LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

13th Assembly

Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours

Public Hearing Transcript

8.00 am to 2.45 pm, Friday, 15 February 2019

Litchfield Room, Parliament House, Darwin

Members:

Mr Jeff Collins MLA, Member for Fong Lim
Ms Sandra Nelson MLA, Member for Katherine
Mr Lawrence Costa MLA, Member for Arafura

Witnesses:

Jo Baxter – Drug Free Australia
Gary Christian – Drug Free Australia
Matt Noffs – Ted Noffs Foundation
Mick Palmer – Australia 21
Gino Vambuca – Harm Reduction Australia
John Ryan – Penington Institute
David Rose – Penington Institute
Jeanette Kerr – Territory Families
Brent warren – Territory Families
Gabrielle Brown – Territory Families
Nicholas Papandonakis - Department of Infrastructure, Planning and Logistics
Simon Saunders - Department of Infrastructure, Planning and Logistics
Vicki Baylis - Department of Education
Susan Bowden - Department of Education
Sue Beynon - Department of Education
Beth Wild - North Australian Aboriginal Justice Agency
Julian Murphy - North Australian Aboriginal Justice Agency
Nicola Coalter - Amity Community Services
Tamara Laing - Amity Community Services
Erin Lalor - Alcohol and Drugs Foundation
Sally Underdown - Alcohol and Drugs Foundation
Michael Byrne - private individual

The committee commenced at 8.22 am.

DRUG FREE AUSTRALIA

On behalf of the committee I welcome you to this public hearing into the Northern Territory Harm Reduction Strategy for Addictive Behaviour.

I welcome to the table to give evidence to the committee Jo Baxter and Gary Christian. Thank you both for coming in before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

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

Could you each please state your name and the capacity in which you are appearing, and would either of you like to make an opening statement?

Ms BAXTER: I am Jo Baxter—Josephine Baxter—and I have the role of Executive Director, Drug Free Australia and I am on a couple of other committees including the Australian National Advisory Council on Alcohol and Drugs, which advises the federal government on alcohol and drugs nationally, and I am very pleased to be here.

Mr CHRISTIAN: Gary Christian, Drug Free Australia. I am the Research Director.

If I can speak first—I will address the issue of injecting rooms and then Jo will go further. The most recent review of the existing science on injecting rooms is the RAND Corporation review of December 2018. I have actually put that in front of you.

The RAND Review only examines scientific studies rejecting the many inadequate and biased advocacy papers, mostly done by one single team in Vancouver. I have ringed, in blue, studies which are negative or not positive for injecting rooms. The red circle that you see indicates Australian studies where changed policing, at the time the injecting room commenced, fully explains any positive outcomes that were found on crime reduction—they were the only success.

On the reverse side is a media article showing the impact of sniffer dogs introduced just three weeks after the Sydney room opened. It led to the melt down—you will see in that piece—of the sniffer dog tracking website which was for drug users.

The orange circle is for Vancouver studies where zero tolerance policing introduced shortly before Insight opened in Vancouver explains every—and I say every—reduction in overdoses that were seen around that facility. Drug Free Australia discredited this study with our letter published in *The Lancet*—that is *The Lancet* article—followed by a letter by the Area Commander for Police which was rebutting the author's misleading attempts—on the other side—to save face in their reply in *The Lancet*.

Thus, the only positives found for any injecting room from scientific studies are explained entirely by changed policing. In other words, there is no science that demonstrates any positive outcome for injecting rooms at all. In Sydney, injecting room clients overdose at a rate which is 29 times higher than their rates of overdose before entering the centre. That is incontestable.

New South Wales *Hansard* records testimony by ex-injecting room clients that the massive number of overdoses comes from experimentation with drug cocktails in the safety of the room. More overdoses equals more drug purchase, equals richer drug dealers. Naltrexone implants will save nine times as many lives as the injecting room for the same dollars. Jo.

Ms BAXTER: Thank you, Gary. I will add to that that in harm reduction the key is demand reduction. We would like to present to you two models—there are more—where it has worked. Demand reduction has changed the course of drug policy in both Sweden and more recently in Iceland. What both of them have in common is that they have introduced the education sector into the demand reduction process and changed

the culture of people's thinking about drugs. If you know a little of economics, if there is no demand there is no sale.

We are currently working on a school project where we are hoping to get more prevention-focused information into school communities—not just the students but the teachers and parents—to help them turn around their thinking that drugs are cool or drugs will help them in some way.

The issue close to my heart is that the Northern Territory has a large component of Indigenous population. These are the most vulnerable, overly represented people in Australia, let alone in the Northern Territory, who can be harmed by drugs.

I have recently been into regional areas in the north of Western Australia. The communities are crying out, 'Please listen to us. We are suffering. Our kids are not getting the treatment they need because we are in remote regions.' Treatment is expensive, so fixing up the problem like the ambulance at the bottom of a cliff is not the answer.

We should encourage—as they are doing with the FASD project in the national strategic FASD plan where they are bringing prevention first and teaching pregnant women and their families—that drinking during a pregnancy is not a safe or good thing to do for the baby. We can do the same thing with illicit drugs. It is just putting the emphasis on that.

I will share with you what Portugal has done. It first sounded very appealing, but we are now finding that youth drug use in Portugal is increasing again, and that much of the dropping of drug statistics in Portugal happened at the same time as it was dropping in Europe generally.

There is a document I will leave with you that shows that—it is a two-page summary—plus another document which shows how the Quit campaign, the Sun Smart campaign and now the FASD campaign is all working on prevention first, reducing demand, encouraging our kids to be safe in the sun, by not smoking in the first place and quitting if they can, and early intervention and demand reduction in alcohol in pregnancy.

Mr CHAIR: We have some questions. On what you were saying, as a committee we have been travelling through the Territory and meeting with people and groups in Tennant Creek, Alice Springs and we are heading to the Tiwi Islands.

That is the message that is coming through very clearly to us. We understand that. Part of what we are interested in is shifting the focus from the expensive rehabilitative treatment …

Ms BAXTER: Oh, that is fantastic.

Mr CHAIR: … and trying to access people early and provide that education and pathways and ability to make better choices. That is something we are looking at. We might not agree on everything …

Ms BAXTER: No, no.

Mr CHAIR: … but we certainly agree on that.

Mr CHRISTIAN: We agree that treatment and education, particularly rehabilitation and education go very well together, and with very good success in Iceland and particularly in Sweden

Mr CHAIR: For every dollar spent there, you save however many dollars at the other end of the …

Mr CHRISTIAN: However, it might need to be resilience education - we might argue that.

Mr CHAIR: That is another thing that is true.

In your submission you recommended coerced rehabilitation as a means of objectively combatting substance abuse. Can you describe how this might play out in practice?

Mr CHRISTIAN: They do it in Portugal and they do it in Sweden. Sweden has had more success than Portugal. Unfortunately Portugal has a decriminalisation model in place which has actually increased drug use overall, by 59%, since it started. That is a big increase. Those who have been to Portugal, you have not been told that but we have the figures and we have the official figures from the gentleman that told you.

They are only new figures but it is genuinely a 59% increase. And as far as coerced rehab, I think, in Sweden, I have been to those rehabs. To me, they are well funded, they are well resourced, and they do a lot of employment type things in those centres, and are actually very good places to be, and we could do exactly the same here.

Mr CHAIR: I understand a bit of Portugal and understand the Portuguese model. How does the Swedish model work in practice?

Ms BAXTER: I have just been able to download the latest on Swedish drug policy. It is an update from the UN document that came out a few years ago, and they have explained it very well where they require mandatory treatment for people—it is almost like an extended detox so that they can get their brains clear of the drugs and substances and make some good choices for themselves.

During that time they are motivated while they are in the, I suppose, coerced treatment situation, to think about 'would this be good to continue for you?' Once their brains are thinking more about the more sensible health trajectory for themselves they are then in a better place to do that. Families are brought in as well. Nobody is pushed in and locked in cells or anything like that. It is as you say, a good healthy environment.

The Hassler environment, you may have heard of, where it works very much like Odyssey House in Victoria and in New South Wales, where they build in jobs, they give them skills to go and get work, they help them and there is extended after care—that kind of thing. That is how it works in Sweden.

Mr CHAIR: How do they get there?

Mr CHRISTIAN: In Sweden, if you come before the courts a couple of times they will then ask you to go. If the police have apprehended you with drugs a number of times you will be asked to go to rehab.

Ms BAXTER: I guess it would work in the Territory with a diversion system where there is no criminal record, as I understand, especially for youth, which is very healthy because kids will make mistakes, and their whole life can often be affected if it is a criminal record.

If the diversion system was geared towards motivational interviewing, asking the families to help, and just to get their brains straight first they then have a really good chance. We all want them to get better. They will not get better if they are on drugs, they are still in the same peer group and then influenced to keep taking drugs.

Mr CHRISTIAN: Drug Free Australia also, when it comes to adults, we advocate still for criminal penalties but with spent convictions, as they do in the UK—five years and your conviction is wiped if you continue to test drug free.

Mr CHAIR: Do you see any role at all for decriminalisation in the Northern Territory's approach to reducing harms associated with substance abuse?

Mr CHRISTIAN: I think we can generalise what happens with decriminalisation. You see this in every country around the world that has actually implemented it, and we have the stats in our submission. Whether it is Australia or whether it is America or whether it is Europe—decriminalisation actually leads to rises in drug use.

In Portugal, as I said, it has actually gone up 59%. That is very marked. That is a big rise. I have a sheet here which I will give you as we leave. That shows that if Australia implemented the same from our present point—2016 is the last stats I can get. If we had 59% we would be higher in drug use than we were in 1998, which was our worst year.

The media did not want to stop talking about drugs then because drug use was high. Exactly the same will happen again—the media will not stop talking about drugs if we implement decriminalisation and go the same track as Portugal.

Ms BAXTER: I will add to that. The question that we get from the community all the time—the people we deal with, the families that are experiencing someone in their group who is suffering from drugs—is they like the fact that there is a deterrent. The criminal justice system offers a strong message that these drugs are illegal because they are harmful. Ice is a typical example of that and just how quickly the brain and people's behaviour can change et cetera.

The deterrent would be withdrawn with decriminalisation. In South Australia we have decriminalised cannabis. When I go into schools and speak to them and their teachers, many kids think it is legal. I say, 'Is speeding on the roads legal?' 'No, it is not'. They understand then that it is not legal, but they are very mixed up about it.

The other thing is they cannot understand why, in a decriminalised system, you would provide the venue for safe injecting or the tools to do it safely—so-called safely—and sanction pill testing because it is saying that this drug will probably not hurt you if you have it tested. All of those things have evidence that is really much against it.

Mr CHRISTIAN: We have to note about the sheet we give you on Portugal stats that drug use for young people at high school went up 60% as well. That is not just adults, that is 60% for kids. Since 2001.

Mr CHAIR: Using statistics in this context is probably not all that useful. Those statistics change over time. You know that, I know that. Picking statistics randomly or selectively like that—you would then know also that long-term use in Portugal dropped off as well. While there was a spike in youth, it was not seen in long-term use.

Mr CHRISTIAN: Okay. The argument we would make is that …

Mr CHAIR: I do not want to get into that argument, because statistics—as I said, we can sit here and argue statistics all day and cherry pick statistics to suit our side. Okay?

Mr CHRISTIAN: Yes, but we would argue …

Mr CHAIR: We have to stick to the issues about what it is that we would like to hear from you on your views on harm minimisation. That is what we want to know about. We want to know about how we can best reduce the harm for our youth and all of our people in the Territory and do that in a humane way.

Mr CHRISTIAN: And that is where we are in profound agreement in that we have said that Australians do not want more drug use, but want less, according to the stats that we gave you in the submission.

If anything would increase it, then that will increase harm. There is no question about it.

Mr CHAIR: Well, harms are also broader than simply use.

Mr CHRISTIAN: Yes.

Mr CHAIR: I do not want to get into a debate about this.

Mr CHRISTIAN: Yes. The criminal harm, as we understand the argument, yes.

Mr CHAIR: Let us look at your submission. You recommended a cannabis criminalisation system whereby the offender is criminalised—you mentioned this before—criminal records are expunged after five years of regular testing finds them clean …

Mr CHRISTIAN: Yes.

Mr CHAIR:… you elaborate on how the system will play out in practice, what would be the criteria for its application and would it be open to all offenders.

Mr CHRISTIAN: Yes. We have said, for adults, it would need to be in place. A person would be tested. They would get a criminal conviction but would be tested throughout a five-year period. If they fail, that period would continue until such time as they have five years clean. If they are five years clean from the start, then the conviction is expunged—it does not appear anywhere against their name.

