do not think so. When we had our funding application with the PHN, we all went up there to have our announcements and all that stuff. There are a couple of programs in the Top End that have drop-in centres with psychologists for these users. We have the only, if you like, street smart-type program.

Mr KIRBY: Yes, There was one, I thought, that the …

Ms TAYLOR: There might be …

Mr KIRBY: … nuns ran that was a few months …

Ms TAYLOR: I cannot say for sure. I have not gone right into it, to be honest. I know we need nine. We are just trying to run that.

Mr KIRBY: Yes.

Ms PURICK: That is good.

Mr CHAIR: Committed change program.

Ms TAYLOR: The committed change program is another program where we noticed there were some gaps. The problem is that when you look at rehab, which was our original core business, if you like—sobering-up shelter and rehab is our core business—it only works for a certain number of people. Certain people just cannot go into rehab.

They cannot afford it in the sense that it is certainly almost entirely subsidised by Centrelink, but if you are not on Centrelink and you have a mortgage to pay and three kids and a job, there is no way you can go into rehab. It will just not happen.

We tried to look at a program—and we were working with justice at the time—to do two things. One was to reduce recidivism because that is their committed program's goal. The other one was for us to provide a program whereby people could come and work with us after hours. We developed this program through the committed program. Ours is committed to change.

They are referred to us if they are appropriate for our program, whereby they can come to evening classes, if you like, or evening things. There are different things on. There are things about, basically, recovery messages and that sort of stuff. There are also physical things they can do. It is a very varied program so that people actually remain interested.

If you send someone off three nights a week to listen to an AA message, two weeks and they will be out of there. So we have to vary that and make it quite—we have drumming and all sorts of stuff happening. When they come along to the program, people tell us what they can commit to do. One bloke said he needed as much as we could give him—that was fine—because he did not trust himself. He is now working.

We have another person who said he did not want to do this. He did not want any more people in his life. He had enough with parole and everybody else there, he would just go once. So, we worked with him and made sure that the one time he goes is the program he needs in order to assist with his recovery.

It is a support program for people who need something but cannot be everywhere, if you like. They need to hold down a job, have a family, have a proper relationship with their family. We have family nights with all sorts of stuff for that.

It is basically to assist the justice system with their commit program, but it also works in with our meth program. Our programs all interlink.

Mr CHAIR: So, what is the eligibility criteria for it?

Ms TAYLOR: I would have liked it to have been much wider. I wanted people to be able to self-refer. I also wanted it to have people who were on home detention. But I afraid the program is very confined and is only for people who are on commit parole through the courts, and thereafter, referred to us through the Parole Board.

Mr CHAIR: Okay.

Ms TAYLOR: That has become very two-funnelled. We are working on expanding that, but Justice is fairly narrow in their opinions.

Mr CHAIR: Are they doing an evaluation of that program?

Ms TAYLOR: Yes.

Mr CHAIR: At the moment?

Ms TAYLOR: Not at the moment. They will do it after 12 months. It has only been going for four months.

Mr CHAIR: Right. Okay.

Ms TAYLOR: And it will be slow because it is not like the meth program which exploded overnight. This is quite a different beast. The two groups often connect.

Mr CHAIR: Okay. What are the treatment approaches and the services that are provided through that program?

Ms TAYLOR: All sorts of things, everything. There is the normal recovery stuff, there is the smart recovery—all those sorts of programs that have been established for a long time. They are all used. We also use things like drumming to recovery and we use the fitness program at the YMCA. We use the YMCA a lot actually. All sorts of things. Depending entirely on where they are at. Everyone is at a different place.

If someone comes out of gaol after being there for quite some time the idea is that they are already detoxed. But they are not because they are in a place where they are not allowed to get any drugs; they are never taught while they are in there how to resist the urge to want them. So it builds—it just builds when they are in gaol. The first thing they do when they come out is use.

Mr CHAIR: Any other questions?

Mr KIRBY: No, that is fantastic, thanks.

Mr CHAIR: Is there anything else you would like to tell us?

Ms TAYLOR: No, not on the spur of the moment. Sorry, I should have prepared but I have honestly not had time whatsoever.

Mr CHAIR: That is good. Thanks for your information you have provided us with. Thanks Carole.

The committee suspended.

Remote Alcohol and Other Drugs Workforce Program, NT Department of Health

Mr CHAIR: On behalf of the committee, I welcome you to the public hearing on reducing harms from addictive behaviours. Andrew?

