



LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder

Public Hearing Transcript

12.30 pm, Tuesday, 29 July 2014

Council Chambers, Katherine Town Council

Members: The Hon. Kezia Purick, MLA, Member for Goyder
The Hon. Bess Price, MLA, Member for Stuart
Mr Gary Higgins, MLA, Member for Daly
Mr Gerry McCarthy, MLA, Member for Barkly
Ms Nicole Manison, MLA, Member for Wanguri
Mr Gerry Wood, MLA, Member for Nelson

Witnesses: Wurli-Wurlinjang Health Service
Ms Marion Scrymgour, Chief Executive Officer
Mrs Suzi Berto, Deputy Chief Executive Officer
Katherine Region Action Group (KRAG) and the Association of Alcohol
and Other Drug Agencies NT (AADANT)
Ms Michelle Kudell, Executive Officer
Kintore Clinic
Dr Dave Brummitt
Sunrise Health Service
Ms Raelene Wing, Child Health Program Coordinator
Chamber of Commerce
Mr Kevin Grey, Chairperson
Venndale Rehabilitation and Withdrawal Centre
Mr Casey Bishop, Manager
Top End Health Service and Katherine Health Centre and Hospital
Ms Angela Brannelly, General Manager
Mr Simon Quilty, Acting Director of Medical Services
Ms Rose Gaston, Director of Nursing

Katherine West Health Board Aboriginal Corporation

Ms Rebecca Gooley, Senior Primary Health Care Consultant

Madam CHAIR: On behalf of the committee, I welcome everyone to the public hearing into action to prevent foetal alcohol spectrum disorder.

I welcome to the table to give evidence to the committee Ms Marion Scrymgour, Chief Executive Officer, Wurlli-Wurlinjang Health Service and Suzie Berto, Deputy Chief Executive Officer. Thank you for coming before the committee. 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 apply. A transcript will be made for use of the committee and may be put onto 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 may ask the committee to go into a closed session and take your evidence in private.

I will ask each witness to state their name for the record and the capacity in which they appear. I will then ask if you want to make a brief opening statement before proceeding to the committee's questions. Could you please state your name.

Ms SCRYMGOUR: Yes, Marion Scrymgour, CEO Wurlli-Wurlinjang Health Service, Katherine.

Ms BERTO: Suzie Berto, Deputy CEO, Wurlli-Wurlinjang Health Service, Katherine.

Madam CHAIR: Did you want to make any opening comments?

Ms SCRYMGOUR: I would like to make a brief opening statement. Wurlli-Wurlinjang welcomes the 26 March decision by the Legislative Assembly of the Northern Territory to appoint a select committee to inquire into and report on foetal alcohol spectrum disorder, or FASD, in the Northern Territory. Wurlli wishes to prepare a comprehensive written submission to the committee addressing each of three specific matters on which the committee has been tasked to report.

Wurlli-Wurlinjang will seek clarification from the committee as to the time frame within which such a report could be submitted and considered, but it is noted the committee has been directed to report to the Legislative Assembly in the October sittings. In the meantime, Wurlli seeks to make the following comments.

When we talk about the prevalence in the Northern Territory of foetal alcohol disorder, Wurli has been treating Aboriginal people in the greater Katherine region since the beginning of the 1990s, both as individuals and as family entities. Over that time frame the destructive impact of alcohol upon generations of patients has become as painfully clear in the health sector as it has in the criminal justice and in the child protection/welfare systems.

When assessing and dealing with health and related problems affecting females, Aboriginal children from alcohol abusing families who themselves become alcohol affected young mothers - treating their infant children - Wurli-Wurlinjang staff have unfortunately been in a position to see all too clearly how prevalent FASD has become. While the long-term clinical effects of FASD are well documented and its debilitating impact increasingly better understood, Wurli believes there should be benefit both in the research context and the health promotion context for the information regarding the impact of FASD on Katherine Aboriginal families, in particular to be documented and disseminated - obviously, it has to be in an anonymous way - so as to highlight to our own community the recent costs of continuing with the lifestyle status quo.

Wurli-Wurlinjang proposes the information relating to the nature of the injuries and effects of FASD on those sufferers who have been treated and assisted by Wurli would be front and centre of the foreshadowed written submissions to the committee.

Wurli's policy position in relation to alcohol policy reform has been, and continues to be, that of a multipronged, multifaceted approach, and one that continues to be needed, and which addresses both the supply and demand issues.

Wurli's board will carefully consider what particular government measures board members believe would contribute to tackling FASD in a timely and effective way, and will present such suggestions in the proposed written submission, in tandem with an outline of proposed measures to be undertaken by Wurli-Wurlinjang.

Chair and members of the committee, whilst that opening statement said a number of things, I have brought a number of bits of information, plus we want to talk to the committee about Wurli-Wurlinjang being primarily acute healthcare where we run a clinical program. We are also in the process of setting up the Strong Indigenous Women's program, which the deputy oversees. We also have what is called the StrongBala program which is looking specifically at men's welfare. Strong Indigenous Women looks at how we get women, men, and families as part of the strong unit, and build strong family units to deal with that.

I have brought a couple of, I suppose current cases - not names, but numbers - of young children we deal with presently at the health service. They are only small

numbers. It is a small number because one of the things that needs to be stressed is the diagnostic tools you need to put in place for FASD is not there. Many of our health staff - our doctors, nurses, and AHPs - struggle with how we diagnose this area.

I have brought to table the Wurli-Wurlinjang strategic plan which goes up to 2016, and our last year's annual report for members of the committee. We could either talk about the women's program first, if you wanted to. We have brought copies for all members of the committee. Minister Scullion, the federal minister, has signed off on and has agreed to fund the action plan, which is fantastic from our point of view. That is the action plan. Then, we also have for each member copies of our Strong Bella program.

Chair, do you want us to just walk through ...

Madam CHAIR: Yes, whatever way you want to do it.

Ms SCRYMGOUR: ... then if there are any questions from the committee?

Madam CHAIR: Sure.

Ms SCRYMGOUR. It was the pushing, I suppose, of Suzie for a long time to look at - we had StrongBala, which looked at how we build men and make men strong, build culture. If you do both those it means you will get strong families and strong futures for our children.

We have been, for some time, working with the government agencies, particularly the department of family and children where referrals are done from the department to Wurli for our family support unit. We pick up a lot of the front end of any child protection cases and try to work with the department to identify at risk children and look at what needs to be put in place. If there are issues that can be resolved with families we will recommend to the department it should then keep that referral with Wurli and we wrap our services around that family rather than the intervention from FACS where children are then removed.

A lot of the time that works. We have had very few referrals back to the department where children have been removed. There is no politics and it is quite open. Susie and I have met with the CEO of the department in Darwin to look at how we can both build our strengths in a community like this where the reality is grog is a bit factor and family dislocation and dysfunction is a major issue.

How do we, as an organisation, place ourselves with government agencies to try to get the best outcome for these kids? That is at the forefront of everything we do. Susie, for a long time, has been designing and developing - if we have a program looking at men and wrapping services around men we are not doing anything for our women. How do we get around it? She keeps telling me to talk, but she is the best one to speak on this.

How do we get these services happening for our woman where we can bring woman - probably some of you are old enough to remember the old homemaker programs. That is the concept we are bringing back – looking at the old homemaker program.

Ms BERTO: They had a homemaker centre located at Kalano many years ago which involved women coming in from the different communities. They had a community from Katherine doing a bit of cooking, learning about nutrition, hygiene, cleaning houses, getting the kids to school and getting kids into little athletics and that sort of stuff. It proved to be quite successful so we have come back to the concept of the old homemaker program but have added a little more to it and have built it so it works really well with our primary health care services at Wurlu.

How do we take that step before people present to the clinic, whether it is for primary health care or chronic disease? It is working with the mums, all the children and we are targeting anaemia, alcohol issues, domestic violence and, in general, women's issues and how to do it in a culturally appropriate way. How do we get and maintain those women coming to the centre and being involved. I think it will be really successful. I said to Marion, blood, sweat and tears, but we will give it 100% and see how it goes.

We have been fortunate to get funding from Senator Scullion - capital funding - but unfortunate in getting operational funding for this program. We have to find money in our current bucket for wages and other stuff.

Ms SCRYMGOUR: That has challenged us and made us look at what we are doing now, how we have been doing it and how we want to shape services into the future. It has been a good exercise for us. We have done a complete - the last six months has meant the organisation has gone on this journey of a complete restructure. We have reviewed our services. We have looked at ourselves within, rather than looking and poking the finger at government. We have said to staff, 'Let us look at what we are doing and how we do this better. We have this, so how do we do that? We have this great concept and the capital funding, but should that mean we hand it back and not do it, when there are people who are doing this work already within? Let us drop all the silos and get a better integrated service'.

That is what we have done. We have not allowed the recurrent funding to stop us from doing that. We have taken people from our AOD team - all the female workers who work in our Alcohol and Other Drugs team, our female nutritionists, our dietician, our targeted family support workers - all the female workers in all of those areas and integrated them as part of our Strong Indigenous Women's program with our female doctors and our female AHPs. So, that has given us a base of workers and resources to be able to do this. All our male workers have been integrated as part of Strong Bella.

Madam CHAIR: There you go.

Mr McCARTHY: In the cultural sensitivities and the cultural perspective, is pregnancy now openly discussed among the Aboriginal community? Is it openly discussed in a non-Indigenous family planning context? Does it have any taboos? Are any of the old cultural influences still very strong that prevent that discussion? In the programs that Wurli-Wurlinjang run, are you guys having that - is that conversation now open and articulate?

Ms BERTO: That cultural stuff has come a long way. You have your different areas where they still say no, this is *pukamunny* and don't talk about it.

Ms SCRYMGOUR: It is gender based.

Ms BERTO: It is gender based. What has happened at Wurli over the years is we had a separate mums and bubs program area. Years ago, the fathers - no males - were allowed to step in there, not even the male doctors. Now, the dads come to the clinic with the mums into that program area. They are actually involved, so it is really good.

Ms SCRYMGOUR: There are single fathers in this town, and that is what we have had to look at. If we have men who are single fathers, we need to work with them, just like we work with mothers.

The other thing we have done with this restructure, which has challenged our health people - well, our doctors get it but people have been so used to operating in one set way, Gerry - sorry, member for Barkly. What we have said to them through this restructure is these specialised area of children's health - and paediatrics became a big part of that - is many of the paediatricians who come to town are male. That is what has been a barrier for Wurli where we have had gender specific - where it is a woman's only area it means we cannot get a male paediatrician to go into the women's and children's area because it is women only. So, the women's area is specifically only focusing on antenatal and postnatal and all the other issues such as breast checks, which affect women.

We are separating the children and child health area so we can allow men and fathers to become a big part of their children's health and wellbeing, and that child's journey. Fathers should be an important part of that child's journey. Part of our restructure has been to look at having that as a specialised area separate from women's health so fathers can have a part of that.

Mr McCARTHY: So, in a sense of generalising, if I look at the Barkly the parents are under 25, so this is partly true? In the essence of primary healthcare, we are talking about nutrition, anti-smoking, and all those programs, and are continually trying to educate and make them aware. Is the FASD story now a big part of that on the ground?

Ms SCRYMGOUR: No. Unlike the Barkly, because I know that Anyinginyi Congress has been quite strong in FASD, and I am hoping it provides a submission to the committee because LT and the group and Anyinginyi have been passionate and been the champions of this. They bring it to AMSANT forums, and that is with my hat as chair of AMSANT on.

Do we have that discussion and is it in Katherine? We have a small cohort of clients, and the oldest person we have with FASD is around 29. All the rest are small children and there are eight young kids we work with here.

It is not a huge topic, Gerry but it is known. A lot of it is, particularly in the health circles, hard to diagnose. What is FASD and how do we put that into place so it is part of our checks. When we are checking people - part of our restructure is what are the basic checks we need to do for patients. Part of our restructure was not just about staff journeys or about staff, our restructure was based on what our patients journey is. How do we restructure and make this organisation better so our patients benefit from it, and how do we get better integration?

Mr McCARTHY: Does Wurli-Wurlinjang have a connection with Katherine High School, St Joseph's Catholic College, or both, dealing with secondary age kids?

Ms BERTO: Yes, we do school screening at the high schools and primary schools. We also talk about sexual health.

Madam CHAIR: What do you mean by screening? Do health checks?

Ms BERTO: School screening health checks.

Ms SCRYMGOUR: We do all the ear, nose, throat - any screening for children. Notes are given out to parents and we do not touch any child unless the note has come back and is given to us. We have to make sure our risk and our liabilities - we sign off on all that. We send letters to all parents and do whatever screening and education. At the high school we have an STI team which does both male and female sexual health. Tobacco people talk about tobacco as a drug and, hopefully, minimises the uptake of tobacco. We have recently - just on tobacco - undertaken a survey in Katherine amongst the Aboriginal community and the uptake is - when you look nationally - across the Northern Territory, Katherine's uptake is quite high. The prevalence of smoking amongst the young is higher than most regions.

Mr WOOD: I presume you do prenatal screenings as well, and we have heard doctors are not asking pregnant women if they drinking. Either they do not want to ask or it is not on their agenda. The issue we have with FASD is people drinking alcohol when pregnant or intending to get pregnant. Do your doctors ask women if they are drinking? Is that seen as something of major importance in prenatal discussions?

Ms SCRYMGOUR: Absolutely, but is not just prenatal, Gerry. Anyone having a screening check or a consult with the doctor is asked if they are drinking, but for women and children - when I spoke to our female doctors working in that area, they ask women if they have a history of drinking, if they have drunk and if they are smoking. Those questions are asked.

Mr WOOD: If pregnant women are told alcohol could be affecting their baby, is that having an effect on whether they keep drinking or do some continue to drink regardless of the circumstances?

Ms SCRYMGOUR: The doctors were saying very few women coming to Wurlinjang will continue drinking once they find out they are pregnant. There are always women who will continue to drink regardless of whether they have been told the dangers of what they are doing - the impact of their drinking and what it is doing to their unborn child.

Mr WOOD: Do you have any idea of the numbers of people who continue drinking? Does that reflect the numbers of FASD babies who are born? Is there any statistical evidence to show that?

Ms SCRYMGOUR: That is a good question. It was an interesting question because it was a question I actually asked the doctors when we were asked to come to this committee.

People have not really looked. When I say they have not, it is just because it has not been collated in a way. It has not been one focus. I will tell you, when we look at Aboriginal women who are pregnant and coming in, yes, we need to talk to them about their smoking; yes, we need to talk to them about their drinking and that whole prenatal care. That is an issue we maintain quite well.

Then, there is all the work we have to do postnatal. One of the biggest challenges for Wurli-Wurlinjang, besides looking at FASD - when I look at FASD I see there are eight young people on our books. In the Katherine region alone the biggest challenge for Katherine West Health Board, Sunrise Health, and for Wurli-Wurlinjang, is to deal with childhood anaemia.

Madam CHAIR: Childhood anaemia?

Ms SCRYMGOUR: In children under two, it is 90%. It is the highest of any region in the Northern Territory, let alone Australia.

Madam CHAIR: What are they not getting? I know what anaemia is. So, what are they not getting?

Ms SCRYMGOUR: Childhood anaemia, it is iron, it is protein.

Madam CHAIR: Oh, protein. Okay.

Ms SCRYMGOUR: When a woman has a baby, one of the things the hospitals have done quite well is when the baby is born they clamp the cord and stop the bleed so it keeps the nutrients – and they keep it clamped longer for Aboriginal kids. Children usually progress quite well up to six months. Then, after six months, when they are home and there are a number of environmental factors that start coming in and start tracking in that child's life, where they then go backwards, rather than forwards.

If we do not deal with childhood anaemia, after two years old - if we have a child who already has a deficit of childhood anaemia up to two years old – a school teacher would say the cognitive development has been absolutely destroyed for that child. If we then expect that child to go to school at three, four, and to start learning ...

Madam CHAIR: It is too late.

Ms SCRYMGOUR: They already have that deficit from the time they were up to two years old with the childhood anaemia. We need to start targeting and looking at how we get childhood anaemia, with all of these – whilst I know the committee is focused on FASD, for us there are so many other illnesses amongst these kids that are unheard of in the western world, but we are still dealing with in Aboriginal kids. For anaemia we could give kids medication, give them the iron tablets and the supplements, but unless we are also fixing the environment in which they are living - all of those issues of housing, the overcrowding, all of those things - that learning pathway for that child by the time they get to four, five ...

Madam CHAIR: Has not developed. The child, if it has its baby anaemia, could also be a FASD child, but you would not know it at that stage?

Ms SCRYMGOUR: Yes, it could be, because the diagnosis has been skewed. That is what we have to get right, and this is going to be discussed at the Aboriginal Medical Services meeting coming up next week: how do we get this consistency happening across the AMSs? John Patterson and I are going to meet with Len Notaras to look at how we can work with the departments and the hospitals. We need to come together. It is a critical mass issue because you could almost predict what is going to happen with that generation coming. We have been saying there is a freight train coming - the train is coming and it is going to be a train wreck unless we can try to do this.

Ms MANISON: Marion, the diagnostic tool you mentioned - you have not had that formal tool and it has been difficult to get a real figure. Do you think the eight you are talking about is an under representation of the FASD number of children you will see? It sounds like you are working on a formal diagnostic tool you can use, but what other guidance would an organisation like Wurli be looking for around which diagnostic tool to use and how to use it?