Ms BAXTER: I suggest that we have a range of three to five years. Not one size fits all and it is fairly important for youth, in particular, not to have their futures destroyed by one silly mistake. So, in the range of three to five years, they can be encouraged and motivated to get their jobs and have the goals in life they want to achieve and start kicking those goals. They will see that there are other highs they can get.

Mr CHAIR: Should we throw on the scrapheap, though, someone who makes mistakes …

Ms BAXTER: Oh, no.

Mr CHRISTIAN: No, we expunge …

Mr CHAIR: … somebody who is young …

Mr CHRISTIAN: An expunged conviction is not doing that.

Mr CHAIR: No, but what if they cannot stay clean for five years? What if they do, say, the occasional joint of marijuana?

Mr CHRISTIAN: The other side of that is what it says to the public—this is the issue—is if we go loose on criminalising and trying to get people into treatment, which it will do, then there is the perception by the public that we are soft on drugs and they can start using more. That is precisely why there is a rise in use wherever you have decriminalisation. The two go together. That is across every country, not just Portugal.

Mr CHAIR: It is assuming that simply using is the worst thing that can happen. So, in overall harm reductions it might not necessarily be the only goal we can achieve.

Mr CHRISTIAN: Yes and we understand the argument that there is harm in criminalising. All right? But we say that the gross harms overall will be greater. By the time it is net, it will still be greater.

Ms BAXTER: One of the success stories, without criminalising, is the Drug Court program, particularly in the US. They are having less recidivism, they are having people not using drugs—it really helps them. We have Drug Courts here. Our diversion programs in South Australia and the Northern Territory are very humane.

That should be enough to help them get over that hurdle you are talking about—the mistake they make—without taking away the deterrent in the back of their minds, because 80% of the kids—and that is pretty reasonable—I am sorry, it is not a statistic, but it is a guess. At least with the people I have come into contact in the schools, 80% would not touch drugs if they knew they are definitely illegal. They are good kids and we want to give those good kids a lot of encouragement.

Mr CHRISTIAN: And 31% in the household survey, year after year it is done—it is around 30% every year they do it—say that they do not use cannabis because it is criminalised, it is illegal. That is a big percentage.

Ms NELSON: So, you are saying that knowing it is illegal is more effective than knowing the effects of that drug …

Ms BAXTER: They need to know …

Mr CHRISTIAN: Not at all. They need both.

Ms BAXTER: Demand reduction in the education system—that change of culture, the knowledge.

Mr CHRISTIAN: Rehab is the most important thing of all. If you add rehab to education, then you have the Sweden scenario …

Ms BAXTER: Yes.

Mr CHRISTIAN: … where your drug use actually goes backwards rather than upwards, as with decriminalisation.

Ms NELSON: I am completely supportive of the education as a means of prevention—very supportive of that. I am not on the same page as you are with regard to forced rehabilitation or whatever the wording was that you used. I have never been convinced of that for anything.

Mr CHRISTIAN: Can I ask, with respect, whether you have a problem with that happening in Portugal?

Ms NELSON: What do you mean, have a problem with that?

Mr CHRISTIAN: It happens in Portugal—coerced rehab.

Ms NELSON: Coerced rehab?

Mr CHRISTIAN: Yes.

Mr CHAIR: One of the sanctions that can be applied is that you can have licences removed until such time as you attend rehabilitation or treatment. It is not quite what you are thinking.

Ms NELSON: No. It is definitely not what I am thinking …

Mr CHRISTIAN: It is not mandatory as in Sweden, where they have no choice whatsoever. But there are strong pressures put on them, yes.

Mr CHAIR: Yes, there is pressure—coercive pressure.

Ms NELSON: Yes, coercive pressure, but it is not like a …

Mr CHAIR: You are still not in a criminal justice system where you get it still through …

Ms NELSON: It is still through the health system. It is still a health issue.

Ms BAXTER: Yes.

Ms NELSON: That is what I am …

Mr CHAIR: Unfortunately, we did not hear from Mr Capaz before you, so …

Mr CHRISTIAN: It is in Sweden a health issue—the rehabs. Mandatory rehab is a health issue.

Ms BAXTER: One of the problems Australia has everywhere—and I am sure it is probably similar in the NT—is there is not enough resourcing and there are people on long waiting lists for rehab already. So, anything that will increase drug use will burden the system even more.

We have a family friend who took his own life at the age of 23 because he could not get into a South Australian rehab. The wait was too long. That is just one story.

If something is to be introduced, even with an element of doubt, that is going to increase drug use—and if you look at the trends rather than statistics worldwide, decriminalisation will encourage use because people do not think it is harmful any more—that is, the education system working alongside that may help to combat that but it would be a big job.

Mr CHAIR: Along those lines, what do you say to concerns that the 'tough on drugs' approach, rather than being effective and reducing harm, actually dissuades people from seeking help for their drug use? For example, because of the shame and stigma that can stem from their drug use.

Mr CHRISTIAN: In actual fact, stigmatisation probably gets more people into doing—take smoking, as an example. You probably get more people who want to quit because of stigmatisation—we know that. I do not know why Johann Hari, when he wrote his book, did not think that through.

It actually is a motivator, as much as we dislike that, and we accept that it is cruel to be kind …

Mr CHAIR: Just on that point, stigmatisation of smokers is one thing but that is not an illegal product. You are talking about people being stigmatised over an illegal product, so in terms of coming forward …

Mr CHRISTIAN: Yes, I am talking motivation, and yes there is a point in terms of coming forward. I think the way that they do it in Sweden, when they have the success to show for it is that they have policing, which is very enlightened and they are more like fatherly figures to young people who are doing drugs. That is their approach. It is amazing, and it works for them. They have the lowest stats in the world.

Ms BAXTER: The police in Sweden are quite compassionate. I have had the chance to meet up and look at the programs they offer, and though policing can be a word that people cringe about, in Sweden it is not. They are more like counsellors, and often they are quite young people that go to some of the dance and music festivals, and they mingle—and if they see a deal going down they come up and they speak to the kids in their own language and bring the parents in very quickly, and often it is an experimentation that can be stopped.

Mr CHRISTIAN: I firmly believe that if we made changes and made treatment and rehab our focus here in Australia, I think police would feel much freer to be like the Swedish police, rather than the bad cop.

Mr CHAIR: I think we are running out of time. Is there anything else you would like to tell the audience before you finish?

Mr CHRISTIAN: We must talk pill testing.

Mr CHAIR: I am happy to talk pill testing.

Mr CHRISTIAN: The problem with pill testing is that Caldicott, or whoever is speaking to the media, is not telling them the truth.

Let me back that up with science. This is not cherry picked. We have one Australian study that looks at overdose deaths—not overdose deaths, because they are not overdose—but deaths from MDMA. One study, 82 deaths. Not one of those was from impurities. Not one. Overdose? Most likely not because any website will tell you that overdose on ecstasy is rare, very rare. You can dose a rat up to its eyeballs and it will not die.

The problem with MDMA is that it is responsible for killing all of those people at normal recreational doses, which is the very thing which they are testing for and giving a green light to. They are saying you have a normal recreational dose here, go and be safe, and in actual fact that is precisely what is killing everybody in Australia. Normal recreational doses of MDMA.

Pill testing is not going to work.

Ms NELSON: I have been to concerts where there has been pill testing, and I did not hear one person that was actually testing the pill say, 'Oh this is really safe, have a great night, go ahead.'

Mr CHRISTIAN: No, they will not tell you that.

Ms NELSON: Nobody even indicated—there was nothing alluding to that; there was no implication of that either. The other thing that I saw, there was an opportunity for them to capture those people at the door, and while they had them there provide them with education materials. At any time when you have an opportunity to do that, why would you not do that?

I am a bit confused—again, it is another argument that I have yet to be convinced of as to why we would not want to do that. Nobody is saying that we are condoning or we are giving approval to condoning it. It is another prevention mechanism; it is an educational opportunity …

Mr CHRISTIAN: It is another chance for intervention.

Ms NELSON: Exactly. Another chance of intervention.

Mr CHRISTIAN: Yes, it is, but at a price and …

Ms NELSON: What price?

Mr CHAIR: At what price?

Mr CHRISTIAN: At a price because people—what was the name of the pill testing in Canberra? Stay Safe. It is not safe. Yes, I acknowledge that they do not say it is safe, but …

Mr CHAIR: But what price because those kids are dying anyway?

Mr CHRISTIAN: … the nomenclature says …

Mr CHAIR: Because of that.

Mr CHRISTIAN: All right. The argument …

Ms NELSON: Would it sit better with you if it was not called Stay Safe and it was just called pill testing?

Mr CHRISTIAN: No. What would be best is if the advocates of pill testing told the truth that MDMA, at normal recreational overdose, has killed almost every Australian, from pills—almost everyone from pills. Normal recreational doses—why do they not say that to them? Why do they not say that to the media? It is like it is a secret.

Mr CHAIR: We will have that opportunity to ask of Harm Reduction Australia and of the Noffs Foundation …

Mr CHRISTIAN: Yes, Gino needs to be asked.

Mr CHAIR: … later today. We will raise that with them.

Ms BAXTER: I will leave with you our document on pill testing as well. There could be some good evidence. We know, though, that in one case—you have probably heard of Anna Ward—she was 15 and with a group of other kids who took the same amount of drugs. It was her allergic reaction to the MDMA. If she had had her pill tested and it had said, 'Yes, it contains MDMA and psychotonin. If the pill testing equipment worked accurately—which is the next question—she would have still died. She did not know she was allergic …

Mr CHAIR: You are assuming that she would not have been given any information at that time about the effect of MDMA? That is what you are assuming? And that …

Mr CHRISTIAN: That was the …

Mr CHAIR: We will take your report, thank you, but we will hear from other people about what happens in that process. We will take on board what you said and we will ask …

Ms BAXTER: I have a really nice summary of evidence also that might be easier to cope with. I will leave those with you. We also have some other material we can share, because we know …

Mr CHRISTIAN: That is the scientific papers on the injecting room and pill testing in there. They are the actual science …

Ms BAXTER: I take from this that you are very committed to doing what is right for the Territorian people you represent. The thing about big tobacco and marijuana—there is a DVD on commercialisation of marijuana and so forth, the one that is always decriminalised first. We have a two-pager on Portugal where the policy is falling down now and has cost them squillions in their budget, together with what is happening in Iceland. So, there are a few options to go with.

Pill testing is not a silver bullet, it could encourage drug use.

Mr CHAIR: Thank you.

Mr CHRISTIAN: Okay, we are all good?

Mr CHAIR: Thank you, yes.

Ms BAXTER: Thank you very much.

Mr CHRISTIAN: Thank you.

The committee suspended

TED NOFFS FOUNDATION AND AUSTRALIA21

Mr CHAIR: On behalf of the committee, I welcome both of you to the public hearing into the Northern Territory Harm Reduction Strategy for Addictive Behaviours. I welcome to the table to give evidence Matt Noffs and Mick Palmer. I thank you both for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

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Mr NOFFS: Mick, do you want to go first?

Mr PALMER: Yes, Michael John Palmer is my name. I am here as a private citizen and also a member of the Take Control drug campaign involved in initiatives surrounding the need for drug reform and consideration of current drug policy for some time—formerly career police officer and lawyer.

Mr NOFFS: I am Matt Noffs, the CEO of the Ted Noffs Foundation and also part of the Take Control campaign for safer, saner drug laws.

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

Mr NOFFS: Sure. I will go first, Mick. Is that okay?

Mr PALMER: Yes, sure, Matt.

Mr NOFFS: Our organisation has been around for over half a decade. It was founded by my grandparents, Ted and Margaret Noffs, in Kings Cross. Ted started working with a young man named Charlie Perkins and they together developed the idea for the freedom rides. After the success of bringing that issue to the attention of the public, they formed the Aboriginal Affairs Foundation. Then the government essentially absorbed that as the Department of Aboriginal Affairs and Charlie and Ted took a step back from that.

After that, Ted co-founded Lifeline with Sir Alan Walker. Again, Ted took a step back from that after they were having conflicts about how religious the service was becoming.

My grandfather started a little church in Kings Cross called the Wayside Chapel, which was essentially an experiment to work with the young people in the area—those naughty beatniks who were …

Ms NELSON: I grew up in Sydney, so I am very, yes.

Mr NOFFS: It was all about poetry, Bob Dylan and freedom of expression. He had people like Allen Ginsberg speak. Krishnamurti and a young future Prime Minister, John Howard, also learned to speak there in what they called question time on Sundays.

Very soon, with the arrival of heroin coming in from the ports and the US soldiers bringing it into the country, Kings Cross became a hot spot for heroin. Soon enough, Ted started having young people being dropped off at the Wayside Chapel who had overdosed. No one knew what to do.

Ted would take the young people up to St Vincent's and would even say at that stage the doctors were unsure of what an overdose was. He really tried to turn the Wayside, at that stage, into a community health centre and work with people like Professor Ian Webster, who is a medical doctor, and encourage places like St Vincent's to get on board with the issue of drugs.