Mr SCHOLZ: Yes, that is right.

Mr CHAIR: Thank you.

Welcome to the table to give evidence and thank you for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and it is being recorded. A transcript will be made available for the committee and may be put on the committee's website.

If, at any time during the hearing, you are concerned that what you may say should not be made public, then simply let us know and we can go into closed session and take the evidence in private.

That being said, can you please state your name and the capacity in which you are appearing?

Mr SCHOLZ: My name is Andrew Scholz. I am a registered nurse with the Northern Territory Department of Health. I work within Central Australia Health Services and as part of a remote alcohol and other drug workforce program and have been doing that for the last three years.

Mr CHAIR: Thank you. You have provided us with a care package. Thank you.

Mr SCHOLZ: That is a list of our tools that we have designed for and in conjunction with our Indigenous AOD workers that work in remote communities and they use these tools extensively. It is also a framework around how we work in communities to address drug and alcohol at a community level.

Mr CHAIR: Thanks for that. Would you like to make an opening statement?

Mr SCHOLZ: A brief statement just to say that I have been in Alice Springs since 1995. I have worked in all areas of mental health services and also as a remote area nurse at Yuendumu back in the 90s. I have been working with specialist alcohol and drugs services at ADSCA for eight years and also in non-government rehab facilities in Tennant Creek. I have and worked in the Top End as part of this program and now back in Central Australia.

I have had fairly good exposure to drug and alcohol services and mental health services. It was important for us to come along and talk to our program and the things that we are offering and innovating in terms of this space, particularly in remote Aboriginal communities.

Mr CHAIR: On that, there is limited data on the prevalence of illicit drug use in remote communities. Can you provide an insight in to the prevalence that you are aware of, of illicit drug use?

Mr SCHOLZ: Yes, that is a good question. I was speaking to our program manager talking through that, and it is hard to find those sort of statistics. In my role as a nurse mentor and a person who does the client reviews with our workers in remote communities I would have to say that the majority of the referrals they get to them from the health centres would be around tobacco, alcohol and cannabis.

Very rarely do we ever get a referral to a worker who is using methamphetamines or any other illicit substance. While we get anecdotal reports that there is methamphetamine use, particularly out in some communities they do not seem to be presenting to our service at the moment—so the workers are telling us.

Mr CHAIR: It is probably all in here, but can you give us an overview of your treatment programs that you provide in the remote communities?

Mr SCHOLZ: Sure. The program employs over 50 workers. In Department of Health centres right across the Northern Territory and also in the large Aboriginal medical services—that is in urban, regional and remote areas. The workforce is nearly entirely Aboriginal workers.

As we are a workforce training and development and support unit some of the workers had not had a lot of training in alcohol and drugs per se but they are strong cultural people. They were chosen by the community to step into this position so they had to have good references and support from the community to do these jobs and they were seen as people that had a lot of collective wisdom. Some of our workers had their own journeys with substances and some are still working through that as well.

They are people generally over the age of 40. We have some younger workers too, which is great to see some young people coming up through this area. It is not a sexy area to work in. We do not get people knocking down the door to work for us. It is very hard to find appropriate people to work in this area. A lot of good people are already working in other areas of health or education or other areas where jobs are provided.

You have to work hard to attract good people and also to train them up and support them. This is important because this work is stressful at time and it is very close to home for people.

Mr CHAIR: Are there any other challenges in delivering services?

Mr SCHOLZ: There are a lot of challenges. Our workers are based within the health centres. Dr Brownscombe was talking about the primary health care—we know that

most Australians will go and see a doctor or some sort of health provider at least once a year.

We are hoping that through that provision of primary health care to clients that they will be screened—they will be asked about their drinking, their smoking and their drug use and that referrals will come through that process.

As Dr Hickey and Dr Brownscombe were saying that there is good evidence to suggest that a brief intervention or some advice offered by a professional person can be quite effective in that short time space.

But we are getting people who are coming back from gaol and referred to us by Territory Families who have had longstanding problems with their drug and alcohol use. The brief intervention in that situation is not as effective as often referral to someone who can support that person through any long-term change they need to undertake.

The barrier is not having enough accessibility to care in remote areas. We only cover about 40 communities. There are a lot more Aboriginal communities in the Northern Territory. Some of our workers will spread out to reach that region. They might go on to some other communities, but it is difficult. We can only service so many people in a week, of course.