Ms SCRYMGOUR: That is why we need to pull in the department - we do not have paediatricians. There are many specialists Aboriginal medical services need access to which we do not have and that is why we have approached the department, and the department has been pretty good to date. Working with the department with the resources we have - we need to plan and develop this tool so we can all be better placed and better informed. The Strong Indigenous Women's Program - using a program like that to get specialists and other people in, where you have a captive audience of woman coming in to an environment where they do not feel threatened - it is not a hospital, not a clinic, it is part of the funding we have that will allow us to buy a house - we are going through the negotiations now – which will be multipurpose so we can use it for these women and it will be like a drop-in centre for woman and kids.

We need to get the resources and work with the department to try and do this. Without the department we will not be able to do it because they have the specialists and the resources.

Mr McCARTHY: A comment you might be interested in, and what Gerry and Nicole said, came up last week in the bush. Fly in and fly out DMOs, agency nursing, and the nature of the health professional industry now does not provide continuity and does not really collect good data, but sustainable RNs and Aboriginal Health Workers can do anecdotal diagnosis because of the knowledge of the family ...

Ms SCRYMGOUR: And the connections they have with the community, yes.

Mr McCARTHY: In the discussions I had last week in the bush - the RN in this particular case has been there a long time and been around a long time. Aboriginal Health Worker staff say their anecdotal evidence is statistics will be way higher yet the DMOs and visiting staff are not diagnosing and there are no diagnostic tools. Maybe there is an element to look at local knowledge and ...

Ms SCRYMGOUR: We have had some long-term doctors at Wurli, and that has been the good thing - we have had some long-term stable medical officers as well as AHPs. It goes back to the diagnostic tools - what we are looking for when screening, how we make sure it is recorded, but we are screening in a better way so we are getting the information. I think we have been missing the mark to date. I think everyone knows there is a problem. We have not have the physiological staff on board and we are about to do that. We now have psychologists and have just recruited to our wellbeing manager's position who is an Aboriginal psychologist trained in IQ testing and child and adolescent mental health wellbeing. All of that is part of a suite of measures we need to take as a health service to try to look at how big that problem is. But, sometimes, you wonder whether we are lifting the lid on something that becomes bigger than Ben Hur. The reality is our resource is finite, and we have got to try to do the best with what we have, and we are doing that. Wurli has done a pretty good job to date.

Madam CHAIR: I better jump in there because of the time.

Ms SCRYMGOUR: Yes.

Madam CHAIR: Thank you, Marion, and also to Suzie. Thank you for the documents as well. That is most useful. How many staff do you have?

Ms SCRYMGOUR: One hundred and fifteen.

Madam CHAIR: Yes, I saw a whole swag in the annual report. It is a big organisation?

Ms SCRYMGOUR: It is a major organisation. We have 11 doctors.

Madam CHAIR: Yes.

Ms SCRYMGOUR: We have 11 doctors and half are female and half male, so we have a good balance of staff.

Madam CHAIR: A good mix for everyone.

Ms SCRYMGOUR: We run a community health program. It is a pity you cannot stay longer, you could get the royal tour. We have had the member for Wanguri as the shadow Health, and we have had Robyn ...

Madam CHAIR: Others come through.

Ms SCRYMGOUR: ... as the Minister for Health. So, next time you are in town, please come.

Madam CHAIR: Maybe next time. We will send you a copy of the draft *Hansard* to check to make sure it is okay.

Ms SCRYMGOUR: All right. Can we put in a written ...

Madam CHAIR: Yes.

Ms SCRYMGOUR: Two of the female doctors who wanted to come – school holidays – are away at the moment. They would be quite interested in doing this written submission ...

Madam CHAIR: No, that is fine.

Ms SCRYMGOUR: ... so we can do more detailed statistics and stuff on the ...

Madam CHAIR: Marion, just sooner the better, that is all.

Ms SCRYMGOUR: Yes. We will get that in.

Madam CHAIR: That would be lovely. Thank you.

The committee suspended

**KATHERINE REGION ACTION GROUP (Krag) AND THE ASSOCIATION OF
ALCOHOL AND OTHER DRUG AGENCIES, NT (AADANT)**

Madam CHAIR: Hello, Michelle.

Ms KUDELL: Hello, how are you?

Madam CHAIR: Hello. Welcome.

Ms KUDELL: I notice it says Katherine Region Action Group. I am the Executive Officer for the peak body for Alcohol and Other Drugs, representing them as well.

Madam CHAIR: Did you get that?

Ms KUDELL: I am a member of Katherine Region Action Group, so ...

Madam CHAIR: You are a member of that, and then ...

Ms KUDELL: Then Executive Officer for the Association of Alcohol and Other Drug Agencies.

Madam CHAIR: Got it, thank you. That has done that bit for the record. Welcome.

Ms KUDELL: Thank you.

Madam CHAIR: Thank you for coming before the committee. We appreciate you taking time to come and speak with the committee and we look to what you have to say.

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

You have already stated your name. Would you like to make any opening statement?

Ms KUDELL: Sure. I have a little document and I will read from it, if that is okay?

Madam CHAIR: Yes, of course.

Ms KUDELL: I have some copies for you. Basically, in preparation to talk to you I circulated a sector survey around the AOD sector, which involved our membership which are predominantly government-funded NGOs. We are kind of broader than that, so I speak to a lot of people who sit outside of that in some health agencies like Wurli-Wurlinjang etcetera. Those sorts of agencies will come under my spamming, if you want to put it that way.

What I have done is collated the responses. I sent out about 138 surveys. We did not get an overly big response, but that is quite typical of the sector because quite often we have trouble. They talk behind closed doors so some of this becomes anecdotal, but a lot is drawn specifically from the responses in the sector survey. Some of the common areas raised was - 100% of the respondents requested FASD be recognised as a disability. I am sure you have heard that over and over again. They see this as a cornerstone to potential recognition of the severity of the problem and the consequent provision of treatment, support and assistance for those living with FASD, their families and carers and the agencies providing treatment services.

Diagnosis rated as the next most significant issue, with multiple agencies citing they had difficulty in assessing how many FASD clients attended their services. This was due to either a lack of training in identifying FASD or a reluctance to label a client without the formal and appropriate diagnosis. Those who attempted to put a figure on the number of

clients with FASD attending their services reported anywhere from 10% to 80% - there is a wide-ranging scale. The highest number of responses sat at about the 10% to 20% of clientele range.

When asked what they felt was lacking in the treatment and support of FASD and what changes they would like to see they listed a number of different things: competent and appropriate diagnostic tools for both adults and children suspected of having FASD; early intervention of allied health services - I have jammed some of this together – a multidisciplinary service response, which I think Marion was referring to - around the different specialists perhaps there is a lack of access to - increased medical care and alcohol pharmacotherapy; strong referral path for case workers to refer a client for testing and diagnosis, and individualised programs or the ability to develop those based on that diagnostic pathway; public education strategies; and individual case management - here a lot of the agencies spoke about the request for training on how to develop FASD-specific case management - behaviour management techniques; support services- what they are saying to assist and advise the agencies in the treatment and management of clients. I have also tacked in here in my response - I have given you a solutions page as well - how we disseminate the information and how we make sure the resources reach particular remote areas. Obviously I cover the whole of the NT so not just Katherine-specific, although my action group is here and this is my location.

There were also education programs for the government and NGO service provider agencies, respite services for carers and parents and support and strategies for carers and parents. So we start to focus on our clients here. There are also safer supported accommodation options. One person said they saw longer-term public guardianship arrangements as a positive - resources and education for the remote services. One of the bleakest comments I saw was there were no realistic FASD services or programs in the NT. The reason I mention that is it is coming from an agency which delivers, potentially, an AOD service and it saying it does not see anything. Is around breakdown of communication of what is out there. Part of the role I am trying to fill at the moment - I took over the role of EO for the peak bodies in February so have only been in the role a few months, and prior to that we were auspiced under another company before incorporating. Nothing really happened, I will be honest about that, so a lot of people said there was no peak body and what were we talking about. We are just starting to gain some real recognition and confidence from the sector because we are starting to put in place some of the mechanisms and communicating with people across the sector which seems to be something they were hungry for.

When I asked what steps did they think the government could take to assist in the prevention, treatment and diagnosis of clients with FASD they ranked the response. A total of 94.74% said the development and provision of FASD-specific resources. This surprised me because I did not think resources would hit the top but it did. A total of 84.21% said preventive education strategies, localised training support and provision and

public education. Next came 78.95%, jointly ranked, FASD-specific funding and stronger communication and dissemination of information. Then we go down to regional training and support. They want more in-house support, which I will explain later, as opposed to having it in Darwin, Tennant Creek or Alice Springs with all coming in, because a lot of our agencies cannot staff to do that so they want something in their own communities.

Capacity building and program implementation support, which is around IT and infrastructure, scored 63.16% of the responses - ticked that off as something they would like.

Some of the other responses which were not necessarily in the choices they had were support groups for the families and carers, mentoring and skill sharing workshops, and Australia-wide META analysis of the extent of the issue to fully scope the funding required to begin to implement sincere long-term intergenerational strategies - which is probably what we are commencing on this journey right now.

My comment is the recent Australian government decision to provide \$9.2m to the National Fetal Alcohol Spectrum Disorders Action Plan is a step in the right direction. It is a hope of AADANT and KRAG group that this funding can find its way into the Northern Territory and into the provision of diagnostic tools, supports and services as we have outlined in this report. We support the listing of FASD on the national disability register.

I have also included here the copy of the survey for you so you can see all the responses we got. One of the comments I make, though - and I have put it on the front page where I have my solutions - is of one of the comments in particular that surprised me. I do not reveal any of the agencies that gave the responses, but one of our agencies which is residential rehabilitation showed a complete lack of understanding of FASD in their response. Their response was, 'We do not have pregnant women, therefore, we do not have FASD comments'. I was quite surprised to read it, so I have drawn your attention to the comment from that particular agency to see the lack of understanding that still exist in the services that are potentially ...

Madam SPEAKER: They might not be pregnant women, but they could be the children who are offspring of pregnant women there.

Ms KUDELL: That is right. Absolutely. Clearly, that particular person who has responded requires some education and training on that.

The point I make is we assume people who are working in the industry are fully versed and understand ...

Madam CHAIR: That is a good point.

Ms KUDELL: How can we expect to diagnose if the agencies do not even understand the condition is not a condition of a pregnant woman, it is a condition that is pregnancy-related, obviously, because of the alcohol consumption, but not actually an illness of a pregnant women, which is the way it is verbalised in there. I thought that was worth highlighting.

You can start asking questions if you like. I will talk about that. Obviously, the solutions we have is to list it on the disability register. I have not really elaborated on that. If we can do that, understandably there will be a lot of flow-on effect from that.

The development of a diagnostic tool, even if that varies in its focus so we could have a basic diagnostic tool the case worker might be able to use. Then, they would know to be able to make a referral right through to a confident diagnostic tool that a doctor or a health practitioner could use to be able to diagnose effectively at that end point as well. It needs to be a broad-ranging diagnostic tool.

Then, I have a bit of self-promotion in here. We are actually trying to seek funding for a project that will see us, as a collaborative effort, mobilising training information dissemination and resources and physically taking it out - I heard you talk about fly-in fly-out earlier as well. That is something we have commented on regularly; that the people who have the most skill in our communities exist but they lack the support of somebody who can mentor and provide face-to-face contact with them and hand out information. The concept we have - and I have attached copies of that for your interest of what we are trying to get ahead with - would include public education strategies. We can roll up, we are quite self-sufficient.

The budget in here is at the top end, in the sense that we said many of our communities do not have enough accommodation or resources to support multiple agencies attending out there. We have put bunks in the back of a mobile unit so we are self-sufficient we do not impinge on the communities. That is the concept behind it. Then, we can collaborate and deliver it. We do not want to replace people who are working. You hear of great things that are happening, but some of those agencies do not have the capacity to go out to communities, so many of our remote areas just get forgotten unless they can come into training. I repeatedly hear of the inability of staff to be released or replaced so they can receive training, which often occurs down the track.

That is just a proposal we have come up with. Yes, we are trying to get some dollars behind it. I am not after a dollar grab, but I think it is interesting for you to read it and see

what the idea is. If it does not come to us that is fine, but it is worth thinking about as a concept.

Mr McCARTHY: I was recently talking to a guy about education, alternative pathways and doing things differently. For his model he wanted an (inaudible) on the back of a Toyota troop carrier. I said, 'You are as mad as I am'. He said, 'Why would we want anything else if we are going left of centre with this?' It is interesting to hear you propose the same concept.

Ms KUDELL: If you look at what we have budgeted for in that proposal it is quite high, but that is because we want to see what it would cost. If you could have a four-wheel drive mobile office with fold down bunks at the back, toilet facilities, and we could stick a generator on it so we have the least impact on that community in a physical sense, but as much impact in a psychological or educational sense, and we are out there - a lot of times I get phone calls.

I held some training yesterday in Alice Springs and had people from Maningrida and Gove asking when they could have training locally. I had a chap from America talking about his work with native American communities who was only here for one day and I could only get him to Alice Springs. I said that part of what we wanted to look at was how we could make some of those training packages takeaway. How do we take them, as a takeaway package, and say we will do it in Alice Springs but will go to Maningrida next or Mimi Arts here. I have been talking to Barbara from Mimi Arts about their wise moves. They do a project where they use art therapy in alcohol treatment basically, and she is always on me to help her collaborate and get people hyped up. I said to her, 'This would be an ideal thing to take to communities'. She said, 'I would love to but I can't'. I said, 'If only we had a vehicle we could take people on board'. If they helped to fund it we are reducing costs because we are collaborating to use those funds.

Sustainability, at some point, is possible. You could get agencies to commit to a contribution to the running cost and the team you have on board become the face the community really knows. Relationship building is reduced in the sense they know them so it is okay. If you say you are bringing a mate along they say that is okay because they trust you. They are starting to see a familiar face so it becomes less of a ...

Mr McCARTHY: To bring it back to the Katherine Region Action Group, when you are working with alcohol management plans and that nature of the business, is FASD now in the conversation?

Ms KUDELL: Yes.

Mr McCARTHY: In regard to the harm?

Ms KUDELL: I believe so. Sadly, I was the only one who volunteered to speak up, but it is probably because I sit with the peak body as well. However, it is starting to be in everybody's conversation. When I talk to my agencies, people are starting to talk about it now and they are still hungry for training. We did a sector forum recently and the one thing they wanted training on was FASD. I thought there was heaps of FASD training - really there is - but they want more. We will do some more training. I will have Prue Walker do some training for us. Yes, it is in the conversation now, but a lot of agencies - you will see that reflected in the responses - are reluctant to say they are working with FASD clients because they are a little unsure of what it looks like and smells like. Do you know what I mean?

They understand there is an issue, you are hearing that more and more, and they can see there is a real danger, but it is stopping there in the sense nobody knows what to do with it.

Mr McCARTHY: Outside the agencies, are licensees talking about it?

Ms KUDELL: Doubtful. I would not think so.

Mr McCARTHY: We will talk to some down the track and I interested to see ...

Ms KUDELL: I have not heard it from licensees, and that is just me. That does not mean they are not saying that, but I have not heard anything. Certainly there is not a lot of public education or anything you are seeing. That can often be driven from that quarter if they are starting to talk about it. That would be something I would be interested in seeing, hopefully.

Ms MANISON: With the reluctance of diagnosis you were talking about ...

Ms KUDELL: Yes.

Ms MANISON: ... why do you think people are reluctant to give the diagnosis? Is it because they lack the diagnostic tool to be able to do it, or is it because they are worried about who can say something like that? Will it be solution orientated like yourself, that they do not have somewhere to pass it on to ...

Ms KUDELL: It is probably ...

Ms MANISON: ... to get them to look at it afterwards? It is ...

Ms KUDELL: It is probably a mixture of both. Bear in mind the majority of my agencies are the NGO-funded treatment services, not health services. We are not talking doctors and, generally, that high level of medical qualification. But, we are talking about people who might run residential rehabilitation or sobering-up shelters even, although they are in-and-out moments. Some are your youth programs - all those sorts of things - would be engaged with us, and they just lack the diagnostic skills. So, whether it is a tool or just simple training in how to diagnosis FASD, it is also what do we do with them?

Once we diagnose them, we know it is fairly complex. They talk in here about the need for supported accommodation, for one-to-one case management because of the high level of dependence, I guess, of the FASD client.

Mr WOOD: If you are saying there is not a great public awareness - and I know you are talking about all this post-FASD in a sense - what is happening in relation to publicising the fact that drinking alcohol when pregnant is basically a no-no? I know there is a lot of discussion and some people say you can drink a small amount or not, but the evidence we have received - and there has even been some debate on television recently - is the safest way is no alcohol when pregnant. Is that message out there?

Ms KUDELL: Not up here, I do not think so. That is from my general observation, even taking myself out of this role, just as a human existing here. I do not see it. It certainly does not appear strongly on TV. There are a few of those FASD ads that come up, but I wonder how effective they are.

Mr WOOD: Well, the word FASD for many people would mean ...

Madam CHAIR: Nothing.

Ms KUDELL: It does not mean much. That is it. I wonder whether is it not broken down. Those ads I do not mind. Some people belittle them and say they are a little child-like, but it is actually effective in that there is this little child saying 'I wish I did not have FASD' or 'My mum drank'. That is happening. How effective that is to the general, primary target group, if you like - a lot of them are homeless anyway, so TV promotion is probably not going to reach them ...

Madam CHAIR: It is pointless.