Moving forward, after my grandfather passed away, my parents decided to move the organisation to a place where it focused on the evidence and research about drugs and alcohol. We formed a partnership with the National Drug and Alcohol Research Centre. My parents founded the first treatment centre for adolescents in the country called Palm.

Ten years ago, I started to think street universities—which were essentially an idea of going back to how the Wayside was set up as a community centre for young people mixed with the evidence of harm reduction and treatment. We created these things called the street universities and there are now seven across the country.

About four years ago, a young girl called Georgina Bartter died at a music festival. There were discussions about the ways of preventing these sort of deaths. I had seen the evidence across Europe, at that stage it had been going on for about 16 years for pill testing, I knew that there was a doctor somewhere in Australia

that I remembered meeting 10 years prior, named Dr David Caldicott, who had set up the Welsh system—pill testing—and I contacted him, got the information I could, and started talking about it in the media.

Today we are obviously a proponent of pill testing, although our organisation will never run pill testing. We will never gain anything by pill testing services being at every festival, although they should be, and those programs should be run by doctors.

Beyond anything else, and we can talk about it further—and you will hear more from Gino Vumbaca, who is the head of pill testing Australia—beyond anything else, this is something that has 20 years of evidence behind it. It is something that has been shown to save lives, to reduce harm at festivals, and also reduce drug use.

That is why we are calling for it despite the risk, both reputational to our organisation, but also funding for our core work which is young people with significant drug and alcohol problems, which I should add is not the young people at these festivals.

Mr CHAIR: Mick, do you want to say anything?

Mr PALMER: Obviously Matt's experience, quite frankly, is probably second to none in Australia in terms of the length and breadth of his experience. Just a short anecdote in regard to the outline Matt has provided. The first time I met Matt was in 1998 when then Prime Minister John Howard launched his 'tough on drugs' strategy. Something that is probably not well recognised is that, at the time, he actually launched it from the Noffs Foundation premises.

I was there as Commissioner of the Australian Federal Police at that time, and Matt Noffs was in the corner as a snotty-nosed little kid. It is very significant that it has come an enormous way since then. Although the title of 'tough on drugs' gave this impression of it just being based on prohibition and strong and tough policing, there was a very significant amount of money given by John Howard at that time for divisionary and demand reduction policies, with which we were quite significantly involved in terms of its development.

The fact that he actually launched it from the Ted Noffs Foundation because of his personal connection with Ted, and also the relevance of what he was launching to what in fact the Noffs Foundation does, has been lost in the press—we at the AFP have been given significant money to create strike teams to interdict drug trafficking, organised importations and the like—and of course that is great media—significant seizures made, and police in black uniforms on decks of ships coming in with large contraband and people under arrest and so on is what got the media, but a lot of quiet work went on in that demand reduction process that is totally relevant to what we are talking about today.

I come to the position in regard to pill testing—as an old police officer from way back, very old sadly—not being pro-drug in any sense at all, but really having come to the conclusions and the position I have come to simply on the evidence.

As I said, governments hopefully do policing—obviously your whole career as a police officer is based on the evidence—I had a long time as a detective in the Northern Territory, I never convicted anybody because of what I believed they did, I could only ever convict them if I could prove what they did.

I came to the conclusion here quite absolutely categorically that what we were doing in regard to pill testing was an abject failure. We were not changing behaviours, we were not properly protecting young Australians who were otherwise in almost every case – 95% plus of the people involved in festival going are people who would otherwise never come to the attention of police at all.

They are not people who cause us trouble in society, they are not a form of social disruption. They are ordinary middle class young Australian men and women who go to a festival for a good time and do things we would prefer they do not. At the moment they are likely to come to the attention of police for reasons that might impact on their careers when otherwise they would never ever be likely to do it.

I became completely convinced on the evidence that what we have needs to be improved, and then the more I looked—and Matt is much more across the evidence than I—but I looked at the evidence very carefully and the evidence coming out of eight or nine countries now in Europe and the United Kingdom and now in the United States as well, is overwhelming. The enormous benefits are being achieved—it is not a failsafe mechanism, nothing ever can be—but it offers enormous benefits in terms of reducing the likelihood of harm to young Australians.

At the same time, actually as an old police officer, it could add some much better environment between the operating police at these festivals and the young Australians who they are there to protect the safety of. I have more to say later but I will leave it at that for the moment, Mr Chair.

Mr CHAIR: Thank you. We have some questions we have prepared. I will ask some of them and they may lead elsewhere. We will see where we go.

The first one is: your foundation often works with young Aboriginal people—for example, through your 'Getting it Together' program. Can you tell us a little about how the program is run and structured, and what you consider to be the key factors that make this program so effective in connecting with young Aboriginal people?

Mr NOFFS: The first thing is that across all of our services there is a large representation of young Indigenous people. It is not a surprise when you look at addiction. Again, with the debate on pill testing, we can often conflate these two things.

Putting aside young people who use drugs, young people who are problematically addicted to drugs quite often grow up in poverty or with severe trauma. So, any of us—black or white, girl or boy—if we are suffering when we are younger for whatever reason, if we have had these adverse childhood experiences, we are more likely to also take on a severe addiction that will not improve the situation but exacerbate the situation. That is often never looked at.

We are often saying young people, Indigenous or not, drink too much and take too many drugs and so on. This is what the headlines tell us. In actual fact, the youngest generation of Australians today smoke less, drink less and take fewer illicit drugs than any previous generation, including ecstasy. All of our programs, whether it is the 'Getting it Together scheme' (GITS) or our Palm programs, work. When we are talking about Indigenous young people, it is not so much the drugs, it is always about the family circumstances, the trauma that the young person has experienced.

I have worked with Indigenous communities all over the country and all of these different services provide different things for different communities and different young people. For instance, the GITS program is really about supporting the young person through counselling, but also through brokerage. It is dealing with those issues, but also saying, 'What else do you need? Do you need some money for a pair of shoes?'—the basic things. It offers casework, counselling and brokerage.

In the treatment services, the young people get to stay there for anywhere between three to six months. More often than not, the majority of young people—including Indigenous young people—coming in with ice as their primary drug of concern, cannabis as the second, or alcohol.

What is really interesting, though, we predicted—it is really hard. I came and spoke to the Police Association up here a couple of years ago, talking about the idea that ice was actually on its way down. It had been for a while. It is still on its way down, which is really hard for only some of the officers to take on board, when you are dealing with the menace of ice that we see. It is something Mick and I have talked about. Ice is incredibly problematic. We need to be focusing on it. We also need to juxtapose that with this bird's eye view of it, where it is going down.

We saw young people 10 years ago who were coming into our programs were injecting heroin. Then, five years ago, heroin dropped away. Then it became ice. Then what we have seen in the last six months is ice drop away and cannabis become the number one drug of primary concern.

To answer your question, whether it is the GITS program, treatment services or street universities, working with Indigenous young people should not be a McDonald's approach. You just cannot say, 'We need a Ted Noffs Foundation in Darwin and we will fix this issue.' Or a 'Headspace'.

One of my issues with a program like headspace is it is fantastic for kids with mild anxiety depression, but when we are talking about Indigenous communities, it needs to be about that community, that family, that young person. It cannot be one size fits all. It cannot be a franchise, it needs to be about working with the local community.

You need to know it will take some time to set up. It needs to have the evidence behind it and of course, with Indigenous communities it has to be about the culture as well.

Mr COSTA: Do you work with the Redfern community in Sydney?

Mr NOFFS: Not really, no.

Mr COSTA: That is separate?

Mr NOFFS: Yes. A lot of our work is out in Western Sydney, like Mount Druitt and Liverpool. Our feeling with Redfern was there were plenty of services there doing really good work. We go where the need is, and Mount Druitt at the time before we started the Street University there really did not have a lot.

It is the same here. I was talking to Peter before about PHN, and having one PHN focussing on drug and alcohol for the entire Territory is frankly ridiculous. It shows how under resourced the Territory is.

The worse thing would be to recommend to any government to come in and just fund this one organisation, whether it is Ted Noffs or whoever it is, to come in and to fix this solution. It really is about a multi-faceted approach. The big thing for me that is really missing, having worked in so many Indigenous communities, is the idea of working with culture, working with young people, helping bridge the law, the stories and helping young people take that on.

For instance, one of the most fascinating and exciting projects I was ever involved in in an Indigenous community was one where there was a generational gap between a particular story that contained over seven layers of law in it, about a bat and a crocodile. It talked about the history of that community, and its purpose was to give young people a sense of purpose and a drive, and the elders felt like it had been lost.

We spent a couple of days hearing that story, recording it, translating it and then getting the young people to turn it in to a reggae song, which ended up being about eight minutes long, and then doing a video about that, which they still use. That group of young people went on to become quite a famous band.

For me, that kind of work is just as important as the counselling and as brokerage because it is about—coming back to this notion of addiction—if we find purpose in our lives, it is more important than money, it is more important than anything else—we know what we are getting up for—even if we have a few beers at night, if we are smoking cigarettes, if you are smoking dope or whatever it is—if you have purpose and you can build a sense of community and getting up for something then the drug will never overtake your life, and a lot of our work is about that. That is the long-winded answer to your question.

Ms NELSON: The drug is a symptom of what is happening in your life at that time. It is not the cause of what has happened. I said yesterday in the Chamber, that you need to have a really solid understanding of where you have been before you can go forward.

I am East Timorese and have a Portuguese background and I grew up in Liverpool until I got married and moved away. I am very familiar with the Wayside Chapel, worked with the St Vincent de Paul as a volunteer, worked at St Vincent de Paul as well and—part of our volunteer program was to help feed some of the people that came in—from Wayside Chapel also.

The issue I have with organisations like Drug Free Australia, for example, who are adamant about—very supportive of them in that they want to help people. I totally understand that. But what they want to help is the addiction. They are not looking at it, like you said, a birds eye view. There is no helicopter view of the actual problem, of the issues or the causes.

Also being Timorese Portuguese, I am a bit old school. I have an 18-year-old son and I said to him throughout all of his life, the punishment needs to fit the crime, Patrick. In saying that as well, we need to understand, why do they do what they do? Why did you go to that? It is not the addiction so much as …

Mr PALMER: The reasons for it.

Ms NELSON: The reasons for it. Exactly. You cannot count the success or failure of a program unless you look at everything …

Mr NOFFS: Yes, the trauma, the poverty …

Ms NELSON: Exactly. All of that.

Mr NOFFS: The other thing is Mick and I are quite drug-free. I have never tried ecstasy in my life, so I agree with the principle. In a perfect world, great, drug-free. I do not want my kids using drugs either. However, that is not what I have an issue with—the current circumstance and laws criminalise kids …

Ms NELSON: It is the criminalisation …

Mr NOFFS: They criminalise kids who are already suffering, especially the Territory's Indigenous kids.

Ms NELSON: Exactly.

Mr NOFFS: Therefore, the question I have for Drug Free Australia is, how does the criminalisation (1) help the kids who are already in trouble and (2) prevent kids who are about to get into trouble? It does not. It is not only kids who are suffering, it is the middle class kids at festivals too. It is not stopping them using drugs either.

Ms NELSON: Exactly.

Mr NOFFS: It is exacerbating a big problem.

Ms NELSON: For the purpose of this committee, when we are talking about harm minimisation and reduction strategies—kids are doing what they do. They are breaking into schools because they are hungry. They need a safe place to sleep at night.

The parents are drinking because of the stresses of life—whatever stresses they are going through. Yes, there is illegal activity occurring and there are laws in place. That needs to be addressed as well. We will continue to see the same things happening over and over, generation after generation, until you can go back to the very bare basics of it. What has happened? What is causing the stress? What has pushed you to this edge?

The same thing with criminalisation with kids and the drug use. There are examples they are following, but again, what are they escaping from at the age of 13? It is all those things.

Mr NOFFS: You are right, you have hit the nail on the head. It is what we fundamentally ignore when it comes to addiction, it is what is underlying. The other thing, though, is we have talked about criminalisation and how it does not help.

What I want to be really clear about, though, is as we create safer laws and change the current system—and I want Mick to speak to this because it is really important—we want to be clear to the police that their role is not reduced, it is simply transformed, especially at festivals but also on the street. That is important for us. That is also why we offer you such an important voice in this. It is not about the reduction of police.

Mick, I will let you speak to that.

Mr PALMER: Yes, briefly, Matt. That is exactly to the point. The comments made are spot on the money, in my view. We have to distinguish between use and criminal behaviour that might flow from it. Sometimes, to get money to allow the use to occur, or other times in regard to ice, on occasion, because of the ice intake, people start acting aggressively and violently.

