The committee commenced at 8.40 am.

**ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES NORTHERN TERRITORY (AADANT)**

**Mr CHAIR:** On behalf of the committee, I welcome you to the public hearing into reducing harms from addictive behaviours. I welcome to the table Richard Michell and Katie Flynn. Thank you for coming to the committee, we appreciate you taking the time to speak to us and look forward to hearing from you today.

This is the bit that does not apply—this is a formal proceeding. When they [other committee members] do arrive it will be a formal proceeding of the committee; the protection of parliamentary privilege and the obligation not to mislead the committee will apply from that point.

I do not know if that means you can mislead us up until then... I am sure you will not.

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

That being said, for the record can you state your names and the capacity in which you are appearing?

**Mr MICHELL:** Richard Michell, Executive Officer of the Association of Alcohol and Other Drug Agencies Northern Territory.

**Ms FLYNN:** Katie Flynn, Project Officer of the Association of Alcohol and Other Drug Agencies Northern Territory.

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

**Mr MICHELL:** I thank the committee for inviting us into what I think is a very important issue that has been continually in Australian drug policy. I will talk about drugs and alcohol under the harm minimisation; it is a lot broader than that but we represent drug and alcohol and would like to speak specifically around drug and alcohol and harm minimisation.

The conversation around drug policy in the way that we deal with drugs and alcohol is a longitudinal thing. We started back with the miners, xenophobia with opium. I just want to mention that harm minimisation is often seen as something from the left but we remember that the reports that still stand are Jeff Kennett's. If you look into the Penington report around drug and alcohol, it still stands as a document today where drug and alcohol services are concerned.

From a political point, this is not about left or right. It is about people and how we best serve through our policy and actions in making sure people's lives are improved and sustainable. We have written a very broad statement around harm minimisation and there may be some things in the report that do not seem specific to the Northern Territory.

What we wanted to put forward is that this thinking has to be involved in… the example would be around safe injecting rooms. Not that we are aware of any need for safe injecting rooms, but we want it to be on the slate.

Working in drug and alcohol we know that drug trends change, we have seen methamphetamine and in the year 2000 heroin would supposedly take over the world, everyone would die. It did not happen. Also, I can remember in my early days in Drug and Alcohol, I could not get anything in the paper about alcohol, because they were not interested. Heroin was the do.

The trends in all of these move and change. The way people use drugs change. Amphetamine has been around since day dot. It has only been in the last 20 years methamphetamine has really taken hold. It has changed the culture of drug use.

As I said, the reason we put up the thing about safe injecting rooms is to make sure it is there, within the scope of government and the Northern Territory, so we can quickly move and it does not become bogged down in bureaucracy and we do this.

That is probably my opening statement. You have read our submission. It is very similar to a lot of other submissions. As I said earlier, it has been really interesting to read the opposing views—I should not say

opposing, but differing views. In my 30-something years in Drug and Alcohol I do not see a lot of new thought there. It is still the same opposing stuff.

One of the main thing we are concerned about is the criminalisation and labelling of young people. For people with possession amounts, it sets off domino-style—it is not only the family that has to deal with that, but being a drug user, unemployed, whatever other categories, just compounds the fact of someone making change.

**Mr CHAIR:** Thanks, Richard. We now have a quorum. You know, Paul Kirby, Member for Port Darwin. Sandra was at a school assembly as well. She thought it was 9 am …

**Mr KIRBY:** It is certainly in my diary for 9 am. My apologies for that.

**Mr CHAIR:** We started. Richard has just given his opening statement. There are not that many, but we have some questions. We tend to ask one or two, then the conversation flows into different areas. So, I will kick that off.

In your submission, you referred to the recommendation by Harm Reduction Australia to introduce heroin prescription program as a harm reduction mechanism. How would this program work in the NT setting? Would it be based on a judicial referral system or voluntary participation by users?

**Mr MICHELL:** Once again, heroin use in the Norther Territory is very low compared to other states. It is quite unique, in fact. The thing we now have is a little like the US. The prescription levels of opiate dependence is really high. Anything around heroin subscription should be based on the same way any pharmacotherapy is—through a GP, drugs poison registration—tightly monitored.

This conversation came up with the Prime Minister's drug advisory group years ago under John Howard. John Howard had flatly rejected heroin prescription in Australia. Yet, in other countries like the UK, heroin is available for people with cancer and a number of different conditions.

Demonising of heroin which comes from poppies—you can use morphine, you can use codeine — well, not so much codeine — and that is fine. It is a slight change in that composition. For people who have cancer, or maybe some dependence issues, it is a preferred drug.

We know from a lot of research that methadone given to people with opiate addiction often does not work because it is a different drug. You have now brought in a number of other longer-acting drugs which are able to sustain people over a period of time. To answer your question, it is around... It still needs to be tightly regulated. That is how that would roll out.

Currently, heroin use in the Northern Territory last year was really low, while other states have picked up. It is a good thing, but the increasing prescription opioid use world-wide has escalated—you might have seen reports in the last week about the number of deaths from prescription opioids …

**Mr CHAIR:** Yes, the fentanyls and the oxycodone and those sorts of things.

**Mr MICHELL:** Which is symptomatic of—sometimes when people want to stop one thing, it is like squeezing a balloon, it does not stop it just moves to somewhere else.

**Mr CHAIR:** I am not sure if you answered this in there. If voluntary, are users likely to see this as a worthwhile alternative to existing supply pathways?

**Mr MICHELL:** With heroin?

**Mr CHAIR:** Well, that is what the question…

**Mr MICHELL:** I guess to answer that—let us change it slightly. Methamphetamine seems to be an issue in the Northern Territory.

There have been a number of attempts to—we have substitute therapy, pharmacotherapy for heroin and a number of other things. Methamphetamine and amphetamine is still—there have been a number of trials by a number of New South Wales and Victorian—Turning Point might have done some things around alternative pharmacotherapy for methamphetamine.

While the trials have happened there does not seem to be any longitudinal—as in methadone and buprenorphine work for opiate, I do not think there has been any—I will not say evidence but they do not seem to have continued in any fashion around amphetamines.

**Mr CHAIR:** Is that the patient themselves or the study?

**Mr MICHELL:** No, the pharmacotherapy. The science behind, the medication to medicate. People withdrawing from heroin, you can give them buprenorphine or methadone so they stop withdrawing. Heroin has very straightforward symptoms of withdrawal, methamphetamines more longitudinal and a lot harder to identify. In that scope, we should look at research and different therapies on how we address methamphetamine, the same as we have done with opiates.

**Mr CHAIR:** Welcome Sandra, as well, by the way.

**Ms NELSON:** Thank you. I apologise to everyone for calling in late.

**Mr CHAIR:** Kirby says 'how rude.' He just walked in before you called.

**Mr KIRBY:** I planned on being 15 minutes early. Turns out I was 15 late.

**Mr CHAIR:** Stigma and shame are regularly identified as reasons why people do not seek support for addictive behaviours, whether it be for themselves, friends or family members. What strategies do you use to reduce the stigma and shame associated with seeking help?

**Mr MICHELL:** I think it is about decriminalising or normalising the fact that people use drugs for different situations, whether it be grief or loss, mental health issues or recreationally. The increased thing about decriminalisation and drug use is, 'I am not only a drug user, I am a criminal as well'. In Australian society, if you want to see how that plays out, ask people who go to their chemist every day to pick up their methadone. Ask them what it is like to walk up in front of other people and they go 'oh you are here for your 'done.'

I often say, show me a career path where someone says they are going to become a heroin addict, 'I am going to commit criminal offences and get Hep C', as a career choice. It is not a career choice. It is a number of factors that put those people—then when we have a system that isolates and categorises you as not only a junkie or a drug user but then a criminal, you have the double whammy. Then the other things on top; maybe you are Indigenous. So all of these things push you further and further away from individuals feeling comfortable in accessing treatment.

I am sure you have read some of the research on this—if we take that away... Safe-injecting rooms in Victoria were brought up 15 years ago and it was knocked on the head because it was seen as a place for people to come and use heroin. I had a little bit to do with that and I know that it was not just that. It is a place where you can wash your clothes and get some food.

It is a place that is your first contact with treatment, which is the hardest thing for anyone. Having the guts to turn up and say, 'I have a drug problem.' I am sure a lot of us would say, 'I do not have a drinking problem' and then have another drink. It is that first point of contact.

Safe injecting rooms were seen as something that gives people the opportunity to use drugs. There are far more opportunities to access treatment, information—somewhere like the streets of Melbourne—rather it is about clothes, food and some social context of having people in the same room listening to each other. It is often thrown out of whack.

**Mr CHAIR:** I completely agree.

**Ms FLYNN:** A lot of work needs to be done with the media as well regarding stigmatisation.

If you have an issue that you do not think is an issue, think it might be an issue or in a stage of change where you want to do something and all you are reading in the news is drunks do this or that. It demeans people in what they are going through.

You are unlikely to reach out for help because you are seeing the perspective of the news, which is supposedly what everyone is thinking. You are supposed to deliver the news in terms of the opinion of the people of the town you write for. If the news only says drunks do 'this'; people are arrested for 'this'; drugs

are bad; why are people doing this?; you are getting gaol for this, why would you reach out for help in a town where you do not think you would be supported?

**Mr MICHELL:** To be further ostracised by …

**Ms FLYNN:** … by someone if you reach out.

**Mr CHAIR:** It was a topic of discussion at the Alice Springs public forum. That is problematic.

**Ms NELSON:** That negative commentary just reinforces—it goes against the whole ethos of positive reinforcement. If people hear often enough that 'you are bad, this or whatever'—it is self-prophesising.

**Mr MICHELL:** Yes. You will internalise it. Can I also say on that statement, we still sit within and deal with a focus of treatment. We deal with this small bunch of drug users.

Drug users overall are a much bigger bunch. People recreationally use drugs all the time. It is only a small portion who end up in the high end of treatment. Other people go through whatever, but let us face the reality. Drug users are amongst everyone we know and everywhere we go. It is always focused on it being problematic. Here, we have a lot of stuff around alcohol, but it is about this small group, not the larger.

We have to get the broader group to take responsibility for their use in how that feeds into it and what we want to do. Particularly for us, because we deal with treatment, we see that side. We also understand—people come to treatment through a corrections system or whatever else. It is not necessarily about change, but they come through the system. They will toddle off and you will never see them again.

Especially drug and alcohol treatment—which is rehabilitation, intensive counselling and all of that. It is the group that has multiple issues. Drug use is symptomatic of a number of different issues: homelessness, criminality, depression and domestic violence. It is interesting. The focus is on this small group, when …

**Mr CHAIR:** Yes. I have raised it before the meeting started. I will go off-script here. Thinking of that broader group—and that strikes me as the main problem, as in the comments I made to you before—all of our efforts are regarding that small group and, effectively, fixing them when they are broken. Are there any ideas or suggestions in how we can broaden our approach, so we are dealing with people with not problematic use, but casual use so that we can provide education before they need treatment and high-end rehabilitation?

**Mr MICHELL:** I think this goes back to the point before. If we demonise problematic drug use, then you get people who are not willing to come forward. They then only come forward when they are arrested or after some crisis based on their drug use.

There has been a good system of drug education in schools across Australia. All schools should have a drug education plan. The way that is rolled out is—we put a lot of focus on teachers teaching our children not only maths, English or whatever, but then drug education.

That is not their area of speciality and it starts from primary school which is about understanding what you take into your body. When you get into the later years of secondary school, it is probably something that people need a little bit more education on. We cannot keep loading up teachers to take on more and more responsibility about drug education.

School nurses have always been a good way. Early intervention is always the best. Particularly these days, there is a lot more informed young people about drug use than what there probably were 20 to 30 years ago. I also think that in that, there is also a lot of people—teachers are trying to do a number of different things. School nurses in some jurisdictions have dropped off.

Coming back to harm minimisation, we need to normalise the fact—people will not like to hear this—that people use drugs.

**Mr CHAIR:** I suppose it going from your comment about the media as well. The normalisation of attitudes towards the fact that people take drugs.

**Mr KIRBY:** I am not sure that Jeff or I are in the position to recommend to the media what they should reporting on.

**Mr CHAIR:** No, what is asked of us at the public forum.

**Mr MICHELL:** The other thing too is if you think about the way that people perceive drugs—heroin in 2000 in Victoria was the same as the road toll. They used to have heroin deaths and road toll deaths. One of the biggest supplier decided he was going to stop doing it. There was a drought. Did it stop heroin use? No.

What happened was that people were using benzodiazepines in gel capsules, injecting it and ending up with limbs falling off. We need to be honest about what we are doing with all of the population around drug use. I do not know if I would say acceptable, but this is what people do.

Squeezing and regulating, the overregulation—it was interesting for me when Tony Abbott was the one who came out with methamphetamine and said we cannot arrest our way out of this. You can put a number of different…

**Mr CHAIR:** Somebody did say that but I do not think it was Tony Abbott.

**Mr MICHELL:** He might have reused it.

**Ms NELSON:** Was it a word for word quote?

**Mr MICHELL:** I am just saying the demonising of drug use started with xenophobic stuff of the Chinese here years ago and it has never gone away. Also, I do not mean offense to politicians, but it works in an election year—crime, drugs, crime, drugs.

We signed conventions in the early 1900s around the importation of heroin and all of that stuff with the USA. Even in the Howard days, around 'we will not discuss heroin' and now how many states have legal cannabis and making billions of dollars. We need to think about what we are doing.

The other example is in the 80's—I went to a harm minimisation meeting in Poland. We were the top of the tree in harm minimisation. We were right up there with any western country around how we deal with drug use. In Chicago 80% of drug users were contracting either Hepatitis C or HIV. We have always had a very small percentage of injecting drugs users contracting HIV in quite a big population.

It is because we were proactive, we took a different stance. The Northern Territory has that opportunity. We are always seen as this or that. We have small enough population to put some things in to at least give it a go. If you want to go to an Alcoholics Anonymous or a narcotics anonymous meeting, what they will tell you is that nothing changes if nothing changes. We just go around and around.

I think we have an opportunity. It is a challenge, you have a small population spread over a really large geographical size but if you look at some of the reports around Portugal. The negative was that Portugal has 10 million people. We only have 350 000 people.

**Mr CHAIR:** Yes, 200…

**Mr MICHELL:** Two hundred and something. I can never keep up with that stat. It is contained. As I said, if the Kennett Liberal government can come out years ago, get Penington on board, make changes that still exist with Labor or Liberal governments around harm minimisation, it is an interesting way of looking at stuff.

We need to try something different. We need to stop labelling people, stop discriminating against people. We particularly need to stop criminalising young people. We are all aware of the issues in the Northern Territory and it is often blamed on youth.

Does a young person say 'I want to be a criminal, I want to go to prison?' No. If you do not have opportunities to have jobs—drug use is symptomatic not a career choice.

**Ms FLYNN:** In terms of education, pill testing can be a really good tool in teaching anyone who comes in, even young people who you say 'yep, you are going to use that recreationally, that is fine. This is what is in it; that is your decision.' They can make their own decision on what they are or are not going to take. That can be a great tool for teaching someone about the substance; 'this is in here', 'this is not what you thought it was' and to understand what the composition of that drug is and to make their own decisions about their consumption. That is a first point of contact as well.

You can have a brief intervention with someone while you are waiting for testing and asking them why they are taking a certain substance or if you want to make this decision that is fine but you can get stats on what

people are taking as well without saying 'do not take this', 'do not take that'. You are just getting that stat from what is available that you would not get anywhere else.

**Mr MICHELL:** I find the conversation around pill testing—because telling young people that even if it is poison they will take it is so disrespectful. You are underestimating the youth of Australia. Some people will probably continue down the same line but if you say to a young person that it is poison, it is ridiculous to think they are just going to take it anyway. It is an insult.

**Mr CHAIR:** My position on that as well is that if they are willing to come forward to get the information in the first place, the likelihood that they are going to continue on and take something is very remote. Even if it were, if there is not pill testing 100% of them would have taken the pill.

**Mr MICHELL:** This is Australia 21. This is a document about young people and their views on drug and alcohol and the way we should approach it. This is from 2015. Very educated, well-informed young people making decisions about the future of Australia, what that looks like and what that means for their society. To say that pill testing is—that young people are just taking it, I think that is a ridiculous statement.

**Mr KIRBY:** The comments that you just made about proactive treatment, whether it is safe injecting rooms or just being able to have conversations at pill testing booths. What else is there, with the issues that we have in the Northern Territory? We have heard up and down the track so far that we are not doing much proactively because we cannot. We are reactively dealing with most of the issues that we have in front of us. If you had the opportunity, what do you think would help us change the game in the Territory?

**Mr MICHELL:** There is still a silo mentality between drug and alcohol services and mental health services. Everyone has their box and everyone plays there. We do not have the luxury of having 10 million people here to have multiple services. They are strained. We need to work better together. That is a really hard thing coming from the historical view because people are in positions about funding.

The bottom line is we represent the NGO drug and alcohol sector, the agencies, but what we represent is the people; the people wanting to turn up to a place, tell one story and get referred to treatment. I do not need to be telling my story 20 times. I do not need to keep dropping out of the system and trying to come back into it. Add on to that, if I have mental health issues as well, how do I circumnavigate a system that does not seem to be able to work together.

I want to be really clear. The system in the Northern Territory does what it does. But once again, geographical size—we know that retention of Drug and Alcohol staff—there is very little planning about what that means for people who deal with Drug and Alcohol.

Some of that comes from the 1970s and 1980s drug rehab when you went to a rehab, dried out, you basically got the kind of boot camp thing. I am not sure that sits well with people these days. But we still need to understand about how we rebuild our lives. That involves people with good training and education. In child protection you would not be asking people to be a child protection worker without training and education.

But we have to understand the restriction here is we do not have the budget. We cannot train even. But we need to ensure that agencies are working together and sharing some of that wealth of—if you have highly qualified people then that needs to be shared across. That is a question for you guys in government, I guess. It is really difficult. You are working with communities. It is very hard because you cannot have someone there every day, necessarily. It is really stretched.

The observation would be we need to work better together. We need to work across Housing, mental health, and a number of different areas. My answer is I do not have an answer. But if we follow the progression of someone entering a Drug and Alcohol system or a mental health system, what does that look like? Is it smooth? Did I get—or am I constantly retelling my story or saying the same thing …

**Mr CHAIR:** Like calling Telstra or Optus.

**Mr Kirby:** Richard, you would be surprised that the things you have mentioned about housing being a key to mental health issues, sharing services, proactive education—they are some common themes that have come up, whether we are dealing with larger centres or small remote communities that say, 'We need help'. Even though you think you have not given a concise answer, you really have helped us.

**Mr MICHELL:** It is difficult. The thing is representing a peak organisation—I come from Victoria originally, but now I am like, everything lives on the east coast. It is. Melbourne would have—at a time before it turned

into consortium—they had 25 drug and alcohol agencies within a five kilometre radius. That is just drug and alcohol. Whereas here, it is stretched to the limit. The thing I will say about it—and it is a credit to the Northern Territory and the people of the Northern Territory—in my 30 years as a Drug and Alcohol clinician and manager, I have never seen people more invested but under-resourced.

**Mr CHAIR:** Yes.

**Mr MICHELL:** You cannot expect people to do things when they do not understand what they are doing.

**Mr CHAIR:** We are a little over time. Do you have anything else you would like to add?

**Mr MICHELL:** No. I want to thank the committee for the opportunity. We are always available, as a peak organisation, to offer any input we can. Thank you for your time.

**Mr CHAIR:** Thank both of you for your time. It has been informative.

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The committee suspended.

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**THE PHARMACY GUILD OF AUSTRALIA – NT BRANCH**

**Mr CHAIR:** Good morning. I am Jeff Collins, the Chair of the Select Committee. We have Paul Kirby, Member for Port Darwin and on the phone Sandra Nelson, Member for Katherine.

On behalf of the committee I welcome you to the public hearing into reducing the harms from addictive behaviours. I welcome to the table, Judith Oliver and Helen Bowden. Thank you for coming before the committee. We appreciate you taking the time to speak to us, and we look forward to hearing from you today.

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

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

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

**Ms OLIVER:** I am Judith Oliver. I am a pharmacist. I am also the Director of the Northern Territory branch of the Pharmacy Guild of Australia.

**Ms BOWDEN:** I am Helen Bowden. I am also a pharmacist working with the Pharmacy Guild of Australia. I work in business support.

**Mr CHAIR:** Thank you. Would either of you like to make an opening statement?

**Ms OLIVER:** Yes. I want to say that you would have noted our submission.

**Mr CHAIR:** Yes.

**Ms OLIVER:** There are currently 39 community pharmacies spread across regional centres in the Northern Territory. Those pharmacies are small businesses owned and managed by pharmacists in accordance with the NT legislation.

They basically operate a number of significant public–private partnerships with the Commonwealth Government through the delivery of the PBS, as well as a number of other programs on behalf of the NT Government and retailing and supplying scheduled medicines to Territorians.

Those pharmacies are involved every day with substance abuse and harm minimisation strategies, usually with an evidence base behind them. Things like needle and syringe programs are delivered wherever possible by community pharmacies and the opiate pharmacotherapy programs. Those are currently known as methadone or buprenorphine programs.

There are also a lot of opportunistic interventions that happen in community pharmacies every day. Those can be as simple as an expectant mother turning up in a pharmacy and asking about nutrition or vitamins to take, and a brief conversation happening about smoking.

This can be through to more complex substance abuse issues around drug-seeking behaviour for codeine as an opiate, or looking for drug testing kits for people to use with their children or employees in their business. It is quite a broad remit that happens within an accessible space that the general community can come and go from every day.

It is important to note that even though pharmacy operates in a retail environment, it is very much a professional space where professional standards apply and the quality use of medicines principles are behind whatever happens there. It is a very accessible place.

Following on from a few comments we heard at the end of the last session, there are all sorts of opportunities for brief interventions to be had with otherwise healthy people who might be presenting to get a script filled or to get a vaccination or those sorts of general inquiries in a non-confronting way in a pharmacy.

**Mr CHAIR:** I think you have heard from our comments that this is something we are particularly interested in.

With the needle and syringe programs you were talking about before, are there any obstacles —because we do have a needle syringe program here in the Territory—that you see in the way you deliver the service to providing it more broadly so that it is more effective?

**Ms OLIVER:** The number one barrier would be disposal of the used syringes. It is something that has been managed in an ad hoc way by pharmacies over the years. Pharmacies get Fitpacks or needles and syringes from users, but they also get diabetic syringes. There is an increasing number of medications that are delivered by injection to patients under a prescription, so they are getting increasing numbers of syringes and injecting material back from those sources as well.

The way pharmacies dispose of those has varied between paying independent contractors to come and take them away, sending them back through to Healthy Living NT through the diabetes program there…

**Ms BOWDEN:** You were able to originally send them back—at the hospital there was a drop-off spot years ago.

**Mr CHAIR:** It is not there anymore?

**Ms BOWDEN:** No.

**Ms OLIVER:** Or NTAHC, the Aids and Hepatitis Council, have a drop-off as well. Often that is then the pharmacy staff having to collect the sharps from the pharmacy and drive them to another drop-off point. It is quite labour intensive and very ad hoc. A program that facilitated that for pharmacies—I do not know in-depth but I believe it is an issue for GP practices as well—is something that would definitely improve the uptake of that from pharmacies.

**Ms BOWDEN:** Another issue is the tenancy, where the pharmacy might be... the landlord may not be happy for the pharmacy to be providing needle and syringes for whatever reasons in the larger shopping centres.

**Mr CHAIR:** In your submission, you spend some time talking about real-time prescription monitoring system. Are you aware of any progress in developing a national real-time monitoring system? Is there anything going in that space?

**Ms BOWDEN:** In Victoria they have started in one region, I think it is facilitated through one of the PHNs, I think it is around Ballarat. I know that it is not in the metropolitan area. That has just started in the last few months. I have not heard any feedback. It is not mandatory at the moment for Victoria. It is running in Tasmania. They have a program.

It is obviously a system that could make a real difference for both health providers but also for supporting people who are going through the system. Historically, people have made assumptions that when they walk into one pharmacy, they will come in with a script or they will not have their script and they will say, ‘I get it from the other place, you will be able to look it up.’ There are no linkages. There is nothing stopping someone

at the moment from visiting three or four different GPs throughout Darwin and then visiting three or four different pharmacies to have their medications dispensed.

**Mr CHAIR:** I do not know enough about it, only that they are extending some deadline for opting out of the My Health Record.

**Ms OLIVER:** That will be a national program. It is patient-controlled though so if you were someone who was drug seeking or doctor shopping, you could go into your own My Health Record and remove those entries.

**Ms BOWDEN:** Or request for it not to be uploaded.

**Mr CHAIR:** At least it shows that you are able to have a platform…

**Ms OLIVER:** A national platform is very possible. The Pharmacy Guild managed a program called MedsASSIST that was for codeine sales, when codeine did not require a prescription before the start of this year.

**Ms BOWDEN:** February this year.

**Ms OLIVER:** If a patient wanted a codeine based product, they would go into the pharmacy and request it. The pharmacy would need some ID to look them up on a national real time recording system. They could look up the patient and see where sales had happened for that patient all around the country, the date and what they got.

**Mr CHAIR:** So it exists? Or existed?

**Ms OLIVER:** Well, it does not exist at the moment because they shut that down once codeine became prescription only. The technology is there and is not the barrier. It is definitely possible.

It is a really useful tool for the pharmacy to have and be able to see that. It prompts a lot of conversations with customers about their use and a lot of people honestly do not realise that their use has got to a level that they are possible reliant or dependent upon it. That starts the next conversation which is about reducing doses and finding alternatives which, without that clinical tool, you just cannot see what people are using.