Ms KUDELL: In all honesty, those people who are living rough and drinking regularly are probably more of those critical areas of people who do not attend medical services or have limited access to medical services. They are certainly not watching telly.

Madam CHAIR: Their literacy is probably very poor so they are not ready any.

Ms KUDELL: Literacy is very poor, yes.

Mr WOOD: There was one group when I was down here last which was going to set up - I am not sure, I cannot remember their name. It was going to set up near the river occasionally so people could come and have a cup of tea ...

Ms KUDELL: That was our yarnning bus. Yes, that was my idea. You see, there we go.

Mr WOOD: That was your idea? What are they called again?

Ms KUDELL: Our yarnning bus.

Mr WOOD: Yes, yes. Who ...

Ms KUDELL: That was Mission Australia. I was with Mission before here. Yes, I do not think they have quite got the wind beneath their sails, and not puffing behind it. Yes, the concept is that. They go out; they have a primary focus on their financial counselling. But, again, you see a very similar flavour in here with this one, where you can take that and just park it. It gets advertised as something the community see as their own. It is skinned in a way that it does not look like a government vehicle. It is quite inviting to the community. But, yes, you pull up, have a cuppa. That is the public education strategy behind this. That is my baby, so I just duplicate it. The fact is it has not really worked as well - I keep an eye on it.

But, yes, that concept would be an ideal strategy because you get people's confidence, you get them to come and talk to you, then you can incidentally start talking about it. A lot of literature in Kriol and things like that - language appropriate that people can start to understand and visualise.

Mr WOOD: Although we are trying to meet them on their terms – not our terms.

Ms KUDELL: Absolutely! Absolutely! That is the whole point. It is a long, slow process of relationship building, too, it is not something where you go 'Hi, let me educate you about FASD'. It is that conversation or cup of tea moment that was that starting point about engaging, yes.

Madam CHAIR: Any more questions? Just keeping an eye on the time. Thank you, Michelle, for coming.

Ms KUDELL: I will leave those. You can all have a little play with those.

Madam CHAIR: We will also send you a copy of the draft *Hansard* to have a look at to make sure everything is right that you have said - or correct, I should say.

Ms KUDELL: Yes.

Madam CHAIR: Did your alcohol and drug group put in a submission?

Ms KUDELL: That is pretty much it. Basically that is who I am more representative of. There are some details on the bottom of the front page with my information.

Madam CHAIR: Thank you.

Mr McCARTHY: Good luck with that project; I look forward to hearing about it.

Madam CHAIR: Yes, than you very much.

Ms KUDELL: I have some partial funding from the Northern Territory government but it is not very much and nobody seems to want to give the infrastructure funding, which is significant. I have made some applications so DSS hopefully ...

Mr McCARTHY: It would be a good pilot to see how it goes.

Ms KUDELL: I asked them to pilot it in the top half. We could pilot from Katherine north, but it would just be - and if that worked we would have more of them.

The committee suspended.

KINTORE CLINIC

Madam CHAIR: On behalf of the committee welcome to the public hearing into the action to prevent foetal alcohol spectrum disorder. I welcome to the table Dr Dave Brummitt, who is with the Kintore clinic. Thank you for coming before the committee. We appreciate you taking the time to be with 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. A transcript will be made 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 say should not be made public, you may ask the committee to go into closed session and take your evidence in private.

For the record, could you state your full name the capacity in which you appear today?

Dr BRUMMITT: I am Dr David Brummitt, a GP in Katherine, and I have lived here for 23 years. I am a bit nervous.

Madam CHAIR: That is all right, we are relaxed.

Dr BRUMMITT: The main people I see in my work as a general practitioner are probably the more educated end of the spectrum of people. I see a lot of pregnant women, and most of the people I see tend to, with regard to alcohol, be concerned about their heavy night of partying early in pregnancy before the diagnosis is made. Most of them will then adhere to the general advice of not drinking alcohol during pregnancy and being very worried about their one or two nights of heavy drinking. Most of the people I see are in that category. However, I am the GP obstetrician and work at Katherine hospital and I see many more people who persistently abuse alcohol to excess during the pregnancy despite advice otherwise.

So, that is my range of work. I was not quite sure why I was asked to come here, but I was thinking about what is the cure for foetal alcohol spectrum disorder, and it is very simple ...

Madam CHAIR: Do not drink.

Dr BRUMMITT: Fix alcohol abuse in the general community. That is the solution. I read the transcript of the meeting a few months ago ...

Madam CHAIR: In Darwin.

Dr BRUMMITT: I was interested to see the concerns of one person about getting the diagnosis right. I heard the last lady speaking about the controversy about diagnosing it ...

Madam CHAIR: As a legal person, explain it to me in lay language. What do they say? Are they saying there is no specific signs and symptoms that you say, 'Yes, you have FASD,' or 'You do not have it'? Is that what they are talking about?

Dr BRUMMITT: Well, there are two aspects. One is the physical changes and it was mentioned in the previous meeting what they are ...

Madam CHAIR: Yes.

Dr BRUMMITT: ... the facial appearance which is probably not a big issue. The more severe thing is the cognitive changes that occur in the developing brain, which then lead to learning disabilities ...

Madam CHAIR: Behavioural problems.

Dr BRUMMITT: ... behavioural problems, difficulty with learning, adapting, and all the problems there ...

Madam CHAIR: But are they saying that medically they cannot diagnose because they do not have whatever you need medically to work it out early in the piece? Is that what they are saying when they say, 'We do not have diagnostic tools'?

Dr BRUMMITT: Well, there is not a diagnostic test. We all like to have an illness where we can say, 'This test is positive. You have this illness ...

Madam CHAIR: I am with you.

Dr BRUMMITT: ... problem solved, off you go. Go and consult the Internet' ...

Madam CHAIR: Do a blood test, you have Ross River Fever.

Dr BRUMMITT: Yes.

Madam CHAIR: Get treated.

Dr BRUMMITT: We all like that, but it is one of those conditions that is not like that. It is a bit like a lot of other similar disorders like autism or, say, depression ...

Madam CHAIR: I am with you.

Dr BRUMMITT: ... or a learning disability, or delayed learning without any known cause. All these things are very vague. I guess it comes down to the impression of the clinician to make that diagnosis. So ...

Madam CHAIR: Just to narrow the field to what you think it could be.

Dr BRUMMITT: Often it will coexist with other psychological disorders. I guess the other thing about foetal alcohol spectrum disorder is if you have someone who is abusing alcohol in pregnancy, then they are presumably going to be abusing alcohol after the pregnancy, and that child is then going to grow up in a house or ...

Madam CHAIR: Not get fed properly, not sleep properly.

Dr BRUMMITT: Yes, with all the problems of alcohol abuse in the family - the domestic violence - and so that will also contribute to their problems with learning or cognition, which means thinking, and problems with learning and these sort of things. It is very vague. It is difficult to make this diagnosis. It is very much a diagnosis of exclusion after other disorders are excluded. If the mother is known to abuse alcohol in

pregnancy, then that is the diagnosis that is made. But, it is not a diagnosis where people come out and say, 'This is what it is and we would not consider anything else'.

Mr McCARTHY: After 23 years working in the mainstream general practice in Katherine, have you anecdotally seen an increase in presentations for behavioural issues with your families and children?

Dr BRUMMITT: Behavioural issues in general?

Mr McCARTHY: Of the kids.

Dr BRUMMITT: Not just related to alcohol abuse?

Mr McCARTHY: No, I do not want to even go there. In 23 years, have you ...

Dr BRUMMITT: There is an enormous amount of behavioural problems.

Mr McCARTHY: Have you seen an increase?

Dr BRUMMITT: There has always been a lot of – I do not know if there has been an increase. As I get older, I see older people. Young women do not want to see older doctors, they go to younger doctors. So, my patient profile has changed.

Mr McCARTHY: If I asked that same question of a school teacher in Katherine for 23 years, I bet you I get a different answer.

Dr BRUMMITT: Yes, I am sure it is increasing, but when I started in general practice I was astounded at the amount of - in paediatrics - how much of general paediatrics is other issues - dysfunctional families and all the things that flow from that. If you interview a private paediatrician I am sure you will hear a significant proportion of their work is dealing with things like attention deficit hyperactivity disorder and other psychological type illnesses.

Mr McCARTHY: In a Territory perspective, with high alcohol consumption – we are some of the biggest drinkers in the world second behind the Germans - and the nature of the community, do you think foetal alcohol spectrum disorder could be impacting on child behaviours relating to deficit disorder or the Tourette spectrum of autism?

Dr BRUMMITT: I am not saying it is a cause of attention deficit disorder. I am sure it is impacting on the cognitive development of children, but it is so hard to quantify how much is related to the alcohol drunk during pregnancy because some people drink a lot and nothing happens.

Madam CHAIR: Some people smoke until they are 80 and nothing happens. Some people can smoke all their life and never get lung cancer.

Dr BRUMMITT: That is right, and some people who do not smoke get lung cancer. The difficulty is if someone drinks a lot of alcohol in pregnancy you do not know the effect of that or other neurological disorders ...

Madam CHAIR: Other factors.

Dr BRUMMITT: ... or other environmental or genetic factors.

Madam CHAIR: Living here for 23 years or thereabouts - and take Aboriginal patients out of the equation and the patients at the hospital – is there a prevalence of white urban women drinking as much? If you take Aboriginal kids out of it, do you think it is prevalent in the white society?

Dr BRUMMITT: Alcohol abuse in pregnancy?

Madam CHAIR: Yes.

Dr BRUMMITT: I think it is fairly low, but I tend to see a more educated motivated population than perhaps some other doctors might see. I spoke to Megan Cope, who I notice is not on the list, a doctor at Wurli ...

Madam CHAIR: We have had the Wurli-Wurlinjang people.

Dr BRUMMITT: I spoke to Megan when I got notice of coming here. She sees an enormous amount of foetal alcohol spectrum disorder.

Madam CHAIR: In Aboriginal children?

Dr BRUMMIT: Yes. That is probably because she works as a female doctor in an Aboriginal health service. She sees mainly young mothers, pregnant women and little kids too.

Madam CHAIR: You are right; if the young woman or young girl is in the town in an urban setting in a relatively stable family and goes to high school or whatever else, either the family will scoop her up and say, 'You are not drinking' or she is educated enough to realise she will harm her baby and stops. You are right; the young Aboriginal girl in the town camp or from out bush does not have the opportunity to understand the problem.

Mr WOOD: Your opening statement about the problem of alcohol abuse, I presume you are saying in general. I have been around for some time and Katherine is not alone with that problem but it has always had many problems. This is \$10m question, but do have any ideas about how to reduce alcohol abuse the government or the community could put in place to turn that around?

Dr BRUMMITT: I spend most of my working life trying to change people's behaviour, usually unsuccessfully. If you want to change someone's behaviour they have to want the change, be motivated and have to see a benefit in doing it. If I tell someone to stop smoking or stop drinking, and they think, 'Well I am fine, thank you', they are not going to stop. So, my job then is to look at what makes that person tick and find the way to get them to be motivated to change. It might be that their dad died young or something like that. Then, I can then ask how can I fit that into this person's life. They are worried about their dad dying young, so how can I fit that into helping them to get some motivation?

Mr WOOD: It is also that the community they live in has a major effect. If you have a community which, as a community, said, 'We do not support this kind of behaviour and we encourage people to not live a certain life'. At least there is an overall community atmosphere which is about good things such as sport and community events, and all that sort of stuff.

Dr BRUMMITT: Sport is a wonderful motivator. My personal opinion is sport is great for ...

Mr WOOD: It gets tied up with alcohol - doesn't it? - through the advertising.

Dr BRUMMITT: Well, it does. But, look at kid sport in this town. It is magnificent the way it gets kids involved.

Mr McCARTHY: When you say stop somebody, what about drinking in moderation? Once again, is that through education? Is that a better educated person that can process that?

Dr BRUMMITT: Well, there are plenty of educated people who drink too much, so I am not implying that if you are educated you do not drink. But, they may be more likely to take advice or see benefit in the advice. But, educated people are not necessarily going to take my advice. I am not quite sure what you are asking.

Mr McCARTHY: No, that is a good comment. To springboard off that, in family planning concept, you are dealing - I will generalise - with the mainstream. Right? In the mainstream, do you think the mainstream can avoid a lot of issues of esteem because the pregnancies are planned?

Dr BRUMMITT: It probably depends on a person's attitude to alcohol before they get pregnant and their knowledge of what alcohol does when they do get pregnant if I told someone they were pregnant. When they went out for a few beers on a Friday night, if I said, 'Actually, you are four weeks pregnant', they would probably say, 'Yes, okay, I do not think I will have these drinks'.

Mr McCARTHY: We heard from a national body in a cohort of 300 000 births in Australia per year, 50% of the women were drinking at that time, 20% of them went on to continue drinking at dangerous levels throughout pregnancy, which you have also told us today. I am just thinking if we can just cut our losses there should be a significant cohort in our society, because they are in the mainstream, things are planned and they have regular health check-ups, that you would make a big difference in raising that in the right time with the right people.

Dr BRUMMITT: I would like to think I make a bit of a difference there.

Mr McCARTHY: I think you would. So, when we look at this low socioeconomic groups and people without education and awareness ...

Madam CHAIR: And literacy.

Mr McCARTHY: ... they are at risk because things are not so planned, not so ordered, and there are all sorts of other dysfunction in their lives, and they are the ones who are the highest risk in the community, so we should be - I like the anecdote coming

out of Anyinginyi Congress in Tennant Creek that we should be putting the emphasis at the top of the cliff, not the bottom of it.

Dr BRUMMITT: Is that John Boffa's words?

Mr McCARTHY: No, actually, Trevor Sanders. I think he got it from somebody else.

Madam CHAIR: Yes, I have heard that expression.

Mr McCARTHY: Yes, we had John Boffa there for a while.

Dr BRUMMITT: Oh, good on you.

Mr WOOD: One of the issues raised - I remember watching this on the morning ABC news just recently - was many doctors are still reluctant to ask a woman if she is drinking if she is pregnant. They were saying that some doctors just do not ask that question. I could ask you, do you ask that question and do other doctors in Katherine ask the same question?

Dr BRUMMITT: I do. I try to. I am not perfect and sometimes I do not. Sometimes I do not because I assume they are not drinking because I know them. But, then, I later find out, hang on, they do drink even though I did not think they did because I know a lot of people socially. Yes, all doctors should be asking about that, and smoking.

Madam CHAIR: What they do then, Gerry is double it. If the patient says they only have two glasses of wine a day, they double it to four.

Mr WOOD: Yes, I am presuming that by their asking doctors to do that it is a very up-front method of telling people about the problems of drinking when pregnant. You have a captive audience, but some people are saying not all doctors are doing that at that time.

Dr BRUMMITT: It is a brief intervention. One question lets a person know it is relevant.

Madam CHAIR: I think they mostly do. Any doctor I have been to asks if I drink, smoke, sleep well and eat well.

Mr WOOD: It came up in a discussion in previous hearings, and it was also mentioned on the ABC by the lady from the Australian nursing association or midwives association saying a lot of doctors do not ask the woman.

Dr BRUMMITT: All the young doctors go through the Royal Australian College of GP training and there is an acronym, SNAP - smoking, nutrition, alcohol, physical activity, and it should all be asked about.

Mr McCARTHY: Have you ever had a patient tell you they are affected by foetal alcohol spectrum disorder?

Dr BRUMMITT: No.

Mr McCARTHY: I had a 15-year old kid, last week, tell me he was affected. It was quite confronting for me and I had mixed reactions about it. I was wondering if anybody has said that to you.

Dr BRUMMITT: I only have one patient who I know carries that label of foetal alcohol.

Mr McCARTHY: Do they talk about it?

Dr BRUMMITT: That person is probably eight or 10.

Madam CHAIR: Probably a bit young.

Dr BRUMMITT: It is amongst other problems. I do not know how much is related to that and how much is related to other genetic and environmental causes. It is not really that relevant because the treatment does not really depend on it. That is what interested me about some of the comments in the previous meeting. A lawyer said we need to have a label for these people, we need to know these people - I assume a person being accused of a crime and going to court has foetal alcohol spectrum disorder. The question I would like to ask him is would you treat this person any differently if they had autism, an intellectual handicap of uncertain origin, if they had Down Syndrome or if they were a victim of domestic violence - would you treat that person any differently in the courts? I would not have thought so. I would think you treat people the same.

Mr McCARTHY: In a school context it can relate specifically to special needs funding. Because the medical profession cannot or will not diagnose, a whole cohort of kids have

gone through without any special needs support. I agree with the legal argument. Put that to one side, but going back the other way I believe that is why it is so important to quantify this for the education system. From what we are hearing, it will be dealing with significantly more cases in the future.

Dr BRUMMITT: Those people for whom the diagnosis is unclear - and it will always be unclear. Even if you put a label on someone it will be uncertain because there is no diagnostic test. You cannot prove someone does not have foetal alcohol spectrum disorder, you cannot prove they do. It is a clinical judgment, which is what I do all the time. I do not diagnose this problem; I would send them to a paediatrician and they would make the diagnosis. However, that person would probably have a diagnosis of learning difficulty aetiology uncertain, or familial factor or something else. They have a learning disability. Perhaps the way schools are funded should be changed to suit that rather than changing the way we diagnose illnesses.

Mr McCARTHY: Unless I can get the matrix, unless I could tick all the boxes on the matrix - I have the acknowledgment that kid needs a lot more help, but we did not get any support to go with it. I am talking about the resources to employ people, to run smaller groups, to do more intensive work - that sort of thing.