Where we treat the use, we punish the criminal behaviour. But we come back to the word purpose. 'Treat the use and punish the behaviour' is by far the best way to deal with this. So, we only criminalise and deal with those people who are really disturbing the purpose we try to achieve. What is the behaviour which we are punishing?

To punish people simply for using and possessing when they otherwise would not come to the notice of police for any reason at all is to defeat the very purpose we try to achieve. It further stigmatises, as Matt has said and you have said, and criminalises people, in many cases where people are clearly disadvantaged in the first place.

There are much smarter ways by which we can do business. There are no bad guys in this debate, just different opinions on the way we should move forward. Under current laws, we are creating an almost impossible environment for police officers, particularly young police. The street policing environment has never been more dangerous in our history than what it is now—much more so than when I was a young police officer. Street beat policing is unpredictable and often very dangerous and many more young people

are likely to be armed than ever was the case in my day, and much more likely to assault police or paramedics and the like than they ever were in my young day.

To create forums that are permitted, if you like, like the festival forum, which puts police, from the moment the festival starts or before it starts, in a position of conflict with the very young Australians who need the most support and for whom they should be offering the most protection defeats the very purpose we are trying to serve. It makes it almost impossible for the young police officers, many of whom live very similar lives to the people they are enforcing the laws on. These young police officers are ordinary young men and women, some of whom I am sure socially take drugs on occasion.

We create an almost impossible situation for them, and we could turn that around so easily. The NT to me stands out as a wonderful environment, a jurisdiction in which the lead could so easily be taken.

With small communities, there's a much more personal interaction. With bigger communities that you see in bigger centres, many police sometimes you find them enforcing the law against and the reverse when you are seen to know the police personally.

The recipe is there or the ingredients are there for a much stronger level of cooperation and support and goodwill despite the fact that these days, for OH&S reasons, we tend to walk around looking like we should be going to war in Afghanistan, which makes it hard to be a smiling face that you want to cuddle.

Nevertheless, we have an enormous advantage in the Northern Territory. The NT, I believe, has an enormous opportunity to really pave the way in terms of changing that relationship between police and young Australians, and creating a role for police that is far more supportive and far more beneficial than the one we currently have to employ under current laws.

Mr CHAIR: They are really topical comments and you almost sound like you are still the Commissioner up here.

Mr PALMER: It never gets out of your blood.

Mr CHAIR: Over the last weekend we had a series of assaults on police officers and it is becoming more and more common, as you predicted, and it is a real concern for us up here.

Mr PALMER: It is a concern and, as you know, personal violence crime has always been quite high in the Territory. I remember in my young days as a detective, the homicide rate was something like, year after year, eight or nine times the national average – personal violence crime rates were much higher. It has always been a difficult environment for young police officers to operate in. Whatever we can do to generate that greater level of understanding and good will between the competing parties, and the lower the levels of the likelihood of that sort of assault.

At the same time, as has happened before in the history of NT policing, the chance has increased that when that sort of violence does occur many of the bystanders will in fact come to the assistance of police. I have been involved in many instances like that in the Northern Territory where lots of support was given to police by bystanders watching assaults by other bystanders or other people, if you like, against police.

This is because of the level of understanding and the relationship the police had with wider community, and that is achievable in the Northern Territory and is critically important as you say now. Because of the nature of that violence and the lack of respect for authority which is pretty widespread, sadly these days, it is a reality of the world in which we live.

Mr CHAIR: Yes, that is unfortunately. Can I get you to perhaps both give some us some comments on pill testing? We heard previously about how it is not the impurities that kill users that it is the MDMA itself, and there was an inference that the pill testing effectively tells young people that MDMA is fine — away you go, happy days. Can you give us some comments on that?

Mr NOFFS: Yes, it is true that the ecstasy can kill a young person or it can cause either over hydration or whatever it is. Yes, it can be the MDMA but it is also the other toxic substances that are sometimes found in the drugs. That is not what pill testing is about. Pill testing is not about purely analysis. That is about a third of what goes on.

The most important part of pill testing for me, and where I believe we are going to lead the rest of the world is, it should always be a doctor in a tent. A doctor in a tent where currently there is nothing. There is currently

a gauntlet of police at the front and still young people will push through those dogs and those police to use this drug.

If there is a tent on the other side where the young person can come and say, 'I am going to get this tested' and where a doctor can intercept that young person and say, 'now listen', as we said to all the young people in Canberra last year, 'the safest way to take this drug, ecstasy or not, is not at all'.

When the young person has still decided to pass that safety net and say I am still going to take the drug, the doctor, not any of us, but a medical doctor can say look at this young person—like the Premier of New South Wales is currently saying everybody is different, every shape of every young person and how their body is going to react—that is right. But let a doctor decide that and give that information to a young person, not a Premier, unless she is also a medical doctor.

That is I want for my kids. If they have still decided—after I have probably told them that I prefer they do not take drugs—that they will take a drug, I want a doctor in a tent to give them, first of all, the advice not to take the drug and secondly to go through a number of different precautions once that person has decided to do that. That is what this is about, saying that a young person has run the gauntlet, got through and decided to do that.

One of the things we have found really interesting is if the young person sees a pill testing tent at a festival, where the risk before was almost like an illusion—you have a politician saying, 'Do not do drugs', then you have your best mate who has gone off to study law, doing really well and taking ecstasy every week and you have never taken it yourself. You are looking at the Premier and your mate and you are thinking to yourself, 'Well, they are actually kicking goals. I will take their advice.' That is the situation we have at the moment—this false binary.

Yet, when that person gets that pill, runs the gauntlet and comes into the festival and sees a pill testing tent, it becomes real. The notion that they could die moves from this idea that 'no one really dies' to 'I better go get this checked'. What was really interesting was seeing that 50% of the stuff that was tested in Canberra was pure MDMA.

To have those young people who had pure MDMA with us in the tent talking to health workers for sometimes up to 20 minutes when this music—I thought they would rather be out there. I could not believe it. We could not move them on, but you would be thinking, 'There is a huge line outside', when there was a group of four in there learning about ecstasy for the first time in their lives.

You want drug education, reduce not just the harm but drug use itself? This has been shown across Europe to do that. It is really important. I ignore comments about the idea that people like Mick and I who have never used ecstasy are telling kids that we are giving them the green light. It is almost like, I could imagine, a satirical song called The Green Light with Mick and I dancing around a disco saying, 'Go and take all the drugs you want.' It is so ridiculous I do not even want to respond to it.

The most important thing is every single young person is told the safest way to take the drug is not at all—it is a doctor in a tent. That criticism has fallen by the wayside, so to speak. The one that is coming up now is that the technology is not that good. Again, the analysis is only a third of what actually happens. I will quickly speak to this and send you the evidence on notice.

Essentially, what is used commonly in pill testing across festivals across the world is a machine – a spectrometer. A spectrometer shoots a laser—the smaller ones are about this big, the size of a briefcase. They shoot a laser through a substance—it could even be a piece of plastic—and the reading will come up saying it looks like it is this sort of polymer and so on. This is the reading.

To some extent, it is taking a very good guess at what is in the drug, but they are very accurate. They are accurate enough that they are used as a gold standard across hospitals and tertiary institutions around the world. So, if it is not good enough for a hospital or a university like the Australian National University, why is it good enough for a festival?

If you go for the platinum technology, that is called a mass spectrometer. You cannot move that into a festival, it is significantly bigger. If you want the best kind of lab tests and results you are talking about a two-day wait period. That is two days too late for a kid at a festival. We agree that pill testing is not a silver bullet, but it is far better to have a doctor in a tent with a medical grade machine than nothing.

The other thing, too—and Mick can speak to this—is the notion of transforming police at festivals. For me, it was really wonderful to see a police force at a festival not focusing the kids possessing drugs, not using drug dogs, but shifting their focus to the dealers. In Canberra, they do not use drug dogs, they use drones. They send drones up over the festival and the drones are looking for dealing.

The young people at this festival felt they could approach the police. If they needed help they approached the police to see where the tent was. The police, at the end of the day, walked into the tent and saw all the samples that were tested. They got an idea of what was in the market. What we know about that is it gives police a better understanding of what is happening in local black markets.

It paints a picture. What was dark suddenly becomes grey, lighter and more understood. We know that pill testing changes the black market. A kid will never go back to that dealer once they have given them something that was not what they expected.

But then again, the kid who gets what they expected—if it was MDMA or not—are more likely to reduce their drug use if they have someone who has no vested interest in them—a doctor who does not need anything from them—saying to them, 'Do not do this and if you are going to, I need you to come back here immediately if you are having any symptoms. I need you to go to that police officer who can get you to me or to a hospital if you are having any adverse reaction.'

For me, it really is a medical intervention. Mick should talk a little about the police aspect because it is an opportunity to enhance and change the role of police as well.

Mr PALMER: For the benefit of the young people we are concerned about, we need to look at where we are coming from in deciding where we would like to go with pill testing. Matt is exactly right. The IDR infrared, the spectrometers, are really highly efficient machines. The level of identification of drugs, both in components and toxicity, is very good. Obviously, nothing is perfect, everybody will have a different reaction.

But if we go back to where we are now, if you like, the only people who will go to those tents are people who intend to use the drug. That is why they are going to test it out before they use it. They have got through the gauntlet, if we still have a gauntlet; they just want to be sure of what they bought before they take it. The current environment means not one of us who buys drugs has any idea of what we are buying.

All we know is what the person we are buying it from told us we are buying. It is quite often—almost always—different to what you thought you were buying—often corrupted or contaminated. You have no idea what the toxicity rate is.

So, anything we can do to improve that marketplace surely has to be a giant step in the right direction. When people talk about the green light Matt mentioned, in my view at the moment, there is certainly no green light in any of this. All of the advice—I have listened to it—given to young people is, 'You should not be doing this; this is a dangerous practice.'

Adding to what Matt was saying, even if they identify MDMA and what it is, and people are clearly showing an indication they intend to continue to use it, they are told very clearly what the symptoms could be if things go wrong and what they should do if, in fact, they experience any of those symptoms.

As you know, in recent times a couple of the last very sad tragedies of fatalities occurred despite the fact that people had not only gone to a pill testing environment but also realised the symptoms too late. When they got bad, they took themselves to medical attention, but left it too late. They realised what it was. Georgina Bartter, Matt mentioned earlier, was a pharmacist for God's sake! The young woman was a pharmacist. She clearly did not buy what she believed she was buying.

At the moment we have a red light—we talk about green lights. We have a huge red light but no one is stopping. That is the reality. It is like the laws we used to have in the 1960s and 1970s for indecent language. As I said, nobody stopped swearing. We used to lock up people now and again for swearing. It sure as eggs did not stop swearing. I could have locked up 20 people in the coffee shop this morning for swearing if this law was still in place. We had to replace it because it was a bad law and ineffective.

That is where we are now. This is ineffective practice. The police role is one of conflict at the moment, obviously. Young people do not trust them, they are frightened to tell police if one of their group gets ill. They are likely to not only tell police lies about what they think has gone wrong, they tell the paramedics lies and pretend it is food poisoning or something because they are terrified of either disappointing parents or getting into trouble.

We have to turn that around and say, 'Hey, guys, police are here to ensure your safety to the full extent we possibly can. We are not here to punitively arrest someone for possession of a small quantity of drugs in your pocket. That is not our main purpose here. Our main purpose is see us as a friend in court, not an enemy.' That is what the future has to be if we are to be effective in dealing with this.

Mr CHAIR: Gentlemen, unfortunately—this is a really interesting conversation and I would like to continue it, but we have a timetable we have to try to stick to a little. It has been really interesting. Thank you both for your input. Mick, I hear that you are on Q&A on Monday night. I heard a rumour about that.

Ms NELSON: Are you?

Mr PALMER: Yes, that is right.

Mr CHAIR: I look forward to watching.

Mr PALMER: Thank you very much for the opportunity and privilege of being present this morning. My heart remains in the Northern Territory. You have a wonderful opportunity here, seriously, to lead the way because of the small communities that exist across the Northern Territory, despite your 1.8 million square kilometres of country.

It is a great place. It is a young population. You have a lot of reasons why this could be a great success. You have a Commissioner who is intelligent, articulate and progressive. You have a lot of things going for you and are a government that, hopefully, will have the courage to do something about it. Thank you very much, it is a pleasure.

Mr CHAIR: Thanks, Mick.

Ms NELSON: I am going to have to break my Q&A ban—self-imposed ban on Q&A. It drives my blood pressure up. But I will break that for you Mick, on Monday night.

Mr CHAIR: Yes, the same here. I said this to Matt.

The committee suspended

HARM REDUCTION AUSTRALIA

Mr CHAIR: To my right is Sandra Nelson, the Member for Katherine and Lawrence Costa, the Member for Arafura, and Jennifer Buckley.

