LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder

Public Hearing Transcript

9.00 am, Tuesday, 12 August 2014

Litchfield Room, Parliament House

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

Witnesses: Chamber of Commerce NT
Mr Greg Bicknell, Chief Executive Officer via Videoconference
Australian Institute of Health and Welfare
Dr Al-Yaman, Head, Indigenous and Children's Group
Mr Geoff Neideck, Head, Housing, Homelessness and Drugs Group
CatholicCare NT
Ms Kim Burns, Senior Manager AOD
Ms Milly Hardy, Safe House Coordinator
Danila Dilba Health Service
Ms Olga Havnen, Chief Executive Officer
Ms Joy McLaughlin, Specialist Consultant
Dr James Stephen, Senior Medical Officer
NT Council of Social Services (NTCOSS)
Ms Wendy Morton, executive Director
Ms Samantha Bowden, Board Member
Ms Nicole Coalter, Board Member
Top End Women's Legal Service Inc
Ms Aditi Srinivas, Solicitor
First People's Disability Network
Mr Damien Griffis, Chief Executive Officer

Mr Scott Avery, National Policy Officer

National Indigenous Drug and Alcohol Committee (NIDAC)

Mr Scott Wilson, Deputy Chair via Teleconference

Australian Hotels Association (NT Branch)

Mr Justin Coleman, President

Ms Amy Corcoran, Chief Executive Officer

Mr Michael Burns, Board Member

CHAMBER OF COMMERCE NT

Madam CHAIR: Welcome, on behalf of the committee, to the public hearing into action to prevent Foetal Alcohol Spectrum Disorder. Thank you for appearing before the committee. We appreciate you taking the time.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. The public hearing is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be placed on the committee's website. If at any time you think something should be taken in private we can go into a closed session.

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

Mr BICKNELL: Greg Bicknell, Chief Executive Officer, Chamber of Commerce Northern Territory.

Madam CHAIR: Do you want to start with an opening statement or comments?

Mr BICKNELL: Yes, if I could. The issue of alcohol and antisocial behaviour is probably the key concern of our members. It has been ongoing in the Northern Territory for many years and has some pretty tough impacts on business as far as impacting on customers coming into various premises.

We are keen, as a business community, to see progress made to address these issues, but we also acknowledge it is a very tough question that people have grappled with for many years and reaches right back to where people have come from and why they are motivated to drink rather than to make more valuable contributions to the community.

We always work with the government of the day to ensure there are policies and regulations in place that will advance that cause. However, we acknowledge the difficulty of that.

Madam CHAIR: The Australian Hotels Association will talk to us after you. Do you cross over?

Mr BICKNELL: I will give some background. We cover the whole of Northern Territory, and I believe you have already heard from Kay Eade in Alice Springs and Kevin Grey in Katherine. We represent about 1300 businesses across the Northern Territory and they are spread across every sector, every size and every issue. Every time this question is asked of our members we get a 50:50 response to any policy, any regulation. Half our members are in support and half in opposition so it is a very tricky question.

Madam CHAIR: Gerry, you have to leave soon so do you want to start with anything?

Mr WOOD: How do social issues fit into your agenda and do you see an issue? You said you see issues in regard to alcohol abuse, but we are looking at a certain aspect about alcohol abuse. One of the issues raised - I presume it will be raised with the AHA - is restricting service to people who come into a licensed premise if they know that person is pregnant. You cannot always tell, of course, until there are obvious signs unless someone tells you. Do you see a role in telling people about the dangers of alcohol abuse or drinking alcohol when pregnant and whether businesses, especially licensed businesses, have any role to play by taking a positive step forward and not serving? That will not stop people drinking necessarily, but it may send a message that you are concerned about it.

Mr BICKNELL: Our members would support education, whether that be through displaying brochures or wall posters to let people know there are dangers associated with drinking while pregnant. I do not profess any expertise in that area at all, and I do not think any of our members do apart from those in the medical fraternity. The education side of things - very happy to help.

In regard to refusing service to someone, that is very difficult in regard to what stage of the pregnancy the use of alcohol has an impact on. From our perspective, there would be some very grey areas in any sort of enforcement by those involved in supply of alcohol.

Mr McCARTHY: Greg, after this hearing - it is great the Chamber has appeared and we had very interesting hearings in Katherine and Alice - would you provide a communique to members? What is the next step for the Chamber?

Mr BICKNELL: We have various methods of communication; we have a website. We put out regular bulletins to members and do regular quick surveys to members to get feedback from them. We have a range of mechanisms we would be happy to use to disseminate information to members to let them know. It is not necessarily the pubs and clubs that are the main areas of interest, but cafes and restaurants that are serving alcohol as well. We have members right across those areas so we would be very happy to spread the word on. It would be good to have some tools people could use - whether that be posters or other forms of education for people coming into licensed premises. Even outside now that, now there are many other forms of social media to get the word out.

Madam CHAIR: I am saying nothing really good happens after midnight or 1 am. Why do - and you may or may not be able to answer this - think or believe hotels and clubs and pubs want to, or need to, stay open until about 4 o'clock in the morning, if not later. Clearly, there is a commercial gain, but is there not some responsibility on the business operator not to contribute to what inevitably happens, which is over-consumption and, then, social upheaval?

Mr BICKNELL: The law currently allows them to remain open those hours. As businesses, their responsibility to their shareholders or their owners is to maximise the turnover of the business. While the law allows that, you cannot really blame businesses for taking the advantage of that.

Madam CHAIR: I suppose that it true.

Mr BICKNELL: As to the question of whether they should be allowed to stay open, I am also like you, I do not get out too much after 1 o'clock in the morning either. I grew up in a time where, if you did not serve supper you were not allowed to stay open past 10 o'clock. Things have certainly changed a lot. People have views both ways, but we are in a town or a city - or a whole of Territory really - that is still developing. Yes, whether that is a good thing or not, I do not think I am in a position to say.

Madam CHAIR: Okay. We have the hotel association afterwards, as I mentioned. We are coming to grips with it on this committee, and we have asked people along the way: why is there such resistance by the industry - as in liquor, hotel - to floor prices, do you think?

Mr BICKNELL: Again, business is about returns to their shareholders, so anything that may impact on that is of concern to an industry.

Mr WOOD: Do you not think - this could apply to any industry - industry also has a moral obligation besides legal obligations? Anything that is a cost to our society in the case of alcohol abuse - which means ambulances, police, nurses, hospitals - are the other side of the coin. Would you not say that businesses also have a responsibility that goes with their right, which means they need to be aware of the other side of the coin before they just look at the economic benefits?

Mr BICKNELL: Most outlets feel that responsibility, but it needs to be a 100% united effort. That is the issues we grapple with. Again, the feedback we have from our members is there is not a united voice on it, so it is either all in or none in really. That is one of the issues we face up here in trying to get some of these things into place that may address some of these problems.

I do not have an easy answer to that because all of these things have been discussed. Some of them have been tried. At all stages, you have situations where you have one-man operations with a licence but, at the other end of the spectrum, you have Woolworths and Coles. Getting all of those parties to agree is a very difficult thing.

Mr WOOD: Did the Chamber of Commerce have a view on the BDR?

Mr BICKNELL: Our view is it was not really in long enough to make a really reasoned judgment. That was one of the questions we asked our members in July last year. The results were 50:50 - exactly 50:50.

Mr WOOD: If you were to break that 50:50 up - obviously you asked all your members. If you took those who would be most affected - that is the alcohol industry section of your membership - what was the break-up of that?

Mr BICKNELL: We do not break it down into specific sectors, unfortunately. We do not have a law for the alcohol industry as part of our membership. It is free, people join by choice, not by legislation as they are allowed to do in some other countries. It would make my life a lot easier if I had everyone in the Territory as a member, but we do not have a complete industry view on behalf of the liquor industry, it is spread amongst the SMA's and…

Mr WOOD: Is liquor wholesale part of your membership?

Mr BICKNELL: Again, any business that operates in the Northern Territory can join the chamber, and off the top of my head, I think we do have one of the liquor wholesalers, but it is generally the retail outlets who are more involved in what is happening with the chamber.

Mr HIGGINS: In terms of the committee's work and reporting to government and then accepting there will be limited resources to address this issue do you see the chamber featuring highly in that? Would you guys be lobbying to be part of it, or do you feel that the chamber is really sitting to one side of this whole issue?

Mr BICKNELL: Our concern is the antisocial behaviour really and the impacts of that, so it is not – we have not focused very much on the health side of things, but anything that it helps to address - and I think the two things go hand in glove - if you are addressing the health issues and restricting supply that is going to have some positive impacts on antisocial behaviour. We would be very supportive of that and we would look forward to having something. There have been many things tried in the Territory over many years and often they do not get to run their full course to say whether things really do work or not, so we would welcome – business would get on with whatever regulations are put out there to address these things, so that is what business has to do.

But in terms of things it addresses, what is the real problem for business - the Chamber of Commerce would be very supportive of that.

Mr HIGGINS: That is good to hear. There seems to be some emerging opportunities and one is in the sector of education and awareness, in which I can see a direct link with the chamber, so if there were resources to go into that strategy then the chamber could play an important role in that education and awareness space?

Mr BICKNELL: And resources are always an interesting question because we do not have too many of them either, but we are happy to do whatever we can to get the word out. We run regular networking events and other things and we can help to spread the word. As I said we have not established policy for antisocial behavior, and anything that feeds into that we are more than happy to get the word out about.

Mr HIGGINS: Are you aware of the athlete role models, the rock stars and all that?

Mr BICKNELL: Yes.

Mr HIGGINS: Does the chamber have any stake in that program?

Mr BICKNELL: No, unless there is something nationally, but certainly not on a local level. We have just entered a partnership a couple of months ago, with the NT Indigenous Business Network to assist in developing Indigenous businesses that are growing quite quickly around the INPEX project, so we would be happy to work on anything like that if there were ideas around business role models. We have got a very good relationship and they are working pretty hard to have a presence in the business community, so they welcome that opportunity too, I think.

Mr HIGGINS: Thank you.

Mr WOOD: I suppose where I thought the Chamber of Commerce might be interested in FASD is that it is the antisocial behaviour that could be caused by people with FASD. Do you get many members complaining about vandalism of their properties?

Mr BICKNELL: Yes.

Mr WOOD: And do they have any idea who commits that vandalism? What we heard in Alice Springs is that there are possibly quite a few people who might have FASD who do not have a clue they are doing something wrong. Do you see that some of the people that commit vandalism and break-ins may be people that really have got a problem, and that it is not just about bad behaviour, but something caused by some other effect?

Mr BICKNELL: A lot of these problems have deeper root causes. I think everyone recognises that. FASD is not very well known – the impacts of that on younger people in the community - so I do not think that that is actually recognised very well at this stage.

The education process is not just for those who are drinking alcohol, it is also for the wider community to understand some of the impacts it is causing.

Mr WOOD: What I was getting out was the slightly broad picture that you have members who run businesses and, from an economic point of view, they get pretty annoyed that they are spending money on damage to their property. However, on the other side of the coin, the Chamber of Commerce can be positively involved in a scheme that would help – I am dealing purely with economics here - reduce that because some of that damage is done by people with foetal alcohol syndrome. If you can assist in reducing that through advertising and promotion there is a role for you.

Mr BICKNELL: Yes, and we are active with the alcohol accords in the regional centres. We are trying to be on the front foot and assist with that and happy to take it to a wider audience.

Madam CHAIR: Thank you, Greg. We appreciate you taking your time to come in today. We will send you a draft copy of the *Hansard* so you can check what you have said is accurate.

Mr BICKNELL: Okay.

Madam CHAIR: Everything is on the website - all the submissions. Some of them are - not the ones we have here, but some of the other ones we have are very interesting so have or look or get someone to look for you.

Mr BICKNELL: No worries.

Madam CHAIR: Thank you for coming in.

The committee suspended.

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE

Madam CHAIR: Good morning, can you hear us?

Mr NEIDECK: Yes, we can. Can you hear us?

Madam CHAIR: Yes, we can; we can see you and presumably you are looking at us.

Mr NEIDECK: Yes, we are.

Madam CHAIR: Thank you. My name is Kezia Purick, I am the Chair of the select committee inquiring into action to prevent Foetal Alcohol Spectrum Disorder. On my left is Nicole Manison, member for Wanguri; member for Barkly, Gerry McCarthy; and on my right, Russell is the secretary to the committee and Gary Higgins is the member for Daly. We may have another member who will come in and join us. Thank you for taking your time and appearing before the committee today. We appreciate this very much.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee applies. This is a public hearing and is being webcast through the Assembly's website. A transcript will be made for the use of the committee and may be put on the committee's website. If at any time during the hearing you feel that something that you want to say should not be made public then we can go into a closed session.

So for the record, could you state your name and the capacity that you are appearing before us today, please?

Mr NEIDECK: Certainly. Geoff Neideck and I am Head of the Housing, Homelessness and Drugs Group of the Australian Institute of Health and Welfare.

Dr AL-YAMAN: Fadwa Al-Yaman, Head of the Indigenous and Children's Group of the Australian Institute of Health and Welfare.

Madam CHAIR: Thank you. Is there an opening statement or opening comments that you would like to make?

Mr NEIDECK: Just briefly - we have provided the committee with a submission previously in writing, which provided some information the Institute has in relation to this particular topic. It indicated some of the data sources and some of the data we have. In terms of how we think we can assist you today, we have some additional information we now are able to add to that submission and we are quite happy to take any particular questions or queries that you have that might assist you and some further analysis for you if possible and helpful to you.

Madam CHAIR: Okay, thank you. So do you want to just start with some of the information or update on you submission?

Mr NEIDECK: Yes, that is probably worth doing. One of the key pieces of information we provided you was information on drinking patterns amongst Australian women while they are pregnant. The latest available data from the National Drug Strategy Household Survey that we provided to you previously was for 2010. We now have data available for 2013, so some more recent data. In presenting this data, I

should indicate that although the National Drug Strategy Survey is a large national survey of over 23,000 households, when we look at the number of the sample in the Northern Territory and particularly getting down to the group of women who are pregnant that are reporting to us, we obviously have a fairly small sample to rely on. The figures that I can give you are at a national level, in relation to women drinking during pregnancy and I will just give you those figures now.

For 2013, we found that when we asked women whether or not they were drinking more or less or the same during their pregnancy, we found that 53% of women indicated they did not drink alcohol at all during the pregnancy, and that figure was up from 48.7% in 2010, so that is an increasing trend of women abstaining from drinking alcohol during pregnancy. Of the remainder, a significant proportion indicated that even though they were drinking, continuing to drink, they were drinking less, so the total proportion of women was 46%, and that was down from 48.9% in 2010. While that number is not down in women drinking less, you have to read that in the context of a similar proportion increasing who are telling us they are not drinking at all.

So, that leaves us with very small numbers of women who are not changing their drinking behaviour during pregnancy, and either drinking the same amount and a very small number, which is not statistically significant, who are actually drinking more - from 2.4% in 2010 down to 1.3% in 2013. So, we have seen a small drop off in the number of women who are telling us they are actually not changing their drinking behaviour while they are pregnant.

Ms MANISON: Did your data give you any indications of why that behaviour has changed, why we are seeing a downwards trend in drinking while pregnant?

Mr NEIDECK: I am still having trouble with the volume in here. Can you repeat the question?

Ms MANISON: Did your data give you any indication of what you can attribute that behaviour change to, with the trend going downwards with regard to drinking during pregnancy?

Mr NEIDECK: No, we do not have any additional information which indicates those changes in behaviours amongst pregnant women. But, one thing we have noticed more generally is continuing trends of increased abstinence in alcohol consumption in the population. This data would tend to be in line with general trends we are seeing in abstinence and less risky drinking behaviour in the general population. But, unfortunately, we do not have any additional information that would indicate why this particular group we are looking at - pregnant women - changed their behaviour.

Ms MANISON: Did you have much of a breakdown with regard to the demographics of the pregnant women you got that statistical data on in lower economic socio status and that type of thing, higher income earners. Did it breakdown a bit further into that so we can really crunch through where the trends are coming from?

Mr NEIDECK: The survey itself was quite clear for a range of data on demographics and had socioeconomic data. But, our problem is when we are getting down to this particular sample, the numbers are very small. So, any additional breakdown in the data is likely to have very high standard errors. It is going to be of limited value. That is not to say we will not be able to get an indication of some specific aspect of demographics.

Mr McCARTHY: Did the survey include family planning? Was the question framed regarding women, families, that were planning to have children?

Mr NEIDECK: No, it was not. The focus of this survey was around alcohol and other drug use generally in the Australian population. All of the range of questions related to drug and alcohol usage. So, we were unable to target – we had a particular focus on the whole population of people who we were surveying. Unfortunately, we did not have any questions on the planning aspect of pregnancy.

Mr McCARTHY: Essentially, the respondents could have continued drinking in the first trimester of a pregnancy, then started to reduce their drinking when they were aware of their pregnancy?

Mr NEIDECK: We have a bit of more information we have not yet been able to analyse on the frequency of drinking, where women have continued to drink. It would be difficult for us to have an indication of the timing during pregnancy that any changes had occurred. They are quite general questions in terms of the quantity that was drunk on particular drinking occasions, and the frequency of those occasions. Unfortunately, no, we would not be able to indicate whether the changes happened early on. We did have some questions about changing behaviour, in terms of whether they had anything before they knew they were pregnant and then after. Unfortunately we have not done any detailed analysis on that as yet, but if there was a particular issue that you were interested in we could have a closer look at that and see if there is anything we could add.

Mr McCARTHY: Thank you for that, and so far in the hearings we have been conducting the medical fraternity has been providing that sort of evidence. In terms of any data collection it would be good to start framing data collection around FASD in relation to those very critical time frames to get an indication and particularly in the family planning area, but thank you for that.

Mr NEIDECK: Okay.

Madam CHAIR: Thank you very much for taking time out today to appear before us. We will send you a copy of the transcript so you can check to make sure it is all okay factually and all of the submissions of other groups are on the parliament's website if you wanted to check, and we have got a few being put on today as well. Thank you very much for your time today.

Mr NEIDECK: I appreciate the invitation.

Madam CHAIR: Thank you.

The committee suspended.

CATHOLICCARE NT

Madam CHAIR: Thank you for coming here today, and I welcome you to this public hearing into action to prevent Foetal Alcohol Spectrum Disorder. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and it is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If at any time you think that there is something that should not be public we can go into a closed session and take your evidence in private. For the record can you state your name and the capacity in which you appear here today, please.

Ms BURNS: My name is Kim Burns and I am the Senior Manager of Alcohol and Drug Programs for CatholicCare Northern Territory.

Ms HARDY: My name is Milly Hardy and I am the Safe House Coordinator for CatholicCare.

Madam CHAIR: Thank you. Did you want to start with any opening statements or any opening comments?

Ms BURNS: I just wanted to make a comment about the submission CatholicCare made; it was put together by our director Jane Lloyd, who is unable to attend today's session, so I am not actually the author (inaudible).

Madam CHAIR: Okay, I have not read it all, but what is the scope of CatholicCare Northern Territory? I know the Catholic bit, but what is CatholicCare?

Ms BURNS: We are a social service, a not-for-profit arm of the Catholic diocese.

Madam CHAIR: Okay.

Ms BURNS: We provide social service programs throughout the Northern Territory, which range from the Tiwi Islands down to the Alice Springs homelands and a range of services we provide in terms of alcohol and other drug programs, safe houses in Daly River and Milikapiti. We also provide a lot of interim programs and counselling services.

Madam CHAIR: A bit like Anglicare, but CatholicCare. It is actually the same.

Ms BURNS: The other care bear.

Madam CHAIR: Got it. I should have ripped that out, but, yes, got it. Does your funding come from a combination of sources from the diocese plus the NT government?

Ms BURNS: It comes from the NT government and federal.

Madam CHAIR: For programs or …

Ms BURNS: We do not receive any funding from the diocese.