Madam CHAIR: Then you have the issue of a family that might have a child. The mother knows she has drunk a lot while pregnant, and the kid does have some brain injury. Is she going to admit she did what she did and now the child is not an ordinary child? There would be some of that cultural thinking, I think, like shame job, telling the world you were not a very good mother while you were pregnant.

Dr BRUMMITT: Well, that is the problem with labelling people ...

Madam CHAIR: Yes, you have produced a non-perfect child.

Dr BRUMMITT: ... they carry a stigma.

Mr McCARTHY: Were you here listening to Wurli?

Dr BRUMMITT: I was not here then, no.

Mr McCARTHY: There was an element there where it became finite resources. With all the things we have to do, really we are going to have to prioritise. Do you see that as an issue government needs to look at?

Dr BRUMMITT: I talk to people all day. I am not a manager. I do not think like that. I leave that to other people - like you people

Madam CHAIR: You just cure people.

Mr McCARTHY: The differentiation was anaemia - an anaemic child. Early childhood anaemia was appearing at astronomical rates, therefore, should we not be working on that and do not worry about the FASD stuff.

Madam CHAIR: Yes, under two years old. They said they have the highest level of baby anaemia in the Territory, Australia?

Mr HIGGINS: I would say Australia.

Madam CHAIR: For here.

Mr McCARTHY: I think it was actually, Madam Chair.

Madam CHAIR: Katherine region.

Mr McCARTHY: I think it was.

Dr BRUMMITT: I have worked in Alice Springs Hospital before I came here for ages in the paediatric ward there ...

Madam CHAIR: It is high there too?

Dr BRUMMITT: Everything here is much less than down there, in childhood illnesses. But, I have noticed since I have been here the improvement. You go to the children's ward up there - when I came here, it was chock-a-block, full of kids with diarrhoea. It is now empty a lot of the time. It is amazing ...

Madam CHAIR: That is good.

Dr BRUMMITT: There have been huge advances, I think, in child health, which is a credit to the people involved with Aboriginal health in the bush. Anaemia is part of that.

Madam CHAIR: Are there any more questions.

Mr McCARTHY: I have one. I have a pain in my right knee. I was wondering if you could look at it.

Madam CHAIR: That old line.

Mr WOOD: You have been watching the Adelaide Crows. Just one question. You might not be able to answer it because, obviously, I am not asking you to be an expert on FASD. An issue I was interested in is whether there is any possibility that FASD could be turned around. I referred to once before about the elasticity of the brain. There has been a lot of work done on that. Obviously, some of this cognitive failure is damage to the brain, I presume. Have you heard of any work being done in that area to try to – or is it not a big enough area for the ...

Dr BRUMMITT: I am not the right person to ask.

Mr WOOD: No, that is all right.

Dr BRUMMITT: But I am sure the person who is born with foetal alcohol syndrome or foetal alcohol spectrum disorder, in an ideal world you would say, 'Okay, you need good parents.' Do you keep them with the parents who have been drinking through the pregnancy and probably will keep drinking – which is probably what we should do, given what lessons we have learned – or do we put them with parents who are not drinking and are going to provide a stimulating environment - which is probably what we should not do which is what we used to do once – not we, but other people.

Mr WOOD: The child is the priority, isn't it?

Dr BRUMMITT: But what I am saying is you create a problem. Okay, a child is born with foetal alcohol spectrum disorder and the treatment is the outside influences of occupational therapists and physiotherapists, the parents, the people that interact with that kid. That is the treatment. If you have suboptimal people surrounding that person, then that kid is not going to develop normally. It is a bit generalised, but ...

Mr WOOD: There is a lot of work to be done on that area, I presume.

Madam CHAIR: Thank you, Dave, that was good.

Dr BRUMMITT: No worries.

Mr WOOD: Thank you.

Madam CHAIR: Thank you for coming. See, it was not so bad.

Dr BRUMMITT: Okay.

Madam CHAIR: It can be a bit too confronting.

Dr BRUMMITT: Thank you.

The committee suspended

SUNRISE HEALTH SERVICES

Madam CHAIR: Hello, Raelene, thank you for coming. On behalf of the committee I welcome you today to this public hearing into action to prevent foetal alcohol spectrum disorder. I welcome to the table Raelene Wing, Child Health Program Coordinator, Sunrise Health Service. Thank you for coming before the committee. We appreciate you taking the time today to speak with us.

This is a formal proceeding of the committee and the protection of parliamentary privilege and obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If, at any time during the hearing, you are concerned what you will say should not be made public you may ask the committee to go into closed session and we will take evidence in private. Could you state for the record your full name and the capacity you appear here today.

Ms WING: My name is Raelene Wing and I am an Aboriginal Health Practitioner from Sunrise Health Service. My role is child health and mothers and babies.

Madam CHAIR: Okay. Is there anything you wanted to start with - any opening statement or opening comments?

Ms WING: I was not sure how this actually worked. Yes, do you want me to just do my little spiel?

Madam CHAIR: Yes, go for it.

Ms WING: I have been an Aboriginal Health Practitioner for nearly 18 years now, and I have worked with child health and mothers and babies for a while. We, as Aboriginal Health Practitioners, can only advise mothers in regard to alcohol, and that is none is best.

Resources are slim, workshops have only just started happening in the last few years. The other issue I thought I would bring up is that not all FASD persons will present with the full characteristics of FASD which is the facial abnormalities, growth retardation, and developmental abnormalities of the central neuro-nervous system.

With FASD, one of our issues is we have children who have behavioural issues. As health practitioners, we cannot diagnose it; that is up to a paediatrician. Our referrals are usually referred on to your specialists and it is up to them to decide whether they want to do it or not. The other issue we came across is that sometimes the paediatricians do not like diagnosing it because it is a real complex condition to diagnose.

We have issues like people saying 'Oh, this child has got ADHD' but we do not know whether it is to the full extent, or what their health conditions are. The only time you can really diagnose a FASD child is when they actually present at school. Then, the teachers will pick up that this child has a learning difficulty. There are other conditions that go with behaviour, so we are not just looking at FASD.

Can I give you a scenario of something I did? I did the RMIT University AOD in Mental Health and Alcohol and Other Drugs. We picked a real hard scenario. We did a case study on a child named Billy Marrar - that is his fake name. One of our health workers said, 'Let us chuck in a scenario where this child has FASD'. We did not realise that this case study was going to be one of the biggest complex issues we have ever dealt with. We did not realise it would be such an issue.

Especially when you are looking at communities I work in - all the remote ones - where service delivery is near to nothing. Northern Territory government provides good services. I am not saying we do not get anything. We get a lot of services out at Ngukurr, especially in all the larger communities.

But, in regard to our case scenario for FASD, we found that, as health practitioners, we had to actually wear more than one hat because we could not address those issues in regard to service delivery. So, we had to put on a mental health worker hat, an Aboriginal health worker hat, a social worker hat. We had to put on all those things because there were no services out there. The only thing I can bring it back to in regard to this committee, was there are no services out there ...

Madam CHAIR: In remote places?

Ms WING: In remote communities. But, not just in remote communities. When we looked at what kind of specialised services would be good for him in Darwin, we really could not work out what was there because we just do not have the knowledge. If there are services out there, where are they and who are they because we do not know anything about it?

One of the gaps we found was the screening tool. We are not specialised in areas of diagnosing people with FASD, we are just health practitioners. In regard to that there are no practical health tools to help us screen to see if this child has FASD. I have a list of stuff I think I better go by before I go off track.

For a screen to be effective it needs to be targeted at those population at high risk of the disorder mainly. Children in care of the state child protection service could have FASD. Children of mothers attending alcohol treatment services should be checked to see if their child has FASD. Youth in juvenile justice systems should have a check to see if they FASD. Regional areas and communities identified as having high levels of alcohol consumption - all the mums you know are heavy drinkers, the children should be screened for FASD.

There are, however, a number of important things for alcohol and other drugs services that relate to FAS, and these include individuals accessing alcohol and other drugs services who may also have FASD. Going back to our RMIT University case study, we found that – this is just us guys brainstorming and everything – you might have a child like that, but that child will end up drinking as well. We have a couple of children in our community who are petrol sniffers. For them it is peer pressure, especially if they are young, to try to fit into a group, so themselves will abuse too.

Individuals accessing alcohol and other drugs services who may have children with FAS, women accessing alcohol and other drugs service who may fall pregnant or are pregnant or breastfeeding. There is an urgent need for research as there is a lack of reliable data and evidence-based tools for diagnostics and early detection of this disorders. The only place I could find which undertook recent studies in regard to FASD was in Western Australia, Fitzroy Crossing, in 2012. I could not find anything anywhere else in Australia, and they got most of their information and ideas from the United States of America and Canada, which have big issues with FASD as well.

Other existing issues relating to FAS are not enough specialist services. Mental health will be a big status. Lack of or willingness to diagnose FAS children, youth or adults who present to our clinics- and this lack of willingness is with our clinicians. We have no real evidence-based screening or diagnostic tools to identify children and youth or adults that may have FAS, and FAS needs to be recognised as a disability.

These are dot points I put together in a rush a couple of days ago.

There should be warnings on alcohol labels sold in Australia to reinforce the message that no alcohol should be consumed by pregnant women as it is harmful to the unborn child. The reason I said unborn child and not foetus is because foetus is not a word we are used to, child is something we know. There is no developmental template appropriate for health practitioners to use. There have been three cases in the Northern Territory of FASD persons being incarcerated for either their own protection or the protection of others. I know there was a case recently in regard to a young girl in Western Australia who was brought back to the Northern Territory, but there have been cases before her.

Factors thought to contribute to the under-reporting of children with FASD include the absence of routine screening for alcohol use during pregnancy. We do that, but whether they do it continuously – we do it in our first screening, but it should be done continuously throughout the antenatal check-ups. The lack of standard routine data collection, the lack of routine screenings for infants and children known to be at risk of harm from prenatal alcohol exposure, limited knowledge of diagnostic criteria for FASD and a reluctance by health professionals to make a diagnosis for fear of stigmatising the family. There are few health professionals assessing children with FASD.

That is basically what I wrote, but the other thing is when it comes to rural and remote communities, those people with FASD – it will be really hard to provide the proper service delivery for those guys. It will not just affect the community; it will also affect the

ability to respond to the effects of FASD on individual families and the whole community, because it is going to affect everybody.

The other thing is my train of thought as a health practitioner is we just do not look at what is presented in front of us. We look at the full picture so we know where it started . We know many of our people have alcohol and drugs issues, but that all comes back to the underlying problem of mental health. That is all I have to say.

Madam CHAIR: I have thought this myself for a while. When you talked about the young girl who is FASD affected and they then have a child. Is that then when you said that child at nine or 10 might get into petrol sniffing as well?

Ms WING: No, I was saying we have a couple of children in our communities who are petrol sniffers.

Madam CHAIR: Oh, okay.

Mr WOOD: That is on top of their FASD, which makes it twice as bad.

Ms WING: Yes.

Madam CHAIR: Oh, I see what you are saying.

Ms MANISON: That was a really fantastic opening statement, really thorough. It is clear you have been working across this field for some time. Some really interesting points were raised there, Raelene.

What I am keen to find out is, given you have a lot of experience working with the health sector in the regions here, what do you think the size of the FASD issue is out here? You mentioned there has not been much diagnosis. How extensive do think FASD is out in the regions Sunrise services?

Ms WING: When it comes to our communities, our communities are dry. A lot of our women do not drink. But, the ones who are closer to town, those women are more inclined to come into town to drink as well. The closer the community, the more inclined they are going to be drinking, - and a lot of our women from our really remote communities are non-drinkers, non-smokers and are Christians. That Christian

background is instilled in them. It is just the guys who are close to town who seem to have a high prevalence for drinking.

Ms MANISON: When they do find out they are pregnant, some of these ladies who are the drinkers and work with health workers, do they tend to reduce the drinking in most cases? Can you get the message through?

Ms WING: It depends on the individual and their educational background. You can lead a horse to water but if they drink it is up to them. It is like us guys with our education with brief intervention. We can tell them this is going to be harmful for your child, but it is up to them whether they are going to stop drinking or not. We have women you can give as much information to, but they will still go and binge drink. It is individual decision.

Ms MANISON: You raised the point about having access to services out in the remote areas and education materials. What would be helpful for you as a health practitioner out there - the materials around FASD and tools to help you work with your clients around the issues of FASD?

Ms WING: First, I do not think this is an NT government issue, this is federal government. They should be paying for it, really. There should be research done into FASD, not just NT but Australian-wide because there is an issue across the board.

Nicola Roxon did some kind of background stuff going into FASD but that was during the intervention period. I know this is still the intervention, but it has slowed down a bit. The funding has slowed down. We are not getting the same amount of money we were getting before. There needs to be more research. The research should be done in prevalent areas that have high consumption of alcohol. In order for the research to be done, then we can have some diagnostic tools that can help us diagnose these kids with FASD or not. At the moment, we really do not have the expertise to be able to diagnose FASD. We are currently looking at facial features, physiology and stuff like that. With things you can see, it is easy diagnose but if that child looks normal and it is the neurological background that has raised the concern then we will have issue and will find it difficult to diagnose. Going on behaviour, we do not specialise in that either we are simply Clinical only. You may consider that this applies to just about all the health practitioners in the Northern Territory – health workers, nurses and doctors. Nurses and health workers are not doctors and even general practitioners (doctors) because they have to refer to specialist as well – we cannot diagnose that FASD, it is up to the paediatrician who specializes in this field.

So, a diagnostic tool but one that has been researched would be good. You have to have a group (Researchers) who are able to get all of this information together. If we had a diagnostic tool it would help us refer these kids on for specialist help sooner.

Mr WOOD: You have worked for 18 years as an AHP. Forgetting the specialists, just as someone who works on the ground, could you diagnose someone who had FASD? I am not asking you to give it a professional opinion, but you work with these mothers. Can you recognise someone with FASD?

Ms WING: Yes I can recognize FASD, but I would not diagnose as it is outside of my scope of practice.

Mr WOOD: You would know?

Ms WING: Yes, providing they have all of their physical attributes ...

Mr WOOD: You also have that background experience of a feet-on-the-ground type of approach to life and would see some signs you could recognise. Perhaps not professional signs, but your knowledge would tell you what that child is?

Ms WING: If they have the child has the facials appearance then it is easy, but if they appears to like normal and they have behavioural problems that is different and it would make it harder.

Madam CHAIR: You could not assume, if you knew the mother and knew she drank then had a child - just because B follows A does not mean A caused it.

Ms WING: That is why there needs to be research in place because we do not know how much alcohol causes .FASD.

Madam CHAIR: And what effect it has.

Mr McCARTHY: If that child presents in the community with significant deficits in their cognitive ability ..

Madam CHAIR: You would assume.

Mr McCARTHY: ... having trouble with school, all that local knowledge comes together to paint the picture but the paediatricians are more likely to diagnose it and we have heard that. Essentially, this committee is researching for government to prevent - that is the big picture - prevention is better than cure, and then the management of this.

I would like to thank you because that is the first time I have heard a pragmatic suggestion relating to limited resources and targeting the resources to children in the care of children and families ...

Madam CHAIR: High risk families.

Mr McCARTHY: ...wards of the state, children where parents who have come in contact with the prison system and parents who have been identified in AOD programs. That was a really good pragmatic suggestion.

Ms WING: That information came from the research done in Western Australia, and it is on the website if you would like to look at it. It is a study that was done in 2012 at Fitzroy Crossing and it is the only one done in Australia that I could find. When I read that I wished I had it for my university study because it would have been handy.

Mr McCARTHY: We have that study, but you are the first person who has articulated it.

Ms WING: When it comes to a FASD person and their family, they all need support and help because there will be a hell of a lot of mental health anguish present.

Mr McCARTHY: That is a good benchmark for government to work on. The other comment I wanted to ask about was where the remotes are remote, the different cohorts and their low risk. Being an Aboriginal health practitioner in the bush for a long time, what is your comment on the mobility factor where people are not so remote anymore? People are travelling all the time.

Ms WING: Yes they do, but you still have your clusters, your groups that do not. They might travel, but they do not drink. You still have a lot of strong women that don't drink. I have experienced this with my own family and friends and have a greater understanding of the the underlying factors. I think there is a huge mental health issue in our community and it is not just Aboriginal people only; it is everybody. I think that binge drinking and the high prevalence of alcohol use is a factor to it all.

Mr WOOD: In the Territory?

Ms WING: Australia-wide. People drink for a reason. Misusing alcohol and other drugs is just a way to cover up all the other underlying pain and suffering. That is how I see it, and something I learnt from doing my studies. A group of Indigenous health workers from Sunrise - Sunrise tries to get us to do training that is worthwhile, not participation on a piece of paper, something useful we can use within our workplace. A group of us AHP's realise that this alcohol issue we have as a group of people is just the surface. There are a lot of underlying issues and we believe that there is a huge mental health issues out there.

Madam CHAIR: Gerry.

Mr WOOD: I might ask my hard question. One of the issues we missed out on is this discussion about FASD is the protection of the unborn child. We hope that child will live a normal healthy life. If the child is born and gets bashed, the government would do something about it. But, if the child is not born and the mother does something which could cause that child to be injured, do you see the government has any role to play? The issue has been put forward that should the mother have a court order to stop drinking and, if she continues to drink, should that mother be held somewhere like mandatory alcohol rehabilitation? I am not saying they should be, but that is an issue that has been put forward.