On behalf of the committee I would like to welcome you to this public hearing in to a Northern Territory Harm Reduction Strategy for Addictive Behaviours. I welcome to give evidence Gino Vumbaca.

Thank you for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply.

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

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

Mr VUMBACA: Gino Vumbaca, President of Harm Reduction Australia.

Mr CHAIR: Gino, would you like to make an opening statement?

Mr VUMBACA: I would. I will be brief. What I would like to say from a Harm Reduction Australia point of view, is that I am also representing a newly conceived organisation called Pill Testing Australia.

Those are two areas that I would like to focus on today from our perspective. One is about the merits of introducing pill testing in festival and off-site or fixed site locations, and that is a means for people to get further information about the drugs they are considering consuming, as well as engage with health professionals.

In that context there is a lot of misinformation about surrounding what pill testing services do. We actually provided the first pilot program in Canberra in April last year. What people need to understand is that it is not a mechanism to tell people it is safe to use drugs or to give them the green light as some people have highlighted in the media that we are giving a green light to drug use.

What we actually do is provide a lot of information to people who are already in the festival, and run the gauntlet of security and dogs and police and everybody else out there, so they are quite committed to using that drug, and we are in a way like the last line of defence or information for them to receive about what it is they are about to do.

In Canberra, we found that people were more likely to moderate their drug use, or in some cases not take the drug they were considering taking, based on the advice and information we could provide them. At no time do we tell people it is safe to use drugs.

It is an area, if governments look at the evidence that has been collated now around the world—and it has been occurring for over 20 years in European festivals—clearly there are benefits. It is not a panacea or a silver bullet to all the harm that can occur at festivals, but it mitigates some of the harms we see currently in festivals here.

The other issue I wanted to raise was I am also a member of the board overseeing justice reinvestment in New South Wales. Although it is at a tangential level, what we are about in justice reinvestment is reducing the incarceration rate for people.

When you look in Australia, and indeed around the world, for the number of people who are imprisoned and receive criminal records for personal use of drugs—particularly those who are dependent on drugs and the harm that does far outweighs what I would say is the crime of personal use of a drug. By the harms I mean in some cases it can be incarceration, but also in long-term effects of impacting on someone's employment opportunities and, in some cases travel, and the stigma associated with having a drug-related charge.

It is something about which we need to look at countries like Portugal about how they have begun to deal with the issue of personal drug use and decriminalising and moving towards a health-centred approach for people who use drugs.

They are the two issues I wanted to raise today.

Mr CHAIR: Good. We have heard a bit about pill testing this morning—first from Drug Free Australia talking about your green light and then from Matt and Mick.

Mr VUMBACA: Oh, okay.

Mr CHAIR: Yes. Thanks for that. In justice reinvestment, though, you are involved in New South Wales, you said?

Mr VUMBACA: That is right. Justice reinvestment New South Wales. We have a major project that has been running for a number of years in Bourke, northwest New South Wales, with the Indigenous community. It is a program that has been run primarily or overwhelmingly on philanthropic funds and which is now starting to attract government support because of the outcomes we have been able to achieve there.

By outcomes I mean reductions in domestic violence and a whole range of other criminal activities and increases in people staying in schools—the retention rate for schools and those sort of things.

Mr CHAIR: Yes. Are there plans to move that program into other rural communities?

Ms NELSON: We have …

Mr VUMBACA: There are.

Ms NELSON: Sorry, this is Sandra Nelson, Member for Katherine. We have the Katherine Youth Justice Reinvestment Group we started about three-and-a-half years ago based on the model from Bourke …

Mr VUMBACA: Oh, good.

Ms NELSON: Yes. It was completely voluntary. I was a member of the group. Since being elected, I am now the patron of the Katherine Youth Justice Reinvestment Group. It is still voluntary, very community-driven and a community initiative—all of that. Why it is so successful is because it is community-driven …

Mr VUMBACA: Yes.

Ms NELSON: … and the same things that you guys are doing. It initially started in Katherine as a way to become engaged with the youth that were overly represented in some of the crime that was happening in Katherine Township, but it has expanded a little more from that over the last couple of years as well.

It would be great if you could explain to the committee a little about what you guys are doing in New South Wales.

Mr VUMBACA: I can. You can follow up on this at a later time. The principles of justice reinvestment is it is a community-driven approach to dealing with problems in that community that often lead to offences or offending behaviour. Part of our project has been, with the help of KPMG and a number of philanthropic partners, to collate some very clear and detailed baseline data on the issues that are affecting Bourke from people, from six months old to adulthood, and about their interactions with the area's services and arms of government, be it education, justice or health.

From that baseline data we introduced a number of programs identified by the community. For instance, probably one of the more successful ones has been the warrant clinic and the driver program. There are a number of people who are facing offences and being imprisoned from the Bourke area because of problems with suspended licences and driving while suspended and those sorts of things.

Part of the issue has been that there is no public transport or alternatives for people in that area and so people tend to drive then accumulate a number of fines that they could not pay and then they end up in prison.

We have been able, through driver programs and the like, to significantly reduce the level of people committing those offences. The other area we have had major successes in is family and domestic violence, by introducing men's groups and a whole series of initiatives—again, community-driven and community-run – and that has been part of our process that that is actually is run.

We now have two pro bono international law firms working with us as well, and they are actually setting up Bourke now as an independent. The group running it, Maranuka, will be independent from us and actually run it there so the local community has complete control of the programs.

We have recently been funded by the New South Wales Government to explore other communities now to move into, which we have just hired staff to do that—we are in the process of doing.

Mr CHAIR: Did you develop the program yourself, or is it based on examples from elsewhere?

Mr VUMBACA: It is based originally on models from the US but we are slightly different here. The US model was very much based on costs, much higher levels of incarceration and in some states and jurisdictions they were going bankrupt because of the cost of incarceration, so they looked at how they could reduce their incarceration levels.

That cost was the main driver and it was also a top down approach and the governments were trying to restore their budgets and find ways to actually reduce those populations. The Australian approach is to actually engage with the community. We engage a lot with the community before we even start the process of Justice Reinvestment and set up structures to support them and also for them to actually have a process in place to take control and manage the programs that are there and collect the data that is necessary.

We are a bit more bottom-up approach and working a lot closer with communities, and not so much cost-driven even though that is one of the benefits for government in the long-term obviously.

If you go to our website, Justreinvest.org.au, there is a good Four Corners program on there, other videos and a lot of—we have just released a community Toolkit about how to establish Justice Reinvestment in your community. Even though they are New South Wales-based, they are obviously applicable beyond New South Wales.

Mr CHAIR: Regardless of whether you are bottom up or top down the cost savings would have to be very similar would they not?

Mr VUMBACA: The only caution we get when we have met with Treasury here—the only caution we give is that the savings are not realised immediately. There is a transition. To save on incarceration costs, like removing 10 people out of the prison population does not really save any money.

You have to have a significant amount of reduction until that point is reached so you can close a wing or an institution down before the tree lights. But you get court savings and police savings in some cases as well, but they are not immediate those savings. You also have to pay to set up some of these programs and they run in parallel for a short time. If you imagine a graph, they gradually cross over.

Mr CHAIR: Just off that issue for a moment. Could you elaborate on your recommendation to introduce heroin prescription programs as a way to get heroin users to engage with treatment services?

Mr VUMBACA: Yes. Again, this is based very much on overseas evidence. Some of you may recall there was actually approval given in Australia in 1996 for this to be trialled and then, for political reasons, it was not progressed and it was halted before it started.

In those intervening 23 years there has been a number of programs operating in North America and Europe providing prescription heroin. There is lots of data information and research available to show how it is effective. You can just take a common sense approach to this.

If you have someone who is dependent on heroin and they have tried other forms of treatment, be it buprenorphine or methadone or residential rehab or counselling or whatever it may be or all of those, or NA in some cases or a combination of those, and still is unable to address their heroin use and dependence then what they should be considered is what we would, in medical terms, call a second or third line approach where they should be able to access prescription-based heroin through a program, and it pulls them out of that system of dealing with organised crime, committing crime to be able to purchase street heroin and locked in that cycle.

Even at a basic human level, many years ago I was approached by parents whose daughter was working as a street sex worker in the Kings Cross area—clearly, in a lot of distress. There were limitations on what we could do. When you have kids and look at someone else's kids and the anguish and the pain that they could not help their child, and had tried everything to try to assist their child about their heroin use, to me it made no sense to keep that person out there because they had been to other treatment services and had not been able to get the benefit that we hoped.

What they were doing in working in the sex industry and committing petty crime was all based on getting money to buy street heroin, which was pharmaceutically only worth a few dollars. It seemed an extraordinary lapse in our system that we would let her continue to do that in order to fund a habit that we could probably address if we had a prescribed heroin program. It is not for everybody and we never suggest it is, and the programs that operate overseas are not. It is for people who cannot get the benefits out of treatment that we hope.

Medical practitioners would say if you present with an ailment—whatever that might be—they have what they call a first line range of pharmaceuticals and treatment regimes. If that fails, they have second line and a third line. They do not just say, 'Well, if you failed at the first, bad luck'. That is what we are saying to people who use heroin, 'We have these programs and if they do not work, then bad luck. We will continue to prosecute and persecute you for your dependence.'

Mr CHAIR: Right. On another angle, or coming from that, I suppose, is safe injecting rooms. We heard some submissions earlier today that there is no evidence that safe injecting rooms have been effective in any way, shape or form. What would you say to that?

Mr VUMBACA: I disagree with that. I have been to the injecting room in Sydney a number of times, and where I was working overseas many years ago have been engaged with the ones in European cities. Again, I do not want to come across—and I also caution people about saying this will prevent overdoses or it is some sort of panacea to all our problems. It mitigates some of the harms and potential overdoses because there are people there who are able to address the situation quickly and medically if an overdose occurs.

What people miss—and this occurs with pill testing as well when people talk about the equipment we use and all that—is the human interaction and the benefits of engaging with people. Needle and syringe programs were the same. I was involved in establishing the first pilot with Alex Wodak and setting up the New South Wales system many years ago for New South Wales Health.

One of the key things with that program is not the provision of needles and syringes—of course, that is important—but it is engaging with the people who are actively using drugs. In most cases, because they are actively using, they are not engaged in any other health service. That occurs with pill testing and medically supervised injection centres. You get to know who these people are in your community and engage with them. The benefits of that should not be discounted. That is an incredible opportunity for intervention and further treatment to be provided.

I know the arguments about 'people will then engage in riskier drug use because there are procedures there to help them if they overdose and those sort of things'. Of course that may happen, you cannot say it will not. But most people are not looking to overdose when they use. That is not what they are looking to do.

Just as with pill testing, they are not looking to end up in the back of an ambulance when they spend $200 on a festival ticket and buy their drugs. They are not looking to be in an intensive care unit half-an-hour later. They want, in their mind, have a pleasurable effect from what they are doing. So, this notion that if you provide a safer environment people will be riskier in their behaviour belies what the overwhelmingly majority of people who use drugs are doing. It shows a lack of understanding about drug users.

Mr CHAIR: Thank you. Your submission calls for decriminalisation of illicit drugs for personal use. What is your response to the concerns that decriminalisation would increase drug use and drug-related crime?

Mr VUMBACA: Sometimes there is confusion between legalisation and decriminalisation. Legalisation obviously means it can be freely consumed and bought. Even with decriminalisation you may get some evidence to suggest there may be some moderate increase at the start and then it levels out.

What we are talking about is removing the criminal sanctions from people engaging in drug use so that if people were smoking cannabis in their home or having a joint out wherever it may be, that should not be dealt with by the criminal justice system. There are people using other drugs who should not be dealt with by the criminal justice system. There will be sanctions in place, as I said earlier, that can penalise someone for the rest of their lives in employment opportunities, travel restriction and those sort of things.

The harms that are caused by criminalisation far outweigh the benefits. The other harms include that we again, as health professionals, have trouble engaging with people. There is the stigma associated with drug use, the illicit nature of it means that people necessarily have to do it as an underground activity—something they do under the cover. That all means that it restricts the interaction and connection we can have with people using drugs because it is an illegal activity.

I do not think that serves the community well. I certainly do not think that clogging up our court and prison systems with people who use drugs—because they are classified as illicit as opposed to other drugs such as pharmaceuticals or alcohol and tobacco which are not—and somehow punishing people who make that choice, is the proper course of action to take.

Mr CHAIR: Thanks for that. Anything else you would like to add, unless there are any other questions?

Ms NELSON: No.

Mr CHAIR: Anything else you would like to tell the committee, Gino?

Mr VUMBACA: I reiterate about pill testing. What the committee should be aware of is that Pill Testing Australia is prepared to provide a free pilot program in every jurisdiction …

Mr CHAIR: Actually, go on …

Mr VUMBACA: … to collect the data, show the government how it operates, work with local police about collection of information and the early warning system that provides Health, paramedics, as well as police about what drugs are being consumed in the area, as well as interact with people.