Madam CHAIR: You are just attached to it?

Ms BURNS: Yes.

Madam CHAIR: Yes, okay. In the course of your work and operation have you, or do you have a lot to do with, what we know as FASD children, or women who are pregnant and have drinking issues?

Ms BURNS: Yes, and in 2012 we also received funding from the federal government to run a project in terms of building capacity amongst alcohol and other drug users. So we received funding to run a project around increasing the capacity of our staff, but also out into community around the awareness of FASD. That was normally focused on our alcohol and other drug workers, but Milly was the coordinator of that project, so she undertook going out to a number of different communities and speaking to community members - predominantly women in the community - about the impact of FASD and drinking whilst pregnant. That enhanced our awareness. We have also developed a number of posters and brochures.

I will not speak for Milly regarding her findings, but one of the things she came back and reported to us was there was a lack of Indigenous-specific information in posters that detailed Aboriginal people as opposed to just white people. Also, there was a lack of information in language. Is that fair to say?

Ms HARDY: When I went out to the communities to deliver the FASD information, there were a lot of the community people not recognising the behaviours and what FASD was about. There are no resources that are Indigenous-specific, which is what they like. It is more engaging for them if they know the people who are in the video - they know who they are from or where they are from. That gets them engaged into the program.

There is not a lot of support out there for kids who have FASD, no support for the parents, especially out in a remote community. There is nothing for the men out there as well. There are no programs run out there for men, so they do not, obviously, recognise the signs of FASD either.

What was really interesting was when I showed the ladies the DVD of the young boy who lives in Fitzroy who has FASD. He is a teenager. His adopted parents have, obviously, been to a lot of workshops and conferences about FASD, and how to deal with it and manage a child with FASD. It was interesting to see the ladies on the community had no idea that a child with FASD has those behaviours. A lot of their responses were 'We just thought the kids were playing up and being naughty', because there is no awareness out there.

Madam CHAIR: They had not made the connection between a mother drinking lots and then producing a child that is naughty, or they are just mucking up. That is the way it is.

Ms HARDY: They thought it was normal behaviour; the kids are playing up - not knowing this is all the effects of when mum has a drink this is the outcome.

Ms MANISON: When you started the program out there with people, what was the awareness of the connection of alcohol on the ground - that you should not drink during pregnancy?

Ms HARDY: It is touchy. For a lot of the elders, they are adamant you should not drink while you are pregnant but, for the younger mums who are pregnant, it is a shame job factor. The elders are telling them not to do it. So, when they have a baby with FASD or those behaviours, the mums go into hiding and they are all ashamed about people are blaming …

Madam CHAIR: Because they did not listen to the elders.

Ms HARDY: … you should not drink when you are pregnant and this is the result. It is very touchy to talk about those things on the community.

Ms MANISON: Going out there and trying to engage with the program about FASD, and education about alcohol awareness during pregnancy, how receptive were people on the ground in the communities you worked with to the programs you were running?

Ms HARDY: With other services?

Ms MANISON: Just trying to get that FASD message out there and educate people about the dangers of drinking during pregnancy, and what FASD is.

Ms HARDY: For me, because I work within the safe house, we run women's groups. So, when the ladies come - and we have a mixture between the elders and the young girls, but it is more the elders who are taking on the role. They are coming in and are learning about FASD, and what alcohol and drugs do to your body, and they are passing it on to the younger people, but it should be more widely out there in terms of FASD anyway.

Ms MANISON: So you would like to – you would definitely see a benefit in getting more education and resources out on the ground, local language and …

Ms HARDY: Yes, and a lot more support, with places for them to go to, even having a mother's group or something where they can go with kids with FASD, just supporting each other and maybe talking through how they can live with a child with FASD. It is not only for the women, but I think the men as well need to be educated and there is none of that out there. There is no support out there for the men with FASD and they play a big part of it as well.

Ms MANISON: As part of this select committee we are trying to get an understanding about the prevalence of FASD out there in the Territory and how often it is on the ground. In your experience going out to these communities, and even with the services you offer in the urban regions, how often do you think you see it? Is it something with the clients that you deal with you see – we keep getting told it is really highly underdiagnosed because there is no diagnostic tool and whatnot, but from understanding what FASD is and understanding a bit more about your clients and the history of what they have probably gone through, whether or not they have had alcohol issues or health problems and so forth before they have had their kids and so forth, how often do you think you come across it with your clients?

Ms BURNS: I think from my perspective I have very minimal knowledge about FASD, and not being a clinician in terms of being able to play any sort of diagnostic tool that might be in existence. I think with an increased awareness now in terms of behaviours, and also sometimes it can be physical features

associated as well, I have kind of – again from a non-clinical perspective – identified people who I think, 'Okay, that behaviour is in line with some of the information that we have in terms of a diagnosis,' but it is quite difficult, particularly out on community. I guess I am a social worker, and with my background, some of these kids I would look at and probably think, 'Maybe it is a bit of attention deficit disorder or it is that' – I would not be able to actually make that kind of delineation between different diagnoses or behaviours, but I think obviously it is that kind of thing that when you increase your own awareness you start to see it everywhere. It is a bit tricky.

I think from an urban perspective it has been less so compared to what perhaps Milly has been exposed to out on community and through the safe house as well, because the women will come with their children, so we see more of the children. Again these are children who are escaping domestic violence situations, so it is quite difficult at that time to actually make a judgment around their behaviour.

I just wanted to add to what Milly was saying in terms of – one way that we found to engage the community, particularly out in remote communities, in conversations around FASD was by involving them in the development of the posters and the educational resources. We actually have a poster that features the face – we got permission from the parents, etcetera – of a child from, I think, Bagot or Belyuen …

Ms HARDY: Yes.

Ms BURNS: … community, so by engaging that family and asking to do it, what colours would be appropriate and what kind of words we should use we actually got a lot of people actively involved, and at the same time increased their awareness and understanding so that they could then go and speak to other people in community about this thing called FASD. But from my perspective as the Manager of the Alcohol and Other Drugs services, there was a very minimal awareness of FASD right across where we went and not just in terms of community members, but also clinic staff and within our own AOD services as well. It was not something that was front and centre on our radar until we undertook the project.

Ms MANISON: I did find – I know you did not write it – this one sentence interesting:

Our experience of working in the community would indicate that women largely learn to live and adapt to having children who may have FASD and that is not recognised as a particular disability and the cognitive behavioural or emotional disorders are normalised.

In the being able to deliver the work and the best possible services you provide to families out there in the Territory, would it make things a bit easier if when you are presented with the family and the child - if you were aware if they had a FASD diagnosis, would that make working with the family a bit easier?

Ms BURNS: Absolutely, yes, and I think it would assist for the family as well to be

able to contextualise their child's behaviour.

Madam CHAIR: We have heard from a variety of groups; lots of groups and organisations are doing lots of different things to do with this matter, but in your dealings with government agencies, would you mostly be dealing with Health or FACS?

Ms BURNS: Health mainly. We deal a little bit with DCF through the safe houses, but it is mainly Health.

Madam CHAIR: Because we are hearing that it is a bit disjointed, this department has this much information, but there is no way to bring it all together. Have you found that?

Ms BURNS: Absolutely, and in terms of our funding for the project, it was quite short. It was that snapshot thing in terms of something that through, again, our enhanced awareness we can see is emerging as quite a large issue. Recently I attended NIDAC, the National Indigenous Drug and Alcohol Conference, and there was a lot of talk there about FASD, the impact and what people are seeing across Australia. In Fitzroy Crossing there has been a lot of work done as well, but it is all pockets and even when we ran our project we did not really have any collaborative partnerships happening. We were not aware of what work - we did some research in terms of what work had taken place prior. It was mainly around Tennant Creek; some work had happened there. But there was no real sense of it being coordinated.

Madam CHAIR: That is what we have been hearing. How can we improve that, because everyone is doing a bit of everything but no one is putting it all together? The other comment - I would be interested to hear what you think - across the communities, not only remote Aboriginal communities, but town urban ones - they know it is a big issue, but it is not being addressed the same way as the quit smoking campaign. Everyone knows about quit smoking and the hotlines and athletes get up and say this - do you think there is good scope for government and everyone to run those kinds of programs and to have role models? Because once the woman is pregnant it is no good having a picture of a pregnant woman saying, 'Do not drink'. You actually have to try and get the message early. Have you got any ideas on that?

Ms BURNS: You were talking about engaging the elders to teach the young men.

Madam CHAIR: It is probably that we just need to do it, I guess.

Ms BURNS: I think too what we discovered as well was that we - I guess this is the power of hindsight through our project - we did target the women, whereas we really need to have their partners and the man on board as well, because it is one thing to be saying to a woman, 'You should not be drinking during pregnancy', but if her partner is not supportive of that, particularly if they have a drinking culture in their relationship - increasing the man's awareness as well the impact that this has is equally as important.

Madam CHAIR: We have heard that from other groups and the other thing we have heard from the medical fields is there is research building that the man who is a heavy drinker can contribute to FASD.

Ms BURNS: I think in terms of what you are stressing about the kind of similar campaign around quit smoking is a good way to go because it is about increasing that awareness, getting visual imagery and enhancing people's understanding. As Jane says in her submission, women do not deliberately drink to harm their baby; it is either a lack of understanding or due to social disadvantage that people make some pretty poor decisions at times. It is part of a much bigger picture.

Ms MANISON: Out of this committee we are going to put a report to government to consider; we will put some recommendations to them, but for an organisation like CatholicCare, which is right out there dealing with people on a day-to-day basis - it sounds like you would like to do a bit more work in the FASD space, so what would you like to see in terms of resources or direction from the government that would be helpful for you to be able to go out and do more FASD work with your clients?

Ms HARDY: A lot more support out there for parents, like a meeting place where they can go and talk about FASD and what it is all about. A lot more of the resources being Indigenous-specific; within their - every community has a different language, so for a lot of them, English is their second or third language. There is probably a big need for resources to be Indigenous-specific.

Madam CHAIR: So they can get the message and understand the message?

Ms HARDY: Yes.

Ms BURNS: If you think of it in terms of being on a spectrum as well, the early intervention and what we are talking about in the educational materials, and skilling up staff such as AOD, and safe house staff, people who are working with families as well so their knowledge and understanding is right up there, you use that early intervention approach. Then, also the diagnostic issue as well in being able to invest in that and having an appropriate tool. Also, where does FASD sit in recognition of whether it is disability? It is all that, which makes it too hard to complex, then we continue to bumble along.

The short-term funding, whilst we learnt - and we benefitted a lot and the communities we serve benefit a lot - you need to have that, 'Okay we are really committed to this. This is going to be a long-term strategy we are going to develop and work on', right across, as you say, health and all of the different areas of NTG and federally.

Then, I guess it is what Milly is saying as well, further along the spectrum, when you have the families who are trying to manage, cope, and understand what this is all about, and where they get that support from

as well. Then, you have the kids when they start to enter school age, and what kind of support is, potentially, available to them. That is probably a very big wish list ...

Madam CHAIR: That is probably a very big spectrum. Gerry, I know you did not miss it. Did you want to ask any questions?

Mr McCARTHY: I am sorry I am a bit late.

Madam CHAIR: No, that is all right.

Mr McCARTHY: No. Thank you for the submission, and I will read up on that. I am sure members will (inaudible).

Madam CHAIR: Thank you, Kim, thank you, Milly, for coming. We will send you a copy of the draft *Hansard* for you to check to make sure it is all accurate. We will be in touch.

Ms BURNS: Thank you very much.

Ms HARDY: Thank you.

The committee suspended.

DANILA DILBA HEALTH SERVICES

Madam CHAIR: Welcome. Thank you for coming here today and taking the time; we appreciate it.

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 through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If, at any time, you are concerned what you say should not be made public, then we can go into a closed sessions and take your evidence in private.

For the record, can you state your names and the capacity you are here today, please?

Ms HAVNEN: Yes sure. My name is Olga Havnen. I am the Chief Executive Officer for Danila Dilba Health Service.

Dr STEPHEN: I am Doctor James Stephen. I am the Senior Medical Officer for Danila Dilba Health Service.

Ms McLAUGHLIN: Joy McLaughlin. I am actually a Senior Project Officer rather than a Specialist Consultant at Danila Dilba Health Service.

Madam CHAIR: There you go. That is why we ask. Thank you. Did you want to make any opening comments or statements other than what you put in you submission?

Ms HAVNEN: We might take that opportunity to make a bit of an opening statement, and we can have a general discussion.

First of all, thank you for the opportunity to appear before this committee. I think the work you are doing is really important. I also acknowledge, of course, the Larrakia as the traditional owners here for the lands in Darwin.

Our submission covers most of the key points with some detail, and we are happy to answer any questions as you go. I take this opportunity, in making an opening statement, to highlight and emphasise that there are several critical and overarching points we make in our submission, in what might be some successful responses to dealing with FASD in the Northern Territory.

The first point I make is that while FASD seems to be, or appears to be, more prevalent amongst Aboriginal Territorians than the broader population, this is not an exclusively Indigenous issue, and it should be viewed as a whole-of-community issue. It can affect anybody, and the impacts are felt across the whole community.

The other point to make is FASD does not happen in isolation; it is part of a broader picture, particularly with respect to the high rates of alcohol consumption in the Territory, and particularly the risky and harmful rates of consumption.

The other point to make is that there is clearly a high level of continued, significant disadvantage that Aboriginal people in the Territory continue to experience across a whole range of measures, and I think without serious attention to some of those broader issues it is probably unlikely we can find successful remedies to address and reduce incidents of FASD.

Key points that I would also make are that I think the committee needs to consider an integrated approach to how we respond and deal with FASD, and certainly a population focused prevention strategy would be one of the key points we would make.

I think seriously reducing supply of alcohol and its availability and the harm that it causes across the whole community is a critical issue of concern. The point I would also make is that I think simply targeting pregnant women is probably unlikely to work. I think the problem really is about the drinking culture across the whole of the broader community, and that needs to be addressed. I think social attitudes to drinking and what constitutes acceptable consumption of alcohol in the Territory seem to be way beyond what would be reasonably expected or acceptable elsewhere.

Targeted prevention as part of an antenatal care program, support for parents and families during and after pregnancy and support for individuals, families and communities in helping people to deal with and manage those people with FASD diagnosis.

I think strategies targeting alcohol related harm, including FASD, must be underpinned by serious attention to the social determinants of health and, again, I would make the point about the levels of harmful and risky alcohol consumption in the Northern Territory, particularly amongst the Aboriginal population. It does not occur in isolation and nor are they necessarily simply a result of a lack of effort or personal self-control.

Patterns of problem drinking often flow from entrenched disadvantage, intergenerational trauma, unemployment, homelessness, overcrowding, poverty and the like and I guess those points would probably be made by many others before us.

An integrated approach, I think, is clearly something that needs to be carefully considered particularly, with primary healthcare playing quite a critical role in the prevention of FASD, given that primary healthcare services, particularly ones like the Aboriginal health sector, generally tend to come in contact with or provide services to pregnant women and women prior to pregnancy. I think it is in that health services context that perhaps we have some real opportunities with early intervention, prevention and some of those kinds of approaches.

I think that there is also a need for additional capacity in terms of identifying and collecting data particularly around alcohol consumption and attitudes to drinking during pregnancy. I do not know that there is a whole lot known about that and I think the previous presentations here before the committee by CatholicCare were probably making those points as well. The key to all of this, I think, is really about continuing to encourage early engagement with the healthcare sector, particularly during the first trimester, during antenatal care - the earlier the better.

There is clearly a need to develop and implement strong evidence-based interventions and to provide ongoing support for families and parents to reduce or avoid alcohol consumption during pregnancy and in the early years in the lives of children.

Another key points that I would make is that the information base on FASD needs significant improvement. There is a lack of updated diagnostic tools, which means you cannot accurately assess the prevalence of FASD, and this reduces our ability to know the extent of the problem and what resources are needed to address it.

Our submission calls for the adequate resourcing of the Aboriginal primary healthcare sector to allow for proper interventions for FASD and for integration of approaches such as family support programs, outreach, the family nurse home visits type partnerships, with a focus on children, infant and maternal healthcare programs to strengthen and support families with a focus on improving the health outcomes for kids.

These approaches have clearly been proven to improve child health and have the potential, I think, in combination with population-wide approaches to impact on the prevalence of FASD.

Our submission proposes the establishment of a safe, health promotion, safe, healthy accommodation, services for pregnant women who are at risk and particularly for those women who might be wanting to avoid living in circumstances where high and heavy drinking, or alcohol consumption, may be prevalent, so I refer in our submission to a program that was established by Australian Red Cross in New South Wales that provides a sort of residential care program for young women - that program was started really as a way of trying to reduce the removal of children from families at risk of going into child protection.

I think a similar sort of program here where you can provide safe secure accommodation, together with education programs and support services for vulnerable pregnant young women, might be a way of trialling to see how that would work.

I think we need some solutions and more than just an education program. I believe you mentioned the effectiveness of those quick campaigns; having a similar sort of campaign around educating people not to consume alcohol during pregnancy or even prior to conception is something we probably need. How effective that would be is probably difficult to measure but certainly the tobacco campaign program seemed to work over a long period of time and maybe we need to take similar steps in that regard.

To wrap this up, one of the critical issues here in the Territory - and it is often mentioned in various other forums and submissions - is around supply reduction measures for the sale and availability of alcohol. I think it is really worrying to continue seeing these two page spreads by Coles and Woolworths and the big liquor outlets advertising multiple bottles of wines and spirits at heavily discounted prices. I do not think that is particularly helpful, given all of the problems we have in the Territory around alcohol-related health and family safety issues.

Madam CHAIR: Buy one, get one free - they have those don't they?

Ms HAVNEN: Exactly. Three bottles of wine for $25.

Madam CHAIR: Buy two, get one free.

Ms HAVNEN: Yes, I do not think that kind of stuff is helpful and certainly I do not think we should be encouraging people to consume more.

Madam CHAIR: Is your client base predominantly Aboriginal people or only Aboriginal people?

Ms HAVNEN: It is predominantly Aboriginal people. We have a reasonable number of non-Indigenous clients who access our services.

Madam CHAIR: It is more than just health or is it just all health services? Do you provide financial counselling, all those kind of things or just health?

Ms HAVNEN: It is primarily healthcare services, but it also include a range of community services so youth programs, AOD, tobacco programs, social- emotional wellbeing.

Madam CHAIR: When we were talking about safe health living and that is something - I am sorry, Gerry Wood is not here, because he asked this question of most people. If a woman has a child and belts the child up the woman gets into trouble, but if the woman knowingly inflicts harm on the foetus in the womb, is there not a role for government to ensure that the unborn child is protected - I did not know about this Red Cross program - he is basically saying in a compassionate way, scoop them up, care for them - where is another issue - and how. He always asks if government has a role to protect the rights of the unborn child. Is that a fair comment on what he says?

Ms MANISON: Yes, pretty much so.

Madam CHAIR: What do you think about that? I know it is contentious.

Ms HAVNEN: It is contentious and it is quite difficult. I am not sure that there is any available evidence anywhere in the world that punitive measures actually work.

Madam CHAIR: Not punitive.

Ms HAVNEN: If it was a referral service, if it was voluntary, if it was about educating those women about the risks of drinking while pregnant, absolutely I think that is important, but it should be a referral program, rather than something that was coercible or punitive in its approach.

I am also saying that if you think about young women that may be living in really difficult circumstances and in particular the town camps where you have high levels of overcrowding - really difficult conditions for anybody, but particularly if it is a household where high patterns of alcohol consumption are pretty regular - it is really tough, I would think, for that young woman to not get caught up in that drinking culture.

Perhaps providing opportunities for other kind of safe accommodation and support services and education and healthcare during that pregnancy and perhaps immediately afterwards, maybe six to 12 months, might be a really helpful way to try to break that whole cycle. I think education is a key component.

Madam CHAIR: You know how you have Ocsober and you have Dry July and I think there is one in February but I have forgotten what that is called.