People are quite mobile too within communities. So, our workers will often say that people are taken out of community for other reasons. While people reside in a community, they are often not in the community. Actually intervening with the client on a regular basis can be a challenge for people to address. They are out for different reasons.

Mr CHAIR: Okay. How did you choose the 40?

Mr SCHOLZ: How did we choose those people?

Mr CHAIR: No, the 40 communities that you service.

Mr SCHOLZ: Oh, the 40 communities, yes. That was done as part of consultation about 11 or 12 years ago. When COAG initially gave us the money—it is federal money which they gave to the Northern Territory government—we went right across the N.T. Originally the program manager, in consultation with some other people, went to a lot of communities and said to them, ‘Do you have problems? Do you have particular concerns about drug and alcohol? We are proposing this model.’

Initially this model was designed to put professional people out there. That was a spectacular flop really. It did not work very well, so we realised that we had to work with the workforce from the ground up. So, we looked at that again and revised that.

Community members said, 'We would want someone, hopefully from our own community. Someone who knows us, speaks our language'. This certainly breaks down a lot barriers and can improve access to treatment for people.

There are a lot of communities crying out for a worker. They say, 'Can we come onto the program? Can we have a worker please in our community?' Of course, the funding does not stretch that far. We have sometimes moved workers from some communities, but generally the community and the health centre have to show an ongoing commitment to the worker—that they support them and value them in the community.

Mr CHAIR: Okay. And what are the opportunities you see for improving the service?

Mr SCHOLZ: There are lots, I suppose. The thing we have already put in place now is great support. Again, we have people who are new, often, to the health field—they have never worked in a health centre. They can be hostile and stressful places sometimes.

We provide a lot of ongoing support on the ground. A lot of my time is spent out travelling out to communities, working alongside the worker. We would see clients together. We would sit down and discuss them and talk about who else could be involved, how we might involve family. I talk to the worker about people's physical health. A lot of our clients are, of course, very sick people.

You just have to look at their electronic health record and see there are a number of medical conditions and a lot of medication. We need to assist our workers to get a big picture of that as well, so they can understand that there are people whose risk and need for treatment is more apparent and important than someone who has been referred on a casual basis who is not having so many problems.

Our workers often have quite an intimate relationship with the client. They know them and are related to them. That can be both helpful and unhelpful sometimes because people say, 'I do not know whether I want to talk to that person'. There are cultural barriers of relationships as well, so it can be a challenge.

We give these workers clinical supervision, which is to support the person again in their development as an AOD worker. It helps them to walk through any issues that affect them at a personal level and their ability to carry out the work as a drug and alcohol worker as well. The workers are part of the supportive process as well.

We bring all the workforce together at least once a year for a forum for training. We have teleconferences where the workers can network with each other. They come in and sometimes they can go to other communities and support other workers. We are really doing our best to try to maintain a consistent workforce that will not turn over and become more and more skilled over time as well. We help them make those networking connections.

We have dozens of different professional people going out to communities—whether they are mental health professional, cardiologists, diabetes educators, podiatrists. Our job is to help our workers see where that might fit into the overall healthcare of that client as well.

We see a lot of mentally ill clients as well. We know the outcomes for a lot of our mentally-ill clients is very poor. They tend to—especially if they are smoking—die up to 20 years younger than people who do not smoke. We are helping those people also access the health centre. Regular contact and support improves their health.

People who are already sick and need to be getting to a health centre more often are supported to get there. We are having an impact on the physical (health) people as well, even if they continue to use. We are assisting them to moderate and look at other areas of their health as well—and their wellbeing of course. We support people to stay in their workplace. We look at people's strengths.

You will see on our tools that we ask people, 'What is it you do within your community that actually keeps you strong?' People identify a whole lot of things. There are lots of pictures about people going out on country, spending time there, being involved in ceremony, dance, art, work, spending time with family. There are a lot of things people do that also restrain them from becoming very heavy or problematic users of the drug. We try to help people reengage with some of those activities that support their wellbeing as well.

Mr CHAIR: All right. We have heard some other submitters talking about the length or continuum of care being critical to supporting people recover from substance misuse.

Mr SCHOLZ: Yes, it is critical.

Mr CHAIR: What sort of post-release support and treatment services are available in communities for people who have completed residential treatment or have been released from correctional facilities?

Mr SCHOLZ: That depends where we have a worker who works particularly closely with the addiction medicine team at the hospital. The doctor, Dr. Delena and R.N Fiona Bell, know our service intimately—we are very well connected. We have good connections to most of the non-government rehab facilities here.