If you believe the mother continues to binge drink when pregnant, how do you see the role of government in that? Or should it not have any role at all?

Ms WING: I said this in a child protection inquiry. I went there on my own, not representing my organisation because I went through the system. I am third generation Stolen Generations with my family. When it came to mothers who neglected their kids and drank heavy, in a real nasty way, I just told those mothers should be in prison to stop them from drinking. I know it is harsh but how else are you going to do it? Aboriginal people are really good for finding loopholes. You can put a court order in place, but they can still find a way to get alcohol. And that is with anything.

Madam CHAIR: Same as the Banned Drinker Register. That had loopholes.

Ms WING: Yes.

Mr WOOD: At the moment, the government has mandatory alcohol rehabilitation.

Ms WING: Then that is human rights issue as you are now interfering with human rights.

Mr WOOD: Then, I suppose you get the complex issue of has the unborn any rights in relation to the mother in relation to ...

Ms WING: And then the law will say the unborn child, if under 20 weeks the foetus is not identified as a Human being if after 20 weeks than they are identified as a Human being.

Mr WOOD: Well, that would open up a very wide debate here, I can assure you, as you mention the word foetus. It has a more legal and biological definition rather than 'the unborn child'. Personally, I think they are a human from day one. Well, you are all human. But, that is my personal opinion and it might not be other people's opinion. It is an issue that I feel it would be interesting to hear what you had to say in relation to the protection of the unborn.

Ms WING: Yes, that is a hard one.

Madam CHAIR: It is interesting. I do not know if you noticed or picked it up, Gerry, but just recently in one of the states in America - and I do not know which one it was but it was the mid I think - they have actually charged a woman and sent her to some prison somewhere because she was abusing the child through drinking and smoking. She has actually been charged under one of their laws, and sent to protective custody to stop her doing that.

Ms WING: Yes, and then it opens up another doorway of smoking cigarettes then. They should not be smoking too; drinking coffee and tea etc.

Mr WOOD: And drugs. I do not think gunga would do you much good.

Ms WING: No, I do not think it does either, but you get some mums you can inundate with Health education but they still won't stop misusing.

Mr WOOD: Thanks for that anyway.

Ms WING: Yes, I am sorry I could not answer your question.

Mr WOOD: No, that is all right. I am not saying it is an easy question.

Ms WING: No, it is not.

Madam CHAIR: It is a tricky question out there in the community at the moment; whether you make the drinking of alcohol the crime or you consider it a crime, or whether it is really a health condition of the woman. Some people who think, yes, stop them, you cannot physically drink anymore until your baby is born. Then, there are others who say no, you have to treat the health condition.

Ms WING: I know this is not related to our FASD, but I can remember back in the 1980s in Beswick community. When we were younger kids and the young children would misused petrol and and was sniffing; the old people used to flog them - put them in the middle of the community, flog them, then take them out bush and leave them out there for three months with family, but away from petrol and everything.

Unless the government has a lot of money to build a rehab that is going to be family friendly, because you are not going to send just one person there. If that woman has kids, her kids have to be there with their mothers

Mr WOOD: Personally, one of the areas government has not looked hard enough - and I know we have a gentleman from Venndale here - is when it came to mandatory rehabilitation there is an alternative to the secure type. It is using Aboriginal people in the community aspect like healing places, to look at those sorts of things and whether you could get people with a court order which said, 'You must go out to a place and stay there'. It could be done in a much more culturally positive way rather than ...

Ms WING: That is a good idea. The Jawoyn Association had that idea for the healing place, but it all comes back to money.

Mr WOOD: Yes.

Ms WING: The government has taken lots of money from us.

Mr WOOD: Alcohol is one of the causes and sometimes I think alcohol should help pay.

Ms WING: Yes.

Mr McCARTHY: A doctor made a comment that the paediatric wards in our general regional hospitals have seen a lot less Aboriginal babies over the last 20 years. Would you agree with that?

Ms WING: I would not know because I would have to look at the statistics first. That is a hard one to answer, because you need to look at the facts before you run off at the mouth and say something not factual ...

Madam CHAIR: Probably not working in the hospital as such.

Mr McCARTHY: As an anecdotal comment, do you think the health of Aboriginal infants in the bush has improved in the last 20 years?

Ms WING: A doctor in the Katherine region has done some studies in that area and found that since the introduction of AMS in the Northern Territory there has been a huge improvement in Aboriginal health. That was Dr Andrew Bell from AMSANT.

Mr McCARTHY: We are generalising here and this is not the Spanish Inquisition; it is not about being right or wrong, but there have been a few comments to suggest this has been the case. I have written down here mental health is really the issue that – from my perspective, I am a schoolie by trade, did 35 years and I have never seen it tougher. Mental health is now higher, more complex, more pressing, more urgent and more confronting than I have ever seen in my 35 years in education.

In health, do you see that as a similar type of challenge?

Ms WING: For ...

Mr McCARTHY: Should governments be focusing resource allocation into mental health now?

Ms WING: I think so. I think mental health is across the board and it does not matter what ethnic background you come from or the socioeconomical status, mental health is a big issue at the moment. That is why a lot of our people in general and I am not just talking about Aboriginal people, I am talking about people across the board – have a high consumption of alcohol and drugs misuse. Yes, I think mental health is the biggest

underlying issue and if we are talking about tackling alcohol and the mums that are drinking - we need to look at their mental status and why they are drinking heavily in the first place.

Madam CHAIR: Yes, that is right, underlying causes. Thank you, Raelene.

Ms WING: Thank you.

Madam CHAIR: Thank you for your honest and frank comments. We will send you a copy of the *Hansard* for you to check to make sure what you have said is all okay.

Ms WING: I am sure you will write everything correct and true

Madam CHAIR: Thank you for coming today.

Ms WING: Thanks.

Madam CHAIR: That was great. Thank you, very much.

The committee suspended

CHAMBER OF COMMERCE

Madam CHAIR: On behalf of the committee thank you for being here today, Kevin. It is a public hearing into action to prevent foetal alcohol spectrum disorder and I welcome you to the table to give evidence to the committee. We appreciate you taking the time to speak with us and 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. A transcript will be made

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 may ask the committee to go into a closed session and take your evidence in private.

Could you, for our records, state your full name and the capacity in which you appear here today, please?

Mr GREY: Kevin Brian Grey, chairperson of the Chamber of Commerce, Katherine.

Madam CHAIR: Thank you. Do you want to make any opening comments?

Mr GREY: I see you have people here today with far more knowledge on this issue than I, but I would like to put a different slant on things or answer your questions from a different perspective.

Madam CHAIR: That is the reason for asking people like you to come along. Yes, we have had health practitioners and health researchers, health experts on the phone and who have appeared when we had these same meetings in Darwin. There is the medical side and the committee is trying to get a feel also for any economic aspects to it, or any impacts on business. Business might have some ideas. Of course, the member for Nelson will often ask about whether the alcohol supplies should be involved. We did invite the hotels association in Darwin. It is that kind of thing; we are just trying to get a feel. We have people for Katherine. We have been doing Tennant Creek and Alice Springs in this trip. Does it impact on your members that you know of or ...

Mr GREY: If you bounce along for a bit, I am sure you will think of questions. But, there is no business position on these sort of issues. Okay? The Hoteliers Association are not predominately members of the chamber - at least not around here. I am a person who disagreed with what they do, to be honest. To make money off someone's misfortune really irks me.

Some information - lately the Police Commander told us when he has the police officers at outlets there, the incidence of domestic violence and issues drop by 50%.

Madam CHAIR: Just in Katherine?

Mr GREY: Yes. But, they cannot afford to man them so it is a balance of resources type issue. I am sure he will be happy to tell you that. There is a bit of an issue there. You would think a lot of people are getting alcohol for a start who should not have it.

I have a lot of things in my head from what Raelene Wing just said, so I might bounce along with those too. She has cases for me. If you drive up Railway Terrace in the morning, the glass is ridiculous. It is just an embarrassment and a disgrace - the containers. I find it ...

Madam CHAIR: That little step park?

Mr GREY: Yes, and all around town. It is not just - more depressing is why are we letting people get hold of this who cannot look after themselves on a day-to-day basis? For me, in the Territory, this issue is not just a one party or one side of government issue, it is a bipartisan issue and you should be digging in to fix it, undertaking measures and not making it political like the BDR and whatever is in now. That is not going to fix anything; it is being going on forever.

Madam CHAIR: I know they have it in Alice Springs, but in Katherine, have police officers been standing at the bottle shops and asking people where they are going to drink?

Mr GREY: That is right, on occasions. That is tried in Tennant Creek and Alice Springs and it is very successful, but it is not their job. The result is dramatic but it is not as dramatic to say those 15 police officers are doing more than they should be.

Flying from those comments, the effect of this particular issue is just an absolute disgrace. Now we are damaging human lives before they have a chance to make a decision or even get on the planet. Mr McCarthy raised some issues with Raelene about human rights. When does a mother have the right, so when does a child ...

Mr McCarthy: Tell us about it (inaudible).

Mr GREY: A good question either way. It is a big question, isn't it? What right does one person have to ...

Madam CHAIR: To damage another.

Mr GREY: To totally damage another person. It is a point that has to be addressed.

Mr HIGGINS: It is a supply issue.

Mr GREY: It is not just a supply. We have had the fortune to travel overseas to lots of different countries recently. It is not a supply issue. You can get it on a shelf in McDonalds in those countries. Okay? I see it as two points of view. One is people who just - as Rae pointed out – if there are issues reaching for drugs and alcohol is just one of them. The other one is in Australia is that we have this embedded psyche that the abuse of alcohol from the early ages is a rite of passage. I am a bit older now. I did it, the same as probably most of us did when we were younger. But, it never went beyond manageable. We seem to be unable, as a society, to keep it in a manageable state. There is something wrong with that. There is something wrong if we cannot enjoy a beer without making it 12 beers or 18 beers in an afternoon is normal. It is not normal. There is more issues.

Education is an issue too. I am sure any young mum would not deliberately want to damage their child. They do not do it for that reason. There is a lot of avenues to pursue.

Mr McCARTHY: Does the chamber look at juvenile crime? Has it emerged in your agenda? Are businesses concerned about it? Is it part of the real issue around the business community?

Mr GREY: A bit of history. The chamber is a member-based organisation. Businesses pay membership fee to get services. Okay? Ten years ago, we were on 20 committees and we spent all our day involved in alcohol management plans and whatever else was on the table. There was no result because where can we go with that? I cannot even have one influence on the outcome. So, we just gave up and now we just do member services because people were leaving. they were not getting what they were paying for. So, it is purely a member-based organisation. Even though, individually and as a group, we are quite passionate about some views, we are very pragmatic about what we can influence

and we get involved in that. If we cannot influence it – we cannot influence your political process one way or the other, so what can I do about that? Unless I really have a problem with it and pursue it vigorously - it is not my mandate.

Mr WOOD: Your alcohol management plan, you said you have given up on it.

Mr GREY: No, not totally. As individuals on the chamber, locally we have different interests. There are two people involved in that group and we report back. It is not a chamber function as such, but we keep across it. We want positive outcomes but, as a chamber outcome for members that pay money, it is not on that list.

Mr WOOD: I want to ask you about the Banned Drinker Register, and say I am the independent. The BDR was one of a strategy of ideas; it was not on its own. I remember when I was debating this in parliament I had concerns about it working because of secondary supply, and further legislation was brought in later. How long did the BDR operate in Katherine? Was it long enough for you to get an indication of whether it could make some difference to supply to people who should not be drinking?

Mr GREY: I do not know the exact term, Mr Wood but a couple of years I think. We serviced the machines that did it, so it was probably running for a couple of years. Casey will probably know exactly.

Mr BISHOP: Eight months.

Mr GREY: There you go. I have seen the stats as well. The Country Liberal Party will say, 'Sorry guys, it was not working'. It was working to some degree, so rather than chuck it for another one - regardless of the system ...

Mr WOOD: I am not worried about the politics. I have been around the Territory for a long time and seen so many people die from alcohol, but the BDR was an attempt and wanted a trial. I do not think the trial was long enough to see if it really did work. There was politics involved, there is no doubt, but I would be interested to know from a local point of view, even in the short period it was operating, were there some benefits from it?

Mr GREY: I believe there were. I agree with you; it did not run long enough and that is why there is frustration that it was a political thing. It was made to be political when it did not have to be.

Mr WOOD: Katherine is a centre, not quite like Nhulunbuy, but you know the locals to some extent, even though it has 10 000 people. People know most people, and you know people coming in from other places I presume. With the BDR, people who should not be drinking would be fairly familiar with licensees.

Mr GREY: I would think so. My feeling was - and without stats to back it up - was it was just getting its legs. It was starting to be effective, I guess, is where I feel it got to.

Mr WOOD: Are saying if it was possible to get a bipartisan approach to it - I am not saying there should not be other things to go with that. I do not think you will have one silver bullet. Do you think it should be tried again in Katherine?

Mr GREY: Again, not being familiar with what is in place now ...

Mr WOOD: Police are standing at the bottle shop and you have the alcohol protection orders.

Madam CHAIR: Are there not opening times for bottle shops as well? The bottle shop here does not open until 2 pm or something.

Mr GREY: Yes, but as they said people are very good with loopholes and their habits just change. We have all tried it. It would be very frustrating, you have been here a lot longer than I have, but it becomes a bit helpless after a while.

Mr WOOD: Do you think it has an effect on people staying in town or tourists staying in town?

Mr GREY: Absolutely!

Mr WOOD: Do tourists look at the place and keep going?

Mr GREY: Absolutely, every day. We try to talk it up during tourist season. It is a great place, it is just this is really the issue. There are no other issues; this is the issue. That is the problem.

Mr McCARTHY: It was very quiet last night. Kirby's front bar was shut by 8.30 pm. Crossways had the roller door down. Where do you get drinks?

Mr GREY: It is takeaways.

Mr McCARTHY: Are there peak periods for problems? Is it Thursday night, Friday night or Saturday night?

Mr GREY: I do not know enough about that to be honest.

Mr McCARTHY: I was thinking last night of looking around town. Are the clubs popular? Do people drink in the clubs?

Mr GREY: Yes, clubs are very popular. The golf club, the RSL.

Mr McCARTHY: In other towns - I come from Tennant Creek - we have trouble keeping clubs alive. But, the Katherine clubs scene seems to be well and truly alive, so they must be good businesses.

Mr GREY: They have spent big money at the golf club. Yes, they are doing pretty well. They are nice places to go – a good meal and they are very kid friendly, so it is a good night out.

Madam CHAIR: But that is targeting a different group of people. I would have thought that was more mainstream urban families.

Mr McCARTHY: Yes, I make those decisions personally. But, I was just thinking in Tennant we have three nights of very intense management that relates to income. Then, the other nights – and so last night in Katherine, or Monday night, I was not surprised to see quiet streets. I felt okay and safe. I am sure they must have the nights when there is action.

Madam CHAIR: Pay day.

Mr GREY: Yes, last week when the show was on it was very busy all around, but that was not just normal crowd, there was other people too.

Mr WOOD: One of the issues of foetal alcohol syndrome which causes people who are hard to manage - and I am only presuming here - I am presuming the lady who was held in a Western Australian prison and came back to Alice Springs, she committed an offence, went to court, was released, committed another offence, got arrested again ...

Madam CHAIR: She is held again.

Mr WOOD: Held again. But, as a local resident, would you know a person - I am not say know a person personally, do you know of people who might have foetal alcohol syndrome and are the cause of social problems in the community, like break-ins or behaviour that ...

Mr GREY: I could not isolate that, no.

Mr WOOD: You could not? So, you would not know a foetal alcohol syndrome person if you saw one?

Mr GREY: No.

Mr WOOD: No, that is all right. Is that part of the issue that you have - and I think Raelene and others have said - alcohol mental illness and a lot of those things are part of the problem we have because of some of this excessive drinking which then causes FASD.

Mr McCARTHY: Does the chamber ever talk about a permit system to purchase alcohol?

Mr GREY: Not the chamber specifically. That has been raised over the 15 years of my time here. It is interesting, from different perspectives, because you have tourists coming in who just expect to buy a bottle of wine for \$13.95 which is a reasonable expectation anywhere. Tradies who visit remote clinics and some people I know are extremely militant about not giving up their rights to buy alcohol whenever they like and how much they like. That is the spectrum back to zero so it is not far from a consensus as to wanting to give up some liberty to control the problem.

Mr WOOD: Is that between the individual rights versus what is best overall for the community, do you think?

Mr GREY: Absolutely.

Madam CHAIR: That is an interesting point though, Gerry, because you have to look at it that the community's rights can exceed the individual's rights, in my view. What is good for the community should be considered - which is a whole multitude of people. It is a tricky balancing act ...

Mr WOOD: There is that management group we were talking about. I thought that was part of the reason that existed. But, if it is not really doing what – it just looks good on the outside, but not actually achieving anything. I am not sure – has it achieved anything?

Mr GREY: I would not bank on that at all. I would not say that.

Mr WOOD: No, I am not bagging it. But, has it actually been able to achieve some changes, do you think?

Mr GREY: Again, I am not close enough to that. With the 1 L containers, that is simply an economics thing. Glass ones are cheaper than an alternative, and not selling 2 L casks – 1 L is limited now for takeaways.

Mr WOOD: In some countries you can buy plastic bottles for wine. That was supposed to happen in Tennant Creek many years ago when the first restrictions came in. I do not know whether it ever happened.