**Mr CHAIR:** Well just look at the problem that it is in the United States at the moment.

**Ms OLIVER:** Absolutely.

**Ms BOWDEN:** It is an opportunity to have that discussion with people when they are using more frequently because there is that fine line between managing pain and having the addiction as a result of poor management of their pain. There is a really great opportunity for the Territory to look at this more broadly and how we support particularly our chronic pain patients.

**Mr CHAIR:** Yes, right. Anything else?

**Mr KIRBY:** Other jurisdictions that have a better proactive approach towards addictive behaviours, are you aware of different things that pharmacies either individually or as a guild, are involved in? With proactive sessions or abilities?

The hint that you have given about just having those conversations with people is an opener and previously we have heard about the opportunities for people who have addictions to have those discussions in a proactive sense. Perhaps it is something we do not do really well through the Territory.

**Ms OLIVER:** I think smoking cessation would be the best example of that. There is a lot of products that people can use to help with smoking cessation; inhalers, gums and patches. There is a full remit. Most of them are available in the supermarket now, so that means in a way the access is better than it has ever been.

But, the advice is not there to go along with it in the supermarket. Whereas in the pharmacy, you do have those opportunities of care if someone is turning up and asking for assistance with their asthma management or their colds, flus and coughs. There is an opportunity to say “Do you smoke? How much do you smoke? Have you thought about quitting?” Just having that conversation and then providing ongoing support.

There is a program that the ACT have run that Helen probably knows more about than I do, that utilises that interaction in a pharmacy to identify people and sign them up to a regular visiting program, which is not onerous in a pharmacy. They just come back regularly or telephone the pharmacy if they have issues and their progress is monitored.

**Ms BOWDEN:** It was project that they ran in the ACT but it was a supportive program. There were two parts: one of them was an education program for pharmacies in training them in brief intervention and upskilling them to make sure they could have that engagement at every opportunity. Part of the project was looking at a more comprehensive intervention where people were supported. Starting the conversation, assessing where they were, were they ready to quit and to start a program.

But then, once they have started, following up, seeing how they were going—whether that was by a phone call or having a face-to-face counselling session in the pharmacy. So, it was very well received—a short-term project. This program has run in Canada. There is the Ontario program where pharmacies have delivered smoking cessation programs really successfully for people.

We obviously see within the NT that there is limited face-to-face counselling opportunities for people who are trying to quit, or not quite sure how to start.

**Mr KIRBY:** They just need that prompt.

**Ms BOWDEN:** Yes, absolutely. The evidence says that that brief intervention can make such an enormous difference. It is just a conversation starter, then people then know where to go to get some help.

**Mr CHAIR:** Do you guys have ongoing professional development obligations?

**Ms BOWDEN:** Yes.

**Ms OLIVER:** Yes.

**Mr CHAIR:** Are there certain streams you have to do—like compulsory? In law there are certain areas where you have to get so many units each year.

**Ms OLIVER:** Yes, it is based on your competency that you require in your practice, so it is self-identifying those streams.

**Mr CHAIR:** Right. I am thinking in terms of almost counselling-type role that you are talking about in identifying someone and then making that approach and getting them into a conversation.

**Ms BOWDEN:** Pharmacists have that skill. They learn that within their undergrad course.

**Mr CHAIR:** Okay.

**Ms BOWDEN:** But I guess with looking at different programs, any opportunity is a good opportunity to upskill, refresh or develop more confidence. People always get a bit—there might be some people who feel a bit nervous, 'Oh, if I ask them, do they think I am accusing?'

Last weekend, we ran a mental health first aid workshop for pharmacists. It was a great success and the feedback from the pharmacists who attended was that it was really quite empowering and they felt much more confident in knowing how to ask those questions.

**Mr CHAIR:** Now just in the conversation we have had, it strikes me that could be an area that may be of assistance—certainly it would help in what we are trying to achieve in getting that initial contact early on.

**Ms BOWDEN:** Yes.

**Mr CHAIR:** Yes, either smoking or a number of areas.

**Ms OLIVER:** It is something that the Department of Health trains its staff to do quite well. There is the potential that the private side of healthcare—pharmacies and GPs—would benefit from that kind of opportunity as well. It may be something the Department of Health could extend to external providers as well—some of those skills.

**Mr CHAIR:** Yes. Okay. Talking about some of the problems with your pharmacies and tenancies the like—lease agreements. That was the disposal of the needles. What about other opiates dependence treatments? Do you have any problems there with people coming in for opiates …

**Ms OLIVER:** We have not heard of any for opiate programs.

**Ms BOWDEN:** Over the years there has been an increase in the uptake of pharmacies providing that service. Six or seven years ago there were only about seven pharmacies within the NT, whereas now we are up to about 19 or 20. That is pretty much coverage of the whole of the NT, with community pharmacies providing that …

**Mr CHAIR:** You do not get any pushback?

**Ms OLIVER:** Looking historically, if you go back to 15 years ago when there was no methadone or opiate pharmacotherapy programs and there were significant numbers of people taking large doses of morphine on prescription because there was no alternative, it was quite confronting in a lot of pharmacies that every morning there would be a significant number of people there waiting for their daily pickup of their dose.

That was a lot more confronting for the shopping centre or tenants and security in the shopping centre than it is now where you have, usually, very calm, well-managed people walking into the pharmacy. You would not know they are getting a dose of methadone or anything else. It is all done very discretely. There is a quick conversation to see how they are going. They generally like to get there early because they have other things to do during the day, like go to work. It is done; it is not hugely visible to anyone that this is happening.

**Mr KIRBY:** Are there any other proactive programs you are aware of that you would like to discuss?

**Ms OLIVER:** Following on from the opiate pharmacotherapy programs, it is probably worth mentioning that we have an increased number of pharmacies participating. Reflecting back to the conversation with the previous group, it is sometimes difficult for pharmacies to know where to refer patients back to. A lot of these people will have issues with substance abuse. It is a cyclical thing. Sometimes they will do really well on methadone and then something will happen and they will regress a little and need a bit more support.

Those pathways are not always so clear in the Northern Territory. That relationship between the hospital-based alcohol and other drugs services where they are stabilised on methadone or buprenorphine and then sent to a pharmacy for their day-to-day management—sending them back if they need to go back is not always a clear process. Sometimes it is hard for pharmacies to know who to call or who is managing this patient. It is often on weekends that these issues come up.

**Ms BOWDEN:** It is more the out of hours that …

**Ms OLIVER:** That is a gap in the program where I think if there was a little attention put to making sure those patients had those referral pathways 24/7 and there was someone the pharmacy could contact when issues arose, it would be a lot better for everybody, mainly the patient because they would have somewhere to go when they need help.

**Mr CHAIR:** Yes. We heard that from AADANT as well. Is there anything else you want to add? Thank you very much for your information and input today, as well as your submission. It has been fantastic.

**Ms OLIVER:** Thank you.

## ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY

**Mr CHAIR:** I am Jeff Collins, the Chair. We have Paul Kirby, the Member for Port Darwin; Sandra Nelson, Member for Katherine, is on the phone. On behalf of the committee, I welcome you all to the public hearing into reducing harms from addictive behaviours.

I welcome to the table to give evidence, Danielle Dyall and David Cooper. Thank you for coming to the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

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

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

**Mr COOPER:** My name is David Cooper. I am the manager of Policy, Research and Advocacy with AMSANT.

**Ms DYALL:** Danielle Dyall, and I am the Team Leader for Social and Emotional Wellbeing and Trauma Informed Care Support with AMSANT.

**Mr CHAIR:** Would either of you like to make an opening statement?

**Mr COOPER:** Yes. We would like to begin by acknowledging the Larakia Traditional Owners of the land on which we are meeting, particularly their elders past and present as well as their future leaders.

I bring apologies from our CEO, John Patterson, who would normally present at this hearing, however he is overseas at the moment. Thank you very much for inviting AMSANT to appear.

AMSANT is the peak body for Aboriginal community-controlled health services in the Northern Territory. In particular, this inquiry is informed by the fact that the Northern Territory has the highest level of alcohol-related harm in Australia for both Aboriginal and non-Aboriginal people. We also have some of the highest rates of tobacco use.

AMSANT's submission did not go into the detail of targeted strategies and treatment options, which we have provided some information on in earlier submissions. Our comments instead probably relate to items three and four in the scope of the inquiry.

AMSANT embraces a social and cultural determinacy of health perspective, which recognises that health and wellbeing are profoundly affected by a range of interacting economic, social and cultural factors. Accordingly, we advocate for an evidence-based holistic and community-led approach to harm reduction strategies for addictive behaviours.

Effective harm reduction must recognise the realities of poverty, class racism, social isolation, past trauma and other social inequalities that affect both people's vulnerability to and capacity for effectively dealing with the harms associated with addictive behaviours.

**Ms DYALL:** AMSANT strongly believes that the major underlying issue that leads to addictive behaviours stems from unresolved trauma. The science now tells us that when a person is exposed to ongoing, significant, stressful situations and their coping mechanisms become compromised and the resources are not available to respond and manage the situation, that a person will find other ways to cope. This presents behaviours that are maladaptive, risk-taking and addictive.

Trauma can be experienced in many forms, such as physical, sexual and emotional abuse. It can be experienced through stigma, discrimination and racism. Poverty can also lead to trauma exposure, not having our basic human rights met, such as housing.

We believe that to ensure efficacy is reached, all organisations engaged in reducing addictive behaviours need to imbed a culturally-responsive, trauma-informed care approach into organisational systems, knowledge areas and practices. Understanding that addictive behaviours are often driven by unresolved trauma, this approach is crucial in achieving health outcomes including harm minimisation.

AMSANT recognises the reciprocal nature of trauma, unresolved trauma and the social determinants of health. We acknowledge the fundamental influence of social and cultural circumstances on people engaging in addictive behaviours, and call for a commitment to address these determinants within a culturally-responsive trauma-informed manner that guarantees a sharing of power, governance and control for all involved.

Particular needs for children and youth must be addressed. For the Territory, this includes reforms resulting from the recent Royal Commission. A recent Australian Institute of Health and Welfare report highlighted the overlaps that exist among young people who experience child protection, youth justice supervision, homelessness, mental health disorders and problematic use of alcohol and other drugs.

AMSANT believes strongly that mental health and AOD services should be integrated into social emotional wellbeing service delivery within a comprehensive, community controlled primary health care service delivery model. It has been reported that dual diagnosis is to be the expectation, not the exception and social emotional wellbeing as an Aboriginal concept, has helped to keep Aboriginal people strong in mind and spirit over many generations.

Providing mental health and AOD services within this Aboriginal framework will ensure that they are culturally safe and accessible as well as being effective. However, funding for an expanded social emotional wellbeing service within Aboriginal primary health care is not secure and is not sufficient to meet the needs with many areas under resourced. There is also no funding for housing for workers, meanwhile still large amount of mental health AOD funding for Aboriginal people is being provided to mainstream organisations that have weak links to communities.

We believe that this is not effective and that the NT Government should recognise Aboriginal community controlled organisations as the preferred providers for services to Aboriginal people in all procurement and grant processes and continue to support the collaborative needs-based funding approach of the Northern Territory Aboriginal Health Forum.

**Mr CHAIR:** Thank you. That was great. Where do we start?

We have heard a number of submissions in Tennant Creek and Alice Springs last week about some of those problems that you have identified as well. The unresolved trauma, I would like to go there for a moment. What are AMSANT's ideas in terms of dealing most effectively with the unresolved trauma that you are talking about?

**Ms DYALL:** I think that as we have mentioned, it is working with the Aboriginal community controlled health services particularly with the social emotional wellbeing teams and also with the clinicians to provide the support to the communities. That support is in holistic manner and across the lifespan, starting from when a woman is pregnant and working with the communities and the elders.

Within the trauma informed framework, as I said, there is that sharing of control and power. The community is involved within what the services should look like. We also, within AMSANT, have a cultural responsive trauma informed care program where we deliver training to the workforce. That training is to then help them recognise the symptoms and impacts of trauma, see when people are responding to trauma so that they can respond themselves, help resist ongoing trauma and rebuild those connections within the clients.

This is training that we offer for the workforce development and there is also a part of that where the trauma informed care principles, the values of trauma informed care, can also become embedded within the organisation. It is a two-pronged approach – there is workforce development and also organisational change to become trauma informed. We support organisations with that which involves an audit tool and a whole lot of other things.

**Mr CHAIR:** When you talk about trauma, you mentioned physical, emotional and sexual trauma. You are also thinking about historical trauma as well. We heard a bit about that in Tennant Creek.

**Ms DYALL:** Yes, that is right. It is important to be able to look at what has happened in the past to be able to understand what is presenting today. It also helps us understand the clients' or community members' behaviours.

Also, for example, if we look at the institutional racism and discrimination that has happened—and also happen within primary healthcare systems—or any trauma that a person may have experienced, then how they respond to primary healthcare and their engagement can help us to understand how to have better practice.

**Mr KIRBY:** Are there any patterns that appear as far as identifying traumas, ages, different sex of people—do young girls start to show earlier than young boys, or …

**Ms DYALL:** It depends on the level of trauma as well, and how complex it is. When there has been early childhood abuse and a person has complex trauma, then that impacts on brain development and the physical symptoms as well that can happen. There are patterns.

We can also look at what age a person has first started experiencing trauma, looking at what time and where the brain is developing at that time. That then can define what sort of behaviours a person will be having.

For example, if it happened at the ages of zero to one or two, we know that the brain stem is developing at that time. That is all about arousal regulation, so there will be difficulties in being able to regulate arousal later on in life. If they first started experiencing trauma at the age of seven, that is when the executive functioning is developing, so that area of the brain will become compromised.

In that, looking at the age when a person first experiences the trauma, we can then see what was happening and what was being developed at that time and we can identify that thing.

**Mr CHAIR:** How long have you been developing this clinic approach?

**Ms DYALL:** I have been with AMSANT now for two-and-a-half years and Sarah Haythornthwaite, who was working with AMSANT prior to me—when did she begin, David?

**Mr COOPER:** A few years before that. It has been probably the last five years we have been actively engaged in it.

The theory about trauma and knowledge about it goes back quite a long way—a very long way in fact. The evidence base is very strong. In fact, in Australia, it has been used within the refugee community for quite a long time, and in an evidence-based way through dealing with victims of torture and trauma. So, it has a very strong evidence base and history to it, but there is particular emphasis that has been brought through Aboriginal practitioners in the field. You might want to talk a little about that.

**Ms DYALL:** I have been trained by Judy Atkinson, and she has spent, I think, 20 years in looking at this work. She is an Aboriginal leader in understanding trauma and trauma recovery, as well as Graham Gee, who is a Larrakia man and a psychologist. He works in Melbourne.

There are a number of Indigenous psychologists who are really focusing on this area of understanding trauma, social emotional wellbeing and how we can recover from the adverse experiences that people have had, particularly Aboriginal people.

**Mr KIRBY:** I know we are not fantastic in the Territory at collecting data, but over the last five years, can you see a clear connection between that trauma and then going on to substance abuse and ongoing adult issues?

**Ms DYALL:** Absolutely. There is a clear connection and it is also highlighted when looking at what happens to a person, their physical system, once we have experienced trauma and then how we respond to that and the behaviours that happen in terms of the sympathetic nervous system. There is a biological response that actually will lead a person to drink or take drugs.

There is also an environmental response, particularly for children when they have trauma. It is through relationship and the people who are there to look after them and take care of them, so they lose that trust in them. When they have experienced trauma, they have no one to turn to, to help them cope with what is happening. They turn to these other ways of coping like self-harm, alcohol abuse and drug abuse, to be able to cope with the trauma.

**Mr CHAIR:** In your development, how broadly are you able to apply the clinic system around the communities in the Territory? How far have you been able to…?

**Ms DYALL:** We have been working with our member services. At the moment we are working with seven of the member services. For example, Congress have a few clinics so we are working with a couple of the clinics with Congress. We are working with Miwatj in Laynhapuy in Arnhem Land, we are working in Katherine as well as in Alice Springs and the Barkly area. So all five regions.

**Mr COOPER:** You might also want to mention the interesting work that has been done with NAAJA and with the NT Government and Territory Families.

**Ms DYALL:** We have also been delivering training to NAAJA as well as Territory Families. We have other interest as well. Top End Health Service has shown interest. It is a capacity issue in that we are a small team and there is only so much funding.

**Mr CHAIR:** I was just about to ask what the limitations are that you are finding.

**Ms DYALL:** It is the capacity. The funding has been an issue. At the moment we only have funding until 30 June. We do not have any secure funding at the moment.

**Mr CHAIR:** When do you expect to know about any future funding?

**Mr COOPER:** We are applying for funding but we have not heard. Hopefully before that date.

**Mr CHAIR:** Are you going onto the five year funding cycles that have been spoken about or is this federal funding?

**Ms DYALL:** We are being funded at the moment through PHN. It is their under-spend.

**Mr COOPER:** It is fair to say that the funding regime, if you like, of government has been very difficult to negotiate, particularly for areas such as this that do not come under a clear category.

There have been issues in the past with the social and emotional wellbeing and mental health funding being passed across to the Department of Prime Minister and Cabinet through the Indigenous Advancement Strategy, which has complicated things a lot, particularly for our community-controlled health services that are generally funded through the Commonwealth Department of Health as well as some funding through the Northern Territory Government. The funding environment is a bit of a dog's breakfast but it is an important need to address.

The other aspect of AMSANT's model is the integration of social and emotional wellbeing, AOD and mental health services. That is the model within comprehensive primary health care that we know works, that the Aboriginal teams that have developed it know works but it is very hard to get a consistent funding source for expanding those teams and that work which is regarded as critical.

It would be fair to say as well that the trauma-informed approach now is widely recognised as being important and fundamental. There was quite a deal of attention on it within the Royal Commission and in the reforms the Northern Territory Government is undertaking. There is consideration around the needs in that area.

**Mr KIRBY:** How often do you have to reapply currently for funding?

**Mr COOPER:** Well it depends. This last lot of funding was a one-year funding.

**Ms DYALL:** It is one year's funding. The previous was two years and again that was a one-off two-year bucket of funds. Once that was finished we then luckily secured this year's funding with PHN. We are looking for ongoing funding.

**Mr CHAIR:** How do you get any work done?

**Mr COOPER:** Good question. It is the challenge of our sector in that our model of comprehensive primary health care, which includes these areas of early childhood, alcohol and other drugs, mental health service delivery and the need to provide that through multidisciplinary teams, social emotion wellbeing teams is critical to the effectiveness of that approach.

It is underfunded to be able to deliver that. It is a constant issue of trying to bring it together.

**Mr CHAIR:** Over bureaucratised.

**Ms DYALL:** In terms of not having the security of funds, it leads to job insecurity for the staff members who are working in highly complex situations with complex issues, mental health issues, alcohol and other drugs issues which comes from that trauma. There is that added burden of that and can lead to burn out and vicarious trauma.

Without having the job security as well on top of that… a lot of the time, within our health services, the people who are working are also living in the environment as well. The community members who they are working with are also family. It is another added burden. That is another way that burnout can occur and why this program is critical because it helps to support the clients in vicarious trauma.

**Mr CHAIR:** I think we heard that from congress down in Alice Springs and the difficulties there.

Off that, gambling in Aboriginal communities. How much of a problem is that?

**Mr COOPER:** We would have to take that on notice. I do not have statistics on hand.

**Mr CHAIR:** That is alright.

**Mr COOPER:** Although, I would like to make the comment that gambling within communities means usually that the money gets recirculated within communities whereas other forms of gambling such as pokies is a complete exit of that money from the family and community.

**Ms DYALL:** I have heard gambling in communities as well—this is again like David mentioned, different from pokies and going to the casino. It is complex because there is a form of connectedness and mob coming together and connecting. There is that to it, but there is also lateral violence that can happen, arguments and fighting. There are two things going on there.

**Mr CHAIR:** That would not only be in Aboriginal communities.

**Ms DYALL:** Yes. That is right.

**Mr CHAIR:** I understand. We heard that down in Alice Springs. In Alice Springs the problem was that when they are in the town, it was the casino that was the drain on the already limited incomes that families have.

Sandra, do you have anything down the line?

**Ms NELSON:** No I do not.

**Mr CHAIR:** It is pretty depressing, the whole funding thing.

**Ms NELSON:** Yes. I was just thinking that it all comes down to funding. We have some good strategies in place and we are doing some great work but the whole uncertainty is very depressing.

**Mr COOPER:** If I could perhaps address that point relating back to our submission?

This is one of our recommendations, which is around government recognition of Aboriginal community-controlled providers in terms of funding for service delivery. We are advocating that Aboriginal community-controlled providers become preferred providers, as far as government is concerned, so that money is consolidated within what an effective community approach is to dealing with service delivery.

There is a tendency—it has probably been much greater in the past, but it is still strong—to fragment service delivery through provision of a number of different NGO providers. In the Territory, what is particularly difficult is that many of those providers end up being fly-in fly-out or drive-in drive-out workers and do not have strong community links. It fragments that investment and creates less efficient and coordinated service delivery. We have numerous examples of that within communities.

One that we mentioned previously was that a small community of 400 people in Central Australia was being provided with social and emotional wellbeing-related services by 16 different providers. They are coming in, falling over each other, often coming to the local community-controlled health service demanding or asking for help to locate people, for resources or whatever, or not coordinating.

That is the kind of thing that could be addressed quite effectively and would make a significant difference. That is one of the recommendations in our submission.

**Mr CHAIR:** We have noted that. We have received a number of submissions. It just makes sense as well.

**Ms NELSON:** I just have one question about AMSANT. With the education material that Aboriginal health services use, is it translated into language?

**Mr COOPER:** I think there are various approaches and capacities that services have around that kind of education material. Where it may not be translated into other written languages, our services use Aboriginal employees who are connected with community so that they have the language and communication skills.

That is the really effective part of our service delivery, relying on Aboriginal team members to provide the services.

**Ms DYALL:** That is something I am advocating for at the moment regarding social and emotional wellbeing education material.

At the moment, a lot of what is around for social and emotional wellbeing workers in having professional development is not actually relevant within the cultural context. Most of it is also in English. I am advocating for being able to develop some training material that can be taken to communities and delivered in a culturally relevant way. That could even be in language when it is for language-speakers.

**Mr CHAIR:** I recognise the time. Is there anything else you want to add?

**Mr KIRBY:** You do not have a quick fix for us, before you finish up? Obviously the funding models are something. You touched on the social and emotional wellbeing side of things needing to be imbedded in almost every conversation and everything you do in community. That is probably something we will need to continue looking at how we can grow that within community.

How do we give them the tools and strategies to be able to do that? How do we give them relief and make sure it is not just family members who are getting bogged down? How do we get that professional assistance to communities while making sure there are not a dozen different people coming out and trying to do very similar things—that is my understanding.

**Mr COOPER:** The other side of that is the provision of services or responses to Aboriginal people from the police and the courts.

There is training needed there for police and people involved in the courts and the criminal justice system, child protection system, so they can recognise those behaviours. Often, those behaviours end up being interpreted differently or wrongly, and that can end up with the child or the youth facing charges for whatever it might be—language or response …

**Mr KIRBY:** Reactive failures.

**Mr COOPER:** … whereas if there is understanding about what kind of behaviours might be triggered by trauma and the events in people's lives, then you can start to prevent those kind of interactions with the criminal justice system. That is the other important side of that.

**Mr CHAIR:** Excellent.

**Mr KIRBY:** Thank you very much.

**Mr CHAIR:** Thank you both for your input and your information.

**Mr COOPER:** Thank you.

**Ms DYALL:** Thank you.

The committee suspended.

## CATHOLICCARE NT

**Mr CHAIR:** Welcome to the public hearing into reducing addictive behaviours. We welcome to the table to give evidence Natalie Sarsfield and Kim Burns. Thank you for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead apply. It is a public hearing and is being webcast through the Assembly's website. A transcript will be made available for the use of the committee and maybe 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 closed session and we will take your evidence in private.

For the recording, could you each please state your name and the capacity in which you are appearing.

**Ms SARSFIELD:** Natalie Sarsfield, Alcohol and Other Drugs Manager, CatholicCare.

**Ms BURNS:** Kim Burns, Senior Contract Manager, CatholicCare NT.

**Mr CHAIR:** Would either of you like to make an opening statement?

**Ms SARSFIELD:** We appreciate the opportunity to present around these issues. It is really great to be able to have an open conversation and explore some areas where we had strengths and some where the NT has a little more room for improvement regarding drugs and alcohol. Thank you for the opportunity to be here today.

**Mr CHAIR:** No problems, thank you.

We have a number of questions set out, but we find we tend to ask one or two and then the conversation goes in different areas. We will just play it by ear. I will open the batting with—when it comes to preventing and/or delaying substance use, what have you found is the most effective approach or program?

**Ms SARSFIELD:** In our submission we talk about it starting at quite a young age and that being a whole-of-school approach including not just the school, but the extended environment as well as parents.

We found in terms of delivering school programs, it is best utilised through teachers delivering that as a part of their curriculum on an ongoing basis, and that being a component of a social and emotional wellbeing and resilience-type programs.

In addition to that, it is providing parents with accurate information on how they can have conversations with their children and young people, which are age-appropriate, regarding what drugs to talk about. It is then about building that into a bigger network in terms of media campaigns and the messaging we send as a community. That can be through sporting clubs, on TV and through media.

It is really about working across a whole area. We are looking at beginning with perception changes to drugs and alcohol and feeding accurate information, understanding the reasons why people might turn to addictive behaviours, as opposed to trying a drug and that not leading to something more harmful. It is being realistic about our society and that we are being relevant in our messages.