One of the people on our staff is a trainer—Tony Hand is recognised in the N.T and now does not give accredited training but we provide lots of training to the NGO sector. We are heavily involved with the training. A lot of the training courses are also a chance to work and emphasise what our service does on the continuity of care. There is big overlap there.

We are getting better at it, but it still needs to be in more places. We need to be able to pick up those people who get lost in the system. If you were to leave gaol a referral might be sent out to the worker at the health centre. But people are often stuck in town for many weeks—months sometimes—before they get back out there. There could be a shortfall there. That client probably needs to come to the attention of maybe someone like Safe and Sober at Congress—their social and emotional wellbeing team. They pick up those sort of people who are not yet back to community.

Our workers will come into town for training. If they have a client who has been referred to them, they will actually go and locate that client in town and encourage them to get back to community. We need to increase the amount of connection between some of the rehabs and our workers. We would love to see some of that discharge planning done within the rehab with the worker and the client, and our workers out bush over the phone, to get a nice, good strong plan in place.

Our workers can bring people to rehab. We have had our workers drive in from Borroloola all the way to Tennant Creek. It is a fair drive—a 10-hour drive …

Mr CHAIR: It is a fair way, yes.

Mr SCHOLZ: They will provide that service to ensure they get into the rehab safely. I am sure we could also organise them to come in and pick someone up and ensure there is a safe passage back to community so there is less chance of people being stuck in town as well. Yes.

We are trying, as well, to create continuity between geographical isolation. Where we have tobacco smokers, for example—there is still high rates of tobacco smoking on remote communities—we are trying to use the NT Quit Line in a more resourceful, creative way.

We try to encourage our workers—where people have phone contact or the health centre will allow that client to come in and sit in an office and use the phone—to talk to Quit Line. We say, 'You need support when you have to go on patches or other medication to try to stop smoking. Let us use everything we have', especially if the person cannot be visited regularly. Especially in the first few weeks of giving up any drug. The relapse rate is quite high, so we use outside services to do that.

There are probably some more creative things we could do around telephone and video link-up. I am sure there are some things we could still look at in the future for these as well.

Mr CHAIR: Okay. Questions?

Mr KIRBY: Yes, we asked different people about the transient nature of the Territory and community people now. It was explained to me that apparently, if men are getting

sick there is not many men left back in community at times when they come in to get treatment. Is that something you see contributing to health problems—the family nucleus breaking down a bit in communities?

Mr SCHOLZ: Families can be supportive and enabling if people are getting treatment. Also, they can act as a barrier. Certainly, we try to get a good gender balance from our point of view—from the workers—because we want men to be strong community models to say, 'You know me, you can trust me. I will give you good advice—good cultural advice—and support you to come to treatment'.

Where there is a lack of men who might support that process—last week I was at the continuous quality improvement forum here in Alice Springs. There was a really heartening story of Anyinginyi Congress, which has developed its own men's health centre up there.

One of the workers who helped develop that was saying that now there is a dedicated men's health space, men are bringing their young nephews and sons, walking in feeling full of pride and happy to engage in that process, knowing that it is gender friendly as well …

Mr CHAIR: Yes, we heard a bit about that yesterday, about Anyinginyi.

Mr SCHOLZ: That is a good move. Our workers are flexible in how they deliver treatment. It could be, 'We will come out to your outstation. Let us go for a drive in the car'. It could be whatever makes the service more friendly to get to.

We are trying to get influential people within the communities so we can work with sports teams, football players—someone who says, 'Hey, I am ready and willing to support you'. We say to healthy role models we know are working and living in that community, 'Would you step up and also be the support person for someone you know is struggling, to come through the door in the first place to engage?'

A lot of effort is made to try to engage the person first. It is very shameful to walk through the door and say, 'Look, I have this issue I am struggling with'. If people can see the service as being friendly and welcoming and not imposing too much initial pressure on them, they are more likely to—treatment can be paced to where they are at.

We do not want to run ahead and say, 'We have the answers for you. It is not what you need to do.' It is like, 'Where are you now? What are you prepared to do? Who would you like to bring on this journey you cannot at the moment?' Carole was talking about burning the bridges with family. Sometimes our workers will go a long way to start rebuilding bridges and links to help people keep on that journey as well.