Ms MANSION: FebFast.

Madam CHAIR: FebFast, that one. Do you think they work? I know it is healthy living and all that sort of stuff, or is it just a bit of a gimmick by someone? Could that kind of thing be translated?

Ms HAVNEN: I do not think it hurts. That is the other thing about it. While you might not have a lot of evidence that it is particularly effective, I do not think it does any harm if it raises that awareness for people to think about alcohol consumption and perhaps saying, 'Well, it might be a good idea to get off the grog', or reduce your intake.

Dr STEPHEN: It does fit in, as well, with the recommendations for days of abstinence during the week. For example, two days of abstinence from alcohol during that (inaudible) …

Madam CHAIR: Yes, AFDS.

Dr STEPHEN: … to that broader picture (inaudible).

Madam CHAIR: Okay. I have never done them, by the way. Nicole?

Ms MANISON: You raised an interesting point with your second recommendation regarding antenatal care and data collection. This is the first time I have, during our hearings, heard talk about developing

performance measures around antenatal care relating to alcohol screening at the first antenatal visit for inclusion in child and maternal health datasets. We have been told generally when you present to your health carer upon finding out you are pregnant, alcohol is one of the questions that will be raised with you just to try to – the GP wants to know if you have been or are drinking, to give a bit of guidance that there is not a good impact on your baby if you choose to continue drinking.

What sort of work happens in an organisation like Danila Dilba now around that initial screening when an expectant mother first comes in to confirm the pregnancy? You clearly recognise you think there needs to be more work done in this area. What would you be suggesting?

Dr STEPHEN: The first point is you are right, the first template or the first part of the pregnancy questionnaire includes a question specifically about alcohol intake, smoking, and a whole range of things. That is there. Then, following that is a series of brief interventions that may occur if someone says they are drinking etcetera. There are referral pathways if someone is drinking excessively.

What we are talking more about is being able to quantify that across the Territory. For example, at the moment, there are certain key performance indicators that do not include this sort of question or statistic. It is being collected. I can only speak for Danila Dilba. I know that within most Aboriginal community health services the templates include that. I would say they all include that. But, that is just not collected generally and reported on, so it is not one of the key performance indicators we look at.

Ms MANISON: That has been one of the greatest challenges we have had so far, as a committee. What has been a frustrating point about sitting on the committee, again and again, is we are trying to get an understanding of how far and wide the issue of FASD is across the Territory. The biggest issue has been, given there is no formal diagnostic tool in place in the Territory, processes change from organisation to organisation, and people are really struggling to quantify how big the issue is and how far spread it is.

We have been talking about diagnostic tools. It is good to bring this point up about saying this is another way we could start collecting some good data and information about how things are going.

Dr STEPHEN: Yes, we have some ideas anecdotally, but we really do not have a good understanding of that aspect of it.

Ms MANISON: If a client does present to you and you suspect they may be FASD-affected, at the moment, what is the process within an organisation like Danila Dilba? Is it referrals on to other specialists for diagnosis, or is it …

Dr STEPHEN: We have a couple of avenues. We have visiting paediatric specialists who come and do clinics with us every week. We have a dedicated child health team that sits around that service. We have a

visiting child development team which comes every week which can do developmental assessments. It would be a combination of those – from GP, Aboriginal Health Practitioner giving a broader sense of what is going on in the person's life and family background, paediatric decisions around that, and the developmental assessments. Plus you can get other assessments - referrals to schools to do behavioural assessments in schools and those sorts of things - to get a bit of a broader picture.

It is like you say, it is not that hard for them to diagnose foetal alcohol syndrome right at the very worst end of the spectrum, but there is a fuzzy tail, and people are struggling to

know exactly what that is, where it ends, how much of it is related to alcohol and how much of it is related to other things. It is difficult.

Ms MANISON: And do you have specific FASD programs that you currently run at Danila Dilba?

Dr STEPHEN: We do not have any specific FASD programs.

Ms MANISON: And is that something that you would see as being something you would like to do a bit more of in the future or would it be something that your clients would benefit from?

Ms HAVNEN: I think so. For us at Danila Dilba, over the last few years we have sort of struggled with maintaining staffing levels, particularly in recruiting GPs. That now seems to have stabilised and we have pretty much got a full complement of staff, so then it allows us, with a full staffing complement and meeting the immediate and crisis stuff walking through the door every day, to then really start to take a much more targeted approach in some of these critical areas. Obviously infant and maternal and child health is one of those areas where I think we would like to do much more work - certainly, the nurse home visits partnership stuff doing much more work with young women who you might identify as being vulnerable and at risk or living in very difficult circumstances - so it would be good to be able to provide additional support for them.

Dr STEPHEN: I think even though in the child health team, for example, which sits out at Palmerston, we are almost at capacity in terms of allocated positions - in order to complete all of the healthy under-fives developmental checks that we would like all of our kids to have from zero to five, there is about 40 000 outstanding hours of work to be done and we have about 3000 available hours in terms of staff on the ground so we are way, way behind the gun. It is difficult and then in that context these more pointy-end issues like FASD tend to fall a bit to the wayside, as you just strive to get kids through. A lot of those hours of contact are about immunisations and all the sort of basic things we would expect kids to be able to get.

Mr McCARTHY: Does Danila Dilba conduct any family planning services?

Dr STEPHEN: Yes, a lot of our doctors work also with family planning and all of the doctors provide - and Aboriginal health practitioners can also provide - advice in regard to that. We do not have a specific

family planning service as such but we have a women's health clinic where women can come and ask those sorts of questions. It is integral to that program.

Mr McCARTHY: So you are looking at all the cultural sensitivities around this area, this discussion in the big picture of prevention is better than cure?

Dr STEPHEN: Sorry, Gerry, I am not quite sure what you were asking me.

Mr McCARTHY: I have asked this question right across the Territory and had some interesting responses - from my personal knowledge, the cultural sensitivities around discussing pregnancy for instance. It has been interesting that some health services have determined the difference between males in that space and females. I was just interested as to whether Danila Dilba is exploring that area and has got some comments they would like to give to government about how it works. Should we be in this space? Is it a resource area? I think that it is important because, essentially, this report will hopefully secure resources.

Ms HAVNEN: If it is about choices for women about planning families and planning pregnancies, yes absolutely, that is very much part of the educational support that opportunistically is provided as women come into the clinic, particularly if they are seeking women's health services. In terms of people's attitudes about when they start a family, the size of their family and so on, they are very much individual and personal choices. Given the mix of our client group, that includes everybody from visitors from remote communities out bush, people who might be living rough or in the town camps through to people who have regular mainstream jobs, so there is enormous diversity in that client group. I do not think you could categorically assert that there is a particular single view about family planning. Clearly one of the clear messages for us, and I think from any health professional, would be for young women to delay or avoid teenage pregnancies. Clearly that is desirable on a number of fronts, but that is also pretty tricky in whether or not people choose to want to make themselves available to access that information. I think it is a highly varied and mixed picture. I do not know - James you might have more to offer.

Dr STEPHEN: No, I agree I think the key thing is this idea of offering choice, so we have a men's clinic, which is exclusive for men. Men can come - and do come - and talk about their own reproductive issues. Women can choose to go to a women's only area and have conversations where they feel safe and all the safe conversations can take place across the other primary healthcare services, where people may not be so worried about the gender specificity of it, so it is a really broad spectrum of people that come to Danila Dilba and we have got this adaptability to manage that.

It is different to out bush. If you were out somewhere like Galiwinku, it would be much more likely that those sort of gender-specific issues would be higher on people's list.

Mr McCARTHY: Sure. A lot of the medical evidence that is coming in looks at the first trimester and a lot of comments have come across the table to say women do not really know that they are pregnant, and it is this period where the damage could be done. I just feel that government really needs to respond to that part of the debate with some interesting new resourcing into family planning and education and awareness, so that people are aware. I understand the complex cohort an Aboriginal health service would deal with, but I think as we go down the road and people start to use the service in more of a mainstream sense as your local GP, and having more contact, then governments could be in that space to resource those sorts of programs, the family planning, the education. That is one thing I have been thinking about as we have been travelling the Territory for hearings.

Dr STEPHEN: Yes, I think having that message out and clear in the community before people are drinking and engaging in sexual activity - they may fall pregnant knowing that and raising the awareness around that and having opportunities to go and seek contraception if people want to, that is a key part of it, there is no doubt about it. Perhaps that could be looked into in terms of resourcing, further resourcing.

Mr McCARTHY: Would you put a priority on a government intervention? Should it be really focused on education and awareness, or should it be dominated by the high-level medical fraternity to start developing diagnostic tools and all those sort of aspects of this whole discussion?

Ms HAVNEN: I do not think it is an either/or, I think you actually need both. Certainly education plays a critical role and clearly the longer that you can keep those young women engaged at school - there is good evidence from the World Health Organisation that says, for any additional year of secondary education for women, you can improve the life expectancy and health outcomes of their immediate family by six to eight years. So even just that thing of delaying pregnancy, moving it from teenage years into their twenties and thirties, that in itself would be a highly desirable thing, but that is not going to happen overnight.

The other thing is coming back to the diagnostic tools. If you have better capability of diagnosing and assessing whether somebody has FASD that may help get better access to services for that particular person that is affected. I think the general education around problems associated with drinking is probably something that needs to be done really well and it has to be targeted to the Aboriginal community in a way that is relevant for people in their local context; it is delivered in local languages, that it is on visual, all of those kinds of messages, but at the same time you would not want to be running the risk that women potentially end up in more vulnerable. Say for example, somebody was pregnant, they were drinking and then they end up getting beaten up by their husbands or boyfriends. That is not a desirable outcome either, so I think you have to be pretty careful about how you construct your messages and how you can provide that support to women that says, 'Please think about what you are doing and understanding what impacts this may have on your unborn child'.

I do not think people set out deliberately to cause harm to kids, whether they are born or not.

Dr STEPHEN: There is a gap as well in services, and I think the last mob talked a little bit about, in terms of linkages and I think you guys were – heads nodding about the communication and the linkages

between the primary healthcare service, alcohol and other drugs, CatholicCare etcetera. It is quite disparate and there is not a lot of really good collaboration, I think, and perhaps the model we approach to alcohol in general when someone is in strife with alcohol is a bit lopsided towards either residential rehabilitation, mandatory rehabilitation, detox and no follow-up support services.

I know there is an increasing move to consider alcoholism more in terms of a chronic illness rather than this other thing we have not wanted to include in that broader definition. We could make some serious inroads into that space by linking up primary healthcare services like Danila Dilba with Alcohol and Other Drugs in the hospital, for example. In the same way, we could have the paediatricians come and sit with us and work with a team around child health issues, and work with our GPs and Aboriginal practitioners around developing care plans for people with alcohol problems. In other words, trying to resource treatment for these problems within that primary healthcare space, rather than it happening in either alcohol rehab or somewhere else.

To do that, it is not enough just to have a GP and a client. You need the ability to go out into a community - family support workers and people to manage those links - to bring people into clinic to link them up with other services to provide that support, that glue - it is not a clinical role but a support tole. We are doing this at the moment, and it is happening all around Australia more and more in the chronic disease care coordination space. We have found it to be a very effective way of engaging people who are otherwise not engaged with their health. It might be cardiovascular disease or someone with cancer. We have several examples of this where the addition of that person into their care team - someone who is able to go out and visit them at home and find out what their real issues are - allows them to be confident to go to their cardiology appointments and come and see the GP. This business is actually working quite well. I believe it could be applied to alcohol problems equally.

Mr McCARTHY: Anyinginyi Health in Tennant Creek have had a lot of recognition around their whole-of-community approach and the work they have done. It was interesting, in a community forum that was held in Tennant, the number of men who turned up. It was great to see a lot of young men in the room. The message was to the family. It was not about 'the woman', it was to the family. It was if you are going to abstain, then it has to be a consensus across the family about the management of alcohol intake, not just focusing on the woman.

There were some really positive moves in that area, in the mirco sense so far. It sounds like that is the model. The Central Australian Health Congress presented some very specific material around the zoning in on zero to three, not only education and awareness around the protection of that child in alcohol abuse, it was also the stimulus - that whole package of development or activities and the education of the family to get through that really critical period before they then attend preschool and, then, formal schooling.

Dr STEPHEN: If that is your first child, then you develop those strengths within your family and education, then your next child is probably going to be more likely not to be exposed. So, you are going to get ahead on that in that sense as well.

Mr McCARTHY: I see it as good evidence for government. We can get some real specifics. Let us face it, there will always be limited resources, so it is about how to apply them for the best benefit.

Dr STEPHEN: That is right.

Madam CHAIR: We heard from people in Tennant Creek, and also in Alice Springs, the police officers at the bottle shops saw a dramatic – well, it is not too dramatic - decrease in alcohol-related violence, assaults and admissions to hospital. Anecdotally in Alice Springs, they were told that attendance in classes had gone up, but they are still trying to get the factual information on that. Some of them support the BDR. Even the publican said he wants it back. Do you have a view on a BDR, or the BDR, or something like the BDR to try to limit the supply or stop those who should not be accessing alcohol for whatever reason getting access it?

Dr STEPHEN: So you are talking about the old …

Madam CHAIR: Yes, show your licence.

Dr STEPHEN: Show your licence.

Madam CHAIR: And if you have some alcohol-related assault or DUI conviction you lose whatever to buy takeaway.

Dr STEPHEN: Personally, I think – I know John Boffa is a big proponent of this and I think the evidence was there of it being successful. Yes, I think it is a good idea.

Ms HAVNEN: I think the experiment in Tennant Creek too, where they had the bans on takeaway sales on Thursday - my brother was involved in helping set that up when he was at Julalikari. I think there are a range of measures that have been tried that have been shown to have some level of effectiveness, and I think we do need to look at that, whether it is the Banned Drinker Register or some other form of saying to people, 'Well, you do not actually have a right to go out there and get rotten drunk and cause havoc to yourselves and to others'.

I am not sure that just that on its own is enough. I think there are bigger issues for us around the whole societal attitude here in the Territory about alcohol consumption. It has still got this notion of the last frontier and the Wild West and this is just what we do and it is part of the Territory lifestyle.

Madam CHAIR: That is the culture you referred to earlier.

Ms HAVNEN: Yes, that is part of the culture and I think that is what has to change. I think the other thing is that patterns of drinking amongst Aboriginal people, particularly the harmful patterns of drinking, are actually quite different to that of regular mainstream other Australians. This tends to be - Aboriginal patterns of drinking tend to be in groups, so there is a lot of pressure on people to drink. If you are with that group, I think it is very difficult for people to resist the pressure of not drinking.

So if you are in town it is almost something that you are going to be exposed to. I think maintaining dry communities and really limiting access to alcohol in remote communities is a good thing and I think that should be retained. Certainly that was the very strong view of people in Central Australia back in the 1980s. How we manage this in town, I think, is a much more complex issue, but again I think you have to bring the general community on side with it, otherwise you run up against this thing where there is this absolute resistance, backlash and animosity about those things because non-Indigenous people, 'Hang on, this is inconveniencing me. I do not have a problem with grog, so why are asking me to do this'?

So changing some of those attitudes is going to be really hard, but I think there needs to be a bit of an education campaign for the broader community around it.

Madam CHAIR: I do not know, but somewhere like Bagot and 15 Mile Camp - are they dry communities?

Ms HAVNEN: They are meant to be.

Madam CHAIR: They are meant to be.

Ms McLAUGHLIN: They are still under the Stronger Futures legislation.

Madam CHAIR: Okay.

Ms HAVNEN: I think it is very difficult again. I know Knuckey and those other town camps where households and families may want police to come in and deal with problem drinking in those town camps, it is very difficult to get police to respond to it in a timely fashion.

Mr McCARTHY: On that comment about the general population and the mainstream, you are spot on, and that is the political pitch. That is really what dominates the debate and it is really sad that it is so powerful. So in terms of putting on the record here the FASD campaign - government essentially has asked for recommendations or a report and recommendations and a way to go forward, so do you think it could be become part of the solution, not part of the problem, because essentially if you look at some of the

initiatives that were created in recent times, the debate was essentially about a seven second disadvantage to buy takeaway alcohol. That dominated the debate, when really we should be focusing on being part of the solution, all in this together.

So do you think this FASD debate could be one of the deal breakers? We should pursue that?

Dr STEPHEN: That would be great.

Mr McCARTHY: Righto.

Ms McLAUGHLIN: I guess I would also say the key to this is bipartisanship. There are people here from both major parties –I do not think we have got any Palmer United people here – but if politicians do not allow it to be a point of division then it can shut down a lot of that debate. If nobody is going to respond to the, 'I do not think it is fair that I cannot buy my alcohol without showing ID' - bipartisanship is the thing that will shut that down.

Ms HAVNEN: I also think, too, it is about what is in the best interests of children and our community. People want a safer community. People do not want to be subjected

to violence. You do not want to see kids being harmed. There is a sense of common interest for others in our community, not just about a personal self-interest.

Madam CHAIR: Sometimes - this has come out and I have made comment before - the rights of the individual are sometimes lower than the rights of the community, which is what you are saying. The rights of the community should be paramount. Yes, the rights of the individual are important, but you have got to do what is good for the whole community.

Ms MCLAUGHLIN: And in particular the rights of the most vulnerable in the community being, in this case, children and babies.

Ms HAVNEN: I think also people need to understand as individuals that you actually bear both the social and economic costs when these things are not addressed in a systematic kind of way. When you realise that kids who do have an FASD diagnosis are not likely to lead an independent life and they are going to need lifetime care, that comes at a financial and an economic and a social cost, not just to the individuals and that family but to the broader community.

Madam CHAIR: I think they have started to put a cost on an individual for the life, haven't they?

Ms MCLAUGHLIN: It was a lot.

Madam CHAIR: It was a lot.

Ms HAVNEN: It would run into the hundreds of millions of dollars, so it is a no brainer.

Madam CHAIR: Yes. Thank you very much for coming here today. It is much appreciated and we will send out a copy of the draft *Hansard* for you to just go through and check that it is all accurate for what you said. Thank you very much.

The committee suspended.

NORTHERN TERRITORY COUNCIL OF SOCIAL SERVICES

Madam CHAIR: Welcome, hi, Wendy. Thank you for coming today to this public hearing into action to prevent Foetal Alcohol Spectrum Disorder, and we appreciate you taking the time out 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 web site. A transcript will be made for use for the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you say should not be made public we can go into a closed session and take your evidence in private. So for the record, could you state the capacity you are here, please.

Ms MORTON: Wendy Morton, Executive Director of the Northern Territory Council of Social Services.

Ms BOWDEN: Samantha Bowden, Board Member, Northern Territory Council of Social Services.

Ms COALTER: Nicola Coalter, Board Member, Northern Territory Council of Social Services.

Madam CHAIR: Thank you. Did you want to have an opening statement or comments?

Ms MORTON: Thank you for the opportunity to present today. I think that the feel from our board and a lot of people I talk to is that it is really encouraging and welcome that this inquiry is happening. As you probably know NTCOSS is a peak body for the community sector in the Northern Territory and a voice for those who are most disadvantaged in our community. Our member organisations span from both very small organisations to large organisations in the Northern Territory, Aboriginal and non-Aboriginal organisations, and those in Darwin and Alice and more remote areas. I think we currently have about 135 members.

The community sector plays a vital role in creating social wellbeing for all Territorians. The sector works in building safe and healthy communities by providing services that enable people to access and participate in education, employment, economic development and family and community life.

FASD has a significant impact on children, families, young people, adults and communities. The culture of alcohol consumption in the Northern Territory means many families may be at risk of a pregnancy affected by alcohol.

The over representation of Aboriginal children among children diagnosed with FASD is of great concern. Aboriginal children are already developmentally vulnerable and many are living in communities of high disadvantage. NTCOSS represents a service sector with a high level of contact with affected individuals and families. We support an evidence-based approach of best practice in public health and other disciplines, a coordinated and culturally safe response to FASD in the Northern Territory.