There are quite a few types of campaigns that work and quite a few that do not. The ones that do not work seem to be the hard-hitting, impactful and scary ones. They can stigmatise that population, but also people who are around people who use drugs and alcohol. It is an unrealistic reality for a lot of them. You will see harmful behaviours on a frontline basis—hospitals and police, however, in terms of the day-to-day, families may not experience the significant impact that we might see from the big scary ice campaigns where they are beating up their mum. They are not an everyday occurrence. Not every drug user will turn to violence like that. Some of the campaigns that worked really well for smoking were regarding the fact that "every cigarette you give up is doing you good", rather than from a negative angle where you will die from heart disease.

The ones that positively reinforce what you will gain, rather than the negatives you will experience in the long term and do not feel relevant to people in their 20s. They tend to work in a much better way.

**Mr CHAIR:** Is there a counterproductive—you are talking about the hard-hitting ice campaigns, which is something we heard about in Alice Springs was that most ice users and addicts are not the violent addict like the image that is put to us most regularly.

If that is the case, are there elements that people then do not associate with that? If ice is being used in their house and they do not see that sort of violence, then they do not associate with it and think, 'That is not us; we can continue on.'

**Ms SARSFIELD:** Yes, because it adds an element of, potentially, this is the level of harm where you need to seek treatment and anything before that is ok. It sends a bit of a double-edged message.

When you talked about there being lots regarding heroin back in the day—you try it once and you will be hooked forever, that is disregarded when they know someone who has tried methamphetamine and has not become an addict, so to speak. It is counterproductive because we are sending false information.

The reality is that most drug abuse or long-term misuse dependency has other elements attached to it—it is not just the drug itself. If I have come from a really good family, really good network, I have a good community around me, my chances of becoming a dependent drug user are much less than from somebody who has come from a dysfunctional family. Why people use drugs needs to be put into perspective, rather than just the drug itself.

**Mr CHAIR:** What programs do you think are good at identifying those people who are vulnerable—apart from the obvious things we have heard about people being in housing stress, which is usually a big one?

**Ms SARSFIELD:** Anyone who accesses any form of social services is at risk. Whether it is homelessness, domestic violence, mental health, physical health problems, there is always an element of risk in there that can put them at risk of substance misuse.

In saying that, if they have all the other good, positive, proactive stuff on the other side, then it may not necessarily… someone can live with chronic pain and not become dependent on pharmaceuticals if they have learned how to manage it in alternative ways – they have a good family connection around them, they are not trying to abuse the substance and they are using it appropriately.

**Mr CHAIR:** Yes. How do you think our practitioners are in identifying those? Regardless of what the social service is that they are coming into. This is a broad range of the measure, as you pointed out. How are the practitioners across those—and it is probably a broad question for you—areas in identifying the potential, and therefore, then providing information that is …

**Ms SARSFIELD:** Probably poorly if we look at prevention. We look at general practitioners generally being the first point of call for anybody when anything is going wrong. To upskill our GPs to identify early mental health symptoms, have an understanding of stress, trauma—to be able to identify those things at an earlier stage is the most crucial point. GPs are our lifeline …

**Ms BURNS:** To look for GPs or for those entry points, it is about looking at the potential risk factors or the triggers. It is our experience that very rarely do people say, 'I want to talk about my drug and alcohol issues'. There will be numerous other conversations held before that one happens.

It is about skilling people in—okay, there is someone who has lost their house or they are having relationship issues, or child protection has become involved, or financial stresses—trying to put all that together as part of the jigsaw—that is potentially someone who is at risk then.

But as Nat said, it is also dependent upon the safety or the support network they may have around them as to whether or not drugs and alcohol becomes an issue.

**Mr CHAIR:** Yes. Is there a role for the Department of Health in providing education and skilling course across the board?

**Ms SARSFIELD:** That would be great if you are offering it, yes.

**Mr CHAIR:** I can suggest it, I do not know about offering it.

**Ms SARSFIELD:** The more upskilled, the more knowledgeable we are at identifying these things... It does not have to get to the stage where people identify it as an issue for themselves, or another service has identified it as an issue. It is an ongoing process, so we get it before it becomes out of control for them. I am not saying it will stop it from happening, but at least we can just start the ball rolling so people know their treatment options.

A lot of the time, people do not know what is available to them—the will stumble across something, one service. They might stop into a housing program because there are issues that they had with drug and alcohol. They are not going there for drug and alcohol, as Kim said, but if they are knowledgeable of what services are around, there can be a direct link.

We sometimes naively think everyone knows the services that are around because we work in the sector and we know everybody. People who are struggling do not know who they can access. That is where GPs are crucial because they are your first point of contact for a lot of things—when you are feeling low and lethargic. Physical health issues tend to be related to emotional wellbeing issues as well.

**Ms BURNS:** GPs, schools, childcare centres—places like that are the common entry point.

**Mr KIRBY:** We heard from some pharmacy people before that enlightened me a bit about people presenting there and them having the ability to proactively start some discussions and how that can be a big help as well.

**Ms SARSFIELD:** Absolutely, and taking away that fear of the conversation can have really positive impacts. The only way you can take away that fear is by providing professionals information so they know what to look for, how to have that conversation and how to deal with it.

**Mr CHAIR:** That is the important thing. Open up the conversation.

We have heard a lot through Tennant Creek and Alice Springs and here about how much money we spend, perhaps ineffectively, on end treatment, so dealing with the problem once it has gone too far. We spend an extraordinary amount of our time and effort when it strikes me that we need to be spending some of that money on the early prevention, which is what you are saying.

**Ms SARSFIELD:** And that in-between bit as well. People will say rehab is the end goal, where people might end up—they will go to rehab a few times before there is any significant change. It could be just for a dry out period which I think we need to acknowledge as an important part of treatment as well.

There is that in-between that is so important in terms of cultural activities, general counselling, financial, housing, domestic violence; all those other things that happen are really important along their journey. We need to recognise the in and out of treatment as well.

**Mr KIRBY:** You mentioned about the dry out period. Is alcohol the main thing that surfaces?

**Ms SARSFIELD:** In the Northern Territory, yes. That comes because there are a lot of environmental stressors that occur around alcohol when we talk about using it as a dry out. Sometimes you just need to get away from family, from the stresses of life, from work, whatever is going on in your life.

It can be an opportunity just to breathe and take some space. It is not necessarily that their goal of going there is to continue abstinence when they leave but just to have a moment to sit within themselves can be really important.

**Mr CHAIR:** Gambling. How often is gambling addiction a concern of the people that you provide support for?

**Ms SARSFIELD:** It is not usually identified as the primary issue. Gambling more often comes as an unidentified issue and that comes out through counselling when talking about financial stresses. Very rarely do we have that coming in as a primary concern.

In saying that, in community, the staff are probably able to have those conversations a little better because they are witnessing it. It is easier to have those conversations whereas in Darwin, it is not like we see people gambling and 'you need to come to counselling.' It is very different the way you interact in community as opposed to the metropolitan city areas. Ours in the city tend to come as a secondary or third or fourth issue along the line of things.

**Mr KIRBY:** Housing stress. Is that…

**Ms SARSFIELD:** Huge.

**Mr KIRBY:** In your opinion does it link pretty closely with substance abuse or alcohol abuse?

**Ms SARSFIELD:** Generally it is a bit of a chicken and the egg story. It does not necessarily mean that drug use will lead into homelessness but homelessness may also lead into drug use. Housing is a big issue across the country in terms of not having enough homelessness shelters, pathways into independent living.

We have public housing but what is the process of getting people into independent housing? That is an area where there is a bit of talk at the moment in terms of some pilot programs in Sydney and Melbourne that are moving towards independent housing particularly for young people. Subsidised housing to start and tracking that up. Building those life skills as they go in terms of financial budgeting and how you actually prioritise certain things.

Homelessness is those basic needs that people need met for anything to really move forward in their life. If you do not have shelter, food, family or a security network then your chances of succeeding in treatment are diminished. You need those stepping stones.

**Mr KIRBY:** Certainly something that we heard down the track that dry out time you spoke about. If people cannot get that when they return to home because of the environment, overcrowded [situations] and whatever their uncles are up to. It impedes their ability to progress in a proactive manner. It does not give them much chance at all.

**Ms BURNS:** I think overcrowding too, particularly in regional areas can result in young people being out of the house and also at risk in terms of picking up drug and alcohol activities or hanging out late at night.

Tennant Creek, by the sounds of it you have been to Tennant Creek?

**Mr KIRBY:** It certainly came up there about the amount of young people on the street at night time and just because they did not want to be home.

**Ms BURNS:** There are lots of people at home and it is really noisy.

I just want to add to the question you asked earlier about what we think can be effective programs, it is programs that take into account the context that they are going to be delivered in as well.

We deliver programs in an urban setting in terms of Darwin and Palmerston but also in the remote settings around Tiwi Islands and Wadeye, specifically drug and alcohol programs. We also provide the youth outreach program. For each of those three different areas, the program is delivered in a different way and it does take into account the context.

What Natalie was talking about before in terms of the issue around gambling, in Tiwi we might see people that we work with sitting around in a group playing cards together and talk to them later about financial stress or drug and alcohol issues. We are aware that they have been involved in gambling earlier that day.

In the urban setting, we are not necessarily going to see that kind of activity. It may not be something that comes up. Having said that, they may link in with our financial literacy program in the urban setting and it may come up there because you are trying to talk about a budget, where that $20 a week is going and where is the bottomless pit for that one.

Any program across the board that is delivered in the Northern Territory really needs to take into account the context. Quite often we experience programs being brought in from down south or the east coast and they are not necessarily applicable to the environment we all operate and live in here.

**Mr CHAIR:** How closely do you operate with local people in places like Tiwi and Wadeye?

**Ms SARSFIELD:** Very closely.

**Ms BURNS:** We have place based service delivery, our staff live and work in the communities. We provide management support from Darwin. Our drug and alcohol staff and the team leaders are all place based.

**Mr CHAIR:** You mentioned in your submission about the investment, or more investment in diversionary programs. Any examples of programs utilised elsewhere that you think would be effective here?

**Ms SARSFIELD:** There are quite a few. They operate differently in each state. I have had the privilege to work in three drug courts across the country. They are delivered differently because of the environment as well.

Sydney drug court as opposed to Adelaide drug court and as opposed to WA drug court were very different. It is hard to say which one would work without actually looking at the models and how they could be delivered. In saying that, Western Australia having a similar size in terms of remoteness. Their ability to have a drug court in remote areas was made possible through working closely with probation, parole, the services and reporting to the court.

The biggest thing with diversionary programs, in terms of a court setting, is having a magistrate that understands. Having knowledge within the model that a magistrate needs to understand before they are allowed on the bench in that court around drugs and alcohol, the effects of that and how it works.

I have been in drug courts where the magistrate has not understood and everyone has been kicked off the program within a week because they have been using drugs. But that is not the point of it. The point is to reduce the harm and slowly move that forward.

The biggest thing is, whatever model we use has to have that understanding of the stages of change and that people do not change overnight. The court has to have a good relationship with the person who is before them. It is about destigmatising that relationship between police, the court and individuals, and that being a support system.

**Mr CHAIR:** Those offenders in those courts, are they only drug offenders or are they multiple offenders? Are they simply possession and use?

**Ms SARSFIELD:** For most of them, there has to be a link, so even if it was burglary, they have done that because they have substance misuse issues.

**Mr CHAIR:** But that is generally the type of offence so there is a burglary or some sort of robbery or violent fighting.

**Ms SARSFIELD:** So there is able to be a link between...

**Mr CHAIR:** Yes, I get that. The Portuguese model is that you take the users completely out of the criminal system so it is simply possession or use and no other associated criminal activity. The drug court with the associated criminal activity makes a lot of sense then.

**Ms SARSFIELD:** Generally for a possession charge, they would not necessarily go through a drug court program. They might go through a pre-diversion.

The drug court has to be a win-win for both, so it is about a reduction in sentence… so if you are not actually facing gaol time, doing 12 months or two years on a program—one, it is costly to the system but they should be able to be supported in community without needing that program if they are on probation, linking them in with counsellors or with a rehab if that is what they want to do. The offences need to be bigger because they are costly compared to simple possession charges. In saying that, it is much cheaper again than gaol so…

**Mr CHAIR:** There is a trade-off.

**Ms SARSFIELD:** Yes.

**Ms NELSON:** I really liked the comment you made in the very beginning where you said we should be looking more at the causes of the use as opposed to the drug that people are using. That is a very valid point.

**Ms SARSFIELD:** People do not misuse drugs for no reason. There is always something.

That is where the idea of having investment into early intervention and prevention is where we can tackle some of those wellbeing issues before it gets to the stage where they feel like drugs are the only kind of medication for them. Build up those coping skills before it becomes too overwhelming for them where drugs seem to be the only way to make them feel better.

**Ms NELSON:** I agree. I think one of the biggest strategies we could implement is actually looking into and resolving some of the social issues.

**Ms SARSFIELD:** Absolutely, yes.

**Ms NELSON:** Thank you for your time this morning.

**Mr CHAIR:** Is there anything else you would like to add?

**Ms BURNS:** I would like to add in about the importance of evaluation, in terms of people such as ourselves needing to be held accountable for the programs we deliver, and there needs to be a strong evaluation framework built into the programs.

We all strive to have evidence-based interventions across the Northern Territory and across the nation but I know from our perspective, something that we have made an absolute commitment to in the last two and a half years is developing a strong evaluation framework. Prior to that, there probably was not a lot of activity in that space.

We have been successful in securing a five-year contract with the NTG around our drug and alcohol programs so that has given us the space to breathe and develop that framework and to build it into program delivery, rather than being reactive which is what we had been in the past for the 12 month funding cycle.

**Mr CHAIR:** That is great to hear. I am constantly amazed at the lack of evaluation that seems to go on, not necessarily here, but in a lot of areas. The failure to take data and follow through what programs are working and what are not.

**Ms SARSFIELD:** I think some of that comes down to funding. It has been an almost three-year investment for CatholicCare, and not a cheap one. It is an investment we have made with our own money—we are trying to build that into programs, but that is where the sustainability of this evaluation process will happen. If there is funding incorporated in—you are funding agreements on the process because our staff do lots of activities to evaluate what they are doing. That takes time and resources.

We have specialised data entry and evaluation practitioners. They are resources we utilise often for this framework. To have a really good evaluation framework, it needs to be built into funding agreements. If you want programs accredited, it is also really expensive.

There are lots of programs, particularly remote programs, that work really well but it is hard to evaluate the outcomes in terms of successes like never using drugs again. It is unrealistic and does not take into account the indirect impact that it can have—a strengthened family, a more secure house and all these other outcomes we have not necessarily measured in the past. We have measured people in …

**Ms BURNS:** Outputs.

**Ms SARSFIELD:** Outputs. People in, people out, not whether they have left and not used drugs again or gone back for a second episode—rather than looking at the direct …

**Mr CHAIR:** The broader picture.

**Ms SARSFIELD:** Yes. Children are safer. Families are healthier.

**Mr CHAIR:** Thank you very much.

## MISSION AUSTRALIA

**Mr CHAIR:** I am Jeff Collins. I am the Chair of the committee and the Member for Fong Lim. We have Paul Kirby, the Member for Port Darwin, as well. On behalf of the committee, I welcome you to our public hearing into reducing the harms from addictive behaviours.

I welcome to the table, Michael Soler, Sueanne Johns and Michael Pearce. Thank you for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

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

That being said, could you each state for the recording your names and the capacity in which you are appearing?

**Mr SOLER:** Michael Soler, Regional Leader for Mission Australia in the Northern Territory.

**Ms JOHNS:** Sueanne Johns, Area Manager for Mission Australia Northern Territory.

**Ms PEARCE:** Michael Pearce, Program Manager for Mission Australia Northern Territory.

**Mr CHAIR:** Welcome everybody. Would somebody like to make an opening statement?

**Mr SOLER:** If that would suit the committee that would be great. Just a little bit of background on Mission Australia to start with.

Mission Australia is a national non-denominational Christian organisation that delivers evidence based, client centred community services with a focus on reducing homelessness and strengthening communities as our two core foundations.

Mission Australia provides a number of programs that provide vital supports to people experiencing disadvantage across Australia. More locally, in the Northern Territory we operate services in Darwin, Katherine and Alice Springs. We deliver housing support services and mental health services in both urban and remote areas especially in central Australia.

We also operate the sobering-up shelters in Darwin and Katherine. We operate the Stringybark residential rehabilitation facility here in Darwin as well as corrections programs throughout the Northern Territory.

In the Northern Territory, Mission Australia has supported over 6000 individuals in the last financial year and very close to half of those were people who accessed alcohol and other drugs related services. The breakdown of that is predominantly a large number of those through our sobering up shelters in Darwin and Katherine, close to 3000.

We welcome the NT Government's recent investment in antisocial behaviour and the services that are available to people throughout the day and the additional funding for day patrols. However, we feel that further investments are needed to address the demand for alcohol and drug related support services, including access to appropriate detoxification and rehabilitation services, particularly those appropriate to young people, Aboriginal and Torres Strait Islander people and people in rural and remote communities.

In 2016-17 there were over 3700 presentations at NT emergency departments categorised as alcohol, drug abuse and/or alcohol drug induced mental disorders. The significant financial costs on NT health is something that cannot be minimised in any particular way apart from appropriate supports at the right time, community based localised alcohol and other drug related supports including harm minimisation measures and detoxification and rehabilitation services.

We note that there are significant gaps in early intervention and prevention programs that target high risk cohorts. Early intervention strategies should incorporate assertive outreach, education and awareness raising about the alcohol and drug related harm and supports that are available, as well as meaningful engagement of local communities in harm minimisation efforts.

A holistic strategy is needed to ensure that alcohol and drug related harm minimisation strategies are capable of addressing multiple and complex needs of people, including addressing housing, homelessness, health and mental issues, financial distress and family domestic violence.

The response to alcohol and drug dependence intersects with a range of government provided services, coordination and collaboration between different government departments such as Health, Territory Families, Housing and Community Development, Justice and other related portfolios as well as community sector organisations including Aboriginal and Torres Strait Islander controlled organisations, elders, sector peak advocacy bodies and people from local communities who are willing to engage that it is vital to achieve meaningful outcomes across the board.

The strategy should also include increasing the employment rates of Aboriginal and Torres Strait Islander people, and service delivery through Aboriginal and Torres Strait Islander community controlled organisations and local elders.

Considering the impact of alcohol and drug dependence on the individual here in the Northern Territory, as well as their families, the harm reduction responses should be brought in scope to engage and support family members of people who are affected by drug and alcohol dependence.

A significant proportion of the NT population identify as Aboriginal and Torres Strait Islander, and therefore the services need to reflect those and their needs. We need to engage with elders and people with lived experience. The same applies for people from culturally and linguistically diverse backgrounds as well as those that do not identify in those groups.

Finally, considering the impact of alcohol and drugs on physical and mental health, the precedence and directions provided by international bodies, it is important that alcohol and drug dependence is recognised as a health issue that is preventable and treatable. Therefore, there should be a clear shift in policy towards health-related responses for alcohol and drug dependency, moving away from criminal justice responses. Thank you.

**Mr CHAIR:** Thanks for that opening statement. It is consistent with a number of things that we have heard. Looking at your sobering-up shelters, could you give us a rough estimate of how many people across the sobering-up shelters you are operating in Darwin and Katherine?

**Mr SOLER:** As in numbers?

**Mr CHAIR:** Yes.

**Mr SOLER:** Absolutely. Looking at the last financial year, for instance, we had just under 2400 through our Darwin sobering-up shelter and just over 300 through Katherine …

**Mr CHAIR:** Is that the placements across a year?

**Mr SOLER:** Yes, across that year. We identify that with Katherine there has been an anomaly with that process. We are working with NT Health, NT police and the hospital there about how we better utilise that resource. It is under-used at this point in time and there are some communication strategies about that.

One of the things we found in Darwin, in particular, was the sobering-up shelter has always been a place of safety and a go-to place. It has been heavily resourced and utilised by NT Police and Larrakia Night Patrol—and now Day Patrol as well.

We had some really good processes in place through multiple committees we sit on, and engagements through other departments as well. Those numbers are indicative of the fact. Just under 2400 clients through the Darwin sobering-up shelter in the last financial year would indicate there is a significant need, particularly in the Top End and Darwin where there is an ease of access to substances people can get their hands on.

**Mr CHAIR:** Capacity? How much? Is that close to your capacity?

**Mr SOLER:** On average, it is very cyclical. There are seasonal movements. During the dry season we tend to find that numbers in sobering-up shelters are not as high. But they are seasonal, so around times like when the show is on in Darwin and Katherine, those numbers will spike. If there is an AFL game that is held up here those numbers will spike because we have a lot of transient people coming through.

A key identifier to note for the sobering-up shelter is that it is predominantly for itinerant people. If they are picked up and they have nowhere else safe to be, they are taken to the sobering-up shelter. When we look at those numbers through the financial year, a large majority of the clients would be—correct me if I am wrong here—from the Katherine region where they have relocated up here—and/or from other communities, being Daly River, Wadeye, Maningrida in particular.

We would definitely find that the instances of people attending those shelters are predominantly around the fact that they have no linkage or they have outstayed their welcome—is probably one way of putting it—with family locally. I heard what other members have said earlier this morning about housing and overcrowding, and even for the want of people not to be somewhere where there are 20 or 30 individuals in a property.

They will choose to stay in the long grass or wherever they might. That becomes a real impact on service for us.

Definitely, it is seasonal. Coming back to those figures, we find that on average, through the wet season numbers will increase. We have a 40-bed capacity at the sobering-up shelter in Darwin. In the last couple of weeks, we have averaged well over 30 per night. But in the preceding months to that, we might have averaged somewhere around 20.

**Mr PEARCE:** To add to that, in relation to the numbers we experienced last year, we are currently trending to be at about 150% of the numbers we had experienced in the last financial year. That has been since the onset of the 24-hour Day Patrol and the sobering-up shelter going 24 hours a day. So, we are seeing very little activity in the mornings, which you would expect. But from 1 pm through until 7 am or 8 am we are seeing a lot of traffic. And it is increasing more and more.

**Mr CHAIR:** Are they all alcohol-related? Are there any who have dual …

**Mr PEARCE:** There are people who have dual dependencies; but as a rule, we do not accept people into the sobering-up shelter who are affected by illicit substances. That is primarily a risk mitigation strategy.

We certainly do experience a number of people from remote communities or dry communities who simply want to drink. They come to Darwin and will disclose, predominantly, cannabis use as well as alcohol use. We are seeing a significant spike in the use of methamphetamines.

**Mr CHAIR:** And you then refer them to FORWAARD or one of the other groups?

**Mr SOLER:** If they presented at a sobering up shelter, they are usually directed straight back to NT Health. If police bring someone who we can ascertain is under dual intoxication, we will refer them to the hospital until such time as they are safe.

Where the sobering up shelter is located at Stringybark, we have our residential rehabilitation. There is a detox facility there as well. If they are not significant, they can be referred in the next morning, especially for anyone intoxicated from alcohol. The next morning we have brief interventions with those clients or when their time is due. We can ask them about wanting to make a change. We can refer them through to detox.

There is a limited amount we can refer through because, at this stage, there is a shortage of addiction specialists in the Northern Territory. We can only get a small number of clients assessed each day to be considered for residential rehabilitation with us or other providers, whether that be FORWAARD or …

**Mr PEARCE:** FORWAARD, CAAPS, Sunrise, Banyan.

**Mr CHAIR:** Is it long-term rehabilitation at the Stringybark facility?

**Mr SOLER:** Yes.

**Mr CHAIR:** How long is that?

**Mr SOLER:** It is a 12-week program, but in the 12 months we have been operating the program we have found that there are a number of people for whom one time will not suffice. Even if someone successfully makes that 12-week program, the pressures of the broader family situations and whatnot will often see some of those people come back three or four times before meaningful changes occur.

Some of our really good ‘win’ clients that we know, and in case studies—people who really hit their mark and made a huge difference to their lives—we find out some months later that there has been a significant incident—whatever that might be, another trauma, family member loss, job loss or something like that occurs. We find they are back through the process again. They are going through that system for a second or third time.

It is hard. The contemplative state of mind for someone when they are at their lowest—you have that small window. We use those brief interventions to try to engage with that contemplative state. We find that as time goes on, trying to compact that program into 12 weeks has been somewhat successful, but there is a lot of self-reflection.

Then people start to say they want to go back home, wherever that might be. They want to go back to community, home and their life. They step out of that maybe half way through and have not necessarily addressed or engaged with themselves regarding where they are at. It becomes a self-fulfilling prophecy that they will be coming back through the doors.

**Mr CHAIR:** Do you feel that the ability to have longer programs would be beneficial.

**Mr SOLER:** Yes. We also have after care. There is the 12-week program and then a six-month aftercare process we go through as well. Longer-term residential rehabilitation programs—absolutely. As to the engagement with or uptake of those for the term of that, whether it was a six-month program or however long it might be—the question of trying to keep those people there would be a difficult one to address.

**Mr PEARCE:** We have seen people who, as we have assessed through the program, have needed to remain with us for longer than 12 weeks, which we are able to facilitate as long as the bed is available.

On the outside of that, as Michael said, we see that when those individuals are progressing through they will get to a particular point in time—which, obviously, may be different for different people—where they are perhaps more confident than they should be and will return home and past relationships will engage.

There might be income windfalls from various sources that certainly contribute to the desire to use again. That will create a significant roadblock in the process.