Mr KIRBY: Yes. Something we have spoken about a bit is the connection with family, country, sport, the Territory's absolute love of sport and how that can be used—and is very successfully in different programs. Listening to you talk then about connections and people encouraging people in, do you think there is room—without having to train up more specialists—for us to support and train up more mediators or connectors—if that is the right terminology—within community?

Mr SCHOLZ: There is some role for training up people or incentivising people to step forward. A lot of the most responsible, skilful people are already burdened with a lot of responsibilities and they are not prepared to step up for anymore.

But there are some good people who could step into that space, but there needs to be some incentive for them to want to do that, other than just doing good things for their own community—which is great in itself—those sort of people are often saying, 'I must not neglect my own family. I must keep my responsibilities close to home first before I spread myself out and help the rest of the community.'

Yes, that is a creative option we still need to look for, for people to step up—just like, I suppose, when we were children there were lots of people who would step up and coach sport and support those things. For those sort of things there are fewer of those people now, so we need to fill that void somehow. It could be through trying to encourage people to see the value of being a good, contributing community member as well.

Mr KIRBY: Yes. Obviously, it would have a lot of cultural sensitivities around who is stepping up, and to ensure it can be explained it was all being done for the right reasons, and not reaching over any elders or anything like that.

Mr SCHOLZ: No. And that is why our workers are culturally astute people. They know not to step on people's toes. They know the right people to talk to before they speak up.

They do not speak for the community without speaking to TOs and saying, 'There is a message here that needs to be spoken. Who is the correct person to deliver that message? If you are, would you support me? Let us go and talk to our young people about methamphetamines, early cannabis use, or sex, alcohol and drugs.' Sensitive subject that need to be spoken about need to be done correctly as well.

Mr KIRBY: What level of formal training is the staff you currently have?

Mr SCHOLZ: Someone spoke to you before about the Certificate III and IV level training. Part of our funding is to assist people to get into that sort of training. We manage to get quite a few of our staff across the line in finishing their Cert III and Cert IVs. Some have done diplomas.

Some people come into the workforce already qualified. Others struggle to do formal studies. That is why we provide a lot of training that is not accredited, but at the similar level without all the assignments they have to do. We will teach people some basic counselling skills, motivating skills, how to provide that initial brief talk about using drugs safely and what we call a brief intervention as well.

That is where a lot of the training is at. We believe that our workers have a lot of the answers already. We do not think that using the worker lies in a whitefella saying, 'Hey, I will tell you something tricky to say to this person. That will persuade them.' It is more about saying, 'Hey, what is important for you in your life? What do you want to achieve for yourself and your family? How does your culture see this? How can we support you to go down that pathway?' It is not about very tricky psychological scores.

There is a need for some of that advanced assessment, and that is where our workers know not to overstep their boundary and work with and refer to psychologists. We have psychologists working alongside our program through the PHN funding at Yuendumu. People can see those people as well when they need to.

We are more about ensuring people are safe—culturally safe, physically safe—and reducing the harms like drink-driving. We are asking people about drink-driving. 'What are the situations of you getting into a car with someone who is driving a car drunk?' We know that there are many drivers who drink-drive. They are probably likely to repeat that pattern, so they will find themselves in situations.

We try to problem-solve that and help people say, 'No, I am trying to make a different path myself and I do not want to get into that cycle of drinking and driving'. A serious death like the one at Kakadu recently shatters the whole community for a while. Our workers too often are related to people as well.

Mr CHAIR: Some other issues have come up as well. Delaying the uptake of substance use is critical to reducing harms. What education and prevention programs do remote AOD run in your remote communities?

Mr SCHOLZ: The Education department has its own set curriculum for that. But sometimes teachers do not feel highly qualified or confident in bringing that about. They will invite our workers into the classroom situation sometimes. Our workers will often speak in language and, with the help of the teachers and teacher aides, get through the clear message about some of that—be mindful of what is happening, you are very young, these are the dangers, these are safe ways to use if you are already using.

I suppose for prevention we are still trying to create a solid foundation for children's lives to progress forward where they do not feel the need. The talks was there about trauma. I am sure people have spoken to you about the intergenerational trauma, the

ongoing trauma and sometimes the role of substances in dampening down some of that stress they might experience from exposure to traumatic situations.

Some of the programs I really like are the family partnership programs where nurses and Aboriginal Health Workers are going in with pregnant women, right from the time they become pregnant through for several years afterwards. Those programs have shown to be quite effective in being a preventative effect of what happens when a person is 18 years of age. They are more likely to have finished school, less likely to end up in gaol, less likely to use substances and be involved in any criminal activities. They are great outcomes.