I wanted to highlight one bit of research we have included in our submission, by Nancy Crawford, who lives in Canada.

> *Poole argues that maternal alcohol use needs to be viewed in a context, both of the mother's health access to antenatal care, stress and nutrition, and within a broader context of her age, genetics, resilience, isolation, exposure to violence and poverty.*

She identified some barriers to FASD prevention, which included: women reportedly feeling the guilt and shame which prevent them from reporting their alcohol use in pregnancy; women are fearful their child will be removed from their care if they disclose alcohol use in pregnancy; doctors and health providers do not feel fully prepared to discuss the issue with women; and problem alcohol use in women is often not recognised or treated.

We wanted to highlight a couple of features of what we think an effective campaign should include. That would include development of health promotion materials, awareness campaigns, alcohol consumption guidelines, warning labels on alcohol, and materials for group work facilitators.

We believe a range of strategies are required, including: a whole-of-government response, with FASD systematically integrated into service development and policy, which is informed by best practice evidence and current research; a commitment by government of all sides, providers, and communities to address FASD through culturally secure strategies, in partnership with all people, and specifically Aboriginal people; comprehensive, population-wide public education campaigns focusing on the risk of alcohol consumption during pregnancy; training for those who are working in the field, including education, justice and care; promotion of evidence-based screening at a population level; brief intervention by a diverse range of health professionals working with women who consume alcohol during pregnancy; intervention of FASD needs to be non-judgemental, sensitive, and cognisant of the likely potential for stigma; specialist services for pregnant women and research on effective treatments for women with alcohol use disorders; recognition of FASD as a disability; and access to a range of services to support those individuals across their life span.

While FASD can be integrated into the service system in many respects, there is a need for a dedicated, local FASD projects to raise awareness of the issue, develop local strategies, and education the community, professionals, and key stakeholders. Education and support also needs to include men, around the issue of alcohol and responsible parenting.

I agree with Olga's comments she made earlier around the economic cost of FASD as well and the idea that if we invest money early and prevent the issue of happening, we will save money later on. I have with me two board members who have a lot of expertise in the area of alcohol and working with women, and I am happy to answer any questions.

Madam CHAIR: I will start. We have heard before from groups about having FASD classified in the disability system. How does your organisation classify disability? If FASD is defined as a disability, what does that give us?

Ms MORTON: I do not think we, as such, have a definition of disability. I suspect, like most others, we go on government definitions of that. But, when you are talking about an issue where people's learning, for example, is impeded, or their ability to be independent to learn from their mistakes, then you are looking at a group that needs some specialist assistance in that area. Anyone else?

Ms COALTER: What Wendy was talking about where it is widely acknowledged, and there is an evidence base that people who are diagnosed will have ongoing, lifetime learning issues and will not be able to completely contribute to society. In that context, if I am not able to then, surely, it makes sense that I am provided with extra social supports for my carers, for my family, and for my community.

Madam CHAIR: Okay, thank you.

Ms MANISON: I know we have some great expertise here before us with regard to alcohol and support services for women and families. When you are presented with a woman who is pregnant, who is grappling

with alcohol issues, what sort of supports do you think they should be given to help them minimise alcohol consumption during pregnancy and, hopefully, stop? What are the pathway treatments you see as most effective to help them through that pregnancy?

Ms COALTER: I also work in a treatment agency, Amity Community Services, where more than 80% of our clients present around the issue of alcohol, and that is not just women. Rarely do we see women who are pregnant with alcohol issues because potentially they are not being screened at their first point of call at a GP, a doctor, at an antenatal process. We would work from the position of alcohol being - it was acknowledged before - an Australia-wide problem. Australia drinks too much alcohol and here in the Territory we drink more than anywhere else. It is definitely a cultural concern around that. There are best practices around working with people with alcohol and that is from a non-judgmental point of view. So it is about first of all reducing the harms; it is not always about giving up, although for a lot of people that becomes the end goal when they can recognise from the information and education provided that it is potentially a very high-risk type of behaviour. If we had specialised programs with first point of contact health professionals, GPs in the antenatal clinics where it could actually be screened and determined that there were high-risk levels of alcohol consumption going on, we could then prevent further issues going on.

But what we are really missing here in the Territory and probably Australia-wide is prevention in its true sense so starting way back when girls can first actually become pregnant. In our sexual health through our schools we are not talking about alcohol consumption there, we are not talking about the potential health risks, so we need to actually look at it in a true prevention framework and incorporate this kind of information in education to the youngest of children who can actually become pregnant, and it needs to be more than just focussing on women. We need to focus on the men in our society as well.

Ms BOWDEN: If I can just add to that - it is really important we support men to support their partner if they are a woman, and on top of that support men in a community to support other men in the community, to say it is okay if our wives do not drink when they are pregnant. One of the studies that came – this is in the NTCOSS submission – of the men the study spoke with, 80% did not want their wives or their partners to drink less. That is a significant population of men and you can imagine the pressure that is on individual women and women across that community to not change their behaviour if they want to. Imagine what happens to a woman who is the partner of one of those men when she says, 'I do not want to drink'. If his attitude is very clearly positioned that he wants her to drink or he does not want her to change her drinking behaviour, what has she come up against, what transcribes in that evening or that daytime when she says, 'I do not want to drink' and she keeps saying that? For how long can she keep saying no? What pressures is she under to hold her position, which might be that she does not want to drink or to capitulate to his position to avoid his behaviours or the pressures from other people in the community?

Another one of the studies in this was focused on Aboriginal women in Canada. They looked at how to support women and it was about providing a non-judgmental, empathetic service where women are engaged to talk about what is happening with their drinking behaviour and what the impacts might be on their unborn child, rather than taking a punitive response to make women feel guilty, and then they are a long way away from any service response, they are a long way from any support for themselves, for their family or their unborn child and the child who will eventually be born.

One of the other studies talked about the risk of termination if women are feeling guilty about how the community sees their drinking and in cases where a safe termination is not available we know what lengths women will go to, which are unsafe, where terminations are not available safely. There is a complexity of pressures on women, so the most important thing is that we have an open conversation where women are not judged as being bad mothers or bad women, that women are under a whole range of pressures in their immediate lives and the pressures that come with them from childhood, which might be reasons why women choose to drink. It is about having a non-judgmental service sector and community where we are all saying – I think you mentioned it, Mr McCarthy – we all want to be part of the solution. We are not pointing out individuals as people to be blamed. We are all here to take responsibility rather than the people over there taking responsibility.

Ms MORTON: Can I add on to what Sam was saying earlier, about the need to include things such as FASD in the current family violence strategy the government is developing. They are looking at an alcohol strategy and the need for all of those things to be linked, because they all play such an interconnected sort of role; that you develop each of them in isolation defeats the purpose at the end and that is how they think, but they are also key to the other.

Mr McCARTHY: Just a comment and for discussion - the report from this select committee and then recommendations to government - I am getting the picture and following NTCOSS's work over a number of years now, working in parliament, it really is important to stress that investment early will reduce budget outlays later. We really need to put that on the record, really push that and FASD highlights that debate. In an economic sense and in these quite big changes we are seeing now about fiscal management at a federal level right through to the states, then it should be put down loud and clear that this is a good strategy to invest in early.

Ms MORTON: I heard a figure, and I do not think anybody knows the figure and that is one of the issues - we actually need to find out what the prevalence of FASD is, but I have heard figures that about 80% of children in out of home care may have FASD. So when you look at how much that is costing …

Madam CHAIR: Say it again, Wendy, how many?

Ms MORTON: I have heard – and this is just anecdotally – around 80% of kids in out-of-home care may have FASD. It is incredibly high and I do not know where the person got the figures from, but we know that – I think one piece of research in here talked about 45% or something - and then I suspect if we looked at the percentage of young people in our detention centres and gaols that there is also an incredibly high population. It is costing our community an awful lot of money and we are putting in strategies for a group of people that are maybe the completely wrong strategies because of their FASD.

Ms COALTER: And we may be missing people in our population because we do not have population-level screening for this disorder. So it seems critical to know what we are actually dealing with, and that we

start off with population-level screening. I do not mean just for Aboriginal people, I mean for all people in our community.

Ms BOWDEN: If we start seeing FASD as a public health issue, like many other public health issues, then we know the evidence is we put in money in prevention and early intervention, and we have hard conversations in the community through health promotion campaigns, and that is where we invest and what that does later goes to prevent chronic disease or other impacts on the economy. Australia was very good in the early days of the HIV epidemic when we had hard conversations about things like sex and drug use and governments were courageous when they formulated the needle and syringe programs. They are really difficult conversations to have in the community, but what they did was prevent a whole range of chronic HIV and Hepatitis C in injecting drug users over now what is 30 years.

If you cost out the cost upfront of needle and syringe programs and health promotion campaigns early on, which are led by the community, it is much cheaper than them paying for hospital care over a person's life time on an individual basis. It is really important we look at this as a public health issue and just apply generalist public health frameworks to it, and then we are all part of the solution and we are not singling out individuals as people to be blamed. We can support them.

Mr McCARTHY: That is a great analogy. Thank you for putting that on the record.

Ms COALTER: Australia was actually the world leader in the public health campaign that addressed needle and syringe programs, but we have somehow dropped off the radar around public health campaigns because we tend to be moving towards looking for blame and criminalising a behaviour that is not a criminal behaviour. Drinking alcohol is not a criminal behaviour.

Madam CHAIR: It is a legal substance.

Ms BOWDEN: If we continue down the HIV analogy, in the HIV sector we are moving towards a more scientific biomedical approach to controlling HIV infection rates in Australia. But, that does not always work. We need to make sure our focus is on the public health frameworks and supporting people to change behaviours or reduce certain behaviours, so people are drinking more safely or, if they can, stop drinking for a period while they are pregnant. If we are not having those hard conversations and not criminalising people, we start to lose traction and we lose contact with the group of people who most need our support.

Mr WOOD: I am interested in the debate about alcohol abuse in general. It is important we are trying to deal with those issues. However, in the case of FASD we are dealing with more than just and adult who had an alcohol problem; we have an unborn child. We have three people really - mum, dad and a child.

If you want to talk about it from a health prospective, then the unborn child should have the right to be born healthy. The question I have is not about criminalisation, but where does the role of the government step in if it believes a child should be born healthy? After all, if it is born and the mother wacks it, the day after it is born mum goes to prison. But, if mother drinks - for whatever reason - and that causes the child to be injured, presently nothing happens.

What I am asking is, bearing in mind we have all sorts of reason why a woman might continue to drink after being told 'do not drink', where does the government sit if it knows a person is continuing to drink and that child is pretty well going to be affected by alcohol? What is the role of government? I have raised this issue at most meetings. I am not talking about putting people in prison, but whether there could be a community-based process where that woman is, somehow, protected and encouraged, but she is not allowed to drink so the baby can be born without that affect. I do not know what you people would think of where the government would fit into that.

Ms COALTER: It sounds, Gerry, what you are talking about is prevention once we have recognised there is potential for further harm. Once we have identified a woman is pregnant and the female is consuming alcohol at unhelpful levels, the medical association would suggest that, once pregnant these days, no level of alcohol is safe.

That is where we can talk about early intervention. It is not prevention, it is early intervention in providing education and information. It is building a workforce - a sector - where our GPs are asking these questions and providing information, education and, potentially, options of services where woman can seek information in non-judgemental ways to help them change their behaviours.

Ultimately, if we move down the same track the Territory is moving around mandatory alcohol treatment, we are going to be pointing fingers at woman. We are going to be blaming them, marginalising them, and incarcerating them. So, essentially, what would be a useful strategy is to build a workforce and population level screening where we can then take systematic action to prevent any further harm happening to the child and the woman.

Mr WOOD: No, what I am getting at – I understand, I am supportive of all of that, but there is another person here and that is the child. We know from the science that if a mother keeps drinking, the child will be damaged.

Ms COALTER: Well, there is potential risk, and a higher risk that the child will be ...

Mr WOOD: Well, from all the information we have been given, the risk is - I have not seen anything that says that child will be born without having some effect, whether it is major or a minor effect. The Senate held some inquiries into the same foetal alcohol syndrome, and it showed that if you were drinking alcohol, especially around conception and the first few weeks, that is the highest risk. I am basically asking where

the government fits in. If after all that early intervention and all that education, does it have a role, either economically because it knows if this child is born with FASD it is going to cost us - we learned in Alice Springs - hundreds of thousands of dollars, probably even millions for the life of that person, and a good chance they will end up in prison? Do they have some intervention which may not be criminalising if it is done in a compassionate way for the right reasons, not judgmental, but saying we are making a judgment which will help the unborn child? Do they have a role to play?

Ms BOWDEN: I think government always has a role to play and I would not support restraining a person, a woman's liberty, or restraining her access to a non-illegal substance. However I understand the premise that government has a role to play in preventing harm in the community and preventing further costs. In the NTCOSS submission on page 19, there is some evidence that came out of the United States, in a 30-year study of a review of 413 cases of women. They describe it as:

… deprived of liberty due to pregnancy …

I will read the second paragraph:

Concerns regarding any form of punitive measures against pregnant women include the likelihood of women terminating pregnancies rather than being incarcerated or charged.

And I know you are not talking about incarcerating or charging, but there is a trajectory between depriving liberty and controlling behaviour to incarceration and other punitive forms of control.

It is also of concern that for every woman who is placed in a locked facility on a treatment order or under some form of legal control during pregnancy, many other women will avoid disclosing their drug or alcohol use for fear of the consequences. Women will be less likely to seek help for their alcohol use in the pregnancy and they will not have access to preventative programs that support the health of the woman and her unborn child.

So on balance across a population there is not a benefit for a population of women who choose to drink alcohol when they are pregnant and the children that are born from them. Across the population, it does not reduce women's access, women's support seeking behaviours if they see that other women are having their liberties constrained in some way.

Ms MORTON: I think adding to that, numerous other submissions talked about this - we do not in ours - but that concern by the time the issue is recognised, whether it is by the GP or whoever it may be, is that they are actually at a point in that pregnancy where the damage has already been done.

Mr WOOD: We discussed that in Alice Springs and that does not appear to be the case. During the first, second and third trimesters, they said there is different damage caused, but when I asked a similar question about damaging the unborn child with continued drinking, they said yes. I am only going on what I am told now. That was the issue that I thought - is it too late, so just keep drinking? But that is not the impression we got from …

Ms MORTON: But I think it goes to that, if we want to look at this issue in the long term way - I am not dismissing that particular unborn child at this moment in time - we actually have to ensure a whole range of things like safe sex, contraception and understanding the impacts of particular behaviours, so that if women - I suspect this happens in many communities - do not realise that they are pregnant until some way down the track, it is about a whole range of things including access to health services and that support.

Mr WOOD: Yes, I understand that – it is not a simple question or neither will we get a simple answer, but my concern is that the government has a responsibility either economically, morally, etcetera to protect that child. So if someone is hurting that unborn child, then it is funny you have a law that says when you are born, you are protected, but then the damage is done. Should they have a role to play knowing that that child is going to be damaged, to intervene? How that intervention is - there will be many an argument of what is good or bad, but that is the person who gets missed out in the debate. The other people are old enough to make judgments, but the unborn is the one that can end up with damage later on of course.

Ms MORTON: I think that when we are talking about particular high risk groups there are some great programs in place, for example, in Central Australia through Congress around the work they are doing with young girls. As soon as someone discovers they are pregnant they are working through that and then working post pregnancy with those families. I think those kinds of interventions, where we are working with people so much earlier in the phase and then in an ongoing way, are things we need to be resourcing more as well.

Mr McCARTHY: I just find the debate -- the committee has framed this question the length and breadth of the Northern Territory - it is really good that NCOSS has put up empirical evidence to show the minister who is asking about a statutory authority, essentially, within this terms of reference that really is not in the terms of reference, that that empirical evidence suggests that it is not good policy, so you go down that road. It is not good policy and I just thank NCOSS for putting that on the record.

Ms MORTON: We oppose any of that and for the record, can you put NTCOSS rather than NCOSS?

Ms BOWDEN: Just a question on whether a government should intervene to protect the health of the unborn child is on balance - if we intervene in one unborn child's life by restricting the mother's access to alcohol - the evidence tells us that when one woman has some level of liberty deprived in order to protect that unborn child, if that means a whole group of women cease to or are not motivated to seek support, then on balance the government has made a decision in favour of the health of one unborn child to the detriment

of perhaps five or 10 or 20, depending on how many women are responding in terms of not seeking support to the women who has had her liberty deprived.

Ms COALTER: If government was to contribute and buy into a massive public health campaign that is long-term and enduring, similar to tobacco controlling this country, we could potentially see this wiped out within a generation because we are going to educate our people and that is the key. I understand where you are coming from, Gerry, it is a difficult decision and probably one that government may grapple with for years. If we set that aside and we actually dedicate the resources now to a public health campaign, we are potentially going to prevent problems in the next generation and the generations forward, and let government argue and debate that issue for years to come.

Mr WOOD: I do not quite agree with my friend Gerry here that it is not part of our terms of reference; it does ask us what the government role is, and whether people take it as being narrow or broad. That will be for us to argue about. I am not saying people should be driven away from the education; what I am saying is that with all the education and all the advice - you may only be a very small number of people, but if that was the case and everyone had that knowledge and continued for whatever reason I am saying that at that point there might be a court order that says you cannot drink anymore. Does the government have a role? It is obviously a difficult question, but it is not much point having this committee if we do not ask some difficult questions because in the end it is going to cost. There is a cost to government, a big economic cost if lots of FASD children are born.

Mr McCARTHY: It was a difficult question, but they have a great answer.

Ms COALTER: The government is responsible for protecting communities when we do not make those decisions ourselves so I guess it falls under that, but this is a years' long of a debate. If we continue down the track of debating just that point we are going to lose the opportunity of providing reliable good information for people to make informed decisions and change their behaviour now. This is what preventative is, preventing once diagnosed which we are not really sure of because we do not do population screening. We do not even do population screening of women who are pregnant, and some GPs do not even ask the question of how much alcohol someone is drinking. There are some studies coming in from the eastern states now that demonstrate that women between 35-45, educated white women are at a high risk because they are continuing to drink 2-4 glasses of wine every night. As I said earlier, this is not an Aboriginal problem, this is not a Territory problem, this is an Australia-wide problem and it needs a response now.

Madam CHAIR: Thank you.

Mr WOOD: Can I ask a question?

Madam CHAIR: Last question.

Mr WOOD: The study you quote, from page 19, have you got the backing for that? When I say that, the background.

Ms MORTON: The reference for it?

Mr WOOD: The reference group, yes, thanks.

Ms MORTON: I imagine it is in the reference list.

Mr WOOD: It is down the back, is it?

Madam CHAIR: Probably at the back, Gerry.

Ms MORTON: Probably at pages 38, 39, and 40.

Mr WOOD: I did not see any little number, that was all.

Ms BOWDEN: Yes, that is the old.

Ms COALTER: We often look to Canada because of their good practices around first nation people over many decades. They have good, reliable evidence basis for the way of working with people which do not criminalise behaviours.

Mr WOOD: You quoted United States figures on page 19. Is that reference mentioned here?

Ms MORTON: Yes. It is Astley Hotel, which is reference here.

Mr WOOD: Thanks.

Madam CHAIR: That is all right?

Ms MORTON: Yes, it is the second.

Madam CHAIR: Thank you Wendy, Samantha, and Nicola, that is very much appreciated. We will send you a draft of the *Hansard* so you can go through and make sure it is all correct for things in case we have slipped up. All the submissions are on the website of all the groups. We will keep you informed of the progress of the select committee and the final report.

Ms MORTON: Thank you very much.

Ms BOWDEN: Thank you for having us.

Ms COALTER: Thank you.

The committee suspended.