You have to realise that most often at festivals a lot of people there are what we call occasional drug users. There are people there who only use when they go to festivals and do not use otherwise. They are ones who rarely engage, if at all, with health professionals or get the information they should have before they make those decisions.

I highly recommend that the NT government consider the offer from Pill Testing Australia for a free pilot program. We provide a full report on what happened. I know the festival promoters are getting more and more concerned about the level of harms and are feeling like they are being pressured to reduce the potential for drug-related harm at their festivals. At the same time, they know our program could help, but they cannot use our program.

Mr CHAIR: Yes.

Mr VUMBACA: In a way, asking them to reduce harm while tying one hand behind their backs is placing them in an unfair position. I strongly advocate that it is best to run a pilot and see how it operates, to learn how it operates, before you make that decision that you are either opposed or not.

Mr CHAIR: When you talk about running a pilot, would that be at a music festival, or …

Mr VUMBACA: At a festival, yes.

Mr CHAIR: Okay. So, what sort of time line would you need? For argument's sake, we have a music festival coming up in the Territory in May – BassintheGrass.

Mr VUMBACA: We would generally need—for instance, in the ACT at the Groovin' the Moo, we submit a full proposal which includes operational plans, risk assessment plans, indemnity letters and insurances we have to put in place, as well as staffing and equipment. That takes some time, so there would be a couple of months run-in to that we would need. But we can move fairly quickly. Our key issue is that we need government support to do it.

Mr CHAIR: Yes.

Mr VUMBACA: I to not mean funding, I mean support for the program to go ahead. We will not operate—we get many requests from festivals saying, 'Please come and do pill testing', and we have to be clear with them that we cannot offer pill testing unless we have the support of the jurisdictional government.

Mr CHAIR: No, I completely understand that.

Mr VUMBACA: I mean, if you were to get approval on 30 April and you wanted something on 1 May to happen…

Mr CHAIR: Does anyone have anything else? Thank you very much, Gino.

Mr VUMBACA: Thank you for the opportunity.

The committee suspended

PENINGTON INSTITUTE

Mr CHAIR: Good morning, everyone. I am Jeff Collins, the Chair and the Member for Fong Lim. I have Sandra Nelson, the Member for Katherine; Lawrence Costa, the Member for Arafura; and Jennifer Buckley, our secretary.

On behalf of the committee, I welcome everyone to the hearing into a Northern Territory Harm Reduction Strategy for Addictive Behaviours. I welcome to give evidence to the committee, John Ryan and David Rose.

Thank you both for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

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

Mr RYAN: John Ryan, CEO of the Pennington Institute.

Mr ROSE: David Rose, Director of Communications at the Pennington Institute.

Mr CHAIR: Thank you. I have just been reminded, as this is being recorded by *Hansard*, each time you speak would you please be able to state your name again, if you are going to swap between speakers. Would either of you like to make an opening statement.

Mr RYAN: I am sorry, I am a little hard of hearing. Firstly I want to thank you for the opportunity to present to you today, also to congratulate you on taking interest in these issues. Drug use is unfortunately causing harm in many countries. In fact, I have been in this field for more than 20 years now.

I have seen that over the last 40 years, drug use has spread to just about every corner of the globe. Not only is it spreading to big metropolises, but to regional and rural areas from the Philippines to Jordan, from to Benin to Denmark, and we have drug problems in Australia.

Part of it is the increase in global trade but part of it is about the profit incentive to provide mind altering substances, in which case drugs are now cheaper, more available and diverse than they have ever been in history. Chemists, as we speak, are inventing new types of drugs to provide the market. My contention would be that within the difficult context where the profit incentive is so high and there is demand-seeking behaviour that is cross cultural, national and regional.

We need to contemplate whether our approach to drugs has been successful and my contention would be that the 'war on drugs' on our end—this is of law enforcement—has been a failure. It has been done with good will and intentions but unfortunately it has not reduced the international trafficking of drugs and it incentivises people to be providing drugs because the profit margins are so big. Five dollars of cocaine in Columbia is hundreds of dollars in downtown Melbourne and so it goes for all of the drugs.

In relation to what we can do about that increasing toll from drug use, we have to face up to the fact that, because of the increasing danger of drugs, we have to change our approach. An enhanced approach to harm reduction would be much better than an enhanced approach to law enforcement.

In the last few days at the American-Mexican border, there was a fentanyl detection which was the equivalent of a million fatal doses of fentanyl. We know about the harm of fentanyl, it is an extremely powerful drug. There was a detection in Canada that was the equivalent to wipe out the entire Canadian population. In Australia we have invested at least 65% of our drug budget in law enforcement. Internationally the numbers might be even higher for law enforcement and it has not worked.

We have drug use in our community and the profit incentive will ensure that there will be drugs. We have invested less than 3% in Australia in harm reduction. Harm reduction is an approach that is endorsed by the World Health Organisation, United Nations Office on Drugs and Crime, and the scientific fact is that it works. It has not been provided the kind of resourcing that it requires to do its job effectively. In Australia we have a bipartisan approach to the introduction of needle and syringe programs, the provision of sterile injecting equipment to prevent HIV.

It was a triumph. We do not have a HIV epidemic in Australia in the heterosexual community because of the triumph of needle and syringe programs. That was in the 80s and the innovation since then has been few and far between. I would commend the innovation of diversion away from the criminal justice system that was supported by Prime Minister Howard. We can do a lot more than the low levels of diversion that we have.

There are models internationally that are looked at as best practice such as Iceland. The Iceland one was preventative in a culturally different setting and has not been successful with illicit drugs. However, the

Portugal model with decriminalisation of drugs, and increased social and health care, have been implemented. There has been a significant reduction in drug related harm.

The Northern Territory, Victoria or Australia is the equivalent of Portugal. We have to come up with our own responses to drug problems. There are some headwinds internationally that suggest the way that we should go forward, one of which is shooting towards a health focused approach and moving away from the expectation that law enforcement can control supply and manage drug use problems. Secondly, part of that health focus should include more in education around the risks and harms of drugs, but also enabling people to intervene in drug use problems.

I'm not saying this is a perfect example of that; it is another reversal drug supported by Alzheimer's and politics, for example, in North America, because it is a drug with no abuse attached to it. In Australia we do not see its availability anywhere near the level that is required. There are so many examples of emotive solutions to drug use problems that come from a harm reduction frame that are framed at first as health and safety.

I commend the committee for investigating this in a proper manner. Referring to a report that we wrote a couple of years ago called *Not Just Naloxone*, which picked up on many of those innovations that vary internationally and should be informing our approach in Australia.

Mr CHAIR: Thank you for that. That was very informative and broad-ranging. You have spoken about the Mansfield project. Could you elaborate on that for members of the committee?

Mr RYAN: The Penington Institute was very concerned about the spread of ice and amphetamines to regional and rural communities in Australia. It happened very radically that high potency methamphetamine became readily available in all corners of the country.

It is impossible to expect a small country town to have the infrastructure that happens in the big cities, so we were looking at a model that would address drug problems in small country towns, but without the expectations that governments would be able to afford a huge investment of infrastructure. In this case, we looked at infrastructure that already existed and tried to shift the focus to include drug and alcohol problems. It was particularly driven by the ice-related problems.

The shift to country towns to rely on policing mostly in relation to drug problems—for example a hospital (inaudible – audio glitch)… The Mansfield model is basically trying to enable networking between different players in a small country town in order to intervene earlier in relation to drug problems.

It includes the GP as a cornerstone of many small towns. In this case, the trial in Mansfield has been celebrated by some of the GPs there. It involves a collaboration between hospitals, police and all the local players who can step up to the plate and address drug problems from a health perspective rather than expecting that the law enforcement system will be able to resolve the issues.

Mr CHAIR: It sounds good.

Ms NELSON: I was just going to ask you about the Mansfield project. I also read in your submission that you suggested GPs play a key role in early intervention efforts. Were the GPs in that small town part of the consultation and establishing the framework and all of that?

Mr RYAN: Yes. I am very pleased to say that they were. Of course, we have had difficulties with GP access in many parts of Australia. I appreciate that. For those GPs who are in place and facing up to the challenges and wanting to be involved—we were fortunate that there were such GPs in the Mansfield case.

In my view, there is a very much bigger role for GPs in relation to drug and alcohol issues and of course, we know in the American context of prescribing of opioids that has been driving the overdose epidemic. So they are involved in a multitude of ways but many times, family members will speak to their GP about drug use problems in family or indeed an individual will speak to the GP.

There is often a deficit of trust amongst people who have used drugs and GPs. That is sometimes based on experience. Dealing with that stigma around a lack of access has been one of the opportunities in the Mansfield model because there are GPs that are willing to step up to the plate but they need support.

They need proper financial support but in the context of their practice, they also need healthy relationships with the local hospital, for example, and also with the local police, social care services and nurses. All of those players that come together around a hub and spoke model with the GP at the centre of it.

Ms NELSON: Yes, of course. We heard from the CEO of Harm Reduction Australia, from Gino, and he is a supporter of prescribing heroin. I wanted to get your take on that as well, not that we are talking about GPs.

Mr RYAN: The biggest public health-scale positive change in relation to medication-assisted treatment for opioid dependence would not be heroin prescribing but it would be improving what we already have in place which is methadone and buprenorphine.

Opioid substitution treatment is not adequately provided in Australia. There are prohibitive dispensing fees for many patients on a daily basis regardless of how often they need to go to the pharmacy; they are typically charged on a daily basis. There are not enough GPs that are prescribing opioid substitution treatment.

At the community-wide level, improving the opioid substitution treatment system within the current drugs framework would be the best return on investment however there is good evidence for heroin prescribing particularly for people who have been unsuccessfully treated through opioid substitution treatment and residential care and other forms of treatment. That form of treatment is worth trialling but it is an expensive model compared to ramping up opioid substitution treatment more generally.

Mr COLLINS: Talking about the Mansfield project and the small Victorian rural town, you mentioned about Portugal, Iceland and the Northern Territory, everywhere is a bit different. We have a few small towns in the Territory and lots of very small remote communities. It is one of the issues that we have seen in this process, so far, is that everywhere is a bit different.

For a small jurisdiction, we need to find a way to address those issues in each of those different communities. If you were going to advise us in a particular way, do you have any ideas about how the government could best approach those?

Mr RYAN: I totally agree with your insight into the variability of issues across areas. Even in a big city like Darwin, there would be different suburbs that have different challenges. Our perspective, from Penington Institute, is that the centralised model of command and control through law enforcement has been a failure. Perhaps what we need is to have localised solutions.

The Mansfield model is an example of a localised solution. We run International Overdose Awareness Day which is now in 40 countries, 700 beds around the world and it is based on a model of people in their local scene prioritising what they think should be important. I think that is the way forward in relation to better solving drug problems and being responsive to local communities.

However there are some centralised legislative frameworks that work against that and I would argue that the criminalisation of personal use and possession, for example, is part of that old idea that you can control effectively from head office. Getting rid of some of the legislative barriers that would free up innovation at the local level is the way forward.

Ms NELSON: I absolutely agree.

Mr CHAIR: Sandra, do you have anything else.

Ms NELSON: No I do not. Katherine is about 310 kilometres south of Darwin. It is a small town but it is the hub of the Katherine region which services about 24 000 people in that region. We have 10 000 people—population—living in Katherine township—just under 10 000. We have one private GP clinic, and there is no bulk billing.

These are the sorts of constraints and challenges that we face in a lot of the small towns in the Northern Territory, and when you are talking about GPs playing a key role in early intervention efforts that would then lead on to the discussion as well about Medicare and how Medicare is set up and what they can claim and what they cannot claim, and that sort of support for the GPs as well. Have you guys done any work on that—to do with Medicare specifically?

Mr RYAN: Yes, there needs to be a Medicare number for dealing with drug and alcohol issues. There is a lot dealt with through a lens of mental health, but doctors need to be incentivised around dealing with drug

and alcohol issues. Much of it is actually—the high level in Mansfield it is the GP, but actually at the daily interface level it is a nurse and healthcare workers and healthcare patient officers that are doing the work.

That is actually a very efficient model so that the GP does not need to be taking up a huge amount of time with drug and alcohol issues but they have oversight of the multi-disciplinary team. That is a much more cost effective model. As long as there is an appropriate link by the psych and the GP, I think you get a positive outcome.

Secondly, I think there are some interesting developments in North America in relation to taking cannabis out of the criminal underworld and providing it legally and taxing it. One of the opportunities that presents is that those taxes, instead of being in the criminal underworld and funding the black market activity and introducing people who want smoke cannabis to the criminal underworld, or consume cannabis, that actually takes it out of the underworld and provides a source of government revenue …

Ms NELSON: That is what they have done in Uruguay, is it not?