The other thing, of course, is the Cash for Containers does not cover wine bottles because we copied the South Australian model. Non-alcoholic wine bottles are cash return. Alcohol, wine bottles, do not have any return. Talk to the wine industry why that is the case, but that is what happened.

Mr GREY: I am sure the next gentlemen can give you more information on that – anything from alcohol management plan that has come about. I know several things have been tried in the past. It is an effective outcome. Back in the days of Mike Reed and what was considered a drinking area, that was another thing was tried, thought it might have worked, but it did not work ...

Madam CHAIR: That is right. I remember that.

Mr GREY: A lot of things have been tried. Neither side of politics is at fault, it is just we keep reaching for the next thing to try, but we really have not got to the root of the issue.

Madam CHAIR: It is a complex issue.

Mr HIGGINS: Maybe it is a combination of all the things that have been tried.

Mr WOOD: There is no silver bullet.

Mr GREY: I had a chat to Mike Reed years ago, but to me if humans are doing things beyond community acceptance - you might be a gambler, a problem person of some description where you are becoming a burden on society and there is a rubbery line in there somewhere, but you do not know how to look after yourself or manage your affairs - there has to be some system. You give people money to control – Jim Forscutt used to say, ‘You are no good to yourself and no good to the community’. It comes down to those words I think. You can apply that across a broad set of problems.

Mr WOOD: He is listening up there.

Mr GREY: Yes, I know he has always got his eye ...

Madam CHAIR: Thank you, Kevin.

Mr GREY: I wish I could offer more. I just wanted to express my frustrations more than anything.

Madam CHAIR: It is frustrating, it is complex, and it is complicated. It is frustrating across the community, frustrating for health practitioners clearly, frustrating whether the child gets to school, and frustrating for families. There is also the whole social fall out of alcohol consumption and alcohol abuse and what happens from that.

Mr GREY: Perhaps I could close with one comment. You asked Rae about the predominance of mental health issues. I do not know if it is more prominent. We are in a fairly affluent society right now; most people do pretty well. Our grandparents were doing it a lot tougher, so put your mindset back two generations and imagine what their stress might have been. We have done pretty well so maybe it is more of an increase in awareness of mental health and depression awareness. My view is we are more aware of it rather than a predominance of it.

Madam CHAIR: That is quite true. Was it around then or is just we know more about it now.

Mr WOOD: Perhaps we are not trying to handle it as much as we used to. Our parents told us to take a deep breath and get on with life.

Mr GREY: Man up.

Madam CHAIR: Kevin, we will send you a copy of the *Hansard* to check and make sure you are happy with everything - no mistakes. Thank you for coming.

Mr GREY: Thank you.

Madam CHAIR: I asked a friend down south - a wise lady – if there is more child abuse now than before or is it just that we know about it. Of course, with all the hearings and commissions now - it was around then but you did not talk about it.

Mr WOOD: You were not allowed to talk about it.

The committee suspended

VENNDALE REHABILITATION AND WITHDRAWAL CENTRE

Madam CHAIR: Welcome, Casey, to the public hearing into action to prevent foetal alcohol spectrum disorder. Thank you for coming before the committee and taking your time today.

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

For the record, can you state your name and the capacity in which you appear today?

Mr BISHOP: Casey Bishop, and I currently manage Venndale rehabilitation, a program of Kalano Community Association.

Madam CHAIR: Do you want to make an opening statement?

Mr BISHOP: Yes. I have not prepared anything, and obviously my knowledge of FASD is very minimal. I have done the AOD studies; there is little covered there. Raelene stole some of my thunder. The discussion we had as the staff base was if anyone would be subjected to this it is our clients' children. Basically we are more interested in seeing where the government wants to head with FASD and how we would play a part in it. We obviously would like to be a part of it.

We believe our long-term goal is to become a family facility. We have not been able to break into that market yet, but I believe that would go a long way - having mum, dad and children present in a program - and we have to find a solution for the current sufferers and current drinkers. Perhaps with the next generation we need to make some changes where we approach everything as a family and not just dad and mum with her children, or mum and dad out there and the kids in care. My knowledge of FASD is minimal, only what I have – it was part of the reason I came early to this, to be honest. Also, obviously, workshops I have sat in, there are minimal bits in the AOD study, but it has come up at training sessions and stuff like that. That is the physical attributes, the mental health effects is really all I know about it.

Madam CHAIR: I will start with a question. You just mentioned something about mums and dads and trying to have them as a family package. In your view, anecdotally or otherwise, the FASD child of a woman - is it a family setting mostly, or is it mostly single mothers, do you think?

Mr BISHOP: I have no idea. I do not know the statistics of where FASD is presenting. It was my belief from my, as I said, lack of knowledge, that FASD was something you could not really prove yet. There is no ...

Madam CHAIR: Diagnostic tools.

Mr BISHOP: Yes. I would not be able to tell you if there are mums, or if it is ...

Madam CHAIR: Single mother thing or is it more ...

Mr BISHOP: You would, obviously, think the reasons the parent drank may contribute to it. Whether that is being a single parent could be a reason. Obviously, there is – I do not know the statistics.

Ms MANISON: With part of the rehab services you provide at Venndale, FASD is not a discussion you have with your clients generally?

Mr BISHOP: I have been there for seven years now. I have had three pregnant women.

Ms MANISON: Yes.

Mr BISHOP: I wonder if, before they get to us, whether they are legally obligated or health referred, whether the people are just not referring them to us because they are pregnant.

Ms MANISON: Yes.

Mr BISHOP: That was two who were pregnant when they came in, and one did not realise until after she had been admitted. We have not had any ...

Ms MANISON: In our previous hearings that were held in Darwin, speaking to some of the researchers, they were saying that sometimes it is the case where they get to the first child with the mother and start the treatment for FASD. Unfortunately, the damage is done. Then, they work really hard, focused and targeted with the family, to ensure that future children, when they come along, are not going to be subjected to the grog during the pregnancy. Do you think it would be beneficial for an organisation like yours to be working with those families or those individuals around the issue of FASD in the future?

Mr BISHOP: Sure, it is broken down into three sections. The first section is we have to treat mum and dad who are already drinking. Then, we have to find a treatment procedure for the kids who are affected already. Then, we have to find a way to teach the generation who are not affected it is not something that should be a part of their life, for the remainder of their life – therefore, their children and grandchildren.

A conglomerate program, a comprehensive program, where it was family treated - I think CAAPS is the only one in the Territory. I believe they are successful in that – if you put aside FASD for a second, when dad gets out he is walking straight back into an atmosphere where he is just going to drink again, because nine times out of 10 where he is walking into is saying, 'Here you go, you can have one with us'. If mum and dad both know how to help each other then, obviously, you limit your chance of relapse.

If your children are a part of it as well - and for lack of better terms - monkey see, monkey do is eliminated as well. So, you are helping the adults to support each other, but you are also showing the kids that is not normal behaviour. From what we have seen

and what our clients say to us, is they want to change their ways so their kids do not think what they do is appropriate, normal, or acceptable. I guess, without a doubt, combining and having a family approach is going to fit. As I said, at the start, we have people for whom it is too late, and we have to work out a way to treat them. That is the first bit.

It is the same with the children who are already affected. But, then, we have to work as a family group at the third level, to push everyone through who has not suffered from it yet, to show them it does not have to be a part of their life. So, yes, is a simple answer. Sorry.

Ms MANISON: What sort of direction, guidance materials from government around the issue of FASD would be helpful to a rehabilitation organisation?

Mr BISHOP: Yes, well, for Venndale – Wurli used to be in the same boat as us but they have moved to RMIT, but we use AOD for our training, so it should be that and medication pharmacology - completely off topic - should be added to the studies the AOD program provides at a Northern Territory government level. I just did the dual diagnosis diploma with RMIT, and for the Northern Territory government specifically to offer something similar would be perfect.

If anyone is familiar with Venndale, we are full all the time. There is not much time to stop and scratch your head let alone get into a text book. The way the current government delivers its training would need to be addressed as well. It is currently at a process of, 'Here's a book; read the first half and answer the questions in the second half and then I will test you on what is in that'. RMIT is a comprehensive two day course once a month and you are covering a certain area each time.

For the Northern Territory government, training would be the first one. I think training is the first step we have to take because not many of my staff would be aware of FASD, especially how to pick it and how to treat it. Obviously we are an abstinence base so we are already - no alcohol is best policy is our approach. That unfamiliarity of not having pregnant women in our program very much has, for lack of better terms, left us in the dark a bit with FASD. My initial thought is the knowledge has to be there and we simply do not have it.

Mr McCARTHY: Do you get self-referrals to Venndale?

Mr BISHOP: Yes, we do. It is nowhere near the count of the legally obligated clients. It is all about to change again I believe with Correctional Services being its own department. I am not really sure. Money already allocated to us under the new era initiative is now, I believe, to be a Correctional Services line so we will only have about

18 beds everybody else is fighting for so. We have to have those discussions soon. Self-referrals would be about five in 20 at a rough guess. We collect the numbers but I did not bring any stats with me. It is not a huge number compared to legally obligated clients. NAAJA, Corrections and NTLAC are our main source of clients.

Mr McCARTHY: Those clients are there because of a court order?

Mr BISHOP: Yes. They initially choose to come to us, but it is on recommendation from a solicitor. We also have 12 community treatment order beds as part of the AMT policy.

Mr McCARTHY: Then you have a suite of services coming through the place to deal with them?

Mr BISHOP: Yes, we have a program that starts at 7 am and basically covers life skills. There are four relapse prevention groups a day. We used to have literacy and numeracy, which we are working on getting back. We have daily jobs and case management time. They have shopping days, which are a nightmare but you have to do it. They have a health day on Thursday specifically for Wurli and that are three clinics you can go to now. We have 15 to 20 people every Thursday. Friday is very much a home day where they do groups and Sunday we go fishing, attend footy or whatever is easiest. Occasionally they go to the movies. I have been there seven years and the biggest criticism from day one was, 'We are bored'. The biggest criticism from other services is, 'You don't really do anything out there'. We have had to combat that and are still combatting it today. I am unfamiliar with a lot of people at the table and do not know what you do - no offence - but we are still hearing that from people who do not visit us now. It is really hard to prove what we do unless you watch us. Getting back to your initial question, we have a jam packed day to keep them occupied.

Mr McCARTHY: One thing I do not do is catch cabs to wineries. I do not get pension when I finish this job either. It is good to get back to the public. This is more about education and awareness. I have been asking health organisations and any services in this sector, 'Do you discuss FASD? Is it part of your agenda here? Can you teach people about it?'

Would you be receptive to Wurli, for instance, coming in and saying, 'Righto, as a relationship with this committee, government has provided extra resources, FASD is going to be on and getting that into alcohol rehabilitation'?

Mr BISHOP: One hundred percent!

Mr McCARTHY: That is good to hear.

Mr BISHOP: It is not just the FASD, they have a lot of services that should be delivered at Venndale. But, it is getting the two services to talk is the other thing. Definitely! They have mobile clinics too. It would be lovely to see them out there. But, there are lots of things that, as a conglomerate of people trying to help the same cause, we need to be at the same table negotiating together, I believe.

Mr McCARTHY: The thing about you have had some women, but it is so important for dad as well. Like that family that you talked about. So, there is real scope. This committee has to come up with some ideas that government, hopefully, will act on. If we can get those small steps, that will be an overall step in the right direction.

Mr BISHOP: If I can offer some proof in the pudding. We take couples, we do not take children. But, it is my opinion the couples' outcomes supersede individuals' outcomes every time, because they are planning their attack. I am not sure about other rehabilitation centres but we have introduced a reintegration manager. Their main outcome is to get jobs for our clients, because a lot of our clients just cannot walk into the main street and ask for a job - they will be laughed at - we have to face facts - because of the underlining issues in town. We are trying to create opportunities for our clients.

To be able to do that has definitely changed the dynamics of what we do. But, having a mum and dad or a boyfriend and girlfriend do that together is rewarding. It is not just the emphasis of supporting each other in relapse prevention, it is being able to support each other from the basic elements of, 'This is what I do when I get home from work. I do not go to the bottle shop, I come home and I prepare dinner. I pick our kids up from crèche, we cook dinner, we eat dinner, we clean up, we have a shower, we go to bed. We do not go to the pub, scrounge what money we have together to buy what we can, drink it so the police do not find us to tip it out, get drunk, fight, end up in the cells'.

I am generalising, obviously, but it is teaching paths of the relapse prevention. It is working as a couple to do all the things. We found at Venndale the results are so much more beneficial as couples, yes, so ...

Mr McCARTHY: That is great advice. In seven years, is the cohort getting younger out there or older?

Mr BISHOP: No, it has not changed. To me, it has not changed. I am seeing more females, which is good because we are not a single gender program we are mixed

gender. The demographic male and female is what I have seen changes in. Seven years ago, there was only three people in Venndale when I got there. We have had to work really hard. We went up to 40, then 12 was taken and given back as AMT – community treatment orders.

So, we classify ourselves as 28-plus community treatment order beds. They all still receive the same treatment, but we have not much control over those beds. We get told who is coming etcetera.

The age difference has not changed at all, no. It is just the same attitudes. The only thing we notice is each demographic of each age level has the same attitude. Working with legally-obligated 18-year-old boys – men, sorry - is completely different to working with a 50-year-old legally obligated man. The young fellas do not want to be there. Somebody said, prior to me, that attitude of self-belief and 'I want to be here' is very important.

We found the self-referrals go a long way. It is the legally-obligated clients who stayed the longest because, obviously, they have a lot more hanging over their head. But, we found the self-referrals are the ones who achieve the maximum outcomes, the ones with shorter time frames but bigger outcomes. But, there are plenty of arguments.

Mr McCARTHY: It is interesting to imagine an increase in women because, anecdotally, over 30 years, I say there has been an increase in Aboriginal women drinking ...

Madam CHAIR: I say so.

Mr McCARTHY: ... within the Aboriginal cohort. Thirty years ago, there were not as many Aboriginal women drinking as - I believe, my personal opinion - that there are now. You just gave me a little hint that you are starting to see more women come through a mandated alcohol treatment ...

Mr BISHOP: Oh, no, I have to correct myself there. Most of the self-referrals are females. We could say the females have more common sense; they have matured enough to put their hand up - no offence again.

The biggest issue in Katherine is the maturity level to ask for help. The ladies have reached that point and are prepared to say, 'Can you help me?' We do not find many

men doing that. If the government could offer anything it would be in the way of resources and marketing. It would be, 'Don't be ashamed to put your hand up'.

All our material says people will not regret it. We put all this stuff out there so people see it and do not have to be embarrassed to come to rehab.

Mr WOOD: How has mandatory rehab been going? Do you get any positives out of people who have been through it?

Mr BISHOP: I received the statistics today and there were 26 admissions. I am not sure of the date. I think this is the last six months. There were 26 people and 12 finished. That is over half running away.

Mr WOOD: How many of those would come back? Theoretically, they would have to come back.

Mr BISHOP: I do not know that figure. How has it gone? It has been interesting. It is nowhere near as patronised as I thought it would be, but I believe that it is because they are all in Darwin. I believe they are sent to a service in Darwin called DATs I think, but I am not really sure.

Mr WOOD: Are buildings built for purpose?

Mr BISHOP: Not especially. They were already there and funded then taken. It was one-off funding, but we had them full. We had 40 people all the time and they said, 'Can we use them for community treatment orders?' They used them for community treatment orders and that is what they are now. As I said, they are not patronised anywhere near where I thought they would be. Out of 12 beds the most we have had in there at one time is eight.

Mr WOOD: They are building a new facility in Katherine are they not?

Mr BISHOP: Yes.

Mr WOOD: Would you prefer at Venndale or do you think it should be in town?

Mr BISHOP: I would have preferred that money be spent on the current facility, but I run Venndale so what else can I say.

Mr WOOD: I have been there and I am no expert either, but I have seen a lot of positive people working there and people doing their early morning walk ...

Mr BISHOP: Yes, they do a walk every morning.

Mr WOOD: It is not just about sitting down in lectures; they are doing other things.

Mr BISHOP: I like being 40 km from town not two minutes from town. If it had been built in the middle of whoop whoop - I think you suggested it before - the healing – Banatjarl is just past us - perfect spot. That would have been a perfect spot for it.

Mr WOOD: What is that place?

Mr BISHOP: Banatjarl was traditionally a women's healing centre run by the Jawoyn Association, but my first priority obviously would have been for an expansion of our facility. I sincerely believe if it is to be built and they are not going to build it with us - it is not a great spot for it.

Mr WOOD: Was there any discussion with people like yourself or other groups about the siting of it?

Mr BISHOP: No, there was not. At this stage we have asked how to tender for it, but only at a department level. We have not spoken to any ministers or advisers. We have asked how we could run the treatment because our opinion is that people will – I think it is inevitable people will – once it is built they will ping pong between Venndale and the community treatment order facility. These are for people in the persistence model we like to call it, where their first try does not work, second try – they are coming back and forth from rehab. I think it will only confuse the situation if they are delivering different education in both facilities. Our theory is maybe the government should allow us to deliver the treatment program inside the new facility so it is all the same.

Mr WOOD: You are 40 km out of town. How far will this one be out of town?

Mr BISHOP: It is where Mitre 10 is.

Mr WOOD: An industrial area is it?

Mr BISHOP: Yes, you are in eastside.

Mr WOOD: It would be interesting to know why that was selected.