TOP END WOMEN'S LEGAL SERVICE INC

Madam CHAIR: On behalf of the committee I welcome you to this public hearing into action to prevent Foetal Alcohol Spectrum Disorder. We appreciate you taking the time today to come and talk with us. 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 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 might say should not be made public we can ask the committee to go into a closed session and take your evidence in private. So for the record could you state your name and the capacity you are here.

Ms SRINIVAS: Aditi Srinivas on behalf of Top End Women's Legal Service.

Madam CHAIR: Thank you. Is there anything that you want to say in an opening statement or opening comments?

Ms SRINIVAS: I can provide a background of the work that we do. We thank the committee for the opportunity to make further contributions to this inquiry. The Top End Women's Legal Service provides information, advice, case work and referrals to women from a diverse range of backgrounds in all areas of civil law. We conduct outreach clinics to Belyuen, Bagot, Acacia, Amagol, Palmerston Indigenous Village,

Knuckey Lagoon, as well as the adult migrant English program, Palmerston, Darwin prison and conduct community legal education at Don Dale Centre and other venues.

The Top End Women's Legal Service strongly recommends against the criminalisation of pregnant women who consume alcohol. Women who are substance dependent are already less likely to access health services and thus have poorer health outcomes for both themselves and the foetus. Criminalisation would further deter women from accessing services both mother and foetus desperately need and fail to address the underlying causes of their drinking in the first place.

The causes of alcoholism are complex and multifaceted. If the government genuinely wants to address this issue it should be looking to tried and tested cost effective approaches such as those implemented in Canada and expanding some of the programs already existing in the Northern Territory.

Madam CHAIR: Thank you. Would you like to start, Gerry?

Mr McCARTHY: I already like the line of questions you have got here.

Madam CHAIR: We will use some of those.

Mr McCARTHY: I will get you to present some interesting information for the committee. I will just jump to 27. In your submission you note that in the state of Wisconsin women can be taken into custody pursuant to child welfare legislation. Can you tell the committee more about how this legislation works and what are the legal and social issues associated with this legislation? There you go (inaudible).

Madam CHAIR: It must have been Wisconsin.

Ms SRINIVAS: If I may read directly from *Parental Drug Use as Child Abuse*, which has been published on the childwelfare.gov website in relation to an explanation of the Wisconsin legislation: .

A child may be held in [physical custody] if the intake worker determines that there is probable cause to believe the child is within the jurisdiction of the court and probable cause exists to believe that the child is an expectant mother, that if the child expectant mother is not held, there is substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered by the child expectant mother's habitual lack of self-control in the use of alcoholic beverages, controlled substances or controlled substance analogs exhibited to a severe degree, and that the child expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not made a good faith effort to participate in any alcohol or other drug abuse services offered to her.

An adult expectant mother of an unborn child may be held in [physical custody] if the intake worker determines that there is probable cause to believe that the adult expectant mother is within the jurisdiction of the court, to believe that if the adult expectant mother is not held there is a substantial risk that the physical health of the unborn child, and of the child when born, will be seriously affected or endangered by the adult expectant mother's habitual lack of self-control in the use of alcoholic beverages, controlled substances, or controlled substance analogs, exhibited to a severe degree, and to believe that the adult expectant mother is refusing or has refused to accept any alcohol or other drug abuse services offered to her or is not making or has not made a good faith effort to participate in any alcohol or other drug abuse services offered to her.

Essentially, the Wisconsin law, as I understand it, grants independent personhood and right to the unborn child. Low-income and minority women are noted to be especially affected by this legislation which provides the power to detain, arrest, force, and even compel the person to undertake certain medical procedures. The American College of Obstetricians and Gynaecologists similarly oppose criminalisation due to its deterrent effect. I also note that alcohol dependence and abuse are described in the *Diagnostic and Statistical Manual of Mental Disorders.*

Mr McCARTHY: Previous witnesses provided some empirical data to support their case that, whilst this is a very definitive, punitive approach, it can have far-reaching effects on another cohort that will avoid that ...

Ms SRINIVAS: Absolutely.

Mr McCARTHY: As a legal practitioner, do you agree with that?

Ms SRINIVAS: We agree, yes.

Ms MANISON: Do you have much data around the women you represent through the justice system - whether or not you have many clients that are FASD-affected in the Territory?

Ms SRINIVAS: It is a tough question. I could not really provide an estimate, but I can provide some thoughts in relation to it.

Ms MANISON: Yes, absolutely.

Ms SRINIVAS: As I understand the issue, Foetal Alcohol Spectrum Disorder can manifest itself in many ways. The lack of a uniform diagnostic tool which incorporates the racial and facial differentiation

characteristics, hinders the diagnosis. Further, some doctors are reluctant to make such a diagnosis because of the stigma that is attached to it - both for the mother and for the foetus – rather, symptoms end up getting addressed in isolation.

I suspect that some of our prison clients who have, maybe, some impulse control and cognitive impairment issues may suffer from this condition. I could also attribute that to a wide range of other experiences that are associated with complex trauma such as serious domestic violence, child abuse, or sexual abuse.

In the past financial year, for example, 53% of our client base has sought assistance for issues surrounding domestic violence. When you add poverty, lack of affordable housing, and abusive partners to that mix, many have turned to alcohol as a means of self-medication.

Mr WOOD: I was just going to ask on the Wisconsin issue, is it the only state that has that legislation?

Ms SRINIVAS: No, sir. In the United States, Wisconsin, Minnesota, Oklahoma and South Dakota all have laws which grant authorities the power to detain women for substance abuse.

Mr WOOD: The issue of detention versus criminalisation - do those states criminalise or do they just detain?

Ms SRINIVAS: I would have to take that question on notice, if I may, to provide the committee with a comprehensive overview of that legislation.

Mr WOOD: To put a local example, mandatory alcohol rehabilitation is detention, but not criminalisation unless you keep nicking off, which is an issue on its own.

The issue about whether people would get put off attending preventative help – I do not know of the cases. What I would have liked to know I may have to do a bit more work on it. How many Wisconsin women have been put in detention out of the total number of pregnancies? Is it 0.1% or is it a large percentage? Do you know if it is a major issue?

Ms SRINIVAS: I would not be sure of the actual statistics, but there was a case that I did make note of here. It was the case of Alicia Beltran; she was arrested towards the end of last year when she was about 14 weeks pregnant, for failing to consume an anti-addiction drug to counteract her supposed drug addiction, one which she had actually stopped on her own, and this was later verified with a drug test.

After being accused by medical professionals of failing to comply with their direction to consume the anti-addiction drug, she was brought before a family court commissioner, who refused her access to legal counsel, appointed a guardian (inaudible) for the foetus, which is essentially like an independent foetus lawyer, and was forced into drug rehabilitation and that case is ongoing. They are pretty controversial measures, even in the United States.

Mr WOOD: I was probably more interested to see whether there were people being criminalised for that particular matter or it sounds like there is another issue involved in this one.

Ms SRINIVAS: Yes, how you go about enforcing all of that.

Mr WOOD: Also there seems to be an anti-addiction drug involved in that, but that is – I am just interested to know what they class - the keeping people in custody meant.

Ms SRINIVAS: Sure, I will make a note of that and get back to you.

Mr McCARTHY: Can we talk then just anecdotally - you work in Darwin and you work in the Northern Territory. You would be working with the majority of lower socioeconomic clients; how do you think they would react to the Wisconsin legislation being introduced by a Northern Territory government?

Ms SRINIVAS: I would certainly think that there would be a reluctance to access health services altogether during pregnancy, or even immediately preceding pregnancy if they were planning it. The other thing to bear in mind is, as I understand it, almost 50% of pregnancies are unplanned and for women who are dealing with other conditions that disrupt the menstrual cycle, they may not even know that they are pregnant and they continue to drink. They might be doing that damage in the first trimester of pregnancy unintentionally. So, the idea of criminalising pregnant women who are drinking at dangerous levels when they do not even have the intent of causing damage to the foetus just seems really absurd.

Mr WOOD: I am not asking for it to be criminalised, but the issue is whether if someone knows and had all that information given to them and they continue to drink, and they know that drinking will cause an effect, where do you go from there? I am talking about - I would have thought that there would be a pretty small minority of people who would end up possibly in that circumstance. Hopefully the education that you give people beforehand gets people to change their mind.

Ms SRINIVAS: I think that educational component becomes a bit tricky. What I gather from anecdotal evidence is that some medical practitioners continue to recommend - not recommend - but say that drinking moderately, or mildly during pregnancy is okay, so you are getting some pretty conflicting evidence and then one doctor might tell you that it is okay and another might tell you it is not.

I think we need to take a pretty firm stance in saying that it is absolutely no alcohol.

Mr WOOD: We have heard mixed reports on what you say is the case. I have heard it on television, and some of what we heard is that all the midwives and doctors in certain areas do tell them. I do not know whether it is different groups of people, but it was on the news this morning. I was just saying to the Chair that ABC mentioned when they were doing a report on NTCOSS that the concern was about women drinking too much alcohol, which is not what we are about. We are saying no alcohol. Immediately the ABC brings out a story which adds to the confusion - put it that way - but I do not think any of us have heard anybody say there is nothing safer than not. You just do not drink.

Mr McCARTHY: What does the Jean Tweed Centre have that is special?

Ms SRINIVAS: The Jean Tweed Centre is really interesting. It was established in 1983 and it has become a leading community-based substance abuse, mental health and problem gambling agency for women in the Ontario region of Canada. The program offers to address a range of issues in a woman's life that may contribute to substance use. It has a day and residential program, including three weeks of intensive programming and healthy family support to provide a holistic support service. It is not just for the women it is for the fathers as well to come in and learn some healthy habits about the drinking dependence and how to break away from that pattern.

It advocates for the inclusion of children in treatment settings, provides outreach services for marginalised women, and delivers trauma support services too. As we were talking about before, women are turning to alcoholism as a means of self-medication. It also has outreach counsellors who are located at various locations across the city who assist women with parenting and substance abuse issues including child welfare matters, prenatal needs, connecting with local resources, connecting back into community and providing them with those social support structures they desperately need.

Madam CHAIR: Looks interesting.

Mr McCARTHY: What do you recommend this committee should recommend?

Ms SRINIVAS: The Jean Tweed Centre model which would provide outreach services, particularly to remote communities that are already ostracised from those health services will definitely be an option, because it provides that ongoing support. They have done studies to show that even if the first child is affected by Foetal Alcohol Spectrum Disorder, the program has reduced the rates in the second and third children and, sometimes, eliminated that cycle altogether. It is about providing them with the mentoring and support they need to raise their children.

Mr McCARTHY: As a legal practitioner dealing with a lot of people, is FASD in the forefront of your thinking when you are interviewing a client and assessing their offending behaviour or their issues?

Ms SRINIVAS: I must confess it is not. I do not know what it would be like for criminal practitioners, but I suspect the legal fraternity does need a lot of training in this area. We need to be able to identify these issues – not just the isolated symptoms but the actual disorder itself.

Mr McCARTHY: Working in the Territory, have you seen it used as a defence?

Ms SRINIVAS: I have not, no. I have seen symptoms like impulse control issues and that kind of a thing being used but, no, I would not say I have seen it as a defence in and of itself. I would refer to criminal practitioners. I can speak to a few and return with an answer.

Mr McCARTHY: Just a general questions we have been asking across all the sectors of witnesses who have appeared. How cognisant are they? Is it in their professional discourse? Does is feature as an important issue? Yes, there is a whole varying range of awareness, really.

Ms SRINIVAS: Yes, yes. It has recently gained prominence because of Rosie Anne Fulton having been returned to the Northern Territory. No, you are right, it is an issue that has not really been given much consideration. I must admit we had not given it much consideration until this issue had been opened up by the select committee and by the Senate inquiry.

Madam CHAIR: Gerry, do you have anything else? Thank you for your time here today, it is very much appreciated. We will send you a draft copy of *Hansard* for you to go through to make sure it is all okay and we have not made any mistakes. We will keep you posted about the final report and what happens.

Ms SRINIVAS: Thank you.

The committee suspended.

FIRST PEOPLE'S DISABILITY NETWORK

Madam CHAIR: Welcome. Thank you for coming today. On behalf of the committee, I welcome you to this public hearing into action to prevent Foetal Alcohol Spectrum Disorder. We appreciate you taking the time here today with us.

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 for use of the committee and may be put on the committee's website. If, at any time during the hearing, you feel something you want to say should not be made public, we can have the committee go into a closed session and take the evidence in private.

For the record, could you state your name and the capacity that you are here please?

Mr GRIFFIS: Damian Griffis. I am the CEO of the First People's Disability Network and I am joined by my colleague.

Mr AVERY: My name is Scott Avery. I am the National Policy Officer for the First People's Disability Network.

Madam CHAIR: Thank you. Are you Darwin-based?

Mr GRIFFITHS: No Redfern, Sydney.

Madam CHAIR: So you have come up for this especially?

Mr GRIFFITHS: Yes, we are in Tennant Creek tomorrow, anyway, so we thought we would take the opportunity to appear.

Madam CHAIR: Thank you for taking the time out. I have some little notes here about what the organisation does. We have heard from many people who feel the need to have FASD declared - if that is the right word - as a disability. Who does that and what does that mean? Is it something we should be recommending? Who does it and how does it work?

Mr GRIFFIS: We would say it is a disability. It is interesting to us it is even a question, to be honest with you, Chair, because if you look at the definition of disability it says if you have an impairment of any kind that leads to some disadvantage or effects your ability to participate in community life, then that is a disability. We cannot even see how there is even a question around it, in many ways. Absolutely, it should be considered as a disability. It is one of the most significant emerging disabilities in the country.

Disability, in general, is an issue that has been overlooked for too long in Aboriginal communities. There are very high rates of disabilities, as I am sure you would all probably be very aware. In fact, the 2011 Census said that 50% of Aboriginal people had some form of disability or long-term health condition. So …

Madam CHAIR: What is …

Mr GRIFFIS: It was 50%, the 2011 Census. That would be consistent with the anecdotal belief that the prevalence was always twice that than the rest of the Australian population. In Australia, as many as 19% of Australians can be people considered to be people with disability. That is because we have a very broad definition in Australia. You have your very classic disabilities - your sensory disabilities such as hearing and vision, and physical disability. But, if you are a person with a long-term health condition, or even a permanent back injury, for example, then you can be considered a person with disability.

When we apply those things to an Aboriginal perspective, you can start to see how we would have such high prevalence. We would say meeting the needs of Aboriginal people's disability is one of the most significant social issues facing the country.

Madam CHAIR: Is there some movement against having FASD declared a disability?

Mr GRIFFIS: There is some resistance. Traditionally, from what we understand, it has been framed as a health-related issue, so it has taken on that fairly classic medical model response. The medical model of disability, more or less in its very simple form, implies there is something is wrong with someone and you have to try to fix them. So, if you have permanent disability, you cannot be fixed - for want of a better term. Social model of disability says it is society that creates the barriers for people with disability, which is more the way the things like national disability insurance schemes are framed.

That is evidenced everywhere we go. You only have to walk down any street in any city or any town in Australia, and you would see, clearly, it is not a world for people with disabilities. There is a move away from that medical model. That is the reason why it is starting to get more attention as a disability, which we would say is a good thing.

Ms MANISON: If it is formally recognised as a disability, what additional access to services and support would you anticipate people would be able to get?

Mr GRIFFIS: First, there needs to be a lot of work done to understand what the consequences of that would be. I will use the example of the Barkly trial at the moment, which is not considering the needs of Aboriginal people with foetal alcohol. We would say that this is a mistake because, at least within a disability sector, and certainly under things like the National Disability Insurance Scheme, there is an opportunity, at least - and I am not romanticising this – for whole-of-life issues to be looked at, as in education, employment, and other aspects. Whereas, if you just take a medical approach, then the health system will support you and that will be the end of it really – you will not necessarily get those whole-of-life support. This is a problem across the country, so moving away from this medical model the pretty easy to diagnose type of approach to a broader more social justice sort of approach is the challenge. We would say it is critical the National Disability Insurance Scheme recognises that foetal alcohol syndrome is people living with that who are severely and profoundly disabled, and should be part of that scheme.

Madam CHAIR: I think they are in Tennant Creek; you will find out tomorrow. We heard that the two women who were with the scheme, they said they had some children on their books, if that is the word, already.

Mr GRIFFIS: Yes, we hearing mixed messages and I am keen to find out tomorrow what is actually happening on the ground because our understanding was there were a little over 100 Aboriginal people that were identified as being eligible for this scheme, and it is our understanding that does not include Aboriginal people living with foetal alcohol. I have heard public statements from the National Disability Insurance Agency that recognise that if there is a cognitive impairment aspect, and it is severely and profoundly disabling, then they should be considered, but I am not confident of them being counted in the first cohort, if you like.

Madam CHAIR: They may not be. I do not know, they can clarify it.

Mr GRIFFIS: So that is the worry for us.

Madam CHAIR: That is what we heard, I am sure.

Mr McCARTHY: That was the definition around foetal alcohol syndrome, that there were kids identified and registered in the system relating to special-needs support in the schools, for instance, but then the broader context of Foetal Alcohol Spectrum Disorder is really what the committee is learning about, and the medical profession dovetailing into the autistic spectrum to all those other links to cognitive disorders and to behaviour.

Is the network New South Wales based?

Mr GRIFFIS: It is a National organisation. We do have members here in the Territory.

Mr McCARTHY: How long has it been going?

Mr GRIFFITHS: We first began back in 1999 when there was a national gathering of Aboriginal people with disabilities held in Alice Springs, so ATSIC and the Department of Families and Community Services supported that, but unfortunately when ATSIC ended a lot of the momentum went with that, so there was a long period of inactivity. We do have a New South Wales network that was well-established, so our national body sort of reinvigorated in about 2008 and then achieved formal peak body status in 2010. We are a very unique organisation in the world actually because we are entirely governed by Aboriginal people who have disabilities. We have had participants from the Northern Territory in the past.

Mr McCARTHY: And has foetal alcohol spectrum disorder been on your dialogue from day one?

Mr GRIFFIS: Yes it has, but it is becoming a bigger concern for us. I think one of the issues that is a real challenge is the understanding of prevalence. I think the previous witness talked about assessment tools and things like that; that is clearly a major weakness. There is not a sense of how many Aboriginal people are living with foetal alcohol syndrome across the country, not unique to the Northern Territory, and then there is no sense of what their interactions are like with the service system. The way we invariably see it, it is usually the job of the frontline service system - the police really are the ones who engage with Aboriginal people with foetal alcohol, and that is problematic and very challenging for them, we would say. It is a huge issue that requires a lot more understanding.

Mr McCARTHY: Are other jurisdictions further down the track? New South Wales should have some serious understanding and monitoring. I started as a teacher in New South Wales in the mid-1970s and that is when I first came into contact with foetal alcohol syndrome in schools. Have they got 30 years head start on the rest of us?

Mr GRIFFIS: No, I would not say that necessarily, happy to be proven wrong. There has been some good work recently in the Kimberley, led by paediatrician James Fitzpatrick. He first of all did an assessment on the prevalence within the community and when he did that he found some pretty disturbing figures. What he is trying to do is build a service response to it. I would say it is an issue that is not well understood across the country. I do not know if you want to add to that, Scott.

Mr AVERY: Yes, and there are pieces of research happening. I know the George Institute in Sydney is doing a lot of work on some of the diagnostic markers, so how you might recognise someone at risk and some of the physical attributes, but also some of the behavioural things and how it might be misdiagnosed as a behavioural problem, when it is actually a cognitive impairment problem and should be treated as such. They are trying to realign some of their treatment programs in saying it is actually not a behavioural issue and if you treat it like that you will not bring any benefit, but if you treat it as an impairment issue requiring support and involve – it starts off with an assessment; how can you actually do an assessment on this? There is some research happening around that. Whilst there is not a uniform accepted medical diagnostic tool, there is a lot of work that has been done on that.