**Mr CHAIR:** Okay. Information sharing—you were talking about taking information when they come in and they go off somewhere else. Do you share your information with other …

**Mr SOLER:** With other agencies and departments? Yes, and like-minded services. We do.

We are in constant contact with other services and agencies similar to our own rehabs simply because we might have someone who comes into our service and might not be a good fit our service, or we may not be a good fit for where their journey is at.

Quite often, with Indigenous clients particularly, we have a lot of work that we do with FORWAARD and with CAAPS as well, and some of the other providers as well. That is usually just a fit-for-purpose type situation.

We share information with Top End Health Service, who share Stringybark with us. They have the detox side—but also with other services and agencies. We have Centrelink come in; Danila Dilba Health Service come into the sobering-up shelter on a regular basis.

We have started to engage those external services to come into our service so they can capture those people when it comes to things like finances, reporting for Centrelink, health checks, return to country services and those sorts of things. We have a captive audience in one way. It is about maximising the outputs for that and trying to engage those other services in there.

**Mr KIRBY:** If we just consider the Darwin-centric—you are saying around 2000 people in a 12 month…

**Mr SOLER:** Around about 2500, that was last financial year. This year we would be tracking closer to 3-3500.

**Mr KIRBY:** Are most of those people known to you?

**Mr SOLER:** Yes. Returned clients, absolutely. We transitioned the facility from Coconut Grove, from Caryota Court at the start of this year back in January across to Stringybark. In that first month of operations, we had one client that had been back nine times in three weeks. It is a common thing.

It is well known within some of those groups that when they are picked up by the night patrol or police, it is not for a bad reason, it is just 'hey come on, we will take you somewhere safe, we will take you to the sobering-up shelter' or colloquially it used to be called the spin-dry. We try and avoid that. I am sure you would have heard that through several places that you have been but we try and avoid that idea.

We will also try to focus on it being a safe space. A lot of those people know it is a safe space.

There was a bit of a culture shock when it first moved out to Stringybark because it is right next to the old Berrimah gaol so there was a bit of that 'oh hang on, am I going to gaol?' This is safe space and we have really tried to make it a comfortable and safe space as much as we can there.

**Mr PEARCE:** If I could just go on from what Michael was saying, we have worked really hard over the last 10 or 11 months to develop the sobering-up shelter from purely a service provision model to a program so we are able to—every staff member is trained in brief interventions. Everyone is able to apply those skills as needed. With the services coming into the centre, we are actually able to provide better outcomes financially, emotionally and locationally to the clients that come in to us as opposed to having them in and bussing them out in the morning.

**Mr KIRBY:** I am wondering whether those numbers might continue to go up as particularly the Larrakia Day Patrol—if we have more opportunities for people to be noticed and picked up and given the opportunity to come out, they might take that up.

I am also wondering if at some stage, if a large body of those people are known to you and you are starting to get some really good data about their issues, about proactively being able to deal with some of their other issues.

Obviously, return to country… if for differing reasons they continue to come back to Darwin and get stuck, then so be it, but if there are differing social or medical reasons, do you think there will be other opportunities, now that it is more of a program type approach, to identify them and assist them and get them out of that cycle?

**Mr SOLER:** Definitely. That is why we took that tack. Instead of just being a service that we provide, we have developed a program model around that and a pathway. Do I think that the numbers are going to decrease into our sobering-up shelters? Unfortunately, no.

What we see at the moment is the demographic of people coming through our sobering-up shelters is an older demographic but the one thing you can be assured of, is that as time marches on and those people leave this earth, there will be other people that will still feed in from outlying communities and other areas where it is much easier to be up in Darwin than it is to be suffering whatever it might be wherever they are.

We tend to find, quite honestly, with people who come in from some of those remote communities, they come in for a medical appointment, something might happen, they might miss their patient travel back to community, and because they have missed it, 'Sorry, you are on your own, you have to find your own way back'.

Because they are here, they have not reported to Centrelink. Because they have not reported to Centrelink, their money has been cut off. They then rely on friends, family or whoever they can here to support them until such time as they wear out their welcome. Then the problem is shifted.

We tend to find that conflagration of events will usually lead someone to hit rock bottom, a couple of months into that. It is at that point that the contemplative state might be a good window to catch them in. But we also find that the complexity of that person and the situation around them is such that it requires multiple levels of assistance from multiple agencies and/or internal departments from us.

It might very well be that they show up at the sobering-up shelter and someone has that conversation with them and finds out their story. We can then internally refer that across and say, 'If you are looking for housing, we might be able to help with some housing support. If you are looking for youth support or you want to help get your kids back …'—whatever it might be, there is always a discussion that can be held.

There is always further assistance we can offer and add to it. It becomes, again, not just a discussion with someone to say, 'Hey, do you want to give up grog?' It is everything else—all the baggage that comes with that.

Hearing what I have so far this morning, the panel seems to be well aware it is not just alcohol or drugs, there is a whole way of life that goes with that, unfortunately, and how things can really spiral out of control for people—things out of their control and those that they feel they have no way of controlling basically dictate where and how they end up and where they get to. It is a very difficult situation.

**Mr PEARCE:** We are also seeing that transfer generationally.

**Mr SOLER:** Yes.

**Mr KIRBY:** You would have heard the conversation with the AMSANT people about trauma …

**Mr SOLER:** Exactly.

**Mr KIRBY:** Would Mission Australia get much of an opportunity to delve too far into that, or you would concentrate more on identifying that there are programs or people who can better assist this person with where they are at, at the time, and …

**Mr PEARCE:** Absolutely. Sorry. In the assessment process through the sobering-up shelter, we certainly do not engage in any in-depth interventions.

What we do though, is once they have entered the detoxification stage and have sufficiently done what they have needed to do with health, we will engage with them if they are referred to us. If we find that they are a better fit elsewhere—as Michael said before—then we would refer them to another service for their wellbeing. We certainly do not try to monopolise an environment.

**Mr CHAIR:** A couple of things. You were talking about your workforce. You work a lot with Aboriginal people as well here in Darwin. What about in communities? Are you getting any …

**Mr SOLER:** Yes. We run one of our mental health programs, Personal Helpers and Mentors, out of Alice Springs. We are funded to work remote, so we have a small office based in Papunya. We have just received, through some underspend, approval to expand that service out to the communities at Haasts Bluff, Mt Liebig and Kintore in that Western Desert region.

That gives us a real chance to reach out to clients in those communities, within the mental health space. We often find that the co-morbidity stuff is part of the cause—anywhere in society, not just in remote communities. As I said before, it is not just one, there are multiple layers to things.

We often find the experience that the staff have out there when they are trying to engage with these people about those mental health issues is that there is often alcohol, drugs, gambling—all sorts of things—that are in there that they have to deal with. We are servicing those areas and we are looking at expanding into those areas. We definitely have hands-on contact.

In Alice Springs, we also have housing support services. We have a transitional housing program called Aherlkeme Village, which is a 12-month transition program for people to step out of the remote into the urban NT Housing stock. For 12 months they will stay in the village we have there. Basically, we are a landlord renting out a property to them. We teach them life skills and all sorts of things about maintaining a property, basic repairs and maintenance of different things, cooking classes, cleaning—all sorts of things that will help.

That does sound very patronising to an extent but it is more about… In personal experience having worked and managed remote community programs, the biggest problems that housing have always found was overcrowding causes repairs and maintenance bills going through the roof because there might be one key for the door, that person is out of town for the day and someone else wants to get in, they will find a way in. Usually a size 12 boot to the door makes it easy

**Mr CHAIR:** The universal key.

**Mr SOLER:** Yes, exactly. The universal key.

We often find there are challenges like that, that we deal with. We work both urban and remote across the Territory.

**Mr CHAIR:** Just about the people in Darwin, the clients that you keep getting in terms of sobering up. We heard about the difficulty with withdrawal from alcohol. If these people are supposed to be going back to dry communities, how do they cope back there?

**Mr SOLER:** I can speak from personal experience having managed some community programs. I have managed Kintore out in the Western Desert, Galiwinku out on Elcho Island and Mataranka in the Katherine region.

It hurts me to say that it all changes and it all stays the same. Sometimes it is just the board or shingle out the front of the community that changes. As recent as about six months ago, I ran into a former staff member of mine from Galiwinku who had shown up at the sobering up shelter and I saw his name in the book and thought I wanted to catch up with him, he was in the detox unit at the time.

He was a shadow of the man that I once knew and I spoke to him and tried to reach out to him and ask what he needed, what support and help did he need. He went through detox and we offered to try to get him into rehabilitation to help him through that process. He wanted to go back to community and transported back to community and probably a month later I saw that he had put a post on Facebook—social media is wonderful these days—saying that it was all too hard and he was going back to Darwin to drink.

The flipside of that coin that I often see a dry community is only as good as the people that police that. Not saying the police in themselves, but the community. How they actually react to it and how the community holds that strength of being a dry community and will not accept it.

In some of those really large communities, the fact that something is illegal or contraband does not stop it getting there, unfortunately. Not for the want of some senior elders really wanting a safe community where people can thrive, they are often caught up with the devils or all sorts of things coming through. Whether it is different ways of making home brew through to importing illicit substances into the community. The isolationist idea of just stopping all outsiders coming in does not change that.

The services that are out there—I did hear something earlier around small communities where there are 16 services providing 400 people. I have seen that and it is just a procession of banners on cars coming in and out and not knowing what that one is there for. There are some communities where there are four services delivering exactly the same program just in a different name.

It is overuse and oversupply. When it comes to things like harm minimisation, you have all these different people singing different songs and communities at large seeing the same story over and over again with no real change. There is a lot of emphasis put on ‘we want to get our story across’ as opposed to ‘we as a collaboration or coalition are here to support you through every step of the journey that you need to take’. As a community we want to look at harm minimisation and are all in this together as opposed to saying ‘we have this limited amount of funding and will not do this’.

We often find that we are adversarial when it comes to tender processes because we are all fighting for those small amounts of funding to deliver those programs. But then we find we are delivering a complimentary program to the other services. For us, with Anglicare, CatholicCare, St Vincent de Paul, FORWAARD and CAAPS, we often fight over these little bits of money.

It is the same again, year on year funding is the bane of every organisation’s and every NGO’s existence. We spend six months writing up tenders and processes only to be granted and then have to start the process again.

We are fortunate that this year our housing contract, which forms about 50% of our workload, has been funded through five years, which is wonderful. Our health contract with Stringybark was a three-year contract. That was good and allowed us to build in that functionality and long-term planning. We are hoping and advise that other NTG departments are moving to five-year funding.

For us, that means we are able to long-term plan and have the workforce capability. The one thing that year-on-year funding really affected was effective service delivery, whatever that was. For us in AOD, for instance, if we had to roll over those contracts every year and we were not sure what we would get, staff would move on to somewhere where they could get guaranteed work.

What you lose is the expertise you have built in those people and you lose some really good staff. You are constantly chasing your tail trying to get those staff. While you might have a really good reputation this year, next year you might not because you are constantly moving staff on. Those really good staff are where the reputation lifts in other organisations. The Territory is small enough that we have all worked in organisations across the Territory and will continue to over time, because that is the way the Territory rolls.

It is a bit different, but we love it. It is one of those things—we are all here to make a difference, and we would not be here if we were not. The idea that services have to keep going back to the table and begging for scraps is really problematic.

The other thing is the potential consideration for government to look at tender processes that are more towards umbrella funding. Rather than direct tender processes of, 'We will tender $1m over two years to one provider', maybe look at coalition bids where there is a lead agency and this or that one will deliver that specific area. If you have a coalition, you have a coalition of minds and strength of knowledge.

It is easier said than done, but it might be a consideration we are all having. I have heard from other experts this morning that we are all singing the same song, maybe just with a different nuance to it. There seems to be a continual situation where when you look at harm minimisation, especially with AOD, there are many different ways but usually two or three pathways people are talking about.

**Mr CHAIR:** That pre-empted the other question I was going to ask you. That is what happens...? I am mindful of the time. Is there anything else you want to say?

**Mr SOLER:** Regarding our facility in Darwin, we want to make that available to the panel should they wish to visit Stringybark and the sobering up shelter in particular to see the work done there and how it operates. Now that it is 24/7 it is a bit easier. It used to just be from 4pm so it was a bit harder.

**Mr CHAIR:** So I could pop in at 4am?

**Mr SOLER:** You are more than welcome to. I would suggest probably around 11pm on Friday or Saturday. You will probably see a bit more action. I want to make that available to the panel, should they wish. I understand there are still hearings to be held in Katherine.

**Mr CHAIR:** And Nhulunbuy and Tiwi.

**Mr SOLER:** We operate the sobering up shelter in Katherine as well. We are happy to make that available. We are here today instead of being at both. We are more than happy to answer any further questions that the panel might have.

**Mr KIRBY:** Just before we finish, you mentioned the restricting of substances in communities doesn't work given the distances. There is no ability to police that or regulate it. It would be extremely hard. Do you have experience in proactively trying to manage that, if not in experience then an opinion on how that could be done better?

**Mr SOLER:** I have a bit of both but I will keep the opinion to myself at the moment. In terms of experience, some of the strongest work I have ever seen done in the AOD space—and potentially the VSA space, volatile substance abuse—was from when I was in Kintore. That was predominantly to do with the strength of and engagement with the elders there.

Now the opinion comes; the only way you can seek to make change is to engage those who have control in those communities. We are kidding ourselves to think that is the council, police, schools or education. It is the people ….

**Mr KIRBY:** Or that it is systematic across the Territory.
**Mr SOLER:** Exactly. It is those people that the people in that community respect. The one thing, particularly in remote communities, that people respect is Indigenous law and the traditional law that they have to abide by within that system. They will listen to what elders say. They know that there are repercussions for things that occur and there are checks and balances within that traditional law that they need to account to. Experience-wise, yes, out in Kintore what I found was, when those elders said things needed to happen, they needed to happen.

In Kintore particularly, VSA situations were rife there through the early 90s. By the late 90s and into the 2000s, especially the early 2000s, those instances had pretty much dried up, simply because the elders took charge and they made sure they left an indelible mark on the young people, in particular, that were partaking in that. It was pretty much negligible.

I was managing there in 2010. We had a slight outbreak when Men's Business was happening and there were outside influences from WA communities, so people from other communities came across the border where those VSA situations were not as tight, so that brought a spike into the community. The elders stepped up and dealt with it.

The opinion stuff is that, having been in places where, especially out in places like Elcho Island, being on an island you think it would be easier to restrict. I saw police everyday down when the Airnorth plane would

come in, I would see police down there every day checking bags and with sniffer dogs and all sorts of things, and the amount of stuff that would come through just because people thought they could get stuff in there.

I have seen small aircraft fly low over the island and drop packages out of windows. I have seen people take tinnies and boats inordinate amounts of kilometres away to come back under the cover of darkness. We would be kidding ourselves to think we could stop everything but as far as harm minimisation goes, the conversation starts with the youngest and moves up from there.

One thing we put in our submission was youth rehabilitation. The AOD rehab for youth, which there is very limited amounts of in the Northern Territory, for us is something we have programs that we operate around Australia. Stringybark was our first foray into adult rehab because we have predominantly worked in youth AOD rehab which unfortunately we have to in other parts of Australia.

**Mr CHAIR:** And we do not do it here?

**Mr SOLER:** We do not do it here. BushMob, down around Alice, was probably the last one that was successful in being able to deliver that, and Mt Theo out near Yuendumu, they have a really good program out there that has always been the standard bearer. It is probably something that we do not invest enough in. We often find that by the time we deal with people of an older age, in their early 20s, it is almost too far gone to try and change that.

**Mr CHAIR:** Thank you

**Mr SOLER:** No worries at all. If there is any follow-up you require, please feel free to get in touch.

**Mr CHAIR:** We will bear that in mind.

**Mr SOLER:** If you want to attend the facility, just reach out. There is no problem. We will arrange that.

**Mr CHAIR:** Thank you.

## COUNCIL FOR ABORIGINAL ALCOHOL PROGRAM SERVICES (CAAPS)

**Mr CHAIR:** A little behind schedule. Thank you for waiting. We have Jill but not Elizabeth. Okay.

On behalf of the committee, welcome to the public hearing into reducing harms from addictive behaviours. Jill Smith, thank you for coming before the committee. We appreciate you taking the time to speak to us. We look forward to hearing from you today.

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

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

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

**Ms SMITH:** My name is Jill Smith. I am the Chief Executive Officer of the Council for Aboriginal Alcohol Program Services—known as CAAPS—in the Northern Territory. I am speaking on behalf of my colleague, our Deputy CEO today. She is unwell and not able to attend, but she has given me some notes on things she felt were important to mention today. So bear with me while I do that on her behalf.

**Mr CHAIR:** That would be fantastic, thank you.

**Ms SMITH:** In opening, I acknowledge the Larrakia people of Darwin region and pay respects to elders, past and present. Our Deputy CEO, Elizabeth, is an Aboriginal woman who is local to this region and has a very strong commitment to culture and the people of this region.

She has prepared some notes for me, so I will speak to those. But I also have some other points I will raise independent of that. As a background, the Council for Aboriginal Alcohol Programs Services has been

providing treatment services for people and their families impacted by the harms of substance use for over 34 years.

Our primary services are the delivery of residential rehabilitation. However, we have recently extended our services to include AOD counselling through a drop-in pilot program in Darwin's rural area. That came about from MDAT funding from the Primary Health Network and is operated in partnership with Amity Community Services.

The majority of our clients identify as Aboriginal and Torres Strait Islander and come from many remote communities across the Northern Territory. In order to support complex needs of clients accessing CAAPS services, we have continued to remain active in our industry with best practice platforms, including representation on the board of AADANT, of which I am the chairperson, through contributions to evidence bases and membership of the National Indigenous Knowledge Centre for AOD as a reference group member.

We would like to thank you for the opportunity to appear before the committee today and as part of our opening statement we would like to highlight some points that we included in our written submission to the committee.

As stated in our submission, CAAPS strongly advocates for prevention and early intervention strategies aimed at reducing the uptake of harmful substance use. While the majority of funding is applied in the AOD sector towards treatment for people with dependent, chronic and complex substance-related issues, greater capacity building needs to focus on treatment services that offer activities to reduce the harmful uptake of substances.

A recent study prepared for the New South Wales Ministry of Health looked at specific effectiveness of AOD interventions with at-risk Aboriginal youth and this study found that there were common themes underpinning the effectiveness of interventions amongst this population.

These themes include solutions that were developed with communities, with real community consultation, strong engagement and leadership within that community, with sustainable funding attached. This study also found that regular programs rather than one-off activities proved to be far more effective.

I add in there that CAAPS actually does run a youth rehabilitation service that is a residential service. We are funded by the NTG to run that service. We have been asked to move outside of the VSU-specific area and look at other substances that are becoming more prevalent with youth. I will talk about some issues around our actual capacity around that.

CAAPS highlights the importance of culturally relevant interventions when looking at service delivery for Aboriginal populations. Genuine consultation as opposed to tick-box exercises are necessary in developing interventions for this population. We welcome the return to local decision-making announced by the Chief Minister yesterday, in particular in the areas of health, education and housing.

A plethora of evidence exists to support the link between culturally relevant intervention and effective outcomes for Aboriginal people accessing AOD services. This evidence includes research from industry experts, mostly from our Western Australian colleagues Professor Ted Wilkes, Dennis Gray and Wendy Casey.

Principles that guide culturally relevant interventions are multi-faceted and not singular in nature and therefore require involvement by Aboriginal people in every step of the process of development and implementation through to evaluation of those services. Transparent evaluation that measures the cultural relevance of initiatives servicing Aboriginal populations in the AOD space should be built into funding agreements.

Just to comment briefly, one of the issues we have around evaluation and even quality assurance with our services, is that they are not specifically funded as part of our service agreement. There is a significant cost to our services in maintaining standards and evaluating our practice to argue for future funding of course.

In addition to this, CAAPS reiterates the need for greater support for families and communities impacted by substance use. As long as there is harmful use of substances in our community, there are families significantly impacted as a result and these impacts have long-term negative effects on those families that include social and emotional development, health and economic outcomes.

Many AOD programs service the primary person within the substance use without offering enough support to the families and communities who are impacted. Looking at the gaps in this area may improve the coping capacity of families to improve life outcomes and reduce the likelihood of trans-generational trauma and subsequent substance use.

We confirm our support of initiatives that provide greater care and coordination across agencies. Information sharing between government and non-government agencies within the realm of privacy needs to be improved in order to enhance the services provided to clients in common.

In this space, where comorbidity is the norm rather than the exception, there tends to be an inherent distrust around information sharing between government agencies and NGOs. We encourage this culture to change in order to improve cross-agency care.

Once again, we are grateful to have the opportunity to speak to the committee today. One of the things I wanted to highlight in particular around this information sharing issue is, in light of the outcomes of the Royal Commission, there is much more pressure from Commonwealth governments to provide accountable practices, assessment of risk around working with vulnerable people and declarations for agencies that are working in that space and receive funding.

One of the issues we are having on a day to day level with the NTG is the cooperation around information sharing with regard to criminal histories of potential clients. Given that we are a family based program working with vulnerable youth and children that accompany their parents into our service, that has become a real issue for us to meet our capacity.

We have a residential service that has 10 beds funded by NTG and we are operating at 50% at the moment, mainly because there is a reluctance on the part of a particular team to provide information around criminal histories that prevent our assessment process from going ahead. This is a dilemma for us when we are asked to provide 85% as our benchmark for occupancy for that funding to continue.

We are a little at odds with that process and I think it is worth highlighting. It is time for some negotiation around that; it appears to be personality based and we are applying some pressure (to seek a resolution).

I think some of the other issues are there is less time for practice improvements and there is less funding for pre- and post-service provision. A lot of the issues that come up with our clients are around homelessness. They are in a 12-week program and at the end of that program, we fundamentally oppose releasing them into homelessness or 'long-grassing'. Often what happens is that we keep people longer than the period after they have finished the program with few options for moving them on.

At the moment, looking at bed numbers, this can be a bit of a stress point for us for our adult (family) program. We do have a high percentage of children that come in with parents which is even more important for us to look at the safety of them moving out of our program.

Funding gaps and collaborations can be another pressure point for us. We are fortunate to have five year funding from the NTG for our programs, three year funding from the Commonwealth for our core business and a pilot project from Primary Health Network for our MDAT funded drop in counselling service.

Again, I concur with the comments from Mission Australia before around staffing because prior to this, we have had a rollover of 12 month contracts which was then putting our staffing at risk. We strive for 60% Aboriginal staffing which is another stress point because people who are highly sought after across the industry need some certainty for their own families and wellbeing.

Often we are in a position where we are not sure whether the funding is going to continue and whether they (our Staff) have any job security. It is a constant churn in the Territory for staff.

The other issue around that is skilling people up. If you are looking at Aboriginal people working in your service at 60% staff for client facing roles and there is a requirement for a minimum qualification of Certificate IV in AOD, often we have put 10 people through a program and sometimes we are left with three at the end because they have either found a better option of a higher paid role or they have moved on out of the Territory into other roles. The churn affects us, we are constantly training people.

That is probably enough from me.

**Mr CHAIR:** Thank you very much. Unfortunately there is a lot familiar themes running through there. You have answered in your submission a number of the questions we have down here in any event. Thank you for that as well.

The importance of prevention and early intervention you touched on in your submissions but also in your presentation, what have you found to be the most effective way to prevent and delay substance use among young Territorians and more specifically Aboriginal people?

**Ms SMITH:** I think working more closely with the communities of origin because (at CAAPS) there are statistics where about 25% (of clients are) from the Darwin region into residential—the majority of our clients come from communities across the Territory.

One of the challenges is that there was some funding in early 2000s for a youth wellbeing project that actually went out to communities, upskilled communities with education programs, helped families see the signs of stress within their own families and community groups, gave them some skills and knowledge around how to address some of those issues and take control themselves. I think having that funding withdrawn has made a big difference to general coping in community itself.

Often we have families relocated to move them away from a cohort that might be a negative cohort that are using substances, or are potentially in overcrowded homes where the stresses lead to more substance use. Children are exposed to adult substance use and there is a lot of transgenerational trauma, which you would have heard from AMSANT that we are all working with.

Our colleague from Mission Australia just spoke about one of their own staff finding that it is just too hard. I think it is hard working in this space in community. If you are not from the community people do not trust you and there is a lot of fly in, fly out and drive in, drive out workers.

Having worked in another national organisation, when I first moved to the Territory my experience of working in Katherine was there was 72 services coming in and out of that place.

**Mr KIRBY:** Seventy two?

**Ms SMITH:** Yes. This is going back five years but I know that there was a lot of debate around who had particular funding, not sharing information between services, not trusting one another to work collaboratively and worrying about their existence in the next funding round.

**Mr KIRBY:** Very siloed.

**Mr CHAIR:** Demarcation disputes.

**Ms SMITH:** Exactly, a demarcation issue to the point where there was a lot of duplication.

The constant churn—people from national services that come in and out of communities as seagulls and I understand why. It can be daunting to know that at any given time you may have a number of different faces coming in and out delivering the same program. The outcomes are pretty poor if people do not want to cooperate.

**Mr CHAIR:** The Member for Barkly told us last week about the white clouds, similar concept to the seagulls, but it is the white Prados that come into the communities.

**Ms SMITH:** Yes.

**Mr CHAIR:** Interesting to see. Working with people from the community gets a much better result. Having them work, training them and working with their own communities. But as you said equally, there are difficulties in working with your own community as well and the closeness. Family members you might be dealing with as well.

**Ms SMITH:** I think that is true. Living and working on a community is incredibly difficult because people know where you are. There is never any down time unless you get out of there for a break and the burnout rates are pretty high.

**Mr CHAIR:** Your submission recommends the inclusion of families in the treatment model. Can you give an overview of how this might be best operationalised?