The start early and support parents to become better parents. They help parents deal with some of the outside pressures and help parents be mindful they are children. We know that one of the protective aspects of children not going to drugs is sometimes parents who are involved in religious activities, parents who are mindful of the dangers of drugs and who tell their children regularly: 'My expectation of you is that you will not use drugs. I do not want you to use drugs. I love you and I am concerned about that.' Parents who are able to effectively convey these messages also help children realise that they are loved and valued and they do not need to run with peers at such an early age.

That sort of stuff is something that is taught. I particularly like BRADAAGs program—a few years ago when I worked up there, about five years ago—they had a family house which was dedicated to a husband and wife and their children and that was an amazing experience for parents who might be under the age of 25 who have never really spent any time with their children.

Even the couple did not spend a lot of time sober together, and the questions were—do kids always talk that much? Do kids always pooh that much? Do kids always make that much mess?

But the experience of saying, 'I just saw my kid eat its first meal with a spoon. I just saw my child read it some words', and the children were going to school, they were supporting that process. The husband and wife were able to talk to each other and iron out some differences.

If you can make some changes at a family level sometimes those families are subject to quite a lot of interest when they go back to community and they are displaying some quite functional activities saying, 'what have they done? I want to be like them because suddenly they are organising their house more effectively, the kids are going to school and people are re-engaging work.'

I like programs in rehabs where people are encouraged to maybe re-engage in work or training. They seem to be valuable. That is why I liked the comment that you made, Bernard, (Dr Hickey) about the streets being so clean, I agree. I love going on to the

streets early in the morning and I like those low grade correctional facilities. I believe they are the next step up from diversion, that they decriminalise some things that make people look less serious or less hidden away from society.

I used to work in the SMART court here about six years ago. We had some great outcomes with clients. Really good outcomes and the clients were made very accountable. They had to front up in front of the magistrate every two weeks. They had to explain any substance use, if they turned in a dirty urine. They still had Corrections going around doing home visits. They had to attend treatment and that was six to 12 months of intensive treatment, but the outcomes were pretty impressive.

That is where you need programs that keep people accountable. That helps some of those people who have serious long-term issues.

Mr CHAIR: Anyone else?

Mr KIRBY: No. We have covered really well. It has been fantastic.

Mr SCHOLZ: Can I just say, those social components of health are still really important. Good housing for people, education, employment and stability within a community—economic and all that …

Mr CHAIR: We have heard that message loud and clear.

Mr SCHOLZ: Yes, I am sure. We have workers who are turning up to work every day, they live in a tin shed with no water and no power and they are as solid as and they are doing it tough. I just wish that a lot of workers who are working very hard had a reasonable house.

We have had workers who live in the same household as people who are dealing drugs and they felt very compromised, very distressed by that process as well. People who are sharing a room and come to work exhausted. Two o'clock and they are just falling asleep because people have been up all night. It is a tough gig for a lot of our people who are working out there.

Mr CHAIR: We do understand that. Thank you very much.

Mr KIRBY: Please thank them on our behalf for their hard work.

Mr SCHOLZ: For sure. They are good public servants and dedicated.

Mr CHAIR: Thank you Andrew.

Mr SCHOLZ: If we could continue with that trauma informed care, we are trying to do some healing camps next year with women and men and will be taking men and

women into country into dedicated areas that they chose to work through and talk about some of the trauma, and we are training our workforce to be more trauma aware and sensitive.

We are working within centres to make those, particularly professional people also more sensitive in the work that they provide that does not re-traumatise people and then say I cannot deal with this health centre, it brings a lot of bad memories.

Mr CHAIR: Great news. Thank you very much.

The committee suspended.

Mental Health Association of Central Australia

Mr CHAIR: Welcome. Jeff Collins. I am the Member for Fong Lim and chair of the committee. Paul Kirby, Member for Port Darwin and Kezia Purick, Member for Goyder and the Speaker of the Legislative Assembly.

On behalf of the committee, welcome to the public hearing into reducing harms from addictive behaviours. You are Merrilee Cox? Sorry, yes, you are …

Ms COX: Yes, I am.

Mr CHAIR: The light is shining on your nameplate.

Ms COX: Oh, okay.

Mr CHAIR: I welcome you to give evidence to the committee. Thank you for coming before us. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and is being recorded. A transcript will be made available for use by the committee and may be put on the committee's website.