Again, with some of the other inquiries there is a lot of scoping happening. There was a WA inquiry, I think a year or two ago. It had very similar terms of reference. It has come up in the Senate inquiry in the Commonwealth level. There is a lot of scoping activity that is happening, if you like, that could be pulled together. What is emerging is now there is an understanding of what is there, but there is also some gaps that are evident, particularly where service systems line up against each other.

If you have a look at early childhood, that is organised around zero to four years, and governments tend to organise themselves in silos so they have a program around that. Then, they start school which is five to six. How do those service delivery systems talk to each other? That is where we think there are some

really good opportunities to get some focused activity. The big areas that are generally acknowledged - and it is consistent when we go to communities - is when they start school. There is the handover from health, what are GP is picking up in identifying people at risk. How is that information translated to something that is like a learning program? Day one, rather than thinking, 'Hang on, they have a behavioural problem', it is actually diagnosed as an impairment and there is learning support. Is there something that can be done between the years four-and-a-half and five which bring those systems together?

The other area is in the initial contact with the justice system. We are aware of a number of pockets of research that are happening - not necessarily the Aboriginal community, but in mainstream community - around how people with acquired brain injury might be assessed by the police saying, 'Hang on, this might be a factor'. Rather than being passed off as a delinquent or a troublemaker, they are actually thinking there is a communication impairment that could contribute to the conflict, and how they could change their strategy in dealing with that individual to deescalate the problem rather than, if you like, recognising there is a communication impairment.

So, with all this research that is happening, there is an understanding there are some really good opportunities, if we think more whole-of-system, whole-of-life, rather than a medical compartmentalised approach to it. That is where we think there are some great gains to be made in some programs and research support.

Mr McCARTHY: Thank you.

Madam CHAIR: I will try to get this right. If you can see the person has a disability - cognitive items are not right, etcetera - if it straight behavioural issues because bits of the brain that look after your behaviour and understanding right from wrong and consequences – does that still get classified as a disability?

Mr GRIFFIS: Absolutely. Yes, absolutely.

Madam CHAIR: Okay, because that person will forever have that inability to fit into society?

Mr GRIFFITHS: Yes. Maybe self-regulate their behaviour and, then, they would be, hopefully, diverted into a behavioural support program. Then, away they would go and, hopefully, get ongoing support.

To support what Scott just said, we call it the bad black kid syndrome - and we talk about this more in our home state - where an Aboriginal kid with disability mucks up in the classroom and, then, it turns out they cannot hear properly, they cannot see properly, they have behavioural issues, maybe do not get enough sleep at home, or whatever it might be, they do not have intervention around their disability at all. They end up being suspended or expelled, then they go on to this journey of hanging around the shops and start getting moved on by police and, away you go, and the criminal justice system starts to become their story.

We would say this is an untold story in the country, to be honest with you - the disability component of what is happening in the lives of many Aboriginal people. Foetal alcohol disorder is one of many disabilities we see that has been overlooked for too long. One of the fundamental reasons why is most Aboriginal people living with disability do not self-identify as people with disability. That happens for a whole lot of reasons, including the fact in traditional language there was no comparable word for disability, which is actually a wonderful thing in many ways, because people were not labelled, so people tend to be more talked about in an impairment-based way, which is very appropriate. Brother there has one leg, a bit slow, or cousin there is a bit slower than everyone else. It is perfectly appropriate, because that is what you need to look out for to help that person participate in community.

Now we have the introduction of a service system where you have to take on the label, many people are very reluctant to come forward and do that.

Parents are often very reluctant too, to seek support because there are a lot of risks with that. There is a lot of interventions that are likely to happen you maybe might not have control over. This is not a unique issue in the Territory, though, this happens across the country. That is why we say it is such a critical issue that requires a lot of thinking. It is not going to be easy.

How do we do this in remote Australia where there is no service system? One of our critiques of the National Disability Insurance Scheme is how will this work in remote Australia where there is no market, effectively? If you are in a community where two or three people have severe and profound disability, that is hardly a market. Because it is taking a market-driven approach, that is really problematic. But, having said that, there are plenty of countries in the world, in very income-poor settings, where people with disabilities get their needs met through community-based rehabilitation.

It is just going to need some innovation. I guess the urgency, from our perspective, is this is not a fringe issue, it is a major issue that has just been overlooked too long, including within Aboriginal leadership, we would say too.

Madam CHAIR: How do we get it to be part of the mainstream health issues, rather than being on the fringe?

Mr GRIFFIS: We say it is not a health issue to begin with, Chair. Health is one component of a person's disability in life. In fact, plenty of people with disability can get their health needs met reasonably well ...

Madam CHAIR: Hang on, I will rephrase that. I should have said, how do we get FASD to be right in the middle rather than be on the fringes?

Mr GRIFFIS: I agree. I think …

Madam CHAIR: I suppose it is a combination of actions required.

Mr GRIFFITHS: Yes, I think so. One of the things we need to do is engage in National Disability Insurance Agency around that. That is what we are going to be doing. We would be encouraging every government in the country, including the NT, to recognise the scheme itself is a potential support for – because the scheme is new, there is an opportunity to change the way things have been done. That is taking a very positive view, but there is an opportunity to change things in that sense.

But, more generally, our approach is very simple, because we are more about getting community itself to engage around disability. We use a very simple peer-to-peer approach. For example, our board members all have different types of disability. When they are out in community, it is profound. When they sit there in their electric wheelchair and say, 'This is what I did to get myself going and moving, and support for myself', that is as simple as it needs to be, in some ways.

I think the work that is happening in the Kimberley is very interesting too, because they have the same issues you have in the Territory. I encourage the committee to engage – James Fitzpatrick, a former Young Australian of the Year, is a world-renowned paediatrician. He has done some great work there. Their work is very much around – at the moment, without wanting to sound too flippant, you can have a diagnosis of foetal alcohol, but big deal in a way! Do you know what I mean? In Australia …

Ms MANSION: Yes.

Mr GRIFFIS: Yes, big deal! We would say that is not unique to Territory. We would say so? You then need a whole lot of supports in place. That is where there is a problem. There does not appear to be.

In the Kimberly, the movement started from parents - classic movement of disability, if you like. Parents came together and saw it as an issue and, then, tried to build support systems around it. That, invariably, is the way it is likely to go.

Ms MANISON: To clarify again. With the trial sites of the NDIS - we have a bit of a question mark over Tennant Creek and whether or not FASD has been recognised there - you are not aware of any other trial sites where FASD is being looked at, given the sense this is a trial, so this is a really good opportunity for us to start engaging it, looking at it as a disability to see how it goes? You are not aware of any other sites around the nation?

Mr GRIFFIS: No, we are having to do a lot of our advocacy around this. South Australia is a critical trial for this particular disability type, no doubt, because that is a child trial. As we all know, South Australia has some of the most remote communities in the country, so we are trying to engage the South Australian

National Disability Insurance Agency component, to get them to focus strongly on that. But, there is some sense that because some Aboriginal health services are involved in the trial there, they are making that case well - if you get my drift.

In Port Augusta in particular, there is a lot of anecdotal stories we are hearing about a number of young Aboriginal children with foetal alcohol disorder who seem to be getting at least registered in the scheme. Because it is a spectrum, not everyone would be severely and profoundly disabled. I am meeting with the health service tomorrow in Tennant Creek, but recently, one of the workers there - it was reported in *The Australian* - was suggesting as many as 400 Aboriginal people have foetal alcohol disorder in the Tennant Creek region who could, potentially, be eligible. I do not know that you would have 400; you would have a percentage of those who are severely and profoundly disabled who could qualify, but either way it does not appear to be well understood in terms of prevalence.

Madam CHAIR: Thank you.

Mr WOOD: I was going to ask, in Alice Springs - I am not sure if it was Dr Boffa from the Congress - he mentioned that if you had early intervention, especially from nought to three, you could certainly create some significant turnaround. I do not know how that can work in practice. First of all you have to work out whether the child that is born has FASD and then how you actually deliver an intense service to a young baby who could be in a remote community or even if it is not in the remote community – it is probably worse if it is in a remote community. How in a practical way could that sort of goal actually operate?

Mr GRIFFIS: Again, I am not a clinician, but there is plenty of evidence that shows that if you intervene early in the lives of young kids for a range of disability types you invariably get a much better outcome. I think, again, the National Disability Insurance Scheme is an opportunity here, particularly if the child is severely and profoundly disabled, because the idea would then be that child or the family would get access to a package of funds and then it should ideally be able to effectively purchase services. There are a lot of holes in this, obviously, because you need to be able to know what to buy and all that sort of stuff, and the role of advocacy will be really important in supporting that family to know what the options are. I really think the National Disability Insurance Scheme has potential there, but I am not wanting to romanticise because it not that straightforward. I think that the opportunity is there.

Mr AVERY: I would just think beyond the NDIS as well, so you look at how early childhood is taught and the reasons for nought to three. That is when your baby is forming and that is where you are learning things and if it is recognised and acknowledged that the learning patterns are going to be different for these cohort of people then I think that will encourage some service innovation in the area of how that can actually happen. That research is not at that stage, but I think if you are saying this is the disability which can be diagnosed, now what do we actually do about it in terms of learning and different types of learning - some of that work is starting to happen about how kids can engage in learning in a different way. For example they are much more creative in utilising the creative exercises. They use that as a way of a learning exercise, so I think there are still innovations that can actually be encouraged by understanding the problem and making FASD and other issues like that - the early childhood is aware of those issues and then going into the

schooling years, teachers are actually pretty much more aware about how they might interact with kids and those sorts of things.

Mr WOOD: My concern is how you identify at nought that a child is FASD and then if you do how do you actually intervene in the family at that very early stage? Would mother want to tell you she was drinking? There is the issue about someone feeling guilty or who does not want to say things about what they did before the child was born. It seems to be one of the few hopes that we have for changing a FASD person after they are born to actually do something because we know that later on, especially when they get to adulthood, it is a lot more difficult to control.

Mr AVERY: I think when you are talking about the self-identification - I said that Aboriginal people are less likely to do that and I think that is where I think talking with Aboriginal people around how you might encourage that, getting conversations happening at community level and working with Aboriginal people. How can we encourage people to reach out and get the support? I think that is going to - because there is that stigma attached to disability and particularly when there is alcohol related things - I think that is the next frontier, if you like, in terms of program development.

Mr GRIFFIS: If I may add again - that is why we believe investing in this peer-to-peer approach is really important; I will give you an example. One of our board members is blind - he lost his sight very suddenly - and when he shares his story in communities it is actually quite profound because he talks about his journey. I am not talking out of school here, but he had a lot of difficulty coming to terms with his disability, as you would, and he turned to alcohol, as many people do, to self-medicate, but he also talks about how he got help for himself and that when he tells that story it is far more powerful than anything Scott or I could ever do. When he engages with the community, in community setting, it is quite profound. Change will take a long time here too. It is going to be generational, and we really know that. We think investing in that peer-to-peer approach is really important.

Mr McCARTHY: The essence of the zero to three that I picked up - and this is really good for recommendations for government – is that an investment in zero is an investment in maternal health? The medicos, the health professionals, said, 'We want access to the family, to dad and mum who are producing the child and, if we can have that normalised, then *in utero* that child then has a great start'.

Then, from birth to three, there were two aspects, which were all about the stimulation and the growth and development and that intensive input into the developing child, both cognitively and physically, compared to the disadvantaged background and all those missing opportunities. The other side of that coin was then kids who were not showing normal growth and development progress through their stages would be identified, then it could be loaded in the extra services.

Mr GRIFFIS: That is right, yes.

Mr McCARTHY: That was a very powerful piece of evidence that came to the committee, as a very pragmatic way of creating a new intervention into FASD.

Mr GRIFFIS: I absolutely support that. It is referral points that do not exist so, absolutely, I agree entirely.

Mr WOOD: Just on another issue. In your submission, you spoke about Aboriginal Canadian communities such as the Asante Centre. What are they and what do they do?

Mr GRIFFITHS: Sorry, the …

Mr WOOD: If this is written in linguist, it is probably Asunta, but I would say it is Asante. A-S-A-N-T-E Centre.

Mr GRIFFIS: Yes, anecdotally, we are aware of some good work that has happened in Canada around early intervention in foetal alcohol because, obviously, there is a similar issue in many Aboriginal Canadian communities. I guess we are just pointing to that; there is not a lot of work on this, but there are some things that are happening in Canada that are worth investigating. We strongly recommend that is something that needs to be looked at.

They are having some success in some parts of the Aboriginal Canadian community around early intervention and ongoing support for people with foetal alcohol disorder. That was just making a reference to that. We have never seen it in practice, but have heard good things about it.

Mr WOOD: All right, thanks.

Madam CHAIR: Thank you. Thank you for coming via Darwin especially to go to Tennant Creek, much appreciated.

Mr GRIFFIS: That is all right. No worries.

Mr AVERY: Thank you very much.

The committee suspended.

NATIONAL INDIGENOUS DRUG AND ALCOHOL COMMITTEE

Mr WILSON: Good afternoon, Aboriginal Drug and Alcohol Council

Madam CHAIR: Is that Scott Wilson?

Mr WILSON: Speaking.

Madam CHAIR: Scott, hello, it is Kezia Purick from Darwin for the select committee looking into action to prevent Foetal Alcohol Spectrum Disorder. How are you? All ready?

Mr WILSON: Yes.

Madam CHAIR: Lovely. In the room, we have Gerry Wood, who is the member for Nelson in the Top End; Gerry McCarthy, who is the member for Barkly which is around Tennant Creek; Nicole Manison, who is the member for Wanguri which is in the northern suburbs; Gary Higgins who is the member for Daly which is Darwin River through to Port Keats and areas on that side; and also Russell Keith, the Secretary to the committee.

Thank you for agreeing to talk with the committee today.

Mr WILSON: No, that is okay.

Madam CHAIR: 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 for use of the committee and may be put on the committee's website. If, at any time, you feel what you want to say should be private, we can ask the committee to go into a closed session and take your evidence in private.

Mr WILSON: No, that is fine.

Madam CHAIR: We have that you are the Deputy Chairman of the National Indigenous Drug and Alcohol Committee. Do you want to make an opening statement of any kind, Scott?

Mr WILSON: Well, my understanding is we did send in a letter to the committee.

Madam CHAIR: Yes, we have a submission.

Mr WILSON: I will just go by what we said in that letter.

Madam CHAIR: Okay. Can I ask one question? I see this committee came out of the Australian National Council on Drugs. Is there another committee that addresses alcohol and drug issues for other Australians, or is it just …

Mr WILSON: Yes, the Australian National Council on Drugs, as you might be aware, was set up in 1998 by then Prime Minister John Howard. I was a member of that for nine years and then at the same time that committee was in operation, as some of you might recall, they used to have these national drug strategy reference groups for tobacco, alcohol and illicit drugs. It was also a national drug strategy reference group for Aboriginal and Torres Strait Islander people, and they are the ones responsible for doing the complementary action plan.

For some reason the Department of Health decided to get rid of all of the reference groups and the Australian National Council on Drugs suggested to then Prime Minister John Howard that they should keep the Aboriginal and Torres Strait Islander reference group, which eventually he agreed to, and that became the National Indigenous Drug and Alcohol Committee. We are a sub-committee of the Australian National Council on Drugs. Anything we do we report through to the ANCD and they report to either the Prime Minister or other government ministers on Indigenous drug and alcohol issues.

Madam CHAIR: Okay, thank you.

Ms MANISON: Hello, Scott, Nicole Manison here. With regard to the bodies of work you have done as a committee, have you been doing much work around FASD?

Mr WILSON: Yes, we have. FASD obviously does affect Indigenous people, although I will say at the start that clearly it is not just an Indigenous issue, but an Australian issue. Obviously our committee is more interested in things that affect Aboriginal and Torres Strait Islander people. A couple of years ago – two and a bit years ago now - on the last night of a conference that was held in Fremantle in 2012, we launched a position paper addressing Foetal Alcohol Spectrum Disorder in Australia. We were trying at the time to raise the issue, to try and get Australian government, and therefore the rest of the jurisdictions, to start taking foetal alcohol as a serious health issue.

When I first got involved in this area 21 years ago the organisation I worked for, which was the Aboriginal Drug and Alcohol Council - in about 1995 or 1996 we started putting out stuff about foetal alcohol

to try and raise the awareness, only to be told by a whole range of different experts that there was no such thing.

As it has turned out clearly we were right, and there is a thing called Foetal Alcohol Spectrum Disorder. I have attended, for example, the international conference on foetal alcohol disorder in British Columbia on Vancouver Island and that was probably one of the - how would you put it? - life changing conferences I have been to. I go to a lot of conferences, but that one had 1500 delegates from around the world. It was the first conference that I had been to where at the start you had a whole range of people getting up, saying, hi, and telling you their names and mentioning they had Foetal Alcohol Spectrum Disorder.

Like I said I go to conferences on illicit drugs, but I would not know if there was anybody in the audience at those conferences that might be using illicit drugs, whereas at the foetal alcohol conference people with the problem were there the whole time, and so it was quite an interesting conference.

Like I said 1500 people were there from about 50 different countries around the world, and it was interesting only eight Australians were at that conference. Obviously that was a few years ago now. The issue has grown. More and more people are becoming aware that this is an issue.

Ms MANISON: One of the aims of this committee is we are trying to establish the prevalence of FASD in the Northern Territory. By all accounts, everyone says it is grossly underestimated. From your view and your experience, what would be a good process to try to establish the prevalence of FASD in the Territory?

Mr WILSON: Well, there are ways you can do it without having a diagnostic tool. My understanding is the federal government has funded the development of a diagnostic tool that can help in diagnosing young people who might have Foetal Alcohol Spectrum Disorder.

I am originally from Darwin, by the way, so I grew up in Darwin. Clearly, in my day, people were not told not to drink whilst pregnant. Now I have, obviously, been involved in this arena for a long time, I can tell you categorically I have family members who clearly have foetal alcohol disorder. It is quite clear to me if you know what some of the effects are, without even having a full-on diagnosis, you can determine whether some of these kids might or might not have some of these issues. In my family, I know there are.

Part of the issue is it is about trying to get a proper diagnosis, because it is not just one thing that might determine a kid with FASD. When I was raising the issues at things like the expert advisory committee on antenatal care, I had the Vice President of the Obstetrics and Gynaecology colleagues tell me there was no such thing - and knowing other doctors as well, the problem for most GPs and medical people is unless a kid is born with sever deformities – that is, the facial features, cleft palates, and things like - they tend not to see kids with these neurological problems until they are about five or six anyway. Those are the majority of the kids we are probably talking about. There, obviously, are those kids who are born with deformities, but more likely the ones who slip through the net, so to speak, are those kids who have neurological problems.

I am not sure whether in Darwin you have behaviour management-type classes in the school system. For example, here in South Australia they do. Kids who, for whatever reasons, misbehave - for want of a better word - at school and are getting a bit difficult to deal with, they are sent to what they call behaviour management places. There are a couple here in South Australia. I guarantee you if you went and did a diagnosis, or did some work with those kids, more than likely they have got foetal alcohol disorder.

That is part of the issue - how do you assess those kids. As they grow older, if nothing is done for them now, they are the ones who tend to drift into things like juvenile crime and, eventually, adult prisons and, obviously, cost the Northern Territory government, in this case, considerable sums of money.

I was reading just recently, for example, that the lifetime costs of a kid with FASD in Canada has been estimated at $1m. If you multiple that by a few people, it does not take long before, all of a sudden, the cost is quite astronomical. In South Australia or in the Northern Territory, they are talking about something like four in 1000 cases, whereas in Canada in some of the Indian communities where people drink similar levels to a lot of Aboriginal folk who do drink at risky or high-risk levels, they are talking about 187 kids born out of 1000 who have FASD. Multiply that by $1m per child, it is quite a lot of money.

Ms MANISON: Granted you are a national voice for advising government on policy development around Indigenous alcohol issues. If you were to be giving some advice to the Northern Territory government - which, ultimately, we are going to be doing through the recommendations of this report - about what work needs to be done around FASD prevention and trying to reduce numbers, what would be the advice you would give them?