Mr RYAN: Yes, and I want to recommend that for ice or heroin, but certainly for cannabis. What we have in our approach is very blunt in terms of comparing the harms from different drugs. In my view, methamphetamine is highly addictive and it is a very risky drug.

If you compare it to cannabis, cannabis is so much less dangerous and really should not be taking up police time. In fact, it is taxable in a country that is very similar to ours, the United States and Canada, and that provides potentially an opportunity to reinvest it in education and healthcare for people who are affected by drug problems, and reduces criminality in the community.

Ms NELSON: I could not agree more with that.

Mr CHAIR: Thanks for that. Is there anything else that either of you would like to say?

Mr RYAN: If I could just be very indulgent. Can I send you a very long report which looks at innovative harm reduction approaches around the world?

Ms NELSON: I look forward to receiving it and reading it.

Mr RYAN: Thank you.

Mr CHAIR: Before you …

Ms BUCKLEY: You referred to a report earlier that you had written.

Mr RYAN: Was that the report we referred to earlier? No, it is a different one.

Mr ROSE: We will send you the two reports.

Mr CHAIR: Thank you very much.

The committee suspended

TERRITORY FAMILIES

Mr CHAIR: On behalf of the committee I welcome everyone to this public hearing into the Northern Territory Harm Reduction Strategy for Addictive Behaviour.

I welcome to the table to give evidence to the committee Jeannette Kerr, Brent Warren and Gabrielle Brown. Thank you all for coming before the committee. We appreciate you taking the time to speak to the committee and we look forward to hearing from you today.

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

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

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

Ms KERR: Jeanette Kerr, I am the Deputy Chief Executive for Families and Regional Services representing Territory Families.

Mr WARREN: Brent Warren, General Manager for Youth Justice Services at Territory Families.

Ms BROWN: Gabrielle Brown, Acting Executive Director, Greater Darwin Region.

Mr CHAIR: Thank you. As it is being recorded and transcribed by *Hansard*, each time you speak could you please say your name again? Sorry, it is a bit of a pain. Would anyone like to make an opening statement?

Ms KERR: Thank you, Chair. Thank you for the opportunity to provide input into this inquiry. In October 2018 Territory Families made a submission to the inquiry. The submission focused on item 3(8) of the committee's terms of reference – support for affected families in communities.

Territory Families deals with the impact of substance misuse and problem gambling and the impact on children and families in the areas of our portfolios. Substance abuse in particular leads to addictive behaviours associated with contact with child protection; youth justice; and domestic, family and sexual violence systems.

The Royal Commission into the Protection and Detention of Children in the Northern Territory made a number of recommendations relating to assessments for children, alcohol and drug education programs and increased staff training to address alcohol and drug issues. Territory Families has played a key role in highlighting the prevalence of children and young people affected by foetal alcohol spectrum disorder, or FASD, in contact with the child protection and youth justice systems.

We have established procedures for referral to a paediatrician, where the health records of a child entering care indicate a history of prenatal alcohol exposure and FASD is suspected. We recognise that there are service gaps for parents with substance abuse issues who may seek assistance and note that the Department of Health has acknowledged that rehabilitative care in a family context is still under development. This may not always be appropriate however, given that substance abuse issues often cause conflict in relationships and between young people and their parents.

In a child protection context there is no solid data available to indicate that notifications linked to problematic substance use and gambling resulted in substantial abuse or neglect. However, the development of a new and contemporary client management system is under way and will assist with data collection in the future. I am not suggesting there is no connection. Our experience is that there is a significant connection, it is just the quality of the data system and collection.

When a substantiation is made, there are case management practices available to address substance abuse and problem gambling, including referrals to the child protection measure of income management; the Banned Drinker Register (BDR) and two prenatal health services. Territory Families has also partnered with the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) to develop an early intervention family support service, which better meets the needs of Aboriginal communities, and is pilot testing that this year.

We also have a relationship with the Central Australian Aboriginal Congress to expand a comprehensive assessment service to focus on priority assessments of children and young people in the care of Territory Families and the youth justice system.

Research and experience in the Northern Territory identifies that young people in detention often have involvement with alcohol and other drugs through their own use, including as a self-medication tool and through family exposure. Programs have been run within the youth detention centres that directly, or more often indirectly, address alcohol and substance misuse, including the DAISY program delivered by Catholic Care, and the CHART program which focuses on behaviour change, with modules that address drugs and alcohol.

Territory Families is working to make psychologists and allied health professionals available to support young people in youth detention and bail support settings, noting that this is a challenging exercise to try to attract and retain these professionals.

Community youth programs operate under a case management framework that involves frequent and specialised referrals of young people to external programs, including alcohol and drug education and rehabilitation services. Territory Families youth outreach and re-engagement officers case-manage and support outreach young people and young offenders, including through assessment of potential alcohol and drug abuse. In this setting, there are limited rehabilitative options for young people, particularly options that can assist their reintegration into the community.

Northern Territory Domestic, Family and Sexual Violence Reduction Framework (2018 – 2028) was launched in May to address the serious, prevalent and life-threatening problem of violence within relationships. There is research in the Northern Territory that has identified that alcohol can lead to an increase in the frequency, but in particular in relation to the severity, of violence in domestic violence relationships.

There are a number of perceived service gaps and challenges faced by our clients. For parents with substance abuse seeking assistance, who need to be accompanied by their young children, there are limited services available, often resulting in the children coming into care. Adult programs are also more geared towards men with both Aboriginal and non-Aboriginal women missing opportunities for assistance.

There are currently no programs designed for the pre-teens age cohort who are sniffing addictive volatile substances. Anecdotally, by the time the substance using teenagers are old enough to access the limited services available, many have already come into contact with the youth justice system.

The Royal Commission into the Protection and Detention of Children in the Northern Territory recommended standardised FASD screening for all children entering out-of-home care. However, the community view that screening for FASD, as well other issues, should be made more easily accessible as an early intervention approach to support all vulnerable children and their families.

Although the need for cognitive, behavioural or psychological assessments is recognised, access is limited due to the lack of availability of specialists across the NT, particularly in remote areas. There is a lack of intensive and residential services in relation to Alcohol and Other Drug services for young people.

Territory Families strongly supports the opportunity to present to the select committee to respond effectively and holistically to addictive behaviours and would support exploration of increased assessments, service responses and rehabilitative options for children and young people.

Mr CHAIR: Thank you very much for that. We heard a bit up and down the track of various difficulties in small and remote communities with volatile substance abuse and the difficulties of trying to access those younger members of the communities, in particular, as you have identified, even a much younger cohort as well.

That leads me to a question about what we are doing, or what can we do, to shift—not so much shift, but a lot of our focus seems to be on rehabilitation. Is there any move to better fund or resource—I understand it is very difficult with trying to get qualified staff, in trying to work with communities to try to access those young people before they enter into the justice system? Is there any sort of programs along that line?

Ms KERR: In early intervention?

Mr CHAIR: Really early intervention, yes. The earlier the better.

Ms KERR: Really early intervention programs? There are a range of programs and grants provided by the Health Department. Unfortunately, in general when families and young people come into contact with us, often it is a high-level response that is needed for parents, siblings and the children themselves.

Mr CHAIR: Yes, through the family unit, broken down and …

Ms KERR: Yes.

Mr CHAIR: … having severe substance abuse problems.

Ms KERR: Yes. I am happy to pass to my colleague who has much more practical experience than me.

Mr CHAIR: Sure.

Ms BROWN: To answer your questions around the prevention spaces, yes, Health has some things. But there are some things that Territory Families is doing in terms of our service delivery as a whole, moving into that prevention space which comes out of the Royal Commission recommendations.

This is not a specific answer to whether we talk about the Mansfield thing around family functioning. That is our expansion of our remote footprint, staff members being allocated and to building our remote workforce across the Northern Territory.

We have implemented our triage and referral service that is before central intake. If families or community members have issues, this is a burgeoning or arising issue. This is a phone number to access resources and potential referral points.

Territory Families as a whole, our responsibility is focused in this context on the higher end when we are dealing with the issues as they are. Our service delivery model is expanding out into the prevention space. Small bits coming together may make a difference over time. However, as you know about prevention it takes a significant period of time for that to change and be functioning, having community functioning, and for the next generation to come through.

Yes, in part. But it is going to take a multi-agency and cross government response to pull all of that together to do prevention in this space which will also move onto other areas like crime prevention and reduction of children in care.

Mr CHAIR: Utilisation of local community people, do your programs focus on that as well?

Ms KERR: Yes. We have a footprint in a number of remote communities where most of our staff are locally employed. We undergo a process of professional development which we are ramping up. We have moved to a model of having Territory Families offices in remote areas as opposed to remote family support offices or women's safe houses alone which only did limited work in this area.

Under the new regionalised model, the full suite of Territory Families services will be conducted out of that office with a combination of professional staff, local Aboriginal staff and building up to having local Aboriginal staff as professional staff.

We are implementing a professional development pathway to achieve that. We are amalgamating women that worked in the women's safe houses with women that worked in remote family support into a more cohesive office with professional staff and social workers working with them side by side and living on community. That will develop over the next number of years.

Locally in the regional areas and in Darwin, we have a lot of local Aboriginal staff—about 20.8% of the FT of the agency. We are committed to achieving bi-levels.

Ms NELSON: Thank you for being here this morning. Along with the increased hire of Aboriginal staff members to work in Territory Families, what is happening with the policy space? Has there been significant changes made or is that still under review?

Ms KERR: The agency, under Jacqueline McCann—who is a senior Aboriginal policy advisor and has worked in the field for a number of years—has worked across the agency, sector and with community partners to develop an Aboriginal cultural security framework which is due for launch imminently.

It is an outstanding piece of work. All of the executive have undergone a self-assessment and an assessment in relation to our cultural security and practice. It is up the top in terms of our strategic agenda. We have an Aboriginal workforce development strategy and are implementing a new practice model called 'signs of safety' which will enable us to work much better with families on the ground. That process is being led by our Aboriginal leadership group.

I am happy for my colleagues to add more to that.

Mr WARREN: From your question, I think you are also looking at whether we have changed our policy framework to do more to identify kids or families that might have alcohol concerns.

Ms NELSON: Yes.

Mr WARREN: There has been some adjustments in the family support and child protection arena around being more structured about identifying a need for referrals out to specials and using paediatricians. In the youth justice detention space there is a stronger focus on using the primary health service delivery inside the centres when kids are admitted, to identify issues that they might have.

Ms NELSON: Yes, that answers part of why I was asking that. The other question I have is: I read through your submission and I was listening to you earlier, both Territory Families and the Department of Health have highlighted some of the service shortfalls.

What are you doing to address that? Has there been any work started or progressed in trying to address those shortfalls? We know it needs to have a whole-of-government approach to this but what are we doing about that?

Mr WARREN: There are a couple of different limbs to this. I will speak quickly first and then throw to my colleagues. We have identified the need to try and support other agencies that are doing work. As a key example, in terms of the FASD assessment, is the commitment we have made with Congress down in Alice Springs to help them grow their assessment capability. We have entered a contract with them initially as a trial for a couple of years so they can essentially double the number of comprehensive assessments they can do. In return, they are prioritising kids in care or the youth justice system for those assessments.

That is an example of where we are trying to kickstart local capability. The reason that we focus on that is because Congress identified just how hard it was to attract workforce, particularly those very specialist skills. At different points in time, they might have had the only specialist in the Territory that could do some of that work. Even with the extra funding we offered, it took a concerted effort to bring more workers into the field.

In terms of other examples where we have primed the system, or kickstart, are there other child protection examples of family support examples?

Ms BROWN: I work in the operational space, so the day-to-day service delivery. We are often working on these matters on a child-by-child or young person-by-young person matter. What I mean by that is care team models wrapped around individual children whether that be child protection or youth justice.

Those care teams are comprised of the agencies that the young person needs, ranging from residential care; child protection practitioners; youth justice; mental health—which is a significant interplay into drug use among young people; and the local drug service to try and work out a resolution for that child on an individual case. We are seeing themes of those young people with those care teams. We are often talking about the same drivers, repercussions and results of the drug use.

On the operational level we are trying to address it in the best way we can, in a care team case management model, while then also feeding up and having the opportunity to present to this committee on what the themes are that we are seeing right across, what are the challenges our case workers are getting when they are trying to address drug use, an addiction most of the time, as well as offending behaviour which is driven by the drug use, as well as trauma-based behaviours from long-term childhood issues, as well as disengagement from school. Those interagency meetings are critical to service delivery.

Ms NELSON: Each case has a representation from each relevant government agency: health, justice, Territory Families; is that correct?

Ms BROWN: Where we can and where it is relevant to the child.

Ms NELSON: Alright. Earlier today we talked about treating the root cause of a lot of the choices that are made and the behaviours that are a result of those choices and also looking at past traumas and the family dynamics, all of those sorts of things.