Mr BISHOP: I know, from our experience, when we tried to get the aftercare facility we had a hell of a time finding anywhere to build. My guess would be this is where government has found to build. They were opposed to a lot of - because we have another facility, VTAC, which is the after-care facility. We tried to build that, we had capital and we could not. Everyone was opposing wherever we wanted to build it. Then, flood levels is your next problem. I would not be surprised, in defence of the current government, that would one of the only spots they could ...

Mr McCARTHY: VTAC on Gorge Road?

Mr BISHOP: No, no. Gorge Road, what would that be?

Mr McCARTHY: The sobering-up shelter.

Mr BISHOP: No, no, that is Mission Australia. Michelle – no, she is not there anymore. Mission Australia runs that.

Mr WOOD: Are you the only rehab in Katherine?

Mr BISHOP: We are the only residential rehab. StrongBala is ...

Mr WOOD: There is no one competing with you for that service?

Mr BISHOP: Not residential, no.

Madam CHAIR: Okay. Thank you, that was great.

Mr BISHOP: No worries. Good on you. Cheers.

Madam CHAIR: Thank you very much for appearing before the committee. We will send you a copy of the transcript so you can just check it for any corrections. Much appreciated.

Mr BISHOP: No worries. Good luck, you all do a good job.

Mr WOOD: Thanks, Casey.

Mr McCARTHY: Thanks, Casey.

The committee suspended

**TOP END HEALTH SERVICE
KATHERINE HEALTH CENTRE AND HOSPITAL**

Madam CHAIR: On behalf of the committee, I welcome everyone to this public hearing into action to prevent Foetal Alcohol Spectrum Disorder. Welcome to the table to give evidence is Angela Brannelly, General Manager; Rose Gaston, Director of Nursing Top End; and Simon Quilty, Katherine Health Centre and Hospital. Thank you for coming before the committee. We appreciate you taking the time to come and speak with us today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If, at any time during the hearing, you are concerned that what you say should not be made public, you may ask the committee to go into closed session and take your evidence in private. Do you have any opening statements or comments you would like to make?

Mr WOOD: Could I ask a general question? How do you fit in with Wurli and Sunrise? Are you all separated or do you ...

Ms BRANNELLY: Essentially, we are part of the Top End Health Service which is within the Department of Health, and Sunrise, Wurli, and Katherine West are Aboriginal

medical services. So, we have a stakeholder relationship with those organisations. I believe they receive grant funding from the Department of Health as well as from the Commonwealth government to provide primary healthcare services to the areas they cover.

Mr WOOD: But you also have people from Katherine Hospital?

Ms BRANNELLY: We are all from Katherine Hospital.

Mr WOOD: You have three operating in the town of Katherine?

Ms BRANNELLY: Correct.

Mr WOOD: Do you work together, or do you just go where they wish to go, or ...

Mr QUILTY: The hospital primarily provides acute care, although there are outpatients services. So, it is combination. Predominantly, the hospital is acute care.

Ms BRANNELLY: So, as the Aboriginal medical services, they do primary care. They refer to us to see clients they provide primary care health services for in the region. So, Katherine West covers the west side of the region, Katherine East covers the east side, and Wurlli is the town-based primary healthcare.

Mr WOOD: And where does Sunrise fit in?

Ms BRANNELLY: Sunrise is the east, Katherine East. So, if you are going off, say ...

Mr WOOD: You said Katherine East and Katherine West and I thought Sunrise must have been another one.

Ms BRANNELLY: Sorry, Sunrise is Katherine East.

Madam CHAIR: Gerry, sun - east.

Mr WOOD: Thank you. I apologise. Very helpful with those difficult points there. That is all right.

How do you see FASD? Is it something that Top End Health Services are concerned about and know about?

Mr QUILTY: I am an adult specialist, and we see a lot of adults with Foetal Alcohol Spectrum Disorder. Presumably, a lot of it is underdiagnosed. It is part of everyday work in Katherine.

Mr WOOD: The kettle started boiling and I could not hear all that.

Mr QUILTY: Yes, it is a part of everyday work. Most of the longer-term doctors and nurses who work in the hospital are aware that it significantly impacts on a small minority of predominantly Indigenous patients' cognition.

Ms MANISON: Do you monitor rates of diagnosis?

Mr QUILTY: No, we do not.

Ms MANISON: Speaking to some of the health practitioners today about the issue of diagnosis, under-diagnosis, and people being hesitant to diagnosis as well, saying they need to refer it through to paediatricians and whatnot, particularly the kids, do you get many referrals to specialist paediatricians to see if the kids are affected by FASD?

Mr QUILTY: There are a lot of referrals for behavioural disorders and amongst that is the possibility of foetal alcohol spectrum disorder. There are probably also a lot of co-contributors contributors like genetic disorders that are underdiagnosed in the region simply because we do not have a genetic service in the Northern Territory. It is quite an undifferentiated area of behavioural spectrum disorder. From my understanding talking to some paediatricians, it is definitely a part of the workload but it is not something we monitor. As an adult physician I do not monitor it at all. Usually the patient has been labelled with the diagnosis by the time they ...

Ms MANISON: From seeing children and adults come in throughout the region, how big an issue do you think FASD?

Mr QUILTY: It is certainly worse than where I have worked in southern states. When you find a person with it where the behaviour is a problem, it can significantly impact on

other aspects of their care. It is definitely there, but it is not a really large issue from my perspective. It would be interesting to talk to the paediatricians about their perspective as well.

Mr WOOD: Who does that diagnosis, the paediatrician or the doctor?

Mr QUILTY: Generally speaking it is a bit unclear in the notes who has made the diagnosis. Generally speaking, nowadays the paediatricians would probably make the diagnosis, but I suspect sometimes a label is put on by somebody who is perhaps not qualified to make that diagnosis. However, they also understand the situation where that infant was born into the world. Once a child is four or five years of age it is very hard to, without knowing the parents and the situation, get a feel for that, but I am sure the paediatricians would have a better feel.

Mr WOOD: As a doctor, when a pregnant woman comes to you – sorry, I will ask the right person – does someone ask them if they have been drinking?

A WITNESS: Not Simon particularly, but the midwifery ward does antenatal screening for ...

Mr WOOD: The midwives could ask that question too?

A WITNESS: Yes, and they do.

A WITNESS: It is part of their standard screening process when they see a pregnant woman for the first time - about the drinking and how much they have had and then ...

Mr WOOD: That is standard now?

A WITNESS: It is part of the screening, yes.

A WITNESS: And for domestic violence as well, so it is all in the antenatal.

Mr McCARTHY: Simon, from your observations of foetal alcohol affected people, is there an age cohort that is specific?

Mr QUILTY: If I was to generalise, I start seeing people about 15 years right through to about 40 I suspect. There are not many people over the age of 40 I see that are clearly identified or referred – kids with foetal alcohol syndrome - but particularly between 15 and 35.

Mr McCARTHY: Which would then define a period in history where this problem has increased, anecdotally?

Mr QUILTY: I presume so.

Madam CHAIR: It is the mid-1960s, roughly.

Mr McCARTHY: Anecdotally, I would say very few people over 60 would be affected by this. However, I have been looking at - and I am a teacher by trade - an increase in my concerns in the other area. In your observations, how would you define developing a concern that a person could be foetal alcohol affected?

Mr QUILTY: Part of my job is as an acute-care physician. It is quite undifferentiated and having foetal alcohol spectrum disorder does not necessarily predispose you to types of conditions like rheumatic heart disease, pneumonia, stroke and heart attack. I see, very much, a general level of everybody.

But, regarding how I would recognise, it is partly the diagnosis that has been made. I am particularly grateful to the paediatricians for that contribution because it certainly helps you understand the patient and what they are capable of doing. But, then, clinically there is a typical appearance of a person who has been exposed to alcohol. One of the problems with it is because we do not have a genetic service in the Northern Territory, you often wonder whether there is something else, possibly, going on underneath. It is often undifferentiated. I certainly do not say I am an expert in foetal alcohol syndrome, but I see a number of types. There are two patients in the hospital today with foetal alcohol spectrum disorder - adult patients.

Mr McCARTHY: Yes, the conversation seems to be more common now, but there still seems to be a reticence for any health professionals to pinpoint a diagnosis. That is the latest. That is where we seem to be at. Our government has commissioned this inquiry to try to find out the wheres and why-fors, which is becoming very difficult to pinpoint.

Mr QUILTY: One of the things that makes it challenging is that other syndrome problems have not been excluded by a genetic system. We are really talking about a very high level of specialist input. There is none in the Northern Territory. I think there

was somebody visiting from Queensland once a month, but you can imagine there probably would be long wait lists, and referral processes are difficult. Also, people just accept that this is who this person now is, and no one really tries to push the diagnosis once they are in their 30s or 40s, because pushing the diagnosis does not change anything we do.

Mr McCARTHY: Yes, that is an interesting comment. I always hark back, in education, to the early years which can have a profound change if governments want to recognise it. That is what this is about. Have you been around Katherine Hospital for a while?

Ms GASTON: Since 2005.

Mr McCARTHY: Oh right. I thought you might have said a bit beyond that. I wanted to ask about maternal health and infant ...

Ms GASTON: He is saying I am old.

Mr McCARTHY: Experience I call it. It is experience.

Mr WOOD: He meant you were young. Sorry, I you have got the wrong way.

Mr McCARTHY: Have you seen real improvements in Katherine?

Ms GASTON: As far as screening or ...

Mr McCARTHY: No, maternal health and infant health.

Ms GASTON: Yes, Katherine has a really good reputation for their maternity unit - their screening, the care of their newborns, the complications picked up.

Prior to 2005, I was in Darwin, but not in a maternity field.

Mr McCARTHY: Is the FASD a regular conversation now in your department?

Ms GASTON: No, not really, no.

Mr McCARTHY: Because there is so much else to worry about?

Ms GASTON: Yes!

Madam CHAIR: Simon, when you made a comment about the two people who presented to hospital today - when you have the adults ...

(Editor's note: Audio missing between 3:29:28 and 3:42:47)

Madam CHAIR: Let us say from 20 and above and you think they have FASD, do they know they have FASD?

Mr QUILTY: They have been told.

Madam CHAIR: They have been told, but whether they take it on board is another thing.

Mr QUILTY: Yes. Generally speaking they are very childlike in their demeanour so I do not know if it means much to them.

Madam CHAIR: Okay.

Mr QUILTY: That is generally speaking, but there is a spectrum so some people are mildly ...

Madam CHAIR: More or less serious than others.

Mr QUILTY: Yes.

Madam CHAIR: Medically, is that what – we have been told from the hearings in Darwin it could be a woman was pregnant and had six bottles of wine one night then did not drink again through the pregnancy but the damage is done. Medically, do they know

if you have this much it will create this much problem, if you have this much it will create this much problem, or is that the unknown?

A WITNESS: Unknown

Madam CHAIR: You do not know how much alcohol creates so much problem?

Mr QUILTY: Any alcohol in pregnancy is bad.

Madam CHAIR: I accept that, but ...

Mr QUILTY: It is a spectrum, and it is also the state the foetus is developing in when it has been exposed to the alcohol. If it is in the early stages of pregnancy, potentially, it has a greater effect. I am no expert in foetal alcohol spectrum disorder.

Mr WOOD: The Senate study on alcohol syndrome had graphs which showed the very first weeks of pregnancy were the most important and where the damage is done. You mentioned genetics, were you saying people are predisposed genetically?

Mr QUILTY: No, my experience in the Top End and Central Australia is there are a lot of genetic disorders that are undiagnosed - higher prevalence in genetic disorders in the communities around here.

Mr WOOD: Do you know of any genetic disorder which would cause part of the brain to be damaged? We know alcohol can do that.

Mr QUILTY: Prader-Willi syndrome is particularly prevalent around here, which has a significant impact on cognition. When you see somebody who is obviously not quite

cognitively developed normally - which is a hard thing to pick off when you are in a superficial conversation. But, when you see that, you often wonder is it some other cognitive disorder, has it been head injury, or is it the result of neglect in younger ages, or ...

Mr WOOD: What is that disorder called?

Mr QUILTY: One that comes to mind is Prader-Willi, but there is literally tens of thousands of genetic disorders that can manifest as cognitive impairment. It is

impossible, without doing a full genetic screen, to be certain of what you are dealing with. I do not think that academic intellectual knowledge of Indigenous populations and genetic disorders is really very well understood.

Mr WOOD: You could work from the other end and well this person 'A' had a baby without alcohol and there were no signs present, then, had a second baby with alcohol and there was a problem. How would you ...

Mr QUILTY: Especially if you know they have been drinking heavily all the way or part of their pregnancy, you know that would contribute to their development.

Mr WOOD: There was a study in the Kimberley at Fitzroy Crossing, or Fitzroy Valley as they called it. It was a fairly widespread survey and pretty thorough one from what we see. They certainly show a connection. Not saying it is defined 100% but, obviously, there is some connection there with heavy drinking. I have not heard of genetic. No one has said anything in our discussions so far about any genetic disorder which could be the problem.

Mr QUILTY: To try to make it clearer, there is one of the gentleman who is in at the moment with a broken leg from a motorbike accident – something completely unrelated. He is, obviously, syndromic and somebody has made a diagnosis of foetal alcohol syndrome, but I cannot determine who that was. His appearance and his cognition could fit the bill of many different types of disorders. I am pretty certain he has never been tested genetically for those other disorders it could be.

Teasing it out is a difficult thing and really best suited for the paediatricians who know that antenatal history, and the obstetricians, midwives, and GPs who care for pregnant ladies, which is usually 16 years before I meet the person. I am probably not the best person to be answering these questions.

Ms MANISON: It has become very clear to the committee that there is a very undiagnosed proportion of people with FASD out in the community. From a hospital's perspective, as treating health professionals, would it be to your benefit of being able to deliver better individual health services and treatment to people if somebody is affected by FASD and you have that diagnosis? Is that going to change much of how you go about your job in treating an individual?

Ms GASTON: Probably the treatment is symptomatic anyway, because there is a variance ...

Ms BRANNELLY: Yes. Part of it is we gear what we do or the treatment we provide to the way the person has presented. So, having a label is not going to change the services we link them into on discharge, or the care we are providing while they are in hospital. It just puts a label on what it might be, knowing the points that Simon has already alluded to. I do not see that being able to go X percentage, or Mrs Smith has a formal diagnosis.

Mr QUILTY: It would be different, though, for four- or five-year-olds where they might need special medication ...

Ms BRANNELLY: Yes, for children it would be different.

Mr QUILTY: Then, I presume paediatricians would know better, they get them into special education programs. By the time ...

Mr McCARTHY: It is interesting to hear that health perspective because, essentially, the question is what is government going to do? All indications are there is this train coming and it is going to go off the tracks. In the system, surely, we would be looking at a big extra load on OTs, physios, and speechies down the track. Right? Is that what the train wreck is going to produce?

Mr QUILTY: I do not think so because, generally speaking, even people who have quite serious foetal alcohol spectrum disorder are - to generalise my experience is they are quiet, cooperative, and they can function independently, but they do not necessarily contribute in any way. That is my limited experience – well, it is not even ...

Mr McCARTHY: Canada suggests a lot end up incarcerated.

Mr QUILTY: I am sure that is true.

Madam CHAIR: Because of their limited intellectual capacity.

Mr QUILTY: I am sure that is true. But, in the OT physio healthcare provision they would be a lot more predisposed to pneumonia. They are more predisposed to a life of poverty, which has a whole range of adverse health impacts.

A WITNESS: From a health service provision perspective, it is about being able to diagnose it when you can make the most difference - when they are young - and having

a screening tool that makes it easier to diagnose where you can then implement the services to enable better outcomes longer term.

Mr WOOD: Can we have better outcomes? Is there a way of reducing the effects of FASD after a child is born, or is it something we manipulate to live with or can we improve that person?

A WITNESS: I would like to think we could always, by doing something, make a difference. That is a lot of the reason why, without putting the hand on the heart – the reason we go into health care provision is because we think whatever intervention you put in place will, at some point in time, make a difference to - whether it is better health outcomes or potentially other impacts on their lives in other ways. That is a view I hold.

Mr WOOD: I am glad you do that, but I was probably trying to be ...

Madam CHAIR: Are you asking if a person can get better?

Mr WOOD: You hope that would happen, but if I was a scientist looking at real figures - can FASD be reversed in some way? I have spoken about the elasticity of the brain, but you need somebody with a lot more experience in that area. Are we manipulating something for society to handle but the person has had really no improvement mentally?

Mr QUILTY: I do not know the answer, but I presume education would be the place to turn to. You can certainly prevent other insults from happening to them along the way.

Mr WOOD: Some people say they have lost the understanding of what is right and wrong. If you do not know what is right and wrong how do you know you should not have thrown a brick through a car? You then have the issue of people in incarceration. Is there a way of giving that person back the knowledge that has been damaged?

A WITNESS: That is a medical specialist. I think that is what you are asking.

Mr WOOD: Yes, but it is important. We are looking at helping people before it happens. We know it does happen, but what knowledge do we have to make a difference for those people?

Mr QUILTY: By the time they are adults there is – by the time I see them I do not think there is any medical intervention but I am not sure what psychological interventions are available. There is no medication or drug you can give to improve their behaviour.

Mr WOOD: I am no expert, but read some of those books. A woman was born with half a brain and has written a book. She had no cognitive skills – could not tell the time until she was 24. Eventually she trained herself to have that understanding. ‘A person had a joke that was witty, if you spoke to me about that joke it would make no sense at all’, but it made someone else laugh because they understood there were two meanings. She was able to train her half brain to overcome that. People who have been shot in the head – that is where a lot of this work came from – were eventually able to use the healthy part of the brain to overcome what had been damaged. Can some of those things be a possible solution?