Mr WILSON: At the end of the day, the majority of people hear about FASD every now and again. It might be on the news and stuff like that. The interesting thing for me is, when I was in Canada and went into a bottle shop, for example, they have cut-outs as you walked in. The interesting thing is they had cut-outs of a family of kangaroos, which I thought was a bit interesting. The cut-out of the family of kangaroos in every alcohol outlet you went to, were probably as big as me - six foot something – and, clearly, as you walked in they were straight in your face about not consuming alcohol whilst pregnant.

One of the things in Australia we have not done very well at all, is to push that whole social marketing message about consuming alcohol whilst pregnant or, if you are intending to get pregnant, or even breastfeeding. We have left it up to the alcohol industry, for example, to voluntarily put on some products. It depends on what product you might drink. You might be lucky and have a very - I am obviously 50-odd, so I need a magnifying glass to look at the image - minute picture of a pregnant woman. Those sort of things should be quite prevalent.

What we should be doing, as a community, is making sure - no different to tobacco, for example. It took 30 years for the prevalence rates of tobacco to go from 60% down to about 17%, and that was because of continual social marketing messages. Whereas, when it comes to alcohol and FASD. for some reason we

tend to not be taking it as seriously as we should. I would be urging any government that it needs to be long-term, sustainable and in-your-face marketing - no different, as some of you might recall, from the Living with Alcohol programs that used to run on Northern Territory television.

I remember every time I used to switch on the television, nearly every ad segment where we had about four different ads, each ad break you had while you are watching television, at least one of those ads would have been drinking and fishing, or drinking and driving, or whatever, but they were all badged under that Living with Alcohol. Clearly, I grew up, as I said, in Darwin when the Berrimah and Dolphin and those types of hotels were quite prevalent. Over time, I can recall that, all of a sudden, I would be going out partying or whatever and people would rock up with low-alcohol beers. I used to look at it and think, what the hell is that?

That was clearly people's attitudes were changing because of the sustained campaigns of Living with Alcohol programs we were doing. So, that is the major thing, from my point of view. The majority of women - and not only just women, clearly males need to be targeted as being supportive of their partner who might choose not to drink.

The whole issue is we need these sort of campaigns. I will give you just a quick example. A couple of years ago, the woman and children's hospital here in Adelaide started running a few posters and things about drinking whilst pregnant, but that only lasted for about a year. Then, all of a sudden, you never saw the posters or the campaign again, especially not on TV. I remember when my daughter went to hospital to give birth, she was still being told that it was okay to drink in moderation. My granddaughter is just turning three in November, so it was only three years ago, and clearly the message to a lot of the medical profession has not gotten through that well. If you have a look at the National Health and Medical Research Council's alcohol guidelines that came out a couple of years ago, there has been no promotion of the guidelines to the general public and clearly one of the guidelines in that out of the four is not to consume alcohol whilst pregnant or breast feeding.

So there is a range of things we would be advising government that they could do straight away. One is social marketing, one is trying to get proper warning labels and do not allow it just to be voluntary because at the end of the day, if you pick up a can of Jim Beam and Coke, there is no label on that, whereas if you pick up a can of Johnnie Walker and Coke there might be a small picture at the bottom. It is not consistent and that is what I think the community needs, consistency in the message, and also sustainability, because we know a lot of kids or young folk who have FASD - I think about 90% will have some sort of lifetime mental health problems, about 60% will have school problems, 60% of people who have FASD will end up in trouble with the law and about 50% end up confined in correctional facilities. Clearly a lot of them have drug and alcohol issues.

The Northern Territory government is in a unique position because it is a smaller population, but like I said you have done some really good things in the past that have clearly shown as changing the community's perception about an issue and I would urge the NT government to go down the track of looking again at the Living with Alcohol program to see how you can adjust that for a foetal alcohol program as well.

Mr McCARTHY: Scott, Gerry McCarthy. What was happening in 1995 that motivated the committee to start a lobby around FASD?

Mr WILSON: What happened is a non-Aboriginal women came into our service and it turned out that she had fostered a young Aboriginal child; she noticed that the child had some sort of obvious developmental issues. She was not told that the child's mother was a full on drinker and all of that. I am not surprised for her as she did not know what was really going on, but she started researching on the Internet and found a couple of sites in the US, for example, that were displaying - we are talking about the same issues that her foster child had. She came in to see us to see whether we would help lobby then Health minister Dean Brown with her about having the child sterilised. She was worried that as she got a little bit older and started becoming sexually active and ended up pregnant that she could not look after herself, let alone a child. Fortunately we were able to talk her out of going down that track of sterilisation because that child is now probably close to 30 and has children of her own. It comes down to - kids with FASD can learn things; the problem for the education system is that these sorts of kids need a long time, they need repetition so you have to continually repeat things to them, and if you have 30 plus kids in your classroom you do not seem to have the time these days to spend the extra time that kid needs so those kids get left behind. And that is what kicked us off; we started thinking 'Hang on, there is a bit of an issue here', and started hearing more and more, and then started looking at what some of the symptoms were, and realised we knew people who had these issues but were ending up in places like gaol and, clearly, if something else had happened, potentially would not have been there in the first place.

Mr WOOD: Scott, you mentioned the changes in smoking habits of people and advertising. The other side of the smoking coin was the cost of tobacco went up quite considerably, so it was taxed very high. What are your thoughts on changes to the floor price of alcohol as a means of trying to reduce the amount of consumption?

Mr WILSON: I had a look at some people who appeared in front of your committee recently who were calling for a minimum floor price. To me, the only ones who really benefit – and this is my own opinion – from a minimum floor price will be Woolies and Coles and the retailers. Clearly, they are already producing or selling alcohol at such a very cheap level. If they could not sell it at a price, let us say, the cleanskins – I do not know about up there, but you can buy what they a cleanskin bottle of wine for $2. It might only cost 50% to produce, which Woolies will buy at 50¢ and sell it through their Dan Murphy outlets for $2. If there was a minimum price, they could only sell that bottle, for example, at, let us say $6, then on every bottle they are making $5.50 instead of $1.50.

The easiest and the best way to change people's drinking habits is through volumetric tax which, obviously, affects everybody who might be drinking, not just those who are picking a certain product. Volumetric tax just means you tax alcohol based on the content and the volume which, to a certain extent, with beer and spirits you already pay a volumetric type tax. It is the wine industry and the emerging cider industry that is paying bugger all – sorry for swearing. They do not really pay that much tax because they are taxed on the wholesale price, not on the alcohol content. Clearly, if you brought in volumetric tax across the board, research has shown that will have a better outcome in dropping consumption across the board. Also, I suppose, from a Treasury point of view, it is raising money as well.

Mr WOOD: Scott, if it raised some money, it might be money that would be well worth spending back into helping people with FASD. But …

Mr WILSON: Well, that is what I would have thought. If you look at the Living with Alcohol, there was a hypothecation that went back in and enabled the Northern Territory to be able to spend a lot of money on the programs. If you recall a couple of years ago when they raised the price of what they call Alcopops, basically, did that reduce you binge drinking? I do not think so. All it did was give the federal government an extra $500m a year, which you would have thought, even if they put just $100m of that back into prevention-type programs, that would have had more of an effect on youth binge drinking that just raising the price.

Mr WOOD: Scott, just another question. In your submission on page 19 – sorry, page 12 – on screening. You say in there:

> *The effects of FASD present early in childhood and persist throughout life. Without intervention early in life, adverse consequences are most likely to manifest in adolescence and adulthood.*

We have heard that also from our other hearings. We have heard that if we can have early intervention, especially between zero and three, there is a pretty good change of turning it around. But, you also say - and I do not know when this paper was produced - currently there is no existing standardised screening tests of FASD in Australia. In addition, there is ample evidence that FASD is poorly recognised by health professionals and that diagnosis is often missed or delayed. How do you see early intervention actually happening if we still have not arrived at a stage where we can screen young people to see whether they have FASD?

Mr WILSON: If you started off with your social marketing-type campaigns and raising the awareness amongst the population that this is a serious issue. Also, you might then be targeting your preschool service system, as well as your school system because kids can learn. They are not going to be rocket scientists at the end of the day, but they can learn basics of how to operate in society whereas, at the moment, a lot of kids with FASD are driven by impulse control. They do not have impulse control so, if they want that mobile phone, for example, that might be sitting on your desk, there is no thought pattern there that if I took that it is called stealing. They take it because they want it. So, there are all those consequential things that, unfortunately, many of these kids will display. If you started getting your educational system gearing up to recognise that these kids who might be dropping behind are kids who have foetal alcohol.

A quick example. When I was in Canada, I met people from one of the prisons there. They know a lot of the Indian Canadians who come into the prison system or the juvenile justice system might have FASD. Basically, they only ask them a couple of questions before they can go on to their programs. One of them is: did your mother consume alcohol? Obviously, the parent has to say yes or no. If the parent says no,

then even though the diagnostic might come back that the kid has FASD, they are still not eligible for the program.

But, if you looked at a lot of the kids or young people who are coming into those early childhood programs, it is pretty easy to work out if mum was consuming alcohol whilst pregnant. With a lot of the people I come across, if you actually ask the question, they do not tend to hide the issue, they tend to be upfront and say, 'Oh yes, I did, but I only had one or two', or whatever. Once you start explaining to them the reason why you are asking, then they have a bit more concern that they might have been responsible for harming their child.

I do not know whether any of you have seen Tristram's story, which was a DVD the Fitzroy Crossing people, as well as the George Institute at Sydney University produced a couple of years ago. If you have not seen it, you should try to get a copy and have a look, because it clearly shows you the amount of time and effort. It turns out this one kid who lives at Fitzroy Crossing who has FASD - it is just a life in time, it goes over a week of his daily life and how disruptive, if he did not have all these sort of interventions, that one child can be for the whole community. The more you watch the DVD, you eventually get the picture that it is not just him who has FASD, it is his siblings as well. My understanding is if you have a child who is born with FASD, the chances of you having another child, if you have not stopped drinking, is 100%. It actually makes sense that you would try to prevent, not just the first case but subsequent cases that will occur after that.

Mr WOOD: Thanks, Scott. One other question. You have a section on primary prevention, secondary prevention, and tertiary prevention. It talks about secondary prevention strategies addressing the issue of FASD need to be aimed at reducing the risk of alcohol-related harm to the foetus. You say:

Strategies will generally be implemented by health professionals and aim to:

- *prevent or minimise alcohol consumption by pregnant women,*
- *routinely screen women for alcohol consumption,*
- *identity and intervene with women who have harmful patterns of alcohol consumption.*

What do you mean by prevent or intervene in this case?

Mr WILSON: Pardon?

Mr WOOD: What do you mean by prevent or intervene in those particular strategies?

Mr WILSON: The issue - I hear it all the time where people say, 'Oh yes, but Scott, you are stigmatising people who might have an alcohol problem'. The issue is that if they have an alcohol problem then you can still try and do some sort of intervention where you try and suggest to the person now they are pregnant it is time to stop.

You might still have a child that is born with FASD, but because most people as you are probably aware - I think some of your other witnesses have said the same thing - a lot of pregnancies occur accidentally. There is not a plan there. People go out, they might get on the grog tonight and obviously you have sex and then they might get pregnant. As soon as you have a diagnosis of pregnancy and you are still drinking that is when you should be encouraged by your health professionals to stop straight away.

If you have material that you could give those sort of clients who are coming into Royal Darwin or to other AMSs or even GPs you could give them information straight away that clearly makes it possible for them to take that step of not drinking any more than what they are.

I do not know whether that answers your question.

Mr WOOD: I suppose I was wondering how you put - the strategy you mention is to prevent. I was wondering what you mean because has been a bit of discussion around whether that people should be lawfully prevented from drinking alcohol. I did not know what you meant by preventing or minimising alcohol consumption.

Mr WILSON: Obviously we would not support criminalisation. If you had a program or there had been information out in the public arena about foetal alcohol for the last 30 years and there was still the amount of people - kids that had been born - then maybe that is something you could look at.

Most people do not even realise today about the potential harms that could happen, and so that is why we would say to do all of the other things such as your social marketing campaigns that are sustained for a long time because you can bring about change through that. Clearly if you had - under a lot of jurisdictions I am not sure about the Northern Territory, for example, but in a lot of jurisdictions - somebody who was a problematic drinker and was continually getting pregnant then I am pretty sure under your mental health act and stuff like that you could have that person detained until after the pregnancy to stop them from further drinking.

At the end of the day it is a pretty drastic sort of measure. I was just reading about - as you probably recall - the lady who was incarcerated in Western Australia and, eventually - I am not sure whether she did - I know the Northern Territory government was considering having her brought back for supported accommodation in Alice Springs.

Madam CHAIR: No, she did come back, Scott.

Mr WILSON: At the end of the day there are quite a lot of people from what I gather that are already in incarcerated situations who potentially should not even be there in the first place because they do not really have the capacity to know what is happening anyway. We would be not supportive of criminalisation at this stage.

Mr WOOD: Thank you, Scott.

Madam CHAIR: Thanks, Scott. That is all the questions the committee have or comment, so thank you very much for making yourself available today to talk with the committee.

Mr WILSON: Thank you for your interest and for inviting me to appear. When they first phoned me and said, 'Scott, Ted cannot make it, are you available?', I thought, 'Great, I have not been to Darwin for a while'. It is pretty cold in Adelaide. Then they said, 'Oh, no, we are going to do it on the phone', and I thought 'Damn!'

Madam CHAIR: Damn! They are a bit mean to you.

Mr WILSON: No, I have seven brothers and sisters and they all still live in Darwin. As I said, I can clearly pick out in my nieces and nephews, even without a diagnosis, because you have to continually tell them, repeat the same requests to do something. Unfortunately, they are now getting into trouble with the police and things like that. It makes you wonder if they had – because when I was talking to my sister who I know drank all the way through her pregnancies, not really thinking there was any issue because, basically, she was just doing what everyone else around her was doing anyway. You do not think you are doing anything that is not normal. But, I bet if you went back to her, if she had her life over, especially, obviously, where I work, I doubt whether she would have drunk while she was pregnant if she had the same information in the 1970s and the 1980s.

Madam CHAIR: Thank you, Scott, much appreciated. We will send a draft copy of the *Hansard* for you just to check to make sure we have everything factually correct - what we have said.

Mr WILSON: Okay, no worries.

Madam CHAIR: Much appreciated, thank you.

Mr WILSON: Bye.

The committee suspended.

AUSTRALIAN HOTELS ASSOCIATION (NT BRANCH)

Madam CHAIR: Welcome. Thank you for coming to this public hearing into actions to prevent Foetal Alcohol Spectrum Disorder. We appreciate you taking the time to be with us here 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 it is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. I have also given permission for the local media to be in attendance during the hearings at all stages.

If, during any of the hearing, you are concerned that something you might say should not be made public, then we can have the committee go into a closed session and take your evidence in private.

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

Ms CORCORAN: Amy Corcoran, Chief Executive Officer of the AHA Northern Territory.

Mr COLEMAN: Justin Coleman, President of the Australian Hotels Association (NT Branch).

Mr BURNS: Mick Burns. I am a board member of the Northern Territory hotels association.

Madam CHAIR: Thank you. Did you want to make any opening statements or comments?

Ms CORCORAN: I will make an opening statement. First of all, thank you for inviting the AHA (NT Branch) to this hearing today.

Mick Burns is here as a board member, but he is an ex-President of the AHA and he is our longest serving President of 13 years, so we thought he would be apt for coming along today. Justin Coleman is the newly-appointed President.

The AHA (NT) is a peak employer body representing the Territory's hospitality industry. We represent community clubs, wayside inns, accommodation hotels, pubs, and restaurants throughout the Northern Territory.

I note the AHA has branches located in every capital city, and a Canberra-based national office. However, we only represent the views of the AHA (NT) here today.

The NT's per capita consumption of alcohol is well above the national average, about 30% to 40% higher. There is no doubt the Territory has a significant problem with alcohol misuse. The AHA is committed to working with government on all levels to reduce alcohol-related harm in the Northern Territory, including the very serious issue of Foetal Alcohol Spectrum Disorder.

We support the development of targeted education and awareness campaigns surrounding FASD, and excessive consumption of alcohol during pregnancy. We support more education on how to live with alcohol. Prohibition has never, and will never, work. We need to start concentrating our efforts on reducing demand and changing social behaviours.

We support measures that target problem drinkers, and not the overwhelming majority of our community who drink alcohol responsibly. We also strongly support the involvement of the hospitality industry and the liquor industry in the reduction of alcohol-related harm in the Northern Territory. The AHA is, and has always been, willing to engage with government and other stakeholders to be a part of the solution.

Madam CHAIR: Thank you. Does anyone want to start?

Ms MANISON: I will get it rolling. With regard to the issue of FASD, particularly across you clubs and pubs, and so forth. What is the awareness of staff around the issue of FASD, and that drinking whilst you are pregnant is not very good for a baby?

Mr BURNS: It is probably reasonable that I answer that. I do not think that there is extensive knowledge. It is not something that is well published within our ranks. Obviously, one of the big problems we have in the Territory is very transitional staff. If you employ 30 or 40 people, there is every chance you will write out 300 or 400 group certificates. That is part of the young employment base we have in the Territory. I do not know of any previous educational programs we have run through our hotels on this specific issue.

Mr McCARTHY: In the responsible sale of alcohol accreditation, is FASD dealt with?

Ms CORCORAN: No, it is not.

Madam CHAIR: Gerry, do you want to jump in?

Mr WOOD: The two Gerrys were of like mind with the question.

Madam CHAIR: Right. Back to Nicole.

Ms MANISON: I will be a bit more specific. If there was a pregnant woman who came into a pub or a club and ordered a beer, is there any policy around service of alcohol to them, generally? Would a publican say that type of service is just not on in their establishment? Are there any formalities around that in the industry?

Mr BURNS: I do not know of any formalities.

Ms CORCORAN: No, there are no formalities around that. The law says if you are 18 and over, and you are not intoxicated, you can be sold alcohol.

Madam CHAIR: Following on from what Nicole asked you, we heard in our travels - we have been to Katherine, Alice Springs, and Tennant Creek - that the clubs which must be could be in remote communities and also at Tennant Creek, if the woman is known to be pregnant or friends or family say, 'Yes, she is pregnant, do not serve her', they will not serve her. One club has taken a stand and no pregnant woman will be served alcohol. That seems to be generally accepted by some of the groups we spoke to. Is it something that could be put into your RSA course in the future, do you think?

Mr BURNS: I say yes.

Ms CORCORAN: It certainly could, except for the discrimination aspects.

Madam CHAIR: Yes, you would have to know.

Mr BURNS: Yes.

Madam CHAIR: Yes, it could be three months and some woman show more than others, some less than others.

Mr COLEMAN: Exactly. As you said, there might be individual policies on a moral basis, that they decide what their policies are in each venue but, as far as the RSA courses and directives, there are not any existing at present. That is not to say they could not form part of the RSA.

Madam CHAIR: In the future. Yes, okay.

Mr BURNS: Sorry, through the Chair. One other thing. That is not to say that individual hotels or licensed premises do not have very particular policies on that. Without a complete ring around - we are a representation of the industry, but we have not spoken to everyone on the industry about that point.

Ms MANISON: It was very positive in your opening statement referring to the fact that, as a hotel association, you are very open to the prospect of education and awareness campaigns throughout the Territory. As part of this committee process, we will be putting recommendations to the government about some of those areas. If government is to come out and say it wants to work with the industry about promoting FASD working towards prevention, do you think places that serve alcohol are going to be open to having posters, possible labelling and those types of issues to promote FASD and the dangers of drinking during pregnancy?

Mr BURNS: Generally, the industry will be supportive to targeted campaigns. To walk into a hospitality venue and just have no, no, no, do not, do not, do not - but in the broader education, the industry would certainly grasp that and take that on board 100% and support it fully.

Ms MANISON: Thank you.