**Ms SMITH:** I think CAAPS does a pretty good job of that at the moment; however, people have to leave their home community to access that. Sometimes that is a good thing if you want a circuit breaker, it gives people some time to get well physically because often they come in with chronic health conditions that have not been diagnosed.

Sometimes they come in with mental health issues emerging. Co-morbidity is a huge issue with substance use. Children having an opportunity to go back into school—a lot of the kids that come into our program have not been in school for a long time for various reasons: a lot of people sitting up gambling at night even if they are not using substances, nowhere to sleep, no routine in the household, overcrowding, all of those things.

When you start getting kids back into learning and knowing that learning can be enjoyable, they can succeed and do well at things, they get a sense of self and pride in their achievements. Even getting parents back into a school environment where they feel comfortable talking to a teacher, knowing they have a right to ask questions, be involved in their child's education and having a say in that is sometimes a new experience for our parents.

We have a children's program and a children's worker who assists them with school enrolments, going in and talking to school staff, being involved in the classroom homework sessions.

It is not just about treating someone for substance use, it is about looking at the whole family as a unit: how are their relationships, how are their parenting skills, are they mal-adaptive, are they building confidence and self-esteem, are we looking at trauma, are we looking at undiagnosed disabilities, perhaps learning difficulties.

As everyone has probably said already, none of this occurs in isolation. There is so much complexity in our families and in individuals and the needs that they have.

**Mr CHAIR:** Speaking of those learning disabilities, some of the submissions down in Tennant and Alice, spoke about FASD and assessment of FASD. What do you know about any assessment?

**Ms SMITH:** We have a nurse on-site, so she is doing developmental assessments and screening, right at the beginning for every person that comes into our service, especially children. If there is anything that we believe needs to be referred to a specialist; that is what happens. Danila Dilba mainly see our clients for most health screenings.

A lot of our clients come in with chronic health conditions that they are not managing very well. We have not had a lot of children come through with a diagnosis of FASD, but certainly developmental delays and undiagnosed disabilities: autism – on the spectrum that need more support in a classroom to manage behaviours.

Parents not understanding why their young person is behaving in that way and using physical discipline as a way to cope with it which then brings in Territory Families and a whole gamut of other issues. Sometimes families come to us to avoid having their children removed.

We are looking at working with the whole system to improve their chances of success as a family and also those children not going into care. Generally, they do not go into care with a relative or another Aboriginal family, they often are non-Indigenous families they are placed with.

**Mr CHAIR:** I think you answered it in your own thing as well.

The New South Wales Government report you spoke about before, talking about these sorts of programs, and you said, I've written down, how do we do in this area? You then went on to talk about the CAAPS program. What about other programs? Are there any other programs that you are aware of or only your own?

**Ms SMITH:** In the Territory?

**Mr CHAIR:** Well probably anywhere, but in the Territory generally.

**Ms SMITH:** For youth?

**Mr CHAIR:** Yes.

**Ms SMITH:** There is a paucity of programs that look at alcohol use for young people under 18.

We have started looking at that as a result of trying to fill our beds with our VSU program because there is a gap. We have a number of young people coming into the drop-in service at Coolalinga because that is a 'No Wrong Door' service. It was funded out MDAT money for methamphetamine, but we do not turn people away.

It might be a young person who is experimenting and concerned about the legality of it as well as the safety and harm minimisation. They may not want to stop; they may want some information on how to manage that. It could be a parent worried about the behaviour of their school-aged children. We see young people from age 12 who may have substance use issues established in that program.

As far as residential services, I do not think there are many in the Northern Territory. I know that CatholicCare do some work with youth through their drug and alcohol program. A lot of it borders on mental health intervention as well.

I came from New South Wales where I worked in a youth service that offered residential rehabilitation in Marrickville in Sydney for young people, but they were mainly injecting drug users and there were various substances. Methamphetamine probably was not as prevalent at the time. That was a live-in service.

It was an exception. Odyssey House and a number of other places were looking after young people. The criminalisation of substance use is a huge issue. I think the money spent chasing people down who are using for their own personal use or for possessing substances is wasted, in a way. We could be looking at how to support people in reducing risks rather than locking them up.

**Mr CHAIR:** That is something we have had a number of submissions on as well. What you have just expressed is consistent with a lot of other views as well. With alcohol in particular, you were just saying there are no services regarding alcohol for children under 18. Do you think that is because of the same concept of criminalisation?

**Ms SMITH:** I suppose when people are looking at service providers, they generally have not looked at the fact that young people under the age of 18 are binge drinking—and not necessarily Aboriginal young people. They have access to alcohol whether it is through their parents—and the drinking culture in the Territory is quite unique.

I think given that the majority of our clients are Aboriginal young people, on community it is hard to police. Even if it is a dry community, in the past there have been issues with young people experimenting with spirits, which were much stronger than beer and other things, because they were easier to bring into community in a small bottle and hide.

That has created a different set of issues. Some parents will say to us that they would prefer the young person to use cannabis because (there is a belief) it is safer. They will encourage them (young people) to do that rather than sniff petrol or solvents or drink alcohol.

A lot of it stems from community attitudes to underage drinking and whether they (the community) see it as a problem, and then where the funding goes.

**Mr KIRBY:** Regarding the significant problems with illicit drugs in communities, we have had a few options or examples given to us. What is your experience? Is it a prevalent problem? Is alcohol considerably more of a problem in community?

**Ms SMITH:** I think alcohol is the biggest problem across the Territory in non-Indigenous populations as well as Indigenous populations.

One of the trends we have seen at CAAPS as a residential service for Aboriginal people is that abstinence is required while they are in our 12-week program. Generally people can abstain from consuming alcohol, with a struggle—especially if they have been through some kind of supervised withdrawal. People generally tend to struggle more with methamphetamine because the withdrawal period is much longer.

They often under-report their use when they come in for assessment. Unless we have a very clear idea of how much they are using, often people will come into the service, report that alcohol is the biggest issue, potentially struggle then and not cope because they are withdrawing from meth, and exit before the 12-week program is completed.

This is part of the reason we looked the drop-in service. We are seeing a lot of Aboriginal clients out there, particularly women with children who want to keep their children in their care.

Clients know there is a potential for Territory Families to be involved if they continue using. They want to minimise the harm to them and their family, but they may not want to abstain. They will not stay in an Aboriginal service or a rehabilitation service where they have to abstain. So, we are seeing the change in the profile of our clients.

Cannabis is probably the second most widely used substance. There is a little more methamphetamine around in community. It seems to be attached to communities close to mining and other industry.

**Mr CHAIR:** That would certainly make sense. Anything else you wanted to raise with us?

**Ms SMITH:** I sympathise with CatholicCare saying how expensive accreditation is, because we have just been through another three-year cycle and it is an incredibly expensive exercise and a requirement of our funding. It will ensure we are meeting benchmark standards as well, providing the best possible services to our clients as we can.

The pressure for accountability for meeting standards, having quality standards and evaluations in place, being able to measure our performance, look at best practice frameworks, look at training our staff—all of these things are vitally important to providing a quality service.

Most of us have a huge commitment to that. But the way the funding models are structured makes it very difficult. Unless you have your own resources or a way of accruing your own income outside of the funding—and most of us are dependent on government funding—it is very hard. Yes, that is one of the biggest challenges we face.

**Mr KIRBY:** We have heard from people up and down the track that their ability to do proactive programs is fairly limited—they are just doing reactive treatments …

**Ms SMITH:** Yes.

**Mr KIRBY:** … and do not have the capacity to expand at the moment.

**Mr CHAIR:** Thanks, Jill.

**Ms SMITH:** Thank you very much.

**Mr CHAIR:** Thank you for your information and input.

**Ms SMITH:** I apologise for my colleague. She is rather unwell, as is probably 30% of our staff at the moment.

**Mr CHAIR:** No problem at all. We are just glad to have someone along. Thank you very much.

**Ms SMITH:** Thank you.

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The committee suspended.

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**360EDGE**

**Mr CHAIR:** Welcome Professor. You have on the line myself, Jeff Collins, I am the Chair of the Committee and the Member for Fong Lim. We have Paul Kirby here, who is the Member for Port Darwin, and we should be having shortly, joining us by phone, Sandra Nelson who is the Member for Katherine.

Welcome to the public hearing into reducing harms from addictive behaviours. I thank you for coming before committee and I appreciate you taking the time to speak to 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 apply. It is a public hearing and is being webcast through the Assembly's website. A transcript will be made available for the use of the committee and may be put on the committee's website. If at any time

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

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

**Professor LEE:** Nicole Lee, I am director of a consultancy called 360Edge and I am also an Adjunct Professor at the National Drug Research Institute. I am appearing in my capacity in the former not the latter.

**Mr CHAIR:** Would you like to make an opening statement?

**Professor LEE:** Yes, I would, thank you. Thank you so much for the opportunity to first make a submission and now provide evidence in front of the select committee. As I said, I am the Director of an alcohol and drug consultancy and Adjunct Professor at the National Drug Research Institute. I have been working in the area of alcohol and drug clinical practice and research and policy development for about 28 years.

The consultancy that I run provides services and workforce development for the alcohol and drug sector across Australia, essentially translating research into practice solutions for service workers. We provide evidence-based practice policy advice for governance.

If I may, I would like to make a couple of key points about harm reduction and some of the points in our submission just to provide a bit more context. I am hoping that you have some slides in front of you that I will speak to as well.

**Mr CHAIR:** Yes, we do.

**Professor LEE:** Great. The first thing to note is that drug policy in Australia is largely directed by the National Drug Strategy which is exclusively based on the minimisation of harm through three equal pillars of harm reduction, supply reduction and demand reduction.

Harm reduction is a pragmatic approach that focuses on reducing the negative consequence of use and it is important to note that it has its basis in human rights and social justice and it necessitates the humane treatment of people who use drugs. That is why it is so important. It moves beyond just the health consequences really to the human rights of people who use drugs.

When you look at the implementation of the policy across Australia, and implementation is largely a matter for the states and territories, it is quite unbalanced. An analysis from the Drug Policy Modelling Program based in New South Wales, showed that only about 2% of drug funding is explicitly spent on harm reduction activities and about 66% on law enforcement or supply reduction.

The remainder is on prevention and treatment. Harm reduction itself as an exclusive strategy is poorly resourced. For me, it is very heartening to the select committee is focusing specifically at looking at this issue because it often gets overlooked.

One of my key areas of policy development is specifically in the methamphetamine or ice area and I wanted to talk about the lessons from the ice crisis around Australia that are relevant more generally to drug policy and to the select committee's hearings.

Ice is just the crystal form of methamphetamine. There is also a powdered form available. What we have seen—you can see the graph of different drugs there—you can see that the percentage of the population that uses methamphetamine is showing a steady decrease in the last 20 years; but if you have a look at the second graph, not the bar chart but the second line graph two points down, you will see that while there has been a decrease in the percentage of population who use, there has been an increase in, for example, treatment presentation and other harm indicators, also hospital admissions, ambulance call-outs and death, primarily because of a shift from the use of the powdered form—which is called 'speed'—to the stronger crystal form—which is called 'ice'.

If you put all that together, it shows that we can actually have a situation where use is declining and harm is still increasing, despite fewer people using. Trying to make an impact on harm and harm reduction through reducing use, you are really using a sledge hammer to crack a nut. When talking about harm reduction in drug policy, it needs to address harm directly, and not try to do that through use reduction.

The other thing to keep in mind is that for most drugs, including alcohol, there is a continuum of harm. That is because the majority of people who use the range of drugs we have available to us, do so fairly infrequently. For illicit drugs, usually it is for quite a short time in their lives. There are very few people in their later years who are using illicit drugs, but a very high proportion in their 20s.

For example, 85% of people who use methamphetamine, 70% of people who use cannabis and nearly 60% of people who drink alcohol do so less than once a month. They will never be dependent on those drugs. They will never see or be engaged with a treatment service, but there are potentials harms associated with their use. Effective drug policy also needs to address harms across the sector—in treatment and pre-treatment as well.

There is a last contextual point I will make. When we say drug rehabilitation or even drug treatment, the first thing most people think about is residential rehabilitation, which is an abstinence oriented treatment option—something with no drugs or alcohol allowed to be used while in treatment. The expectation of the outcome from treatment is that participants will continue to be drug-free.

I make two points. There is a range of effective options to address alcohol and drug use problems and actually only a very small proportion of people choose residential rehab and benefit from it. Most of the other forms of treatment are not necessarily abstinence oriented and tend to be more suited to the range of people who use drugs that I was referring to before.

The second thing about that is that drug-use problems, like dependence, tend to change over time and relapse is very common. Even for people who achieve abstinence, harm reduction is important because they may not be drug-free 100% of the time.

Just to round up, the imbalance of funding and the focus on eliminating drug use in society, rather than reducing harm, and the heavy focus on abstinence oriented drug treatment is essentially a reflection of the prevailing war-on-drugs approach we have engaged in forever. This has impacted on our ability to apply harm reduction principles across the spectrum of drug use, from occasional use to dependent use and in treatment.

I commend the select committee in the parliament for reviewing their harm reduction strategy. If you agree that people should use drugs or not, we need to broaden our approach to drug use and treatment, acknowledging that in reality we will never be able to eliminate drug use entirely. We know that any time we crack down on drugs, new drugs just pop up elsewhere that are unregulated.

Drug responses can be highly counterintuitive, especially if you are looking at that through a ‘war on drugs’ lens. We really need to rely on evidence-based policy to government rather than ideology.

**Mr CHAIR:** Thank you for that. As you have probably heard, we have just had Sandra Nelson, the Member for Katherine, join us.

Professor, we have a number of questions but we generally range across topics as you provide more information for us. I will start with this.

Given the widely dispersed nature of the NT population, how would you envisage harm-reduction strategies like medically supervised injecting centres and heroin-assisted treatment programs being operationalised? Where would they be located? Would they be mobile facilities?

**Professor LEE:** It is a challenging question for a state or territory that is very sparsely, diversely and widely populated. There is data and analysis that is required to be able to see what we call the ‘hot spots’ for injecting drug youths are. For example, in most states and territories there is about 1.4% of people using methamphetamines, but relatively few actually inject it—about 12%.

If we focus on areas where there is high methamphetamine or cannabis use, for example, that will not be very helpful if we are talking about medically supervised injecting facilities. We need to find out where the really keen hot spots are and place any harm reduction services where they are most needed.

Of course, it is very difficult. A medically supervised injecting facility is a relatively expensive undertaking. It is very cost effective, but it takes dollars so we cannot put them in every jurisdiction. We need to think about where the most harm is occurring and place the harm-reduction services there.

**Mr CHAIR:** I think we heard earlier from AADANT as well about the fact that, when it comes to injecting drugs in the Territory, we have a very small number. It is probably similar elsewhere. As you said in your opening statement, these trends can change over time. Different drugs get used at different times. Setting something up would be a worthwhile exercise anyway in that sense.

**Professor LEE:** Yes. I think as a general rule that as many services that we can offer to reduce harm, and offering as much choice as we can, will be of benefit to people who use drugs, but also to the community. We know that those services reduce use, crime and improve health among people who use drugs. Just because we cannot get the ideal situation, pragmatically, we should start somewhere.

**Mr CHAIR:** I am not sure that I have the authority to make this offer, but it is a question anyway. If you were appointed as a consultant to the Territory government, what would you identify as the key areas for the government to address in relation to reducing harmful, addictive behaviours?

**Professor LEE:** I think one of the things about the Northern Territory is that there is quite a high rate of drug use across the board. However, the majority of that is non-problematic drug use.

It is important to look at a full range of harm reduction activities including things for people who do not use regularly but are at risk of acute harm. Needle and syringe programs with people who inject for example, are very easy to place in multiple types of services. That's one really effective harm reduction strategy for people who inject drugs.

For people who do not inject drugs, we need to make sure that all of our health services are across asking the right questions about drug and alcohol use and making sure that they can do a reasonable job with screening, assessment and referring to the right place if someone does need help.

Often people do not seek help and if you do not ask the right question, they might not volunteer that information. If you do ask the right question then they may be prepared to hear some harm reduction information or go to see someone.

Especially when it comes to people involved in general practice, other primary health care and community health, that are not drug and alcohol specialists, we need to really harness their interest, time and expertise to make sure there is a good harm reduction advice around.

**Mr CHAIR:** This one might be a bit leading, but what are your views on the idea that illicit substances should be decriminalised and how would this affect drug use in the Northern Territory?

**Professor LEE:** My personal view is that there is no reason why drug use should be a criminal offence even if you believe that people should not use drugs and we maintain their illegality.

The minimal sanctions applied to people who use illicit drugs can cause more harm than the drugs themselves and I think that is counter to the intention of our laws and are potentially less diverse from historical ideas about drug use.

From a personal point of view, I agree that illicit drugs should be decriminalised and that would make a significant reduction in harm. Something like 80% of people who are arrested for drug use charges are arrested for possession. They are people who use drugs – and majority of people who use drugs use fairly irregularly – are not dependent and do not need treatment.

Very few drug arrests are for people who distribute and sell the drugs. We can significantly reduce harm to people who use by decriminalising.

The evidence suggests that in places where drugs have been decriminalised, there has not been an increase in use. In fact, in some places there has been a decrease in relative use, an increase in people attending treatment and harm reduction services and a significant decrease in the harm.

**Mr KIRBY:** I am interested in the harm reduction side of things and alcohol being a major issue through the Northern Territory.

We have had some discussions this morning around regulated access to alcohol. Have you had much experience in remote communities and some of the specific problems that they throw up? Have you got any suggestions or insights you would like to share on that?

**Professor LEE:** That question is outside of my expertise. I will not make comment on that. There are definitely other people who are more expert in that area that can answer that better.

**Ms NELSON:** I do not have any questions right now.

**Mr CHAIR:** We have one here about education as an important tool for preventing and delaying the uptake of alcohol and illicit substances. In your experience researching and consulting on alcohol and drug-related policy, can you tell us anything about the types of educational programs you consider to be most effective in schools?

**Professor LEE:** There has been two systematic reviews that have looked at all of the evidence around drug education in schools. There are two programs that have been developed in Australia that are amongst the top in the world.

One of the interesting things is that if you look at what happens at school, not that many schools use evidence-based drug education programs, many of them use programs that are not particularly evidence-based. For example having police come into schools and lecture kids is not considered best practice, but integrating information delivered by teachers or online has been shown to improve outcomes.

We need to be very careful with alcohol and drug education at school because there are some programs that have actually been shown to increase interest in drugs which is the opposite of what we want with young people.

**Mr CHAIR:** How do you best counter that? You mentioned two programs developed in Australia, what are those ones?

**Professor LEE:** Yes, one is called Climate Schools and the other one, I temporarily have a block on its name. I will have to find that for you.

**Mr CHAIR:** That is okay. Beyond those education type programs, what else have you found to be effective in reducing harms associated with substance use?

**Professor LEE:** There are a range of options available to us in terms of harm reduction and I think one important thing to note is that we need to think about that full range of youth and harms and addressing harms at all those different levels. At one end, there are people who we would sometimes call recreational users who use occasionally, who are more at risk of acute harms and less at risk of things like dependence.

People who use MDMA or ecstasy, for example, may be at risk of overdosing from contaminants or taking too much so that is the reason why the sector is interested in trialling drug checking or pill testing. Those people will probably never come into contact with a health service and disclose their drug use and that is an excellent way to get harm reduction information out to people who use drugs occasionally.

We have talked about medically supervised injecting facilities, Heroin Assisted Treatment, and methadone and buprenorphine treatment, for example, and they all kind of fall into the regular use and people who are potentially dependent on drugs or may have more severe problems. So we need to address harm reduction among those people as well, even if they are not saying that they want to be abstinent.

As I said in my opening statement, drug use is a chronic and relapsing condition. The most common outcome from treatment is actually relapsing. People will relapse several times before they find the right treatment for them. Even if they do want to be abstinent, they may not be abstinent 100% of the time. I do not want people to die just from using drugs if they are having a slip up.

There is a range evidence based hard reduction strategies we can draw on for a range of drugs across the spectrum of use.

**Mr CHAIR:** Anything else? I really enjoyed your submission, thank you for your written submission. There is lots of really good information in there.

Is there anything else you would like to tell the committee?

**Professor LEE:** I do not have anything further except to say that it is really great that Parliament is looking at harm reduction specifically. I think that has been significant within many other investigations and enquiries that we have had, which is huge.

**Mr CHAIR:** Thank you. Hopefully we will come up with a well thought-out report that encourages the government to take some action.

**Professor LEE:** Excellent.

**Mr CHAIR:** Thank you, Professor Lee.

**Professor LEE:** Thank you so much for the opportunity.

## MENZIES SCHOOL OF HEALTH RESEARCH

**Mr CHAIR:** Thank you for coming before the committee, we appreciate you taking the time to speak to us and look forward to hearing from you today.

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

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

**Mr STEVENS:** I am Matt Stevens and I am a Senior Research Fellow at Menzies School of Health Research, predominantly working in the gambling space but in addictive behaviours in general. So around alcohol and illicit substances as well.

**Mr CHAIR:** Would you like to make an opening statement?

**Mr STEVENS:** I was not sure how it was going to go. I have a long winded thing but I do not think I will go there.

**Mr CHAIR:** Feel free to do whatever you like.

**Mr STEVENS:** I will talk to my main speciality which is gambling and harm minimisation around gambling products that are in the market.

We have talked a bit about supply, demand and harm reduction. There is opportunity that they are all already operating to some degree in the gambling space but to greater and lesser degrees in terms of how well they are working.

I guess looking at what we have known for a long time is the most dangerous gambling product – that is poker machines, pokies or electronic gambling machines, as I prefer to call them rather than electronic gaming machines. I think that is a little misleading when we talk about gaming and it is actually gambling. It is actually a game of chance that people are playing.

There is certainly a lot that can be done with electronic gambling machines to make them a safer product. Some recent research—I have just submitted this paper, so it is going through the review process at the moment. Some of it was in the written submission I gave you.

You have structural characteristics associated with the games. These can be tweaked. In the last four or five years the Territory has changed from only being able to load the machines with coins to being able to put notes in the machines. Now we can load $1000 in one go into a machine.

Comparing that to other states, it varies a lot. New South Wales have just reduced theirs from $7500 to $5000. Queensland has a $100 maximum. Victoria has a $1000 maximum. Tasmania and South Australia have the coin approach, like us. It varies a lot.

What we have seen in the Territory since this introduction is an around 40% increase in revenue over a four year period after pretty stagnant growth since the smoking ban. That was the other very effective policy in reducing gambling spending. A lot of people who have problems with playing poker machines also tend to be addicted to other things, such as alcohol or smoking. They seem to go hand in hand.

By stopping the smoking, it meant people would go outside and have a smoke break and then realised they have just spent $200 so would not put any more money in the machine. These structural characteristics are a pretty strong lever. That research also shows that between 2005 and 2015, the percentage of the population playing pokies has gone down, but the absolute numbers are roughly the same. There is around 20 000 people and 4000 more regular players.

When we look at people who are classified as problem or moderate-risk gamblers who play pokies, the losses per person, based on my research, sort of increased from around $30 000 per person per year, up to around $50 000 per person per year. You have nearly double the revenue with the same number of people contributing to that revenue. It is similar to what the lady was saying. Even though the use [prevalence] of amphetamines might be going down, the harms are increasing.

I also draw attention to the recent work that was done in Victoria where they used a burden-of-disease approach to measure the burden of harm that gambling causes. They do this sort of thing with alcohol a fair bit and all the illnesses. You come up with a figure like the years of life lost based on whether you are a problem or heavy drinker, you use drugs or you are suffering from leukaemia. They do it for all sorts of conditions.

That showed gambling is very similar to alcohol in the level of harm to the community. They called it the 'prevention paradox', where most of the harms occur not within that pointy end of addictive behaviour, but amongst all users. The harms are spread out through the population. This information was not available in our last prevalence survey, which I ran. We found 13% of Territory adults had been negatively affected by someone else's gambling, so they had experienced harm directly as a result of someone else's gambling.

The sort of harms people were experiencing were things like raiding their savings. Around 5% of people said they were stressed or depressed because of someone else's gambling. You have relationship problems, running out of money for rent and food and things like that. That was 13% in the general Northern Territory adult population.

Amongst the Aboriginal sample of that survey, it was 28%. You are looking at a quarter of Aboriginal people in that survey saying they had been negatively affected. The work we have done in remote communities is only a small study of three communities, but it was 60% - that was pretty consistent across all three communities. Of the adults we spoke to, 60% had been negatively affected [by someone else's gambling].

There is certainly plenty of harm occurring because of gambling. These harms contribute to psychological and physical health detriment. They can affect people over the course of their life and be intergenerational when you are at the sticky end where people are losing houses, going bankrupt, relationship breakdowns and those sorts of things.

Getting back to that harm reduction, there are some particularly good levers we can do with things like electronic gambling machines, where we can maybe reduce that. It is interesting too, because if you look at the Productivity Commission report from 2010—which is sort of like your Bible of what would be best practice policy to some degree in the gambling spaces—their recommendation is for a $20 maximum load limit into machines. The Queensland government has come the closest to that at $100, whereas we are at $1000.

There are plenty of other characteristics on the machines that could be changed. The machines are pretty well designed to make people keep playing. They have losses disguised as wins. If you are playing multiple lines, you might lose on four lines and win on one line, so you have lost 80c out of your $1 bet, but it will still play a winning sound. This keeps people playing. The research shows that will keep people playing. Queensland and Tasmania have legislated against losses disguised as wins, so they do not have them.