If, at any time during the hearing, you are concerned that something you might say should not be made public, just let us know and we can go into closed session and take the evidence in private.

That being said, could you please state your name and the capacity in which you are appearing.

Ms COX: My name is Merrilee Cox and I am the Chief Executive Officer of the Mental Health Association of Central Australia.

Mr CHAIR: Thank you, Merrilee. Would you like to make an opening statement?

Ms COX: Thank you for the opportunity to talk with you today. I am relatively new to Alice Springs, but I have previously worked for a very long time in Victoria in mental health services and community-based services where we have had a very strong focus on dual diagnosis and the comorbidity of mental health and alcohol and other drug misuse.

The committee is an opportunity for us to explore potential for doing some developmental work in this area. The recent merging of the Alcohol and Other Drug and mental health branches within the Department of Health provides a real opportunity to start working together across those two branches. To date, there has been insufficient crossover between those areas.

In our organisation, one of the big parts of our work is mental health promotion and suicide prevention. We host a program called Suicide Story which works in remote communities trying to build capacity in those communities to respond to suicide risk.

As you will be aware, the recently released figures for 2017 identified that suicide in the Northern Territory has increased, as it has across the whole country. The likelihood of suicide increases with the degree of remoteness.

The other thing that is very evident in those figures is there is a very strong relationship between substance use and suicide. A significant proportion of people who take their own lives have abused substances and have them in their system at the time.

Mr KIRBY: What sort of percentage? Would you know, Merrilee?

Ms COX: I have read that it is above 50% in remote areas. That is possibly a little low in my understanding. Across the country, I think it is about 20%. But in the Northern Territory, it is much higher. We see people when they are in a state of distress taking alcohol principally, and then making really poor decisions, feeling desperate, hopeless about their situation …

Mr CHAIR: And it is a depressant as well.

Ms COX: Yes. There is lots of room for us to do more work in this area, in particular to join up Alcohol and Other Drug and mental health services, particularly at the community level. There are some very simple strategies that can be put in place for

doing screening and identifying people who are at risk or who experience a comorbidity, and then developing some joined-up strategies.

Mr CHAIR: What sort of strategies would you think?

Ms COX: In the past, when I worked in Victoria, there were centres of excellence developed within the acute health service system that resourced mental health agencies. They provided training, developed screening tools, developed intervention tools and supported the introduction and use of those tools.

The other big part of that strategy was encouraging worker exchange. Workers who worked predominantly in mental health did periods of time in Alcohol and Other Drug services, and vice versa, so that there was a growing relationship and understanding of the differences and the commonalities that were possible within those service systems. Much of that strategy is about workforce development, but also the development of the common tools that can be used across the various settings.

Mr CHAIR: We had some questions pre-prepared. Research indicates a strong link, as you just told us, between drug use and mental illness. Are there any integrated mental health and AOD services available in Central Australia for dual disorder clients?

Ms COX: No, there are not.

Mr CHAIR: None. Okay. What are the challenges in delivering services and the barriers to accessing them? What are we able to develop? Do you think the Victorian examples are worth applying here, or looking at how we can adopt them?

Ms COX: It is certainly worth exploring that potential. I am not sure whether you are familiar with this document. It is a much longer document so I have not printed out the whole thing. It is called *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*

I am not clear to the extent to which these guidelines have been implemented, but as far as I understand it I do not think there is a very strong drive or push for that to occur, and we do not have to reinvent …

Mr CHAIR: Is that a Commonwealth publication?

Ms COX: It is a Commonwealth publication, yes. I do not think we have to reinvent the wheel. There are a lot of resources and there is a lot of practice in other jurisdictions that we could draw on to help bring that …

Mr CHAIR: Did you get the title of that?

Ms COX: I will give this to you.

Mr CHAIR: Thank you.

Ms COX: I suppose the other thing is that one of the key strategies that was employed in that dual diagnosis strategy in Victoria was the link between the clinically focussed services and the community based services. That is where there is some real opportunity to build relationships and resourcing here.

Mr CHAIR: Okay. Another one we have—the stigma and shame that can be associated with both substance misuse and mental illness can prevent people from seeking help for themselves or another person. Are you aware of any strategies or campaigns aimed at reducing the stigma and shame associated with seeking support and treatment?

Ms COX: There are the broad campaigns in the broader community, things like R U OK and Beyond Blue and various strategies like that. The way that we often approach it in our workplace is we work on what is called a recovery model and we focus on people's goals and interests.