Mr QUILTY: The neurological insult for foetal alcohol syndrome disorder is the whole brain.

Mr WOOD: It is not just a section?

Mr QUILTY: No. It is a global insult on the brain and affects the way the brain grows so every part of the brain is impaired. I do not know if any psychological or education intervention could not overcome some of those difficulties. I am not sure of the science in that regard, but the whole brain is altered.

Madam CHAIR: It is not just a bit here or here?

Mr QUILTY: As the brain grows from two cells onwards, if you damage that process, then it affects the whole brain.

Madam CHAIR: Of course, the first four weeks of a baby growing - that is why it is so crucial.

Mr QUILTY: Yes, so crucial.

Mr McCARTHY: Quite innocently - it was quite confronting - I accepted that a dad of a 15-year-old foetal alcohol- affected child, who refers to him as ‘he is drunk. He does things as he is drunk’. After spending a couple of days with this kid, I got to realise I understood that. It is not a nice definition, but it was what dad had come to terms with.

Mr WOOD: I have one of the questions here about your relationship with some of the alcohol services. We have had Venndale here and Wurli-Wurlinjang in relation to what we are talking about. Do you have workshops, even with your nurses and Aboriginal health - I was going to say workers, but that is the new term of practitioner.

Ms BRANNELLY: Yes, Aboriginal and Torres Strait Islander Health Practitioner.

Mr WOOD: My wife used to be just an Aboriginal Health Worker once.

In Katherine, do you occasionally have educational programs or workshops to work through some of these issues together, so people are aware and people are trained in at least trying to assess what is happening?

Ms GASTON: There is always ongoing education and lots of things. Nurses keep up to date with what is going on.

Ms BRANNELLY: We work closely with our Alcohol and Other Drug partners in town to target education for the staff, when we need it and ongoing. Some of it is around providing brief interventions at that point of care contact. Some of it may be if we feel there is a specific need we want to have specific targeted education, and we will work closely with them to get the experts to come and provide that education to the staff in Katherine, or at Katherine Hospital specifically. I know from the medical officers they can also tap into education that is occurring at Royal Darwin through videoconferencing. Where we can tap into it, we do. We assess the needs we have around that kind of education.

Mr McCARTHY: What about at university, doctor, in your initial training? They tell me ear, speech is about a week and seven years. How about FASD?

Mr QUILTY: I went to Sydney uni, and I was told that rheumatic heart disease was not a problem in Australia anymore. Sydney is a very long way from the Northern Territory.

Madam CHAIR: Wow!

Ms BRANNELLY: When I did my maternity training at Royal Darwin Hospital, we did part of the old hospital-based apprenticeship system. It was part of the course work we

did around foetal alcohol syndrome. I know that the course that is offered at the university - the Bachelor of Midwifery - alcohol and other drugs is one of the core topics embedded within the course. So, it would be part of that, as it is also a core topic embedded in the Bachelor of Nursing.

Mr QUILTY: And at Flinders University, I think they deal with the topic of alcohol much more rigorously than those topics at uni.

Mr WOOD: You are all people who live in Katherine. I ask a non-professional question. People have said to us there is an alcohol problem in Katherine. Would you say that is true, and do you see that being reflected in some of the issues that you deal with in the hospital, week in, week out, night and day? Do you see - and you do not have to answer - any ways things could improve?

Ms BRANNELLY: I will answer first, if you like. Alcohol problems we see in Katherine are no different to those we would see in Darwin, Alice, or Tennant Creek. Sometimes, it is on the street and sometimes it is behind closed doors. Sometimes it is quite visual, and sometimes it is not. That is the Northern Territory and you will see it. I have lived in the Northern Territory since I was 13. If I think about when I was growing up in the Northern Territory in Darwin, is it any different now? Sometimes I think it is a little more visual on the streets than it was when I first arrived in 1978.

From what we see in the hospital, we see a lot of our work - particularly our emergency department presentations - is due to alcohol-related issues, whether it is violence or drugs. It is not just alcohol; there are issues around drugs as well. It is a part of the healthcare we deliver here. However, as a citizen of the town and a long-term Northern Territorian, it is something you see and is there. It is not unique to Katherine, and if I am being truly honest as a Territorian citizen, part of it is unique to the Northern Territory.

I travel every month to Melbourne and I do not see on the streets of Melbourne what you would see here, but perhaps in other places it is not as visual. I do not know if others would like to answer that question.

Mr QUILTY: I came from Newcastle and was there when they introduced the restricted trading hours. I lived three doors from a pub and it made my life much better.

Mr WOOD: I should talk to you later. We tried something similar in parliament but did not get anywhere.

A WITNESS: One thing you notice as a citizen is when our colleagues in the police force are visual at the bottle shops, we do – anecdotally, we see a reduction in what is presented to us at the hospital and also what we as the people, community, or the citizens of Katherine would see in public.

Madam CHAIR: Yes, someone said today that violence dropped by about 50%.

Mr WOOD: My only problem with that is they do not go to the bottle shop near me. From a bigger perspective it looks like one group is being targeted. I am not saying it does not make it – it has some benefits, but

A WITNESS: From what I have seen they go to every bottle shop here.

Mr McCARTHY: I raised the issue with some senior police the other day at an alcohol management reference group meeting where I said already there is some interesting anecdotal evidence on the street where the temporary Beat locations are being exploited. Funnily enough, five days later I was pulled over on the Sandover Highway for a licence check and a breath test by the superintendent of police and the officer-in-charge of the Tennant Creek Police Station, who just happened to be visiting and doing some work, which is another thing I discussed at that meeting. It was not anything bad; it was good and we had a great conversation. However, they were interested already - temporary Beat location - exploitation is starting to take place in some very creative ways.

A WITNESS: People will find ways around ...

Mr McCARTHY: Not in Tennant Creek.

Mr WOOD: It is a little place in a big country.

A WITNESS: And one road.

Madam CHAIR: Thank you. There are no more questions or comments? Thank you for coming here today and sharing your views with us and answering questions. We will send you a copy of the draft *Hansard* so you make any corrections that we have not recorded properly. Thank you very much.

A WITNESS: Thank you.

Madam CHAIR: Much appreciated.

The committee suspended.

KATHERINE WEST HEALTH BOARD ABORIGINAL CORPORATION

Madam CHAIR: On behalf of the committee, thank you for coming today into this public hearing into action to prevent foetal alcohol spectrum disorder. Thank you and we appreciate you taking the time out of your day to come and talk with us. This is a formal proceeding of the committee and the protection of parliamentary privilege and obligation not to mislead the committee apply.

A transcript will be made for use of the committee and may be put on the committee's website. If, at any time during the hearing, you are concerned that what you say should not be made public, you may ask the committee to go into a closed session and take your evidence in private.

For the record, could you state your name and capacity in which you are here.

Ms GOOLEY: My name is Rebecca Gooley. I am the Senior Primary Health Care Adviser with the Katherine West Health Board. I suppose I am representing the service delivery aspects of FASD in our context.

Madam CHAIR: Would you like to make some comments?

Ms GOOLEY: Listening to the guys before me, I suppose I could repeat a lot of what you have heard today. What Nicole was saying, you have probably heard a lot that foetal alcohol spectrum disorder is actually under-diagnosed, the difficulties with diagnosis, and also the difficulty with dual diagnosis. I probably do not need to repeat that.

I wanted to talk a little in the context of remote service delivery, and the challenges where we are already delivering services to the Katherine West region, which is the remote clinics in Lajamanu, Kalkarindji, Timber Creek, and Yarralin. We provide care across the lifespan of the community, high burden of chronic diseases and a high burden of alcohol use.

Generally, we have a high ratio of women who identify as using alcohol during pregnancy. We also have a high rate of women identifying using tobacco during pregnancy as well and then, the flow-on effect with children who eventually end up with developmental delay, and where that may or may not be diagnosed or picked up early. In fact, the specialist care to diagnose in that context is very limited.

We have visits from paediatricians every three months, but there are so many other acute things they are probably busy looking after. It probably goes to the bottom of the pile.

In the context of remote service delivery, the lack of services - the complexity of dealing with developmental or behavioural issues is difficult because you need a multidisciplinary specialist team, which is just not available in the bush. There can be services at different times of the year, but the intensity of the therapy requires – it is just not available.

Often with FASD there is discussion now about early intervention - if you can intervene early and put the supports in place for the child to enter school the trajectory to gaol or the justice system is reduced significantly. That is where I wanted to come from in the discussion.

Mr WOOD: Raelene Wing gave me an impression that the number of women drinking - there were areas Sunrise covered which were remote, which sometimes were missions or people with a Christian background, and a lot of those people did not drink. There were also people who came closer to town, some of whom drank. If I go to the west side you have Timber Creek, Top Springs, Kalkarindji – do you have places which make it easier for people who access alcohol as compared to the Sunrise area? Is there a difference between the two cohorts?

Ms GOOLEY: I think it would be easier for people on the east side to access alcohol because they are just closer to town. Obviously in places like Timber Creek you can buy alcohol, and you can buy alcohol at Vic River, Katherine and Kununurra. Access to alcohol is probably more on the east side. The further away from alcohol points we tend to see less alcohol use. In Lajamanu there may not be as much alcohol use, but there might be more use of other drugs.

Our data is incomplete. It is a difficult area because we are largely relying on self-identification of whether it is alcohol use or smoking. If people want to access it they will it.

Mr WOOD: Is your limit the Western Australian border or just Western Australia?

Ms GOOLEY: Yes, we provide services pretty much to the Western Australian border. The furthest community we have a health centre in is Kildurk, but we also look after all the cattle stations and ranger stations. We have a mobile team going as far as Kununurra - Keep River National Park - to the border.

Mr WOOD: Do you overlap with Kununurra at all?

Ms GOOLEY: Yes, OVAHS provides some of our mobile service in that they look after the Duncan Highway. We have to communicate as a service, but also the practitioners are always talking with – from Timber Creek mostly - to Kununurra. There is that connection of – people might drive themselves into hospital. We do not transfer people across the border, but people might take themselves there and then a discharge process happens between Kununurra and OVAHS, so there is communication there.

Ms MANISON: Does Katherine West provide any specific FASD programs or services at the moment?

Ms GOOLEY: None that are – I suppose we provide child health services across a model that is reliant on – it is systematised. We have a high turnover of staff and a lack of specialist staff in the area of child health. We systematise our care and we screen for alcohol use in pregnancy. It is self-identified once again. Obviously, that would trigger a care plan as such. But, even if it gets to a point of diagnosis, the difficulty then is the therapy and the ongoing treatment and access to that. So, it is ad hoc. It is chaotic really, in that even if we had, at the primary healthcare point, all the ducks lined up, there are still going to be gaps, or there is going to be limitations of how far the care can be provided within the primary healthcare context.

Ms MANISON: I suppose resourcing has been an issue that has been brought up today. Everybody has very limited resources with what they can do and what they cannot do. From seeing people on the ground, would you see it as being more beneficial to have, if somebody has FASD to get a diagnosis done at least so they can get those care plans ...

Ms GOOLEY: Definitely. If you have a diagnosis, then you have the evidence you need to move forward with making noise about needing the services. If we stick our heads in the sand and go, 'Well, there is no point diagnosing it', then we have nothing to address it with.

The difficulty also with diagnosis is the diagnosis in itself is complicated because the child may have a dual diagnosis. There might be other reasons the child is not developing. Unless it is frank symptoms of foetal alcohol syndrome, it might be diagnosed as something else. That may not necessarily change a child's world as, for a lot of the spectrum syndromes, intensive therapy is the response. You respond to the symptom, then you provide the intensive therapy at that point.

We are primary healthcare environment and we provide generalist care. There are things we can do, but resourcing is limited.

Mr WOOD: Initial contact is the simplest way of telling people not to drink. Is it widespread amongst most of the people in your area? I presume most of those people are Aboriginal people. You might get station people who come along. Would you say that most women, or at least most pregnant women, would have any idea that drinking was not a good idea, or would there be some women who just have another sense of the world that 'Regardless of my knowledge, I will not do anything that could possibly harm my baby either with smoking or marijuana'? Is there a knowledge out there?

Ms GOOLEY: That is a hard question. For people who have a good grasp of literacy and have access to good amounts of information, it would be hard not to know that there are issues with drinking during pregnancy. At a primary healthcare level, we try to intervene with an antenatal pregnant woman quite early to have the discussion, so it happens as a one on one.

In social media that is specifically targeted to our community, there is probably not a lot. If there was more information that was targeted specifically to our communities, whether that would change behaviour or not, we just do not know.

Mr WOOD: I was at the Merrepen Festival, and one of the signs up at the store there - I do not know whether Nauiyu comes under your area - I am fairly sure it said FASD Day, 9 September, I think it was.

Ms GOOLEY: Is that Daly River?

Mr WOOD: Yes, Daly River. I do not know where that came from. I do not know whether it is exclusive to Daly River, but I thought there must be someone out there starting to promote. But, I do not know who it was, I probably should have taken a photo. I can ask the local member when he is down there – Gary ...

Mr HIGGINS: I can find out.

Mr WOOD: Thank you very much. He lives there.

Madam CHAIR: No, we have seen it somewhere. Some international day, yes.

Mr WOOD: Is it? It is an international day?

Mr HIGGINS: Yes. A national day.

Mr WOOD: I know we are dealing with a complicated problem and dealing with issues

afterwards, but how many people are aware and, as midwives and doctors are a lot of times the first contact, how much of that message can get out there?

Ms GOOLEY: From my experience and the contact I have with pregnant women, I would say there is an understanding that alcohol is not good during pregnancy but I could not talk for the entire community.

Mr McCARTHY: What is the reaction from bush clinic staff when they hear a radio story that the government will be taking action on FASD?

Ms GOOLEY: They might roll their eyes a little. That is a positive. There will always be a cynical side of a clinician who may not necessarily see the resources required to address or may not understand the complexity of tunnelling resources. I think they would be happy there is a focus, a growing awareness and that some action is being taken.

Mr McCARTHY: If government came through with more resourcing what would they ask for?

Ms GOOLEY: I think it would be around the information or guidelines they need to diagnose – to be able to pull in the resources. The context of remote health is we do not have a prepared specialist workforce, even for remote health, because there is a high turnover of staff. There is only a certain amount of time a bush nurse, a doctor or an Aboriginal health practitioner works in the bush because there is a high burnout. There is a whole range of reasons.

We rely heavily on we call the 'rark workforce' which is the agency fly-in fly-out workforce. We need to be prepared to respond to an emergency more than to be prepared to respond to foetal alcohol syndrome. I think that is the starting point - some clear guidelines on the diagnosis and the treatment so those people can then call in the second point, which is the specialist services they need. This is talking about the allied health workforce required on the ground to provide these therapies. This is not specifically related to FASD, this is related across many developmental disorders we see in the bush where there are no resources to - it is the soft part of health. It is not seen as important as giving a vaccine, some antibiotics or curing something. It is long term.

These things require therapy over a long period of time and then collaboration with the other agencies: the schools, the hospital, the specialist services and the family support system or FACS where children need to be managed from a central point. In the current system they get lost in the follow-up and some resources there would be good.

Mr McCARTHY: That is a good, comprehensive answer from a medical professional who has to manage the problem. Let us quantify - \$9.2m is just dropped from the federal government. Would you say, if we had this windfall, we should push it all into preventative? Should we, with all the different agencies, really hammer the education and awareness about this spectrum disorder and syndrome?

Ms GOOLEY: It would be very well utilised in primary healthcare. Prevention is very important, but you can never entirely prevent something. What you can do is intervene early, so that child can be put on a trajectory with the services they require, and supported to get into the education system and move them forward. I know this is probably going around the bush a little but it is more complex than just saying, 'Let us just put it into one area'. I am a big fan of prevention. It is completely preventable. The reality is it will continue to be a problem, people will continue to drink. I just do not know what you would do to stop people from - really seriously stopping – drinking. Other than incarcerating women and taking all the alcohol away, I just do not know. The reality is there are going to continue to be children who suffer the effects of foetal alcohol spectrum disorder.

Mr McCARTHY: In my opinion, the big announcement will be dominated by the big researchers who will go for the diagnostic tool. This will be a very tertiary-level expenditure and exercise, while at Lajamanu we are still dealing with this problem.

Ms GOOLEY: Absolutely, yes.

Mr McCARTHY: I do not think it is about stopping drinking. It is about understanding the effects of alcohol *in utero* on that child. That is why I was asking from a perspective from a person in the field.

Ms GOOLEY: Yes, I totally agree we will get a very good diagnostic tool. But, we will not be really any further ahead with providing support for people who are affected - acknowledging there is a limited bucket of money. That is the research, the evidence that gets up. It is a poorly understood area and I do not that we know the extent of the problem in our region, let alone across Australia probably.

We see a lot more developmental issues in children just generally. We are not entirely sure why.

Madam CHAIR: Thank you. That was good.

Ms GOOLEY: Pleasure. I hope it was.

Madam CHAIR: Oh, yes, definitely, Rebecca. We will send out a copy of the draft *Hansard*, the transcript, so you can just check it and make sure it is all okay with what you have said. Thank you for your time here today in sharing your thoughts and comments with us.

Ms GOOLEY: Great. Thank you for listening.

The committee suspended