There are these little structural things that vary across states that have not been very well studied at the national level because gambling is a state-based thing and most of the funding is given out by state governments to do the research into gambling. Often, they are quite particular what they fund you to research as well.

I can talk a little about alcohol-harm minimisation from a project I worked on with Jennifer.

We visited eight communities. The project was about setting up a method to monitor and evaluate alcohol management plans in communities. That project was a fairly large, busy project. We conducted qualitative interviews with 90 people from those communities, of which half were community residents. We also conducted surveys with about 300 people across those eight communities. We measured alcohol consumption, people's experience of problems and things like that as well.

Part of the project was all about putting together a whole lot of different information and giving that back to communities so some of these community elders and leaders, the police and so forth on their safety committees could use that information and see if some of their programs were working. We put it all together, but unfortunately the report is sitting on a shelf somewhere. But I can table it.

**Mr CHAIR:** That would be nice if you have it.

**Mr STEVENS:** Yes, I have it so I am quite happy to table it.

**Mr CHAIR:** Be good to have a look at it.

**Mr STEVENS:** I have separated it into two. And there are another two volumes.

**Mr CHAIR:** That is one copy.

**Mr STEVENS:** That is one copy of volume one. That explains what the project was about. They were essentially called Community Data Reports.

On top of the interviews and surveys, we also collated administrative data. We had police offences. We had assault, alcohol involvement, family violence involvement around alcohol. We also had general break and enter and things like that. We collected hospitalisation data for alcohol attributable diagnoses, emergency department admissions. We also had school enrolment and attendance and NAPLAN.

In that second bundle you have there are the data reports, essentially. I separated them out. The survey data that was related to crime we put with the police offence data to see how well it matched each other.

It did not completely surprise me, because I have looked at community level data and administrative data sits quite a few steps up here. A lot of people say it is not good enough quality to look at that community level data, but what we found was the coherence between different data sets was very good.

We had wholesale alcohol data. In one of the locations, the wholesale alcohol data went down, assaults went down—perfectly matched. You see that matches up with your hospitalisations and things too. So, that points to the data being reliable.

One of the things we found talking with community residents is they had been crying out for this sort of information for many years, so they can have some real data and information at their fingertips to make their decisions and get an idea of their programs and policies they are running.

**Mr KIRBY:** It was across eight communities?

**Mr STEVENS:** Yes, it was piloted in eight communities …

**Mr CHAIR:** And it never got back to them?

**Mr STEVENS:** No, unfortunately not. So it was quite embarrassing for me personally as a researcher, it was not good for Menzies' reputation and it was not good for the government's reputation either.

**Mr KIRBY:** I just looked at the date of the final report coming in which probably explains…

**Mr STEVENS:** Yes, the timing was pretty bad because we submitted it about a month before the election, I think, when we had the change of government.

**Mr KIRBY:** Were they all dry communities or a mixture?

**Mr STEVENS:** It was a mixture. They were deliberately selected to give a bit of a spread. They are identified in that report that you have. No they are not actually. I have got a list.

**Mr KIRBY:** We are not even going to get through your opening statement before we starting pinging you with questions. But correlations of information that came back? You said you could line up police stats, medical stats and hospital stats. Is that consistent across the different communities—reasonably?

**Mr STEVENS:** There is a bit of nuance that you do need. For example, if you are looking at assault data, the further away from the police station the community is, the less assaults they have. Police make a decision whether they are going to visit a community, whether it is a serious enough assault.

Pretty well all the communities in this study either had a police station or were close enough to a police station where you could use their data. There was one small desert community which is a little bit different to all of them because it mainly had old people living in it – that seemed to be a bit of a declining community.

Interesting though too in that project, we collected information on community problems and gambling was one of those community problems that came up and it was about 50% of people that said gambling was causing problems a bit of the time or more, and it was up around 30% most of the time or more from memory.

**Mr CHAIR:** So this is card-based gaming in communities?

**Mr STEVENS:** Yes, in communities it is pretty well all card-based.

We are being funded by the Attorney-General's department at the moment, myself, someone from ANU and Amity Community Services to—I am pretty well on the evaluation team and we are evaluating health promotion activity or approach to reducing harm in three communities. It is a pilot.

The project is probably not going to be finished until the end of next year I think. Amity are struggling with it. Gambling is a pretty hard space to work with in communities; people are quite personal about it. Essentially by law in the Territory it is illegal but it has been allowed to go on basically. It is a tricky one.

I have a few ideas about that myself which I think I am going to pursue in the future. In the paper that I published about five years ago, I was aware of one Arnhem Land community that were looking at some of those things but it was about reducing harm from card games and what could be done. At the moment there is already a bit of social regulation that goes on with card games in communities.

Generally people will not be allowed to drink for example, and if someone is drunk they will kick them out and say you cannot play. The main issues that seem to be coming up are amongst young mothers gambling and no one looking after the young kids. That would be the biggest one. If there is card gambling in communities, there are things like having it in a set space, making sure that the kids of people playing are being looked after and things like that.

Currently some of these card games, you can have $50 000 in the middle, on royalty days and after tax and things like that. It is an interesting space. I know police get very frustrated at times because they are more or less told by the Attorney-General's department not to do anything about the games.

There are alcohol and drug services out in most communities now and we need to seriously look at getting gambling in with that mix of addictive behaviours because it is pretty clearly causing harm in a lot of communities as well. People are identifying that themselves.

**Mr CHAIR:** Talking about smoking and poker machines before, would smoking and the card games go hand in hand as well?

**Mr STEVENS:** It has not been looked at a great deal. We have researchers at Menzies doing tobacco control work in communities and a new person has come on board doing more alcohol research as well. It is something to look at in the future.

I know it is experienced in places, people will gamble to try and raise money if they have a canteen or club on the community. They will try and gamble to raise their $60 to get their five or 10 cans or whatever they do for the day. There is a bit of a connection there.

Sitting around gambling, you are not exercising. It is a very indolent activity and there is a lot of opportunity cost that goes with the time people spend gambling. If you go to most communities you will see the card games start generally in the mid-afternoon and they can go on for hours. If you go to Tiwi Islands, there are pretty regular card games from about 10 in the morning.

They are one of the communities we are looking it. Amity is working with health promotion there.

**Mr CHAIR:** Bringing it back to the mainland, or the main cities. Have you done anything about the effect of advertising on gambling? In the sense of seeing a huge increase in advertising of gambling everywhere.

**Mr STEVENS:** Mostly that is around your online sports betting and a little bit of racetrack betting as well, which is online as well.

Across gambling, what we have seen in the Territory is pretty well a reduction in the prevalence of most types of activity except for sports and racetrack betting and that is predominantly due to the online aspect of it.

No doubt the advertising has contributed to that. There has not been any research done up here in the Territory but in Victoria and New South Wales they have done a bit around that. Some work of Professor Samantha Thomas. They interviewed children and their parents or carers, at least one of their parents, and found that some of the advertisements lead kids to believe that gambling is safe and that you do not lose your money, when they have these advertisements saying 'cash in at half time and get money back'.

They hear these sort of 'money back' stuff and do not associate it with making a bet that you lose or win. That is coming through in the research, that children are noticing these things.

We have all seen it. The number of ads on television, they have now put the ban before 8.30 but there is still wriggle room around that. If the Territory has any powers to be able to regulate what is advertised here, nothing stopping you from doing it, or is that a Commonwealth thing? I am not sure. I think some of it can be regulated at the state level from what I gather.

**Mr CHAIR:** What about resolving gambling? What do you think is the biggest impediment to us in addressing gambling?

**Mr STEVENS:** I will go back to most harmful form of gambling and it is electronic gambling machines. The previous changes that were made to allow note acceptors on and then increasing the cap as well, which also happened in 2015. Pubs went from 10 to 20 machines and clubs went from 45 to 55.

These decisions were made with zero consultation with anyone. No academics, no counselling services, no community, no one. There is a bit of an issue there around the way these decisions get made that affect the general population in a big way.

Currently, the NT does have a responsible gambling committee but is made up of about eight industry representatives, one government person and two counselling services. I have asked a couple times to be on it but I do not hear back. I have presented to that committee once… they seemed really happy to hear what I had to say.

**Mr CHAIR:** Yes.

**Mr STEVENS:** I guess on that responsible gambling committee coming back to the sort of the language we use when we talk about these things as well—these are industry-made up words, 'responsible drinking', 'responsible gambling'.

This is what industry comes up with. It places all the emphasis on the individual. They do not call it, 'responsible gambling awareness week' in Victoria anymore; they call it Gambling Harm Awareness Week.

I think changing the language is important, getting rid of these 'responsible gambling committees' and referring to it as a 'harm reduction committee'. I will not deny that industry needs to be at that table, but they need less representation and more representation from the other side.

Accessibility—do people need to be able to play pokies from 10 am to 2 am or 4 am? That is questionable. We have these clubs staying open until 2 am with four people in them, playing pokies. It is profitable. We know that those four people are very likely at that pointy end of experiencing and causing [gambling-related] harm.

I think more general advertising about the harm gambling causes is also needed. We have had some pretty hard-hitting campaigns around alcohol and drink-driving over the years. I think something similar could be done for gambling. If people are experiencing issues with their gambling or because of someone else, I think these sort of programs will reduce stigma around getting treatment because it will be understood that this happens to people.

It is interesting that there is more research coming out now about gambling—like I said, a lot of the harm is occurring not only to that problematic gambler experiencing harm. A lot of other people are experiencing

harm as well. They estimate between five and 10 people are negatively affected by the 1% of the population at the extreme end.

In my research in this last survey I did, we found that there are 25 000 adults in the Territory who have been negatively affected by someone else's gambling. It is probably a bit higher in the Territory compared to other jurisdictions, partly because of our Aboriginal and Torres Strait Islander population, which has bigger kinship networks and things like that—and just generally there is more social and economic poverty and things like that. There are more issues along the lines of, if someone loses money, there is more borrowing of money and things like that.

**Mr CHAIR:** What about internet betting, including for the races? What is the impact of internet betting on gender balance in gambling?

**Mr STEVENS:** Interestingly, I think more females are partaking in racetrack and sports betting through online betting.

**Mr CHAIR:** There is a new market for them.

**Mr STEVENS:** Yes. It is a little bit of a new market, because I guess in the past most women did not want to walk into a TAB, for example. They were 'men's spaces'. I think that kept a lot of females away. I think when that female jockey won the Melbourne Cup it made a difference as well.

I have not personally done a lot of specific research into it. We have information on it from the 2015 survey. We tend to find the type of things people bet on is associated with their risk of harm from gambling. If you have multiple options to bet then people who chase it tend to use all those different options. They will bet online, go to the TAB and do it wherever they can.

There are certainly levers. I think the Commonwealth are looking more at them. There are some Commonwealth levers to make sure the companies—they have their own algorithms.

There was a case recently where they fined Betfair, I think, quite a decent amount of money—$150 000 or something. Maybe they made it give back $150 000 to a guy they had taken money from. They used the term, 'red flags'. I guess this is in our code of practice. It is called the Code of Practice for Responsible Gambling. A name change would be good. They have a separate code for, essentially, pokies versus online and racetrack betting.

They are currently reviewing… someone from ANU is reviewing the pokies Code of Practice at the moment. I have done a submission to that. We do not need to talk too much about it …

**Mr CHAIR:** Fair enough.

**Mr STEVENS:** The whole legislation around that space is a bit weak. I reported a venue because I saw a guy playing three different machines at once, some months back. You have to remember these are games of chance. Playing three means you are losing three times as much money—your money – three times more quickly. I pointed this out to the gaming manager and they did not like it. I ended up being told to leave …

**Mr CHAIR:** Warned off.

**Mr STEVENS:** Yes. Anyway, they did speak to that. The legislation actually says it is up to the gaming manager if someone wants to play more than one machine. To me, that is just crazy. The *Gaming Machine Act* needs changing.

**Mr CHAIR:** Sandra, do you want a bit each way on this one?

**Ms NELSON:** Ha, ha, funny. No. In fact, it was interesting. I was with a group of senior citizens this morning and we talked about the select committee and harm reduction strategy and everything we talked about today. One of them raised gambling addiction as an issue. She talked about elder abuse related to gambling addiction …

**Mr STEVENS:** Yes.

**Ms NELSON:** Go ahead.

**Mr STEVENS:** It has not come up specifically when I have been talking to people about gambling when I am out in communities. I have heard anecdotally that older people, because they are on that more regular pension, as opposed to someone on CDP and unemployment benefit.

The other is people mentally not there being taken advantage of in communities with the card games and are dragged into card games knowing they will lose. That is anecdotal, it has not come up specifically.

**Mr CHAIR:** It does not only happen in communities.

**Mr STEVENS:** No, not at all. I image it does all over the place.

**Ms NELSON:** The other thing they raised when I was talking to them was that legislators, government and all of that tend to put so much focus on finding harm minimisation strategies for addiction to drugs and alcohol, and we sometimes forget about the gambling addiction. At the end of the day, the reason why people are addicts is pretty similar across the board. You are an addict for a reason.

**Mr STEVENS:** Yes, certainly …

**Ms NELSON:** People do not consider gambling addiction in that conversation.

**Mr STEVENS:** Which comes back, I guess, the difficulty in getting Health to take it up as a serious issue.

The latest ICD coding, which is the type of coding they use in hospitals, includes addictive behaviours. I do not think the latest one is used by Health up here yet, but they will go to it at some point. There is the World Health Organisation which puts that together has recognised that.

Interestingly, some of the research looking at brain scans shows that it is exactly the same chemicals going off in a drug addict or a gambling addict. So, there is no difference. Humans are addictive by our very nature. Most of the time, those addictions are healthy—go to bed early, eat well, do a bit of exercise. We get a buzz from doing those things.

**Mr KIRBY:** The changes you spoke about to the amount of money you can put into machines. Is there enough data to suggest improvements or any positive changes from that? Or would it be really hard to quantify? I guess it is easy to assume. There must be benefits.

**Mr STEVENS:** Benefits and harms. The benefit is there is more money available for the small community grants that the Community Benefit Fund distributes. They are up to $10 000 for your Greek clubs, netball clubs, soccer clubs and so forth. There is maybe a little more money going around for sporting clubs.

**Mr KIRBY:** You were saying what states had regulated the amount of money you could put into the machine at one time …

**Mr STEVENS:** Yes.

**Mr KIRBY:** … Queensland being $100. Would there be any quantifiable data to show that …

**Mr STEVENS:** That causes less harm or more harm?

**Mr KIRBY:** Or just a dollar figure intake at the end of the day do you think?

**Mr STEVENS:** We can have a look. Part of it depends on the saturation of the market as well. Since the increase in machine numbers up here, even though the revenues and player losses are still going up, the money loss per machine has dropped because suddenly pubs have got double the machines. It will creep back up again.

The NT is actually very high in amount lost per machine compared to New South Wales and Victoria—Victoria is about $40 000 or $50 000. In the Territory, the top 10 performing pubs are making about $120 000 per annum, per machine. That compares to about $70 000 per annum per machine for the casino, and the top 10 clubs are up around $90 000. I have the data here somewhere. That gives us a measure of intensity.

We also know that venues where they have a higher loss per machine have more problem gamblers, people experiencing harm from gambling. It is a way… if regulators wanted to do a bit more unannounced observing in venues and actually start regulating and enforcing the code which is enforceable.

The data availability, the last three years, the Director-General's report that comes out is reporting less information about venues and losses and numbers of machines. In fact, they do not report any numbers for venues anymore. They just list the top 10 in terms of losses. I do not know the reasoning behind that change was.

My understanding of the electronic gambling machine legislation is that it was deliberately designed so this stuff was publicly available and reported annually. It is interesting that those changes occurred around the same time that they put the note acceptors in and changed the cap as well.

I managed to get some data from them though, so they do make data available but it is not regular and they used to report it.

**Mr CHAIR:** You have to know it is there and go asking for it.

**Mr STEVENS:** Yes. I looked at it as machines got note acceptors; it did not happen all in one go. What you find is that your bigger venues that already had 45 machines, or your pubs that already had 10, were the ones that switched their machines the quickest and put the note acceptors on and their revenue started going up.

**Mr CHAIR:** I think you have covered the field.

**Mr STEVENS:** I have covered a bit.

**Mr CHAIR:** You can tell us anything more that you think we need to know.

**Mr STEVENS:** General. Around the decriminalisation of illicit substances. I totally agree with Professor Lee that it will reduce harm. Criminalising personal use of these things is worse than the harm that comes from most of these drugs.

On cannabis, I think it is really important to get the legislation right because at the moment we have personal use, two plants, 40 or 50grams, but if someone grows two plants and they harvest it, they are going to end up with about 500g. Then you are counting a plant that is this big against a plant that is six or seven foot, weight versus dry weight. There is a lot more nuance that can go into cannabis decriminalisation legislation anyway so it is important that they get that right so it works properly.

**Mr CHAIR:** Thank you very much for that.

**Mr KIRBY:** Thanks for this report. I am pretty sure we will be looking at that executive summary as soon as we can.

**Mr STEVENS:** You have got a copy of a PDF of volumes two and three and I would suggest having a look through some of volume two, which is the qualitative, key informant interviews with residents. It has some really fascinating insight into harms and barriers to why alcohol is causing a lot of the issues in communities.

**Mr CHAIR:** Thank you.

## NORTHERN TERRITORY AIDS AND HEPATITIS COUNCIL

**Mr CHAIR:** Welcome.

I am Jeff Collins and I am the Chair of the Committee and Member for Fong Lim. Paul Kirby is the Member for Port Darwin and the ethereal voice on the phone is Sandra Nelson the Member for Katherine.

**Ms NELSON:** I do enjoy your introductions Jeff, I must say. Thank you.

**Mr CHAIR:** Welcome to the committee Kerrie Jordan and Peter Sidaway. Thank you for coming to us and we appreciate you taking the time to speak to us 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 apply.

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

That being said, for the record can you state your names and the capacity in which you are appearing?

**Ms JORDAN:** My name is Kerrie Jordan and I am the Executive Director of the Northern Territory AIDS and Hepatitis Council. I will tell you a little bit more about myself and my background when we come to do our introductory remarks.

**Mr SIDAWAY:** Peter Sidaway, I am the Harm Reduction Coordinator for the council. I manage the three primary NSPs in the Northern Territory.

**Mr CHAIR:** Would you like to make an opening statement?

**Ms JORDAN:** I had not prepared a long introductory statement because I think that we can probably get the most out of questions and answers in terms of what we have to feed into this inquiry.

Thank you for carrying out the inquiry. It is really heartening to see that consideration is given to harm reduction given Professor Lee and other people who are contributing in an academic capacity have probably given you plenty of data and evidence. I am not going to do as much of that as talk more about personal experience.

The Northern Territory AIDS and Hepatitis Council is a peer driven organisation. Our programs are staffed by people with lived experience of injecting drug use, when we are talking about our harm reduction program. When we are talking about our care and support program, lived experience of living with HIV and viral hepatitis. In terms of our sex work program, we have peer sex workers working in the program.

We are a peer led program and that gives us a bit of a competitive edge because we not only bring our own knowledge that is learned in a similar way through universities and other educational institutions, and learnings that we have learned of the job, we also bring our personal experiences. That is an expertise that only we have and an expertise that cannot be replaced by academics or other people contributing to this debate.

I wanted to make that point. I personally have, a long time ago now, lived experience of injecting drug use and most of the people that are working in our harm reduction program also have lived experience. We are talking from a personal, professional and academic perspective and shining a different perspective and light on this topic.

One of the things that Professor Lee talked about when she was addressing the committee was the National Drug Strategy and its three pillars; harm reduction, supply reduction and demand reduction. They go together hand in hand and should be given similar weighting—certainly different weighting than I think they currently have at the moment.

As Professor Lee stated, only about 2% of the funding under the National Drug Strategy goes into harm reduction—that is a major oversight and something that seriously needs addressing—with 66% being directed into law enforcement.

If you look at the Portuguese model of partial decriminalisation, they are still working in those three pillars, although it is not articulated through a national drug strategy such as ours. They are still working within those three pillars, but they give a much greater emphasis to the harm reduction side. They have actually shifted resources from the law enforcement side of the equation and put those into both treatment and harm reduction programs. The balance in resourcing the different elements of the strategy is somewhat different to what we have in Australia at the moment.

The data coming out of Portugal is testament to the fact that decriminalisation works and a greater emphasis on harm reduction and a lesser emphasis on law enforcement is working well in (1) the patterns of drug use in Portugal and (2) the harms associated with drug use in Portugal. That Portuguese model is working very well and I advocate it being picked up as a pragmatic response in other jurisdictions such as the Northern Territory and, potentially, other parts of Australia and the world.

The part of the Portuguese model that is not working so well for people who are using drugs, and injecting drugs in particular, is that supply of a substance is still illicit. People who are using drugs are still subject to the harms and vagaries of that black market. When you do not know what you are buying, there can certainly be problems and harms associated with buying a product that is adulterated with substances that are harmful.

We are seeing in the US and Canada a huge issue with the contamination of opiates such as heroin with fentanyl, with some very serious overdose problems. I cannot see why that will not happen here eventually. That is very frightening and take-home naloxone and peer distributing naloxone is one of the answers or strategies we could be using to overcome that problem.

Putting aside the potential for street drugs to be cut with fentanyl and other dangerous substances, there are still a lot of things we can do in reducing the harms associated with any kind of drug use, but injecting drug use in particular. It would be really useful to expand the remit of harm reduction programs, and needle syringe programs in particular, to engage with people who are not injecting.

For people who are smoking methamphetamine, for example, distributing pipes is a way of starting to have a dialogue with people who are still using substances and experiencing the harms of those substances, but not injecting substances or necessarily engaging with the programs we currently have in place.

I will stop there. That was a general introduction. If Peter has anything to add to that, please do.

**Mr SIDAWAY:** No, that is very good.

**Ms JORDAN:** That was, more or less, a general introduction and a bit more detail in some of the issues that I have heard being raised today. I thought it would be really useful for you to ask us some questions following from that.

**Mr CHAIR:** We have some questions we have pre-prepared. I might not go onto those, because listening to your opening, you have raised a few things I would like to talk to you about.

**Ms JORDAN:** Sure.

**Mr CHAIR:** You mentioned naloxone and peer distribution. How does that work?

**Ms JORDAN:** Naloxone is currently a Schedule 3 …

**Mr SIDAWAY:** Three and four.

**Ms JORDAN:** Three and four medication. The only way we can distribute naloxone is through a chemist so the only people that are allowed to physically hand over naloxone to someone is a chemist, a nurse practitioner or a medical practitioner.

**Mr CHAIR:** Under a prescription?

**Ms JORDAN:** Not necessarily under prescription. You can go into a chemist and buy it but it is often prohibitively expensive. We run a naloxone program. We will do a brief intervention in the Needle and Syringe Program setting. We will take someone aside, we will do some education and information on how to recognise an overdose, how to respond in the first instance to an overdose, how naloxone works and how to use it.

We deliver that part of the program and we will give people a package of all of the equipment they need but we then need to send them over to the chemist to collect their naloxone, which is just another step in the process and another barrier to getting that naloxone out there.

**Mr SIDAWAY:** The bottom line is we cannot hand it out ourselves. We purchase it.

**Mr CHAIR:** So you are the peer that you are talking about, your group and groups similar to yours.

**Ms JORDAN:** Yes, potentially. A number of local health districts and academics have got together in New South Wales and attracted an NHMRC grant to trial a different approach; an approach that allows the distribution of naloxone through the NSP.

A peer or non-peer worker in a Needle and Syringe Program setting can do both the brief intervention on naloxone and also hand out the naloxone. So that gets the naloxone straight out there without any further steps in the process and without any further barriers to distribution.

**Mr CHAIR:** And naloxone is a good alternative for which drugs?

**Ms JORDAN:** It will reverse an opiate overdose. We are talking about heroin, prescribed opiates such as oxycodone…

**Mr SIDAWAY:** MS Contin…

**Ms JORDAN:** …morphine sulphate et cetera. So any kind of opiate, it will reverse an overdose.

When we are talking to people we talk about poly-drug use, so if people have got other drugs in their system that are contributing to an overdose, so a central nervous system depressant such as Valium and the like… it will not reverse an overdose of Valium. So it can sometimes be partial acting.

There are a whole lot of strategies that we put in place for teaching someone how to deal with those issues at the same time. One of them is, regardless of the fact that you are administering naloxone, we still recommend that you call an ambulance. An ambulance still really needs to be involved if there is alcohol or any other central nervous system depressants on board.

**Mr CHAIR:** Talking about Portugal and the supply. That is always going to be a problem in a system where… any decriminalisation system where you are not actually taking that step to legalisation, so those levels remain illegal so that is always going to be a difficulty.

It struck me though, while you were talking about it, we had AADANT here this morning and brought up the issue of pill testing and it was brought up by others as well. It is something I particularly support. That is in a music festival context but what about the possibility of organisations like yours having a drug testing type unit? So somebody could go along and they could check whatever drug it is that they are using.

**Ms JORDAN:** That would certainly be a feasible initiative. We would have both the expertise and the capacity to do something like that.

**Mr CHAIR:** So provide the information about what is included, what the likely effects are, any contaminants. Like pill testing, anytime somebody is prepared to come forward to get something checked then the likelihood is that if there is a contaminant in it, they are not going to take it. This is my belief. They are not going to take that drug. They might, you cannot stop them.

**Ms JORDAN:** Yes. Or they will play with dose so that it is down to a level that is tolerable. But with information people can make those choices about dosing et cetera.

**Mr CHAIR:** It is anecdotal but I was speaking to Matt Noffs about the pill testing trial in Canberra back in March. He was saying that one of the things they got from that was a lot of information about the distributors of the pills that had the contaminants in them. So it is sort of a de facto quality control on the black market.