We very much pick up on an issue which was raised by the previous speaker and that was about people's physical health and seeing physical health as the way to start to work with someone. Generally, if you talk to people about the things that they want, concerns about their physical health often come first rather than concerns about either their mental health or their alcohol and other drug use.

So we will start when that person is ready to work. There has been quite a lot of evidence in the community base sector that shows that kind of approach; you do not need to tackle these issues head on. You tackle them at the place where the person is ready to start. Once you have formed relationship you are then able to start addressing those issues.

Mr CHAIR: This is an issue that has been brought up with a few people. Overseas and in some Australian jurisdictions there is some evidence of a shift towards treating illicit substance abuse as a health issue rather than a criminal issue.

What effect do you think that decriminalisation of illicit drugs would have on substance abuse in Aboriginal communities?

Ms COX: I really do not feel qualified to comment on that particular issue.

Mr CHAIR: These guidelines would you recommend all of our providers to effectively work from the same song sheet?

Ms COX: I suppose I would be thinking at a Territory government level it would be a matter of considering those guidelines and working out what of that is applicable and

then putting in place the supports and the structures and the monitoring that would support what is essentially a best practice guide.

Ms PURICK: I have a question. With your association do you have any engagement with people on cattle stations given they are remote too in Central Australia?

Ms COX: We work with remote Aboriginal communities principally in the Suicide Story program. It is a program that has been developed by the Aboriginal community and targets that population.

Mr KIRBY: The isolation and the emotional wellbeing of that group of people, particularly through the droughts and things on the East coast that have been well advertised—is that something that you see much through the Territory?

Ms COX: Again, I am probably not able to comment on that because suicide intervention or response is not an area we are funded to, or in which we, intervene. Our work is more at the level of suicide prevention. I could not really comment on that.

I am certainly very aware of those issues, particularly in Queensland where that has been seen as a major issue. I am unaware of the extent to which that is the case in the NT.

Mr KIRBY: Yes. We have asked a few different people, obviously, their connection with other service providers. In some areas it is good and it helps a lot and in other areas they feel quite isolated and siloed—for want of a better term. Does that have much of an effect on your access or ability to help people?

Ms COX: There is siloing at the clinical level. There probably are not really strong connections between the community sector and the clinical sector, from a mental health point of view. Our clients can have difficulty navigating the service system. In the past, the Mental Health Association of Central Australia and DASA have done joint work together, but that has been limited in recent times.

I believe that is an area, in a way, that is our responsibility to develop and make that work better because we have a number of shared clients. We all just get drowned in the volume of the work we have. Some of that networking and linkage work is put as second priority. We need to put it as a high priority.

Mr KIRBY: That is probably something we have asked a few different entities as well—your ability to be proactive in the spaces you would like to be through the Territory. Is there any ability, or are you just that reactive through the way …

Ms COX: I hate to go back to the funding issues, but one of the issues that will come up for us, as an organisation, is the introduction of NDIS. That means we have to pare all overhead costs back very low in order to survive. That networking and linkages and

those sort of things, are things that are potential casualties in that process. We need to be thinking of the impact of NDIS, particularly in the alcohol and other drugs sector.

You mentioned before alcohol and other drugs being seen as a health issue. There are some people who also see it, in some ways, as a disability issue. Alcohol and other drugs is not recognised by the NDIS. They see that as a mainstream service. So, there are issues about how disability support services like ours and the AOD sector will be able to integrate in the future.

Mr KIRBY: Yes, particularly if that is a large area where the federal support will go.

Ms COX: In some other sectors we see that peak bodies have a role in facilitating linkages across services and networking and those sorts of things. We host a mental health interagency group and there could be room for expanding that to include Alcohol and Other Drug services. There is some potential there as well. But we do not specifically receive funding to do that.

Mr KIRBY: Yes.

Ms PURICK: That is all good. Thank you.

Mr CHAIR: Is there anything else you would like to tell us.

Ms COX: No, I will just say the same thing that the other chap said at the very end—the fact that so many of our clients are in unsatisfactory, insecure housing. Even if they attempt to make some difference in their lives, they often bounce back because the fundamental circumstances of their lives do not make it possible for them to make the changes that they might want to make.

Going back to that, social determinants, particularly homelessness, are a massive issue for our clients. It has a very big impact on the capacity of people to make change.

Mr KIRBY: Yes.

Mr CHAIR: Thank you very much.

The committee suspended.