Mr WOOD: I was wondering how it would work in practice if you said you could not serve someone who was pregnant. First of all, you would have to make sure the person was not just fat. Otherwise, you are likely to get a big argument over the bar if you stopped and told someone they cannot drink so I am not sure how that would work in practice.

Mr BURNS: There are other complications, of course, that some people send other people up to the bar to get them a drink in a round type situation. We would have to be careful about the way that was addressed through any RSA policies. We would obviously have to build some protections in for our staff because they may well be doing what they think is the right thing, and often it is not. We have seen a number of examples where you have some people with some disabilities and they have been interpreted or seen to be drunk or intoxicated and they are not; that has created a lot of issues and a lot of embarrassment for staff. We would want to make sure our staff are very protected with any education program, so that they go well beyond the staff themselves, but obviously out to the women who are pregnant and the other people they are with.

Mr COLEMAN: I think that is what may make it easier for community clubs and remote communities where - I think the words you used were 'known to be pregnant'. In those situations it may be easy to know they are pregnant than in a pretty transient place …

Madam CHAIR: The urban setting.

Mr COLEMAN: Yes, tourists and whatnot.

Mr WOOD: It raises a couple of other questions because you are not the only ones that sell alcohol, so you have your grocers and your restaurants. I would hope if there was a campaign that it was uniform across the board, because you can still consume alcohol at the restaurant. and people in the restaurant industry should probably know it is not a good idea. I sometimes wonder about the legal aspects. If the government, for instance, believes that alcohol will affect the unborn, and the unborn could be born with FASD, then does that put someone in a difficult position in the industry if they serve someone knowing the person is pregnant? In other words, where does it sit from that perspective?

Mr BURNS: I think the whole issue of vicarious responsibilities and liabilities is something that gets addressed by people a lot smarter than the three of us. There is a very big moral position about this and I think that is probably a really good point to start at, but in terms of how far legally your responsibility goes, that presents a real problem for our industry on a range of fronts.

Mr WOOD: Yes. I just think that we would need – someone would need to go through all the implications of saying that you cannot, by law, serve someone.

Mr BURNS: I think that is one of the things I was touching on when I said we would expect some degree of protection for our staff. It has to be very general because it is someone that could be reasonably deemed to be pregnant, and what do you do if you ask a lady and she is not pregnant? It is not an easy situation, even though I think we all morally agree we have a responsibility to properly educate people about the negatives of drinking while pregnant, but personal responsibilities obviously have to play a big part in this.

Mr McCARTHY: This is probably a question for Amy. You would have a network with the national AHA?

Ms CORCORAN: Yes.

Mr McCARTHY: All the new dialogue now is around social licence and the supply chain, and I think a good example would be the live export issue and the consequent ban. Is the AHA nationally now discussing FASD in the light of social licence and responsibility around the supply chain?

Ms CORCORAN: I am not sure whether they are concentrating on FASD. I know there was a voluntary product labelling agreement. I know the industry was involved in – I think it is a pregnant woman with a cross across her, but I think the federal government has now come in with stricter, now mandatory obligations.

Of course, the AHA nationally is concerned about alcohol-related harm. FASD is harm that is caused from the excessive consumption of alcohol in the most part. I might be making an assumption here, but you would think the people that were drinking excessively whilst pregnant y were probably drinking excessively before they got pregnant. I guess what the AHA is thinking is about minimising harm and misuse of alcohol in the first place, education, creating jobs for those people who obviously are misusing, problem drinkers, and not to say that every FASD situation is caused from problem drinking. I am not an expert.

Mr McCARTHY: Do you see that the Northern Territory AHA could play a leading role in this national debate?

Ms CORCORAN: In what respect? As in …

Mr McCARTHY: We have the highest level of alcohol consumption in the country, so is it feasible we could lead it out? That is a good thing?

Ms CORCORAN: Absolutely. The AHA is always keen to get on board with anything that reduces alcohol harm in the community. How we do that is, obviously, the golden question.

Mr McCARTHY: I can say it is a great start by appearing before the committee, because this committee will report to government and, hopefully, there will be resources allocated. So, working together is the way to go, and having all aspects of the issue.

Mr COLEMAN: From our experience, if there are successful national targeted campaigns, that is often taken up by other states. What you are saying is it could lead to the rest of the AHA seriously taking on board whatever measures we put in place, particularly if they are proven to be successful.

Mr McCARTHY: We have heard from various stakeholders, from very high level-medical professionals right through to community groups and individuals. It seems to be a common thread that there has been a great resistance to acknowledge, to diagnose, to look at this issue within our society, over a long period of time. It is really now coming to a head and, I suppose, if the Northern Territory wanted to be in that space, it would be a great thing.

Mr WOOD: You mentioned reducing excessive amount of alcohol. We would say absolutely no alcohol needs to be the message. From all the reports we have had, there is no safe amount of alcohol you can

drink when pregnant. So, that is the message. It is going to be hard to get over, especially if someone pops into the pub with all their mates and it is a social outing. It is a case of you do not drink when you are pregnant or if you are planning to be pregnant, which is a hard message to get over. That would reduce some of our consumption.

Madam CHAIR: In Alice Springs and Tennant Creek, they have the police officers outside the major bottle shops. Speaking to the people in Tennant Creek from one of the hotels, and in Alice Springs various groups, they have said they have noticed a dramatic reduction in what would have been alcohol-related harm, and police have reported drops in assaults and those kind of things, and less admissions to hospital. Anecdotally, they have been told school attendance in some of the schools is actually starting to rise again. Does the AHA have a policy position on the fact that police officers are outside bottle shops to try to stop people from drinking in places where they are not meant to drink - for example, dry communities? Did you form a position on these temporary police beats, as they call them?

Mr BURNS: In a broader sense, if you are talking about some of the designated dry areas and the like, 100% we support that. Some of the concerns we have had feedback from our members – you talk about the alcohol protection orders and the Banned Drinker Register and the like. I do not think our industry is unified with a position on that. We do not know the Banned Drinker Register, for example, had enough time to actually see the results. We have a very similar position in that we are very pleased to hear there are positive outcomes with the APOs.

The concern we are getting feedback from some of our members is with regard to high, visible police presence outside some of the drive-through bottle shops is that might deter an Amy Williamson from driving to that bottle shop and buying a bottle of wine. That is the negative side to do it. They have, obviously, noticed a substantial drop in takeaway alcohol sales. But, the concept of making sure there is a police presence so people who are on alcohol protection orders are not buying or sourcing alcohol first-hand, or second-hand, is something absolutely we support.

Mr WOOD: I saw for the first time in Tennant Creek the policeman standing out the front, but he had an iPad. Do you get the impression that APOs are, basically, the human BDR? You used to swipe a card to tell you who they were before, now the policeman checks you out by checking up their iPad.

Mr BURNS: One of the platforms the association has held for a long time is we like that the government - excuse the French - has the balls to target problem drinkers and anything that actually targets the majority and seems to be wishy-washy around the problem drinkers. If you are talking about off-premise sales, we are talking about the people who wake up, and what they want to do that day is get drunk. Whether they are pregnant or not, they wake up and their aim that day is to get pissed. They are the problem drinkers. They are the face of the problem drinkers we see and experience.

Some of the social things that flow from that are what concerns all of our industry and all of our community. What we like and think is if we can get very measures specifically targeting those people, that

is going to go a long way to addressing the perception of what we face in some areas. We have seen it in Alice Springs with comments that are made, justified or not.

The specifics about what our industry would and would not support - we will do anything that is morally correct. We will do everything we think targets the problem. But, we are a little against everybody - what we see is if we get the community to come with us then we are going to have a lot more chance of getting success with this. Whereas, if we create barriers - and there was no question there were some barriers with the BDR within our industry. There were a number of people who had issues with the BDR. There is no question about that. There are some people, obviously - and it will be more specific with regard to the APOs because they are the people who just cannot buy it. But, that does not mean to say they do not get it.

What we are talking about is a high police presence at some of our off-premise hotels. You then have 75% of the grog, of course, consumed off premise, not on premise. If you then have almost no presence at the large retailers, the large supermarkets and the like, all you are really doing is displacing sales from one point to another point. I do not know that gets any result. So, I believe what we have to do is something that is across the board. The community would actually support - and I think the community does support - the police presence at the point of sale. I do not know the community and our industry necessarily supports such a high visibility, where you have a number of police cars, an ambulance, or a fire truck - to go to an extreme, which I do not know has actually happened. You have an actual deterrent there - I use Amy Williamson drive along and says, I might have a bald tyre, I will go to the one up the road. That is some of the feedback our members have had. As I said, our industry does not have a clearly defined level of support for one structure or the other.

Mr WOOD: In relation to reducing the amount of alcohol consumed - it was raised before with Scott about having a minimum floor price but, also, having a volumetric tax. Has the AHA any opinion on either of those?

Mr BURNS: Yes, from a Territory perspective, which is not necessarily reflected from a national perspective, we do not have any issue with a floor price. When I go back to those people who just wake up to get drunk, one of the problems with that is they are going to go for the best bang for buck they can get. If they can get 10 standard drinks for the price of three standard drinks, they are going to buy the 10 standard drinks. That is what they are going to buy. To that end, we actually did a presentation a few years ago in Alice Springs. We, as an industry, are not against floor pricing.

That is certainly not the position in the national office, but they do not have our Territory issues, and we represent where we live. We represent our people and our community. We are members of the community before we are members of the liquor industry.

Mr WOOD: What about the volumetric tax?

Mr BURNS: I do not know whether you are in a better position to talk on volumetric tax than I am, Amy, but one of the things, obviously, was a lot of issues and a lot of incentives to create a lot of wineries many years ago. Of course, they were all based up and we ended up with a hell of a lot of really cheap wine.

There are many people who are a lot better educated on the volumetric tax and have a better understanding of it than me. It seems there is some degree of sense with having a tax rate for a standard drink. There are, obviously, a number of other arguments depending on costs etcetera, that may be fair or unfair that go way beyond my knowledge.

Mr WOOD: Particular sections of the alcohol industry might have a bit more power in convincing the government not to bring it in.

Mr BURNS: But, is a volumetric tax actually going to address the problem drinker who wakes up to get drunk and does not adversely affect the people who drink responsibly? That is one of the key issues. That is the part I do not know completely without having a full structure of the volumetric tax and the implications of it. We are certainly very interested in anything that is going to target, and make it much more difficult for the problem drinker to drink and, if they do drink - and that is why I have a very firm position on a floor price. We do not care whether they drink two standard drinks or four standard drinks, but if they can buy twelve standard drinks for the same price, that is where it becomes a problem. I understand that some time ago there was an issue about profits and the like that may come from that, but that is all a bit of nonsense because they only go to the biggest bang for buck based on price.

MADAM CHAIR: Once the money has gone, it is gone.

Mr BURNS: If you could buy, for example, based on a VB price - people are not going to buy the cheap and nasty cask wine when they could buy, for the same bang for buck, a VB, which they might like. They are going to switch their drinks. They are only those dirt cheap drinks because they can get pissed more cheaply or they can get pissed more often for the same volume of money. We have put it on the record that we do not have issues with it. We have to be careful in the detail as to how it is rolled out.

Mr McCARTHY: The positive link with the AHA and the alcohol management plans - essentially we are seeing local communities participate in solutions. What is emerging where I come from in the Barkly is a discussion around permits. Do you guys have a comment on that - a permit system to drink in the Northern Territory?

Mr BURNS: I again say we have to bring the community with us if we want to get real long-term results. Again, if you are going to issue a permit to a problem drinker and then they take that permit away and you can get secondary supply or third or three-tiered supply - somehow or other we have to target that problem because the rest of it is just warm and fuzzy. We are seen to be doing something or having a crack, but are

we really a lot better off than we were thirty years ago? I do not know. You people probably know better than me. Are we?

Madam CHAIR: No, we are worse off.

Mr McCARTHY: I have never seen it worse.

Mr BURNS: We have done so many things and we have changed so many things, but we are not getting results and what we really have to do is have the balls to target it and that is a tough call.

Mr McCARTHY: The thing about the permit system and interesting places that are debating this is that we all start on a level playing field and we all get treated on a level playing field by Northern Territory legislation. If play up, you lose your right. Secondary supply is always going to be an issue. We talked about prohibition in the opening statement. With secondary supply, there is now already very creative exploitation of the temporary beat location. You only have to to Tennant Creek and the locals will tell you about them; they are not avoiding the policemen at the bottle shop because of the bald tyre either. They are exploiting that to get access to alcohol very creatively. So what do you reckon about this? There was discussion today - and it has come up before - that we talk to the Territory about all being part of the solution - the seven second disadvantage for swiping your licence which could become the permit, and the technology is there to reinstate the BDR. Is it worth going down that road to try and tell Darwin they can help Tennant Creek?

Mr BURNS: It is not my position to ask questions, but how do you go with Internet purchases? We can then target the Territorians who have businesses, and those businesses sell grog, but they have got a licence to sell grog; there is nothing wrong with them selling grog. These are about some edges around it. We do not actually want to create an environment where everyone jumps on the Internet and they buy all their grog interstate. I am saying some national company or national retailer gets the grog because they will not go to the supermarket. If we are only going to address this in isolation - I think if that was something to come out nationally the Territory could slot in there, but if you have these problem drinkers and they know that you can - you would have creative people getting out there buying grog to supply to these people.

Madam CHAIR: Like the Chrisco hampers.

Mr McCARTHY: Yes, I introduced the Chrisco hamper issue. You heard about that emerging in Borroloola. Internet sales have thrived; anecdotally, the Internet sales represent the high income earner. They do not represent the fixed income problem drinker we are discussing here.

Mr BURNS: That is until that particular group of people, whether through their own initiative or through somebody else's initiative, introduce them to that, because you and I know those people just want to get pissed, and that is the problem. We actually like the idea of putting a fence around the top of the hill instead of having that ambulance waiting at the bottom.

Let us do all the preventative things we can. Let us do the education things. Let us try to work on the employment opportunities, trying to regionalise some of the employment opportunities. Let us actually even start to consider to teach people to drink grog, but teach them to drink it in the right way. I am not saying encourage it, but I am saying if people are going to drink, maybe start in some of these areas where we can think of it outside the box. Because the problems in the Territory are not the same problems that exist in Ballarat and Bendigo - they are just not the same problem.

Mr WOOD: Too cold.

Mr BURNS: Exactly.

Mr WOOD: Definitely cold in Bendigo and Ballarat.

Madam CHAIR: I know one of the hotels in my electorate, Goyder, on special fun occasions will actually have free bottled water for people. Do any of the in-house drinking establishments have those kind of incentives, like …

Mr COLEMAN: It actually forms part of licence to have free water.

Ms CORCORAN: Yes, you have to provide free water. Not bottled water necessarily, but …

Madam CHAIR: Theirs was bottled water. But, you have to provide free water?

Ms CORCORAN: Yes.

Ms MANISON: This is a big question. Continually down the track, as we have spoken to medical experts, legal experts, disability advocates, researchers, they keep coming back to the continual message of reducing supply will ultimately reduce harm with FASD. That big question is about how you get people to drink less and more responsibly. Up and down the track, we have seen the temporary police beats, for example, in Tennant Creek and Alice Springs. Then, I look at Darwin, for example, where we have – you just said before if you put some attention at one pub then, gosh, in Darwin people have an array of different bottle shops, outlets, where they could go. I look at temporary police beats going with the resources you need of taking a policeman off the road, then putting them out the front of a bottle shop. It is resource intense. I just do not know how that would be feasible in Darwin.

We do not have a BDR now, which was there to stop problem drinkers getting grog at the point of sale for takeaway. Do you see any mechanisms that would be effective to work in the Top End around helping reduce supply and reduce those problem drinkers you keep talking about we know are just out to get drunk every day - helping them stop getting their hands on alcohol?

Mr BURNS: The issue of supply is, obviously, a very sensitive one for our industry. The reason it is primarily sensitive, if you go to the ridiculous extreme and you open bottle shops for an hour, who is going to get served in that hour? The responsible drinkers are just going to go, 'This is too hard, I will buy it on the Internet', and the problem drinkers will just be lined up there and they will just be flooding through in that hour. Now, an hour is, obviously, a ridiculous extreme. The demand is one of the big issues. We have to, somehow or other, start to address it before it becomes a problem. That means we need long-term results. The knee-jerking – knee-jerking is not the right word; my English is not the best. If you have, 'We are going to try this. We are going to try that. We are going to try that', all it does is un-commercialise our industry and it does not get us anywhere.

That is why I asked the question: are we any better now than where we were 30 years ago? We have gone left, we have gone right, we have gone straight, we have gone left again, we have gone backwards, and we have not come up with a solution. We do not have a solution either - not one we know works. I completely agree we have to try, and continue to try. That is one of the key things about having the AHA, which is local people. I know they talk about hoteliers and this, that, and the other, they are predominantly local families, local businessmen. We do not want to see the violence, the drunks, the pregnant women drinking and causing harm and the like - absolutely not.

We actually want to be seen as being a part of the solution. That is very clear. That is why we are always happy to talk - and talk proactively - about solutions we think can actually try to deliver some outcomes, as opposed to solutions that just simply say we are going to target everyone so we have a moral obligation to be seen to be doing something. Let us try to have a go at trying to target the very evident and obvious first. When we can target that, then we can start to broaden it out from there.

But, we have not been successful in targeting the problem and you see it up and down the track, and generally. There are people who are just horribly pissed, and you know they have grog stashed in one of the trees or somewhere. That is the face of it, let alone the people who are problem drinkers at home, which might actually be the worst of the lot. They are not in our face, but we agree about the statistics that surround it.

Mr WOOD: I suppose the issue I have, of course, may not be directly to do with hoteliers. You said you see people who are pissed around the place and stash alcohol. I go to the Darwin Cup and see pissed people after race nine - well and truly. One of the issue we have here is we tend to see the obvious, which is Aboriginal people, and we tend to focus on that. What I have noticed in my 44 years, or whatever it is, in the Territory is we have moved from beer to spirits. If you look at my bottle shop, there is no policeman standing outside the Howard Springs Tavern bottle shop. But, go and see what alcohol is consumed and

the amount of spirits that is consumed. If people think this is just an Aboriginal problem they are not on the right planet ...

Mr BURNS: That is why I said that drinking at home is probably the big sleeper. That is where we see a lot of the stats. That is where a lot of the problems are happening.

Mr WOOD: I was going to move on from then is we do not have anyone here representing the alcohol industry. It is the alcohol industry that has the Carlton United tent at the races, the advertising at the football matches, and the smart ads on television. So, you benefit from the advertising the alcohol industry spends to promote its business or its product, which is alcohol. Do you see they have a role to play just as much as the hoteliers have a role to play in trying to turn around this 30% to 40% consumption amount we have above the rest of Australia?

Mr BURNS: The liquor industry, in a very broad sense, has a very good community conscious. I genuinely believe they would play a role, yes. When it gets down to a number of things - and we have had a number of liquor supplies that have not supplied product where they have been made aware of particular incidents, when we talked about some of the spirit casks that were not brought into the Territory.

But, by the same token, you have this element of competition which we cannot talk for. That is, they say the bulk of their ads are trying to get people drinking product A to go to product B, C, or D, and vice versa. That is the bulk of the advertising. I do not think anyone in this room can force a view on that, except that I quite genuinely believe they would willingly come to the table and talk through it, and present issues. I am confident about that.

Madam CHAIR: Thank you Michael, Justin, and Amy. Thank you very much, we appreciate you coming here today to talk with us. We will send you a copy of the draft *Hansard* to make sure everything is correct that you have spoken about. We will keep you posted and informed about when the final report goes to parliament, and any subsequent items. All the submissions have all been uploaded on to the parliamentary website. If there are any late ones we will try to get them on as quickly as possible as well. So, thank you very much.

Mr BURNS: Thank you.

Ms CORCORAN: Thank you.

Mr COLEMAN: Thank you.

The hearing concluded.

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