**Ms JORDAN:** Absolutely. It seems to me that we are now operating in a context where people are thinking more about these issues and are giving more thought to stronger harm-reduction approaches to manage drug use and other dependency issues.

We are a little uncomfortable with the word, ‘addiction’. It has a range of negative connotations that do not sit comfortably with us. We prefer to use the word, ‘dependent’, or, ‘dependency issues’.

**Mr KIRBY:** This is more a comment than a query, but I think Jeff is probably right. People heading into a festival may still take—or they may take a reduced dose. If they have that information that will play on them… at some stage it will have to play on them about what sort of toxins are in what they are taking. Any ability to test and give people a risk-free option to have their substances tested will have to get some gains.

**Ms JORDAN:** We are in the game of giving people as much information as we can to assist them to make an informed choice around their drug use. The more information, the better.

**Mr CHAIR:** It is power.

**Mr KIRBY:** I guess you would see decriminalisation as an extension of that, giving people more ability.

**Ms JORDAN:** An extension of disempowerment of people who are using drugs. People have been using drugs since time immemorial. Prohibition has not had a huge impact on the amount of drug-taking in a community. It has not worked.

**Mr CHAIR:** I would suggest that is probably correct.

**Ms JORDAN:** Possibly. It has been an abject failure, which I think is being recognised more broadly and by prominent people in the community. They are coming to the conclusion that the war on drugs is not working.

**Mr CHAIR:** That has pretty much covered all the questions we have pre-prepared. Thank you for being succinct. You covered everything.

We have heard a bit about safe injecting rooms today. We have a relatively small population of injecting drug users, but that is not to say something like this would not be important anyway in the Territory. We get that. Thinking of those, how can we be more effective in the Territory? We have needle and syringe programs; how can they be more effective?

**Ms JORDAN:** Yes, we have needle and syringe programs. The literature shows they give a really good payback in terms of return on investment. A few years ago a return on investment study was done that showed for every $1 invested in needle and syringe programs, the state will get $4 back in savings to the health system. I cannot remember who wrote that report—the Kirby Institute. It is broadly available.

In terms of how we can improve our needle and syringe programs, I think we could do much better in remote areas. I am not sure whether you are aware, we recently did a trial of after-hours dispensing units, which has been incredibly successful.

We have a unit in Darwin, Palmerston and Alice Springs. The Alice Springs unit is near the emergency department in the hospital. That is a really cost effective way of getting equipment out there and it is anonymous.

People who have concerns about being identified as an injecting drug user, even walking into a program like ours where we are incredibly welcoming, completely non-judgmental and share some kind of history with the person accessing our services… there are still barriers to accessing our services because of stigma and discrimination of injecting drug use.

The dispensing units are a really good way of getting equipment out there and it would be a great mechanism to get into remote areas. I did want to mention Aboriginal people who inject drugs. In Alice Springs, 50% of people that use our Needle and Syringe Program are Aboriginal and Torres Strait Islander, and 30% of the people that use our needle syringe program in Darwin are Aboriginal and Torres Strait Islander.

People on communities are injecting but because of the shame, stigma and discrimination, it is kept very quiet and tends to go under the radar. That does not mean there is not a need for equipment in remote areas.

The after-hours units offer a cost effective mechanism for expanding the reach of Needle and Syringe Programs into remote areas.

**Mr KIRBY:** Are you saying there is a unit in Darwin?

**Ms JORDAN:** There is one in Darwin.

**Mr KIRBY:** Where is that located?

**Ms JORDAN:** It just around the back of our building. The Darwin and Palmerston ones are adjacent to the buildings that we operate from. The Alice Springs unit is an exception, it is near the emergency department in the hospital.

**Mr CHAIR:** Do they operate 24 hours a day?

**Ms JORDAN:** Yes, 24 hours a day. With any kind of initiative we have got to choose a type of a machine and there are strengths and weaknesses of different machines. They are a great way of getting equipment out there.

The other thing that I mentioned is expanding the remit, if you like, of Needle and Syringe Programs to be more of a broad based harm reduction program so that we can better engage with people who are not injecting around harm reduction as well.

In terms of alcohol, we work with a lot of people who are experiencing problematic alcohol use. Not necessarily through the Needle and Syringe Program but through our other programs and we do a lot of harm reduction in that space.
It might be, if someone has diabetes we will have a conversation with them about sugar free alternatives, low carb beer that does not have as much sugar in it. That is a harm reduction measure and it comes out of a conversation that we are having day in and day out with the people that we see.

It would be really useful for us or others like us to do more workforce development within the alcohol and drug sector to make sure that harm reduction is seen as a useful strategy alongside and not competing with abstinence based strategies. I would like to see those alcohol and drug counselling and treatment services thinking more about harm reduction.

**Mr CHAIR:** Just on the medically supervised injecting centre, where would you recommend if there was to be something set up, what would best suit the Territory?

**Ms JORDAN:** We see most of the injection of opiates, in particular, in Darwin and Palmerston.

I would say the Top End would be the best site without having done a lot more research. I could certainly go and have a look at our Needle and Syringe Program statistics to give you a bit more information on that should you wish to get that information from us.

We move a lot more equipment through our outlets in the Top End than we do in Alice Springs. I think it would be worthwhile doing a small trial. We talked earlier when you were talking to Professor Lee about the high cost of medically supervised injecting centres. When we look at New South Wales, they have chosen the Rolls-Royce model, I have worked there so I know the service really well.

**Mr CHAIR:** It used to come from New South Wales, it was very problematic at the time.

**Ms JORDAN:** It was at the time, yes. But it is a really well accepted service in the community now and it has really provided some positive benefits for the local community of Kings Cross in particular.

It is a Rolls Royce model. They have three sections. There is a registered nurse in each section. There are health education officers in each section. They have counsellors and mental health workers. If we looked at a lower cost option and could do a lower cost option, taking into account all of the risks and managing all of those risks, we could certainly do a peer-led service.

If you had a peer-led service, staffed by peer workers and only one nurse in the service—because there has to be a nurse to administer naloxone at this point in time—a peer-based service would be a much lower cost option in relation to what they have in New South Wales at the moment, and also what they are currently implementing in Victoria.

There are different models. The medically-supervised model has been chosen because it is a politically safe alternative. You have nurses, the risks are managed, but there are ways of managing those risks with other kinds of models.

**Mr CHAIR:** Okay. That will be interesting to hear. Anything else?

**Mr KIRBY:** I think we have covered everything. That is great.

**Mr CHAIR:** It has been really informative. Thank you very much.

**Ms JORDAN:** Thank you. We are always available. If you need any further information, please let us know. We can dig into stats if you want to dig into stats—NSP …

**Mr CHAIR:** That would be great.

**Ms JORDAN:** … and whatever you need from us. We are happy to provide because we are really pleased that the Northern Territory government is giving harm reduction a hearing.

**Mr CHAIR:** Thank you very much. As I said, thank you for your input.

**Ms JORDAN:** No problem. Thank you.

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The committee suspended.

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**CRIMINAL LAWYERS ASSOCIATION OF THE NORTHERN TERRITORY (CLANT)**

**Mr CHAIR:** Are you there, Sandra?

**Ms NELSON:** I am here.

**Mr CHAIR:** Excellent. Mr Aust.

**Mr AUST:** G'day, how are you?

**Mr CHAIR:** Good mate. Yourself?

**Mr AUST:** Excellent.

**Mr CHAIR:** I have to go through the spiel.

Welcome to the public hearing into reducing harm from addictive behaviours. 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 apply. It is a public hearing and is being webcast through the Assembly's website. A transcript will be made available for use by committee and may be put on the committee's website.

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

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

**Mr AUST:** My name is Marty Aust. I am here as the President of the Criminal Lawyers Association of the Northern Territory.

**Mr CHAIR:** Thanks, mate. You are free to make an opening statement.

**Mr AUST:** I suppose our opening statement is we are grateful for an appearance at this hearing. We stand by the submission we produced in writing that was nine paragraphs.

We acknowledge that the criminal law is really a peripheral issue in some respects, to the greater and broader nature of this inquiry. However, there is an absolute link that cannot be denied between addictive issues, particularly drug and alcohol addiction, and ultimately the criminal justice system.

What we are hoping to achieve, and what we acknowledge as the Criminal Lawyers Association, is by the time you are in the court system, the horse has bolted. What we want to try to do is have fewer people in the criminal justice system by addressing these issues earlier.

For the ones who do ultimately slip through the cracks, we want to set up a system in which the criminal justice system acknowledges addiction as a health issue primarily and, as a consequence, finds a more therapeutic and needs-based approach to dealing with people who offend, where the underlying issue is an addictive issue.

**Mr CHAIR:** Thanks, mate. We have some prepared questions, which may lead to conversation that may go in other directions. You alluded to, at the end, other forms and ones who slip through the crack. You spoke in your submission about Alcohol Court, SMART Court and credit and bail programs. Can you explain those?

**Mr AUST:** Yes. What I have said is an aspirational idea for those who slip through the cracks.
At the moment, the court's hands are tied. We do not deal with offences in which the underlying cause is a health issue such as an entrenched alcohol or drug addiction, we deal with the result of that addiction and the community sees that assaults are up, property offences are up and the community wants the government to be tough on crime.

The Criminal Lawyers Association would pose the question to the community: do you want to be tough on crime? Or do you want to try to reduce and ultimately, as far as possible, prevent and end crime? To do that, what you need to do is not lock people up and leave them in prison and then they get out and there is no change whatsoever to their behaviour. Noting of course that you are dealing with people with entrenched issues.

What you need to do as best you can is educate and address those issues and deal with it in a therapeutic manner which promotes those individuals not reoffending. For instance, specialist courts might take the form of a court where somebody has committed an offence that is related to alcoholism or they were significantly intoxicated at the time of committing an offence.

Now that court, rather than, for instance—this is probably not the best example—a man or a woman gets drunk, one of them pushes the other, the other pushes them back, the police are walking past and see that and both parties are charged with assault. They are both drunk. If they have a prior conviction at any time, whether it be 30 years' prior, the starting point is that they both go to gaol for three months.

What we want to do is say, how about we go to an alcohol court where rather than sending these two individuals to gaol for at least three months where they will not have access to any programs – and any programs that are facilitated will not be in their first language… where there are no Indigenous liaison officers anymore—and send them to a court where the court will look at the behaviour, get medical records and information as to the nature of the health status of each of those individuals and put together a plan in conjunction with alcohol and other drug counsellors and perhaps with a residential rehabilitation type scheme.

Rather than sentence someone to gaol, sentence them to rehabilitation or a therapy-based sentence within the community on the basis that, hopefully, they will be able to complete that. If they fall off, or do not finish what the initial treatment regime is, they can come back and touch base and work out where it went wrong, focus again on that, send them back out to complete that therapy or keep recalibrating to get them on the course. Ultimately the hope is that they do not come back.

**Mr CHAIR:** Tell me, are you saying that aspirational or gold standard or whatever… but we had a SMART court operating here for a while… it is no longer, is it?

**Mr AUST:** No, it does not exist.

**Mr CHAIR:** That was under…

**Mr AUST:** Hannam, I think.

**Mr CHAIR:** Yes. Would there not be enough work in the criminal courts at the moment to warrant, if you are taking that work out of the current local criminal court, to fill a whole court on its own?

**Mr AUST:** It would but the way that it would sit and the way it has sat, is that it is really just another list in that court. So nothing changes.

For instance, the way the local court sets up in the criminal jurisdiction, on Mondays and Fridays there is a list for domestic violence order applications. Most of those, you would not be surprised to hear, are non-contact when intoxicated type orders. They are the ones that are almost always breached when someone comes before the court with a breach.

There is that list on a Monday and Friday. In court three and probably court one, you have the general list. In court four, you have hearings that are running. In court two you have the mental health diversion list, which is up and running, under Chief Judge Lowndes.

On Mondays and Fridays you have the directions hearing list, which is an administrative list to move matters towards hearing dates. On Wednesdays you have a PEM list, which is for committals, matters that might need to go to the Supreme Court.

There are multiple courts sitting at any time. It is readily achievable to just have legislation in place that allows a departure from the current sentencing regime without re-budgeting it as a smart court, or calling it anything other than the local court. Accordingly you could have a smart court list or an alcohol court list.

**Mr CHAIR:** But it will not take away from the resources that we currently have available.

**Mr AUST:** No. You are not creating more work; you are just doing that same work in a different way. You would create more work in terms of the requirements for court clinicians for staff to assess the needs of the individuals for liaising and setting up conduits between the relevant services that are hoped to be connecting with the court process. Like everything in this world, it will cost money, but you save it in the long run.

**Mr CHAIR:** That is the bottom line.

**Mr AUST:** You save an enormous amount in the long run, not just money but people's lives.

**Mr CHAIR:** Alright. Chief Judge Lowndes is a supporter I believe.

**Mr AUST:** I cannot speak for Dr Lowndes but I was at a criminal justice forum on Tuesday morning and we were discussing different options moving forward, including specialist courts, community courts and things of that nature. It sounded like if we had the money we would do it.

At some point it is not what you want to do, but what you need to do.

**Mr CHAIR:** That is right. What about Alice Springs? What is the court list like there?

**Mr AUST:** My understanding is that the court list is similar except that they do not yet have that mental health diversion list.

There are processes that the list—there is a connection to this addictive type scenario, because a lot of people who have an entrenched drug issue find themselves in touch with the criminal justice system or are alleged to have committed offences, or have committed offences.

When they are mentally impaired, mentally disturbed or are in a situation where they are not necessarily accountable to the same standard as if they were not labouring under a mental health issue… often that mental health issue is connected to that drug use.

Alice Springs is labouring in the same way as Darwin under what might be deemed the scourge of addictive or health issues that lead... My strong belief is that—I do not want to get ahead of ourselves—some offences that people commit are not going to be the types of offences that a SMART court or an alcohol court will be able to deal with.

People sometimes, for what they think at the time is a good reason but generally never for a good reason, commit horrendous crimes. They are not the matters we are dealing with. What we are talking about is unfortunately common, run of the mill, day to day, what might be described as lower end, but of course any assault of any nature is a serious matter. Mr Gunner and the government have called it antisocial behaviour type offences that arise in that context.

There is not legislation in place that deals with those head on. We have the Alcohol Harm Reduction Act, which was the 2017 legislation that came into play and reintroduced the Banned Drinker Register and Banned Drinker Orders. That is something that has the potential to meaningfully assist in addressing addictive issues.

If you read it—I have brought it here today and I have gone through it time and time again—contrary to what is being asserted by the Attorney-General and the Minister for Health from time to time, there is no therapeutic aspect to that legislation.

That is not me being critical, necessarily, or being critical for the sake of being critical. The people that are charged with offences and placed on the Banned Drinker Register and issued with a Banned Drinker Order, do not have recourse, as a direct result of that occurring, to rehabilitation or pathways to rehabilitation.

There is some scope for people who are the subject of another person making a report to the registrar in circumstances where they might appear before a family court type scenario, having issues with access to children, welfare dispute or something of that nature where they might have the ability to go before the

registrar of their own volition and engage in some sort of therapeutic progress to keep them off the order or avail them of access to their children.

For somebody that is picked up on a drink driving matter or on any sort of offence, they are not assisted towards any sort of therapeutic pathway and if it is an offence that attracts mandatory sentencing in some way, shape or form, they are off to gaol.

**Mr KIRBY:** There used to be—I am not sure if it was for high range drink driving that you had to do an Amity program? I think it was only a one day or over a series of days.

**Mr AUST:** If you commit an offence in which you are under the *Traffic Act* and where your licence is disqualified, in order to attain your licence again, before you can get your licence, you have to undertake the drink driver course. This still happens, which is good.

A problem associated with that is unfortunately, often people who have their licence disqualified may not have a licence in the first place and those who find themselves within a particular demographic or coming from quite a disadvantaged background and having a low socioeconomic environment or situation, they might not have the money. You have to pay for the drink driver course. They might not avail themselves with that opportunity simply because they cannot afford it.

Of course, driving unlicensed is not necessarily a serious offence. It is not an offence that would attract gaol. But driving whilst disqualified is seen as a very serious offence that almost certainly has a starting point of gaol.

**Mr KIRBY:** Yes, I was just going to raise that as I wondered if you want to call that a therapeutic program. But you are saying under banned drinker orders, there is no automatic trigger to say, 'You are now in this situation. This is where you go for help'.

**Mr AUST:** That is right. As part of the submission—I do not know if you have the submission before you—it was number eight. This was all a talking point, really, just as starting a conversation and looking at where we have some things in place that look like they have the potential to lead to something. How do we join the dots and get things moving?

Sometimes, on a day-to-day basis, it takes a second or third set of eyes. A lot of people have really good ideas and get that starting point, but we have seen that there has been some negative flow-on effects from the Banned Drinker Register. That does not mean you scrap it—that means you make it work …

**Mr CHAIR:** You have a look and make amendments.

**Mr AUST:** Yes.

**Mr CHAIR:** Yes, you see where it is not working and you …

**Mr KIRBY:** Yes, and certainly some of those were predictable but not to an extent where you could implement any of the changes necessary to avert some of those flow-on effects.

**Mr AUST:** What it has done, I suppose, is really drawn to the surface this significant issue we have always known is ever present – alcohol-related harm in our communities. Maybe it is giving us an opportunity to address it head-on now.

**Mr CHAIR:** Yes. I take us back to the SMART Court and the like you were talking about before and the fact that there are some offences that are committed that will recur. In conversation with someone, somewhere along the line—it may have been Rob Park from the AMA—about the two different types of offences ... You have offences that are committed because of the addictive behaviour—drug taking, alcohol or whatever—and then you have other offences that are committed but there is an associated drug or alcohol element but that is not the—yes, not that.

Where would you see that the determination of that position? If you are dividing up people to go into a SMART Court or the normal court, would you have some sort of clinician to assess that early on, or would that be an early directions hearing in the process to determine …

**Mr AUST:** My recollection of the last—because we had the Alcohol Court and then we had this SMART Court. It needed to have a quality of factors that enabled it. One of them was—at that time under the old

SMART Court—a matter that could not be a strictly indictable matter, which means it is not a matter—the jurisdiction is within the Supreme Court.

That is a reasonably arbitrary way to do it, because there are some examples of offences that might go to the Supreme Court that could be dealt with, potentially, in a more therapeutic way—often drug offences.

The serious violent offences that fall within the Supreme Court—homicide matters—often, if not always unfortunately, alcohol or drugs are involved in those matters. You would not think that would fall within something like that, because people are looking at very long sentences.

Also, if somebody has a sentence of well in excess of five years, they generally have a much better opportunity to get some sort of meaningful rehabilitation within the prison system. At the moment, for instance, if you commit a violent offence and you get a non-parole period fixed, you have to undertake an intensive violent offender course in order to be released on parole.

At the moment, the waiting list is about 18 months. If you get a three year sentence, but you are on remand for a year, then they fix an 18 month non-parole period, so strictly you are eligible for parole in six months, but you are not. In fact, you will never get parole. You will do your three years and you will come out with nothing because you simply cannot achieve the prerequisites to make a parole application that has any chance of success.

I would like to see—and this is always a little bit contentious because often matters in the Supreme Court where somebody is driving a vehicle and they cause serious injury or death to another person and inevitably there is alcohol or drugs involved by the driver, very regularly sentences imposed look to address those issues.

Often people get fairly stern sentences of imprisonment from three to five years but sometimes they are fully suspended or there is only a very short period… those types of offences, people who offend in that way, my belief is that sort of offending could fall within that umbrella. They have taken the same risk as somebody that might go drink driving and does not crash into somebody. It is only by sheer luck. Our road toll is horrendous as it is, we are all aware of that. The Northern Territory has a shameful road toll and there are many reasons.

There is a need, in many respects, to not limit the offences to which therapeutic courts could access offenders. Before it has just been limited to the Local Court or what used to be the Court of Summary Jurisdiction.

**Mr CHAIR:** I might have a chat with you later on when we are looking at making some final submissions about that sort of thing. Diversionary programs: which ones do you reckon are most effective?

**Mr AUST:** The diversionary programs are an interesting situation because police have generally been heavily involved in driving those programs and they can be really good. It seems like at the moment, Territory Families is also trying to become heavily involved and that is something of a—power struggle is the wrong word.

I think everybody wants to be moving together but they each have their own ideas and of course it is hard to implement because a lot of youthful offending happens in communities as well. There is a bit of a disconnect between relevant departments and the police department in what the best approach is.

You also have this situation where you have police diversion at first instance for some offences, other offences a child might get charged and the court orders diversion and so there are different types of diversion. We at CLANT see diversionary programs as absolutely essential but they are not going to help unless there is a way to get those children completely on board and involved.

Where it is a situation where police are running those programs, what is really helpful particularly in communities is where there are some really prosocial and proactive relationships built between police and the community and youths in the community. In Wadeye we have seen football being a really positive connector.

Sometimes it is through—I can't remember where it was but I think it might have been somewhere in the outer Katherine region where there was some music. It might have been out in—I cannot remember off the top of my head. A music type thing or blue light discos, things of that nature. Anything that can attract out in those relevant community, there is a real pride and keenness.

Then you can overlay that with really important learnings and teachings about how to better manage yourself in the community I suppose. To steer them away from offending.

It is a different situation in the urban centres because some of the criminogenic factors that arise in youth for offending in community are not present in the same way as they are, or they differ to those in urban areas where there is greater access to school, extracurricular activities and things of that nature. Then you fall into an entire new area of criminogenic risk factors where you look to the environment in which the children are growing up. Their peer groups and other things.

Diversion is a very difficult area. What we do want to see is the ability for more offences be dealt with by way of diversion. At the moment, no driving offences under the *Traffic Act* or *Motor Vehicles Act* or regulations can be dealt with. That would be a good manner in which to extend diversion if not simply for the strange scenario where a kid could be driving a stolen vehicle or be a passenger in a stolen vehicle… either way you could be charged with unlawfully using a motor vehicle. It does a lot of damage… let us say you drive it five meters… If you are the driver of that vehicle you can go on youth diversion for the more serious charge of unlawfully using a motor vehicle which is an offence under the *Criminal Code Act*. But you have to go to court for driving unlicensed, it does not make any sense.

When that is not even an offence that would draw any sort of real sanction whereas being in the stolen car is the more serious offence. You can go to diversion for that but you cannot if you were driving it. It is odd.

**Mr CHAIR:** Sandra, do you have anything to ask of Marty?

**Ms NELSON:** No. Just a whole bunch of different questions about other issues.

**Mr CHAIR:** Yes, I get that.

**Mr AUST:** Sorry about that.

We have not touched on the decriminalisation of the possession of drugs but I know for a fact that you, Jeff, have done some real ardent research in that field. We had the pleasure of hosting you as the speaker at the Fitzgerald Memorial Lecture, which was great.

**Mr CHAIR:** I think I may have posted my colours to the post.

**Mr AUST:** Yes, so I do not think we need to go over that too much. But, that was something that got a reaction when we made the submission and again, that was just opening a dialogue and getting people to think. It is something where you can criminalise, or at the very least over-criminalise to some extent, silly mistakes by young people.

You can stigmatize people that have an underlying addiction issue that are regularly in possession of small amounts of personal use narcotics or other drugs. In a situation where, as you would be well aware in the Portuguese model there are two principles. Basically one is of accepting...

**Mr CHAIR:** Pragmatism and humanism.

**Mr AUST:** Yes, pragmatism and humanism. I think there is a lot to be said for an approach like that.

Especially in the Northern Territory, where we know we have a really big and broad range of cultures—and our First Peoples, unfortunately many of them come from a background of disadvantage and trauma. A little bit of understanding, acknowledgement and assistance could assist in moving a real generational change through acknowledging addiction as what it is and to try to separate criminality and health issues as best we can.

**Mr CHAIR:** Just on that point, I was recently in Canada and I spoke to some researchers over there. One of them made a very good point that the criminalisation of drug use, and where that often leads, is one of the greatest harms of drug use as opposed to just the use.

Ultimately it is the build-up of a couple of offences and then all of a sudden you are in position of possibly going to prison and the affect that has on your family and your own job prospects. That is a harm that we can really look at dealing with.

**Mr AUST:** It is interesting, under the Portuguese model if you had what is considered personal use which I think is the average dose that an average user would have for 10 days. Again, this is not the best example I suppose.

If somebody was an ice user and they used half a gram a day and had 10 days' worth, that is five grams of methamphetamine which would be considered as two and a half times the trafficable quantity in the Northern Territory. That would attract not only mandatory sentencing but it would mean that there was a presumption that you had that for the purpose of supply.

You may be looking at incarceration for up to a year in circumstances where, under a different regime, you could be—obviously the drugs would be taken from you—channelled into an administrative type tribunal where you have access to medical professionals and are moved in a different way. This is different, of course, to somebody that has two or three kilos of the stuff and they are looking at a massive amount of years of jail as they probably should be.

**Mr CHAIR:** Time has run out on us, I am sorry. Thank you for your input, it has been great to hear from you and to have elaborated on your submission that you made earlier.

I think I may be contacting you again to talk about sentencing and the like as we get closer to the end.

**Mr AUST:** No worries, thank you all for having me.

## TOP END WOMEN'S LEGAL SERVICE

**Mr CHAIR:** Welcome to the committee, thank you for coming before us and we appreciate you taking the time to speak to us and we look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead apply.

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

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

**Ms LETHLEAN:** Vanessa Lethlean, Managing Solicitor, Top End Women's Legal Service.

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

**Ms LETHLEAN:** The service welcomes the opportunity to expand or talk to the submission that was lodged.

Can I just correct one omission, just to add two words: on page two of six, it is the second paragraph under our submission, just to add in the words 'women's sector'? That is just to clarify that our service is the only service that goes out to the women's sector to provide a civil legal clinic. It is the first sentence of the second paragraph of our submission on page two. Just to add in the words 'at the DCC women's sector.'

Can I just reflect on the submissions of Marty Aust because he speaks in a very gender neutral way and that is obviously partly why we have lodged a submission. Often in this dialogue around harm or incarceration, there is no specific consideration given to women.

You will notice from the focus of our submission that it relates to women who are incarcerated and the cyclic intersectionality of drug and alcohol use, domestic and family violence, contact with the criminal legal system, incarceration and inability to access services during that period of incarceration.

More specifically as a precis, as a consequence of the long-standing clinic that we have had at the women's sector, it is very clear to us that there are very high levels of both addictive behaviours and substance abuse problems both pre- and post-incarceration. In essence there is very minimal access during periods of incarceration. Sixty percent of our clients have domestic and family violence indicators.

There is a very significant proportion that will have substance abuse matters and as a consequence of the ongoing legal services, we would endorse the position that the Northern Territory Ombudsman has previously

stated which is if an incarcerated woman's time in custody is not spent with an intensive focus on rehabilitation and preparing them for their future lives, these are likely outcomes that will continue to weigh on the community.

For several years, our service has been advocating for the need for specialised counselling to be available, with connectivity both across harm minimisation, alcohol and other drugs, mental health and domestic and family violence.

**Mr CHAIR:** What about the—we were talking with Marty before about the SMART-type courts. I assume that would assist your clients as well.

**Ms LETHLEAN:** It is actually an area that is outside of our expertise. So the women's legal service focuses exclusively on civil law matters so when we are out at the prison, we are addressing a whole range of related matters that are foundational and underlie the incarceration, trying to address or redress those so that when women exit, there is a straighter path forward for them.

Typically that will include a range of matters around tenancy, fines, debt, sexual assault, domestic and family violence, child protection and family law matters but we are not engaged with, and nor do we appear…

**Mr CHAIR:** In criminal matters.

**Ms LETHLEAN:** Yes, it would be very rare for us.

**Mr CHAIR:** In your experience, what are the substances most commonly used by women you represent and support?

**Ms LETHLEAN:** In terms of women who are incarcerated, we see high-level alcohol usage that we would connect with Indigenous women and there is also ice usage but that is more so amongst younger women and it crosses Indigenous, non-Indigenous and CALD women.

**Mr CHAIR:** Okay.

**Ms LETHLEAN:** But the alcohol and the ice use presents quite differently.

**Mr CHAIR:** Okay. In what way?

**Ms LETHLEAN:** The typical client we might see that has alcohol use tends to be Indigenous spanning a range of age groups whereas the ice use that we would see tends to cross all of those Indigenous, non-Indigenous, CALD—but a much younger age group.

**Mr CHAIR:** Okay.

Your submission suggests the period of incarceration is a key period in the women's lives when treatment for addictive behaviours can be most effective. Are the women generally receptive to the support they receive when they are addressing their addictive behaviours in this time?

**Ms LETHLEAN:** It is one of the issues that we have and it is specifically flagged. It is our experience that whilst theoretically, there is access to alcohol and other drug counselling within prison, the experience of women who are incarcerated is that they get advised that there is insufficient capacity and therefore there is no access for them.

That has happened most recently for us with a client, maybe two months ago. Arguably, holistic alcohol and other drug counselling therapeutically should pick up the foundational issues about why that addiction is occurring. In the absence of specialised domestic family violence counselling and then linked up, none of those issues are being addressed.

It is unfortunate that the prison does present as an opportunity and the research shows for women who are incarcerated, they are likely to have much higher levels of mental health issues and there is the connection with drugs and alcohol.

Preceding and underlying that is domestic family violence and we see that consistently in our clinics out at the prison. We are unable to secure funding from the Commonwealth, the Northern Territory Government or through corrections, to actually try and value-add to reduce the recidivism at that particular time.

It is unclear why women are not being prioritised or why their access is not being provided regularly for alcohol and other drugs.

**Mr CHAIR:** Now, you say you're exclusively civil law jurisdiction… domestic violence? You do not deal with domestic violence?

**Ms LETHLEAN:** We absolutely do. Funding within the legal services is quite structured. All services are required to be collaborative and where there is a specialist service to refer, we would refer to domestic violence legal service because that is the specialist service.

However, by agreement they do not attend the prison. We would pick up any applications for either a domestic violence order or a variation while women are incarcerated. That is an area of expertise for us because 60% of our clients have domestic violence indicators. Understanding also, there is likely to be nondisclosure of sexual offending.

**Mr CHAIR:** We had a submission from the women's refuge in Katherine. They were telling us they were having some good results in the sense of they were probably the only group that we have spoken to, certainly down there, that was getting in and talking to their clients beforehand and providing them with some education.

Talking to them about domestic violence, getting the message out amongst the communities and getting the women to, once they recognise the indicators that something was about to happen, come in. They are actually having some positive effect in that sense. I was wondering whether you have any similar work? If you are dealing with women when they are incarcerated and they have been the victims of domestic violence, are you able to?

**Ms LETHLEAN:** For women who are incarcerated, we would provide what is called a linked up holistic legal service. In essence it is a legal health check. Everything that is raised that is legal, we will seek to address. Specifically with you discussing the women's refuge out of Katherine, we run a clinic at Dawn House. We go out every week.

It is just not part of what we have highlighted in the submission and again, it is an excellent location to try and address in a holistic, linked up way. It is the same for us at Royal Darwin Hospital, we run a health justice partnership.

We are out there every Thursday morning—again, because that location should be a confidential location where we know people are presenting with domestic family violence or other needs and because recent research tells us that people who are employed within the Allied Health areas have a 40% risk or they are recording domestic family violence indicators.

We are extremely proactive. But this submission has focused on incarceration and …

**Mr CHAIR:** Okay. I understand that. Apart from providing greater access to counselling services for women in incarceration—or before and after incarceration—what other strategies would you recommend for reducing harmful addictive behaviour amongst these women?

**Ms LETHLEAN:** Who are incarcerated?

**Mr CHAIR:** Even beforehand or afterwards.

**Ms LETHLEAN:** We would say there needs to be early and preventative work and programs, but that is not an area of our expertise. It is the connectivity and the interrelationship between the domestic family violence, the need for access to therapeutic programs and the legal issues that is our focus. Clearly, there needs to be critical mass.

**Mr KIRBY:** I was most interested in proactive treatments or availability to access—is one of the things we have heard reasonably consistently up and down the track—a lot of operations only have the ability to do reactive …

**Ms LETHLEAN:** I think that also about crisis point—at what point do people elect in to (programs)? That, again, is quite a difference between what Marty Aust was talking about. He was talking about court-ordered mandated programs, whereas for us the focus is on voluntary election in.

That is that discussion within therapeutic processes about whether a mandated or voluntary requirement should be the prerequisite. But in being proactive for us, if there is a good, positive link that is initially established, you would look to build on that in a whole range of ways regarding therapy.

We would facilitate the access and attendance through that. It is reflected in the fact that for years we have been trying to organise these types of programs for women at that location, which is probably one of eight or nine clinics for us.

**Mr CHAIR:** Yes, okay.

**Ms LETHLEAN:** The other issue we flagged in the submission is whilst there are services available, it does not mean pre- or post-incarceration that people find an ability to actually avail themselves of, or access, those programs.

This is why the time in prison, unfortunately, is a time where people are mentally available—they are not on grog, they are not affected, they are being well-fed, in theory their medical needs are being addressed, they are really available. If the service that came in was available to them once they had exited, then you should be able to grow and strengthen that.

We do not say we are the locator for that service—that is not our expertise—but we say it needs to be there and it has to be external, meaning separate from DCC so there is confidentiality of the content in order for it to be therapeutic.

**Mr CHAIR:** Yes, okay. Sandra?

**Ms NELSON:** I do not have any questions.

**Mr CHAIR:** Okay. I think that has covered—is there anything else you want to add?

**Ms LETHLEAN:** No, not at all.

**Mr CHAIR:** All right. Thank you very much for your information and for coming along today and your submission as well.

**Ms LETHLEAN:** You are welcome. Good afternoon.

**Mr CHAIR:** Thank you.

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The committee suspended.

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**NORTHERN TERRITORY PHN**

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

Welcome Nicki and Peter. Thank you for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead apply. It is a public hearing and is being webcast through the Assembly's website. A transcript will be made available for the use of the committee and maybe 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 closed session and we will take your evidence in private.

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

**Ms HERRIOT:** Nicki Herriot, Chief Executive Officer, Northern Territory PHN.

**Mr BURNHEIM:** Peter Burnheim, Health Stream Lead for Alcohol and Other Drugs, Northern Territory PHN. I might just note it is PHN and not Primary Health Network just for the record. The actual listing.

**Mr CHAIR:** I do not even have even PHN on this side.

**Ms HERRIOT:** That is so we can remember who we are.

**Mr BURNHEIM:** Clearly. It is a technical issue.

**Mr CHAIR:** So that is the actual name of the group, PHN, even though it stands for Primary Health Network.

**Ms HERRIOT:** We probably won't go into the complicated issues around that.

**Mr CHAIR:** I will not put the hyphen in or the apostrophe. No problem. Would one of you like to make an opening statement?

**Ms HERRIOT:** Yes, sure. I am happy to do that. I would like to begin by acknowledging the Larrakia people, the traditional custodians of the land we are meeting on, paying respects to elders both past, present and emerging. I would like to thank you for inviting us here today and giving us the opportunity to share our views.

Being the primary health network for the NT, there are 31 across Australia, we work towards improving health outcomes of the NT population. We do this through building local partnerships and directing resources towards an integrated and high quality primary health care system.

Commissioning is our core business and a large percentage of our funding is to commission mental health and alcohol and other drug services across the Territory. It is important to emphasise that we do that in the context of a significant number of other services that are in existence.

Having read your terms of reference for the inquiry, we felt that there were a number of key considerations which you wanted to highlight and I am just wondering if I could do that for your now?

**Mr CHAIR:** Sure.

**Ms HERRIOT:** As you would know and no doubt have heard, there are wide ranging reasons to individuals engaging in illicit substance use and the impact of this use can range from negligible and negative to severe and life-threatening outcomes. The services that we fund in the NT can contribute to reducing the potential harms caused by harmful use of illicit and illegal substances. We have outlined those in our submission.

In addition to funding programs, we also support the development of the alcohol and other drugs workforce in the NT by providing training, support and policy development to enhance the capacity and skills of the sector. It is probably true to say that primary health networks, at their core, are what you would almost call the glue that attempts to bring the parties together across the health system.

In developing the harm reduction strategy for the NT we think that it is important that you consider a range of factors, one being the stigma associated with drug users. This is often a barrier to users seeking help and the negative impact of stigmatising illicit drug users needs to be considered in future government support projects, media and policy.

What is also really important is accurate and relevant education and health literacy about alcohol and other drugs. It is a key factor to reducing the risk of harm to users. With the large range of training and education packages and service delivery systems available across the NT, it is important that these are assessed for effectiveness and safety. NTPHN supports the ongoing development, delivery and evaluation of alcohol and other drugs education through funding and collaborative program design.

In the NT, with such a large geographic area and widespread population this presents a challenge to ensuring equitable access and opportunity for treatment. What we see as important for that is different modalities of treatment being required for different consumers at various points. To support the provision of diverse service models, collaboration and coordination of funding bodies and service providers is essential.

We see that as one of the key points. We probably see from our perspective—and I am sure you have heard this—that there are a number of services, but it is the ability to bring the services together at all points of the system to work together collaboratively for best effect.

The size of the Territory is not the only barrier. To a person accessing appropriate support service other factors that may impact access, including a fear of criminalisation, a lack of awareness, when and how to seek treatment or support, and unavailability of culturally-appropriate services. This really needs to be considered in the development of the strategy.

Considering the significant proportion of Aboriginal and Torres Strait Islander people in the NT, culturally-appropriate treatment services is crucial. One of our other key points is that those are made available. We strongly support the development of programs that are Indigenous designed and led.

A well-trained, well-supported and well-resourced NT Alcohol and Other Drugs workforce is critical to ensuring best possible delivery and outcomes from Alcohol and Other Drugs services. We have recently commissioned NCETA to develop a five-year workforce development strategy which will guide our work towards workforce development for the Alcohol and Other Drugs sector.

Our needs assessment identified the need to support harm reduction measures for people who inject drugs through the provision of sterile injecting equipment, health promotion and referral to appropriate options and rehabilitation support services. NTPHN co-funds a needle and syringe program through the NT AIDS and Hepatitis Council. This service plays a vital role in harm reduction.

There is also considerable evidence to support the harm reduction impact of offering medically supervised drug consumption facilities. However, with the low number of people in the NT injecting drugs, the introduction of this would probably not be viable. Other harm reduction strategies for people who inject drugs should be considered, such as training and the application of naloxone for overdose prevention.

You may well be aware—no doubt you probably are, through this process – that pill testing or drug checking services have been made available internationally and evidence shows positive harm reduction outcomes from this practice, with increased knowledge and awareness for potential consumers and health staff of the content of testing materials, including purity of intended substances. We recommend further investigation into the viability, potential impacts and mechanisms of such a program for the NT.

Currently, there is a significant gap in existing data and areas where data is out of date. While NTPHN is working in collaboration with stakeholders, including health research bodies, further research needs to be undertaken to inform development of our AOD sector. Continuous improvement of NT services through monitoring and evaluation of frameworks for AOD programs needs to be supported and researched to address data gaps and work to incorporate knowledge and learning from interstate and international policy.

Finally, with prison populations being recognised as having a high risk of AOD and AOD-related problems, we recommend that a review of the current application of harm reduction frameworks for prison populations is undertaken.

That is probably it in a nutshell. I thank you for the opportunity to present our views and I am very happy to take your questions.

**Mr CHAIR:** No problems. It is a big nutshell.

**Ms HERRIOT:** It is a big nutshell. Right.

**Mr CHAIR:** Thanks for that. That is really good. Your submission which we have been through is really good as well.

You mentioned a number of issues that reflect some consistent themes throughout a lot of the submissions: pill testing, criminalisation, learning from international experience—something that we just do not do enough of. Things happen around the world and we do not seem to take any notice of it and everybody else seems to be off reinventing their own wheels. I agree with you on that.

We heard from the NT AIDS and Hepatitis Council earlier about the injecting centre and some potential other models that might be more cost-effective for the Territory and that is something worth looking at as well.

We heard earlier in the day, I cannot remember exactly who it was, it might have been AADANT, but the fact that even though opioid injection is not a big number of our drug users in the Territory, it is still something that is worth looking at because we never know when things are going to change on us. Better to be prepared and provide a service.

**Mr BURNHEIM:** In the original submission, there was an outline of the need to increase the knowledge around the impacts of injecting drug use and the rate of overdoses that are actually occurring in the Territory because it is quite hard to find that information at the moment. To see what the actual extent of demand is for that sort of program.

**Mr CHAIR:** We can provide information if we can find out who they are and we can gain information just by knowing who they are.

**Mr BURNHEIM:** The conversation you had earlier around the location of such a facility as well is another one that would require a fair bit of investigation before figuring out how that would actually be viable.

**Mr CHAIR:** We have some questions prepared. I will launch into this first one. Your submission mentions three out of 40 AOD educations evaluated in a 2016 study that showed some positive effects on reducing the uptake of alcohol and other drugs. The programs are Climate Schools (Australia), Project ALERT (USA) and Allstars (USA).

Can you give us an overview of these programs and what they have in common regarding their approach?

**Mr BURNHEIM:** To be honest, not particularly.

I read the study and you actually had Professor Nicole Lee who undertook that study earlier on. She would be able to give a much better oversight of it but it is certainly something that has been highlighted in a number of areas that not only are a majority of the drug and alcohol education programs that are happening ineffective, some of them are actually harmful. Some of them embed some very deep gender stereotyping and behavioural stereotyping that does not really aid anything.

The point we are making more is the need for some sort of evaluation over those programs to ensure that we are…

**Mr CHAIR:** So if we just pick one off the shelf…

**Mr BURNHEIM:** Yes, so we are actually seeing some standard and some benefit coming out of them in schools. And also some need for guidance and standardisation because at the moment it seems each school or each educational organisation has pretty free reign to deliver what they like around drug and alcohol education.

**Mr CHAIR:** That has been another common thread.

**Ms HERRIOT:** So while there is a need for that evaluation and monitoring and a need for consistency, there is also the need for that to be tailored to the various population groups as well but within that evidence-based framework.

**Mr CHAIR:** The other common thread that is flowing through some of our submissions is that they are not being funded for it. So these groups are not being funded to carry out the evaluation properly so we are actually not getting effective evaluation of the programs.

**Ms HERRIOT:** That is often a theme that we find too is a need to fund evaluation and I think we would agree with that and over time that needs to be part of embedding evaluation into the funding programs. It is essential.

**Mr CHAIR:** Otherwise you end up with 37 of the 40 crappy programs.

**Mr HERRIOT:** You get many flowers blooming and some of them not so well.

**Mr CHAIR:** Yes, most of them are weeds.

**Mr BURNHEIM:** It is something I have discussed directly with the service providers we commission is the need, when designing and co-designing budgets with them, to include those elements around evaluation from the outset, not something you look back and go ‘did that work?’ but having evaluation frameworks in place.

The PHN has done quite a bit of work over the last six to 12 months designing an outcome-based monitoring and evaluation framework that will be applied to all of our programs.

**Mr CHAIR:** Another thing we have found is a bit of a common theme is that most of our money is spent patching up the problem once it is almost intractable. How do we move to the other end of the spectrum so we can start dealing more effectively with people before they become problematic? Any ideas?

**Ms HERRIOT:** Investing and recognising the work around understanding health literacy, and investing in programs that educate and build resilience in people. That is challenging because public opinion is always around when there are things that are not so great happening, the public want those fixed, they want what they can see fixed.

It is funding bodies such as governments allocating funding towards the front end of the spectrum rather than treatment services. There is quite a significant amount of money involved in treatment services.

**Mr CHAIR:** It is quite expensive from what we can see.

**Ms HERRIOT:** I think Peter and the work he has undertaken has really identified the need for development of capacity. It is the capacity of the workforce too to be able to identify and be more effective in the way they do things. Have you got some ideas?

**Mr BURNHEIM:** I think the other big thing that needs to be addressed is, if we are looking at alcohol and other drugs and we are, like you are saying, looking at the far end of it—looking at the symptoms—especially in the Indigenous health sector, now we are moving far more towards social and emotional wellbeing models of care.

That needs to be extended from what it is at the moment where it is seen as a very health-focused approach to care and we need to extend into the other areas of government and support for people to be looking at a truly holistic model.

We know that addressing the social determinants that underlie these issues, and that includes things like providing good education, housing and health support and family support, all of those aspects play into the symptom of AOD coming out. They play into things like the rates of suicide being high and the rates of youth crime.

As long as we focus and address the symptoms and do not address the causative factors, we will really struggle. There is obviously always going to be the need to have that treatment end but there needs to be a dedicated effort to start integrating care into a person-centric, holistic model if you ever want to see the numbers really dropping off.

**Ms HERRIOT:** There is evidence around—and it is strongly supported by the Aboriginal community-controlled sector—the use of the social and emotional wellbeing model. So from our perspective we have commissioned social and emotional wellbeing services combining some specific funding for Indigenous people around mental health and drug and alcohol services.

**Mr CHAIR:** I think we heard that down the track as well when we were down there. You spoke about stigmatisation but I will ask the question: your submission points out the significance of stigmatisation as a barrier to users seeking help for their addictive behaviours. Can you elaborate on some of the types of stigmatising behaviours and communication that need to be avoided to encourage users to seek help?

**Mr BURNHEIM:** Yes, there is the instant correlation, and it is the legislative issue, that drug use is still criminalised. A move towards decriminalisation would obviously separate that level of stigmatisation from the criminal behaviour and we could focus on things as a health issue.

As far as media output, things like language, recognition that when talking about alcohol and other drugs there is a need to have referrals for services much like we do for suicide-related media, I think that would be an excellent move to have that sort of stipulation under alcohol and other drug reporting.

**Mr CHAIR:** Okay.

**Mr BURNHEIM:** The barrier to service—people do not want to walk into a doctor's surgery or a treatment centre and admit to having alcohol and other drug problems.

**Mr CHAIR:** Yes.

**Mr BURNHEIM:** It is not seen as a great thing to be addressed, and it seems like most of the time people are only really seeking treatment when things have really fallen apart for them. People need to be more aware that it is okay to get help earlier on.

**Mr CHAIR:** Yes.

**Ms HERRIOT:** One of the factors of that too is about developing the workforce to know how to respond. It would be true to say that doctors and various other—often GPs may be the first port of call—are not necessarily that well trained in how to address these issues.

**Mr CHAIR:** I asked that this morning of …

**Mr KIRBY:** Pharmacy.

**Mr CHAIR:** … the Pharmacy Guild, that is right. They were saying that doctors and pharmacists are often that first point …

**Ms HERRIOT:** Yes, like nicotine …

**Mr CHAIR:** Being a lawyer, we had a continuing practice development or legal education requirements, 10 …

**Mr KIRBY:** Professional development.

**Mr CHAIR:** Yes, 10 to 12 hours a year. There were certain elements that you had to do. There were core competencies, effectively. Ethics was one of them. Some of them missed out on that, but anyway.

As part of doctors' and pharmacists' professional development education requirements there might be an element they have to do—even if it is only an hour a year—to look at addressing people and being able to bring up conversation and …

**Mr BURNHEIM:** The federal Department of Health has just signed $20m to the GP colleges to increase AOD education for GPs. There are moves in that direction.

Talking about early intervention measures, there is a real need for a much broader community education and health literacy about alcohol and other drugs as well. Family members will be the first one who notice realistically. They often have no idea how to respond, other than to panic, primarily.

**Mr CHAIR:** How to start the conversation is …

**Mr BURNHEIM:** Yes, there are things like brief intervention training which we are about to commission some more as well, that can be delivered far more broadly than just to the health sector. It is about getting that health literacy about AOD, that intervention point, much earlier and in many more people's hands. In a community a youth worker may be far more likely to pick up on some troubling behaviours than a GP sitting in a clinic.

**Mr CHAIR:** It is a bit more specific—a ship leaving. That was you, Sandra. You cannot hear it, but …

**Ms NELSON:** That is definitely not me.

**Mr CHAIR:** Leaving port.

It is a bit more specific, but when I was in Canada, I spoke to the people there and in conjunction with legalisation of recreational cannabis they are taking a very educational approach. They have produced these education material that is for all sorts of people—families, school teachers. That is exactly what it is about—starting and having that conversation in a non-judgmental way to talk about dangers without telling them, 'You have to …'

**Ms HERRIOT:** From our perspective, we might be PHN—primary health network—however …

**Mr CHAIR:** Do not mention that, though.

**Ms HERRIOT:** But we do not call ourselves that. We acknowledge the social determinants of health. The community approach is probably one of the most important aspects. It is not just about health services.

**Mr CHAIR:** Yes.

**Mr KIRBY:** We had some people mention earlier some of the extreme advertising that goes on.

Family members, as you are saying, might not always recognise—or they might identify that if someone has an ice problem if they are doing these extreme behaviours, because that is what we have advertised. Whereas, day-to-day non-functioning problems might not absolutely or initially recognised …

**Mr BURNHEIM:** The Reefer Madness approach. Come back again.

**Mr CHAIR:** Yes, that is all right.

**Mr BURNHEIM:** Unrealistic ideologies of thinking about what a drug user is. We know statistically that about 43% of Australians have used an illicit substance in their lifetime. Really, you will not be able to tell a lot of the time …

**Mr CHAIR:** And most people just function normally.

**Mr BURNHEIM:** That is right. We know that most of that drug use is not harmful. It could be less harmful if we took harm reduction measures.

**Mr CHAIR:** Sandra?

**Ms NELSON:** I do not have any questions.

**Mr CHAIR:** Nothing? All right. In your submission and opening you have covered almost everything. Anything else you would like to say?

**Mr BURNHEIM:** No, I think we have covered off pretty much everything there.

**Ms HERRIOT:** No, I think we are fine. Thank you for …

**Mr CHAIR:** You have done a very good job …

**Mr BURNHEIM:** Sorry, I might frame one more area, the research work being done at the moment.

We are co-commissioning Menzies on a number of research pieces that will probably be very relevant to the harm reduction. The BDR evaluation they are undertaking, which is quite broad and looks at the social implications of people being on the BDR. There is also—what else have we got going on?

There is training on increasing the health data that is coming out of remote Aboriginal communities through the remote AOD workforce.

**Ms HERRIOT:** We would be happy to provide that if you are interested in that …

**Mr CHAIR:** Yes, when do you think that will be ready?

**Mr BURNHEIM:** That is a while off. The BDR evaluation is a long-term study to monitor it over its lifetime—or the start.

**Mr CHAIR:** We are happy for you to contact us with any information you have …

**Mr BURNHEIM:** I can provide you …

**Mr CHAIR:** We have to report back on 31 August next year. Feel free.

**Ms HERRIOT:** We could provide …

**Mr BURNHEIM:** We can throw a few more details about that.

**Mr CHAIR:** Contact us and let us know. We are more than happy to have any other conversations with you as well.

**Mr BURNHEIM:** Great.

**Ms HERRIOT:** Thank you very much for your time.

**Mr CHAIR:** Thank you for coming along. Thank you for your interest.

**Ms HERRIOT:** Thank you.

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The committee concluded.

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