I know that Territory Families does that also but the young people that are in detention, can you just talk through the protocols and the processes? A young offender is sentenced to detention, he goes in so we are addressing the behaviour, but what are we doing in the background to address the root cause that led to that behaviour, in detention?

Mr WARREN: There are a couple of limbs to this. One of the ones we have been digging into is how you amalgamate the different efforts that have already occurred by different agencies? We did some work late last year on the cohort we had in detention in November and that was about 35 kids at the time, and we went

and got our hands on all of the records from Health and Education as well, to see who already had a diagnosis.

A significant number of those kids had a diagnosis and had assessments done by each of the agencies already. A challenge for us is getting that on one page so that when a new case worker in a detention setting is looking at a young person, they do not re-traumatise them by exposing them to more assessments when they do not need them. That is the first bit.

We are still figuring out how to get all that in a systemic way across to our holdings when we need them on a day-to-day basis. The door is open and we are sharing. It is making bureaucratic structures fit together. One of the long-term solutions to that will be—there have been a number of significant government investments in fixing the back-end databases for each agency. Health and Territory Families are both on the journey of building new computer systems which will be connected and share information. That will be part of the solution.

In terms of day-to-day operations in the detention centre, we have been given the opportunity to put new resources into our specialist assessment and treatment services team. That is a combination of professional clinical staff and staff with casework experience who are able to conduct assessments, identify need, connect to other services and potentially operate therapeutic programs inside the centre. We have, in a little bit of a sporadic fashion so far, delivered some programs over the last couple of years. We need to fill those positions permanently so we can deliver them in a more regular basis.

We have been through a couple of rounds of recruitment to try and find some of those key clinical staff. At a national level, we are struggling to get people to apply. We are in the recruitment phase again for senior clinical positions as well as frontline professional staff in that team. We appear to have some healthy interest this time around. As we build that, it grows that capacity to do more one-on-one work.

Mr CHAIR: It is a very complex web of things that all work together. This committee is looking at what we can do to reduce harms. We cannot cure everyone's problems. Money is always necessary to fix most things. You seem to be—the processes you are putting in place with the other agencies seem to be, to me anyway—if they are not perfect, you are still working on them and trying the best you can. What can we do? I probably went to this earlier.

We want to find the best way of stopping people coming to you—that early intervention. If I could ask for anything from you, it would be your concepts or ideas around how we could assist in what could be done in that early intervention stage. We cannot get to everybody. Fundamentally a lot of the problems, particularly in remote and regional communities, are housing.

We have heard that time and again; it is one of the fundamental problems as well as economic involvement and a meaningful existence—all of those things that we understand, or do not really understand and cannot cure. It is that early intervention stage—if we can get anybody off the track of heading towards all the services you are putting together to wrap around them in the end.

Mr WARREN: One of the key cornerstone projects we are working on at the moment is called 'back on track'. It is a major attempt at refreshing how we do early intervention and youth diversion for younger people as well as trying that last ditch effort to keep people out of detention at the older end of the spectrum as well. That project has been set up to target the kids in two cohorts.

There is a younger cohort of eight to 13 year-olds. We are separating them out from the 14 to 17 year-olds for a couple of reasons. One is the different family dynamics and expectations on caregivers for the younger group. There are different levels of involvement and expectation about school work and industry training. There is as very clear focus for both those cohorts on health and wellbeing as part of the assessment and targeting for kids who are referred in there.

There is an opportunity, as we grow that and find some providers, to move kids early in the piece across into a service environment where they can get some extra help with their health and wellbeing needs. That would include addiction, or hopefully for kids that young, signs of the tendency to addiction rather than actual.

The other part to the project is about getting people back on track with connection to meaningful education and work training, which in my anecdotal experience is part of what we are looking at here. Both those programs are focused on re-engagement with school for the young kids, or finding vocational pathways for older kids who may not be able to, want to, or have the right temperament for traditional classroom-based education.

We have called for expressions of interest on that program and that is closed now. We have had quite a healthy response. The procurement panel is actually going through them at the moment. That is slated to start doing some work in July of this year. That is probably the key piece of new work on the horizon that will be targeting intervention at an early stage.

Maybe handing off to my colleagues, one of the things we have struggled with, in my view, is when early starts. Arguably, the Health Department would have come in here and spoken about prenatal and the first 1000 days …

Mr CHAIR: Yes.

Mr WARREN: … and we talk about when we first start to get our contacts through direct reports and notifications of kids who are about to hit the justice system. So, early means different things to different agencies as well.

Ms NELSON: I guess it is, how far back do you go?

Mr WARREN: Yes. But if we stay focused on where we are setting it and who has the lead on it, that is the go.

Ms NELSON: Yes, exactly.

Mr WARREN: There is probably some other …

Ms KERR: From a whole-of-government level it is essential that the agencies work together with a common vision and philosophy and there is a level of accountability for that, in my mind.

Potentially, there could be a whole-of-government outcomes framework in relation to some of this work in the human services area. Then, there are no surprises—and I am sure you will be well-informed—in relation to alcohol supply. There is a whole range of initiatives there that I am sure you have already been briefed on by people more knowledgeable than us.

Ms BROWN: From my perspective—to add to Brett's conversation—in Darwin we are on the cusp of commencing a team called Crossover, which will effectively work with families who are at risk in both the child protection and the youth justice system—not necessarily entered the youth justice system, but antisocial behaviours are indicating that if it continues the likelihood of touching the YJ system will occur.

It is also looking at the whole-of-family response and our case management response rather than just targeting the young person's behaviour. Certainly youth justice works with the family, but this team is very much targeted at the whole-of-family response to strengthen families' response and their ability to support and parent their children to try to bring those families back from the cusp of both child protection and YJ at the same time, which is a significant prevention effort for the tertiary end.

Once again, I agree with, where do you meet for prevention? The other thing I need to raise here is that while we talk about prevention, I am an old-school social worker and I am right with you at any point from the start. We have a cohort of young people who are already trapped in drug use.

There is some drug use that is normal adolescent behaviour, but the trauma-based drug use is a symptom. We are seeing an increase in use of meth and related behaviours occurring because of the impact of that drug, but also driving offending behaviours about funding that addiction. For me, prevention starts with those young ones as well because they are our next parents.

Mr CHAIR: Yes, absolutely.

Ms BROWN: So, on the continuum—and I know you have an unenviable task of recommendations—it is all of that scope because, for us, we look at our current generation as the next generation of Northern Territorians, with all of the social and economic baggage that will bring if that behaviour and drug addiction continues all the way through.

Mr CHAIR: Yes. Anything else, Sandra?

Ms NELSON: No.

Ms NELSON: No.

Mr CHAIR: I have a number of questions here. There is one about gambling, we have not touched on gambling. How much of a concern is that for the families that you support?

Ms KERR: It is probably more evident in remote areas where there is late night card circles and things like that. We have matters brought to our attention involving young people being neglected, domestic violence and conflict around the gambling and lack of money due to either gambling or spending money on grog running which is very expensive.

In a number of communities there have been reports of sexual activity and exploitation of children where they are running around unsupervised at night while parents are gambling. This results in a range of issues, obviously.

Ms NELSON: What is the biggest hindrance to resolving the harms that are associated with gambling from your department's perspective?

Ms KERR: You could either deal with the gambling issue or you could deal with the kids being unsupervised and that there could be a community-based response to provide mechanisms. It is essential that there is a cultural authority in the communities where it is happening who identifies the rules and says what is okay and what is not. Until that can happen we need mechanisms, safe places or options for the children at night.

Ms NELSON: Yes, exactly.

Ms KERR: Including food programs.

Mr CHAIR: Yes, we have heard that before too.

Ms NELSON: The interesting part for me with this committee, the work that we have been doing, the people we have been speaking with and listening to, is where do you start?

Mr CHAIR: That is going to be a problem in terms of making recommendations.

Ms NELSON: Then the 'how far back do you go' question comes up. Talking to Territory Families, we are at the end of the problem.

Ms KERR: And the start of the next.

Ms NELSON: Exactly.

Ms KERR: We have children in care now whose parents I dealt with in my other job when they were children. Ms Brown and Mr Warren probably as well. Some of them we are coming on to dealing with grandchildren.

Ms NELSON: I think as well, in some parts of the community, it can be as simple as awareness and education. It is pretty evident that it is not a 'one approach suits all'.

Mr WARREN: It would be remissive of us not to mention looking for more opportunities around residential rehabilitation for young kids. There is some focus on adult residential rehabilitation but for kids and teenagers, we do not have anyone operating at the moment.

Ms KERR: Nothing.

Ms BROWN: Residential care for teenagers, especially teenagers affected by trauma, is an incredibly difficult circumstance to run. There is an absolute service gap in terms of ensuring safety and rehabilitation—I mean safety for the young person themselves but also other members of society and peers groups as well, because of drug-affected behaviours. There is a service gap in recognising that we have a cohort of young people in the Northern Territory who need residential care services and drug rehabilitation.

The service delivery in this space needs to recognise and be persistent in its engagement of adolescents because they are adolescents. They are not going to come up for the 3pm appointment every Thursday afternoon. It is the external engagement and relationship that is going to get you through. That is a service gap.

Mr WARREN: That is even more so once we go remote. When it has been done well, there has been some reward in having a concerted, coordinated and whole of government response. We have seen some spikes in petrol sniffing, for example. It also highlights the risk in accidentally pushing kids into the child protection and welfare system when they actually need rehabilitation and drug and alcohol support.

There is work for us to do with the Department of Health in how we do the concerted work together without accidentally putting kids into the system.

Ms NELSON: Is there anywhere in Australia where there is a government rehabilitation facility for teenagers or young people?

Ms BROWN: Definitely not government-run. Certainly outsourced into the non-government sector or health sector, more particularly.

Ms NELSON: I know of one in Western Australia called Teen Challenge. It is pretty expensive and privately run, but it is hugely successful. I was just wondering if there is one that is government-run.

Ms BROWN: Not within the government. It would be outsourced.

Ms NELSON: You are right. I think something like that here would be brilliant and desperately needed.

Ms KERR: Where it gets tricky around that is where the young people are not compliant or able. Where there is comorbidity with mental health or where there is the view or diagnosis that it is the drug or alcohol abuse or behaviour that is triggering the apparent psychotic behaviour. It is a particular challenge.

In terms of residential rehabilitation services, it is something for parents where they can take their children that is available in a limited way, but it is still important to keep that connection. As part of that, they can learn parenting skills. Parents can be successful but they come back to five kids in the house and it can quickly fall away. It needs to be something that is done in a unified way.

Ms NELSON: That is something I have raised often when there are conversations within communities about setting up, for example, cultural camp for youth as an alternative treatment centre. I am really supportive of all of that, but if you are not supporting the parents while the youth are in these cultural camps and are getting better, what ends up happening is that the youth go back home to the exact same environment. It is the same thing with the parents.

If the parents are being supported and are accessing services like mental health and drug and alcohol rehabilitation services and support in a residential setting, and they get better but then go home to the exact same environment they left, which led to them becoming addicted to whatever—it needs to be a whole-of-family approach. We say that all the time. You also need to have a whole-of-government approach.

Ms KERR: To have a whole-of-family approach.

Ms NELSON: Exactly. Where do you stop? Where do you start?

Mr CHAIR: That is going to be a problem. Is there anything else you would like to say? Thank you very much for coming along. It has been really interesting.

The committee suspended

DEPARTMENT OF INFRASTRUCTURE, PLANNING AND LOGISTICS

Mr CHAIR: On behalf of the committee I welcome everyone to the public hearing into a Northern Territory Harm Reduction Strategy for Addictive Behaviours. I welcome to the table to give evidence to the committee Nicholas Papandonakis and Simon Saunders. Thank you both for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply.

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

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

Mr PAPANDONAKIS: Nick Papandonakis, I am the Executive Director of Strategy, Policy and Legislation within the department.

Mr SAUNDERS: Simon Saunders, Executive Director, Transport Safety and Services with the Department of Infrastructure, Planning and Logistics.

Mr COLLINS: Each time you talk, if you could state your name for *Hansard*, thank you. Would either of you like to make an opening statement.

Mr PAPANDONAKIS: Yes, thank you. On behalf of the Department of Infrastructure, Planning and Logistics, I thank the Select Committee for the opportunity to appear and provide input into this important work. Together with us, we have in attendance the following supporting officers: Alexia Hohipa-Wilson, Program Manager for Drive Safe and Glenda Thornton, Director Road Safety and Compliance. We will call on them if they have any detailed questions about the programs that we deliver.

As you are probably aware, the level of road trauma in the Northern Territory remains at an unacceptable level. The road toll per capita is nearly four times the national rate. On average, around 48 people die and 540 are seriously injured each year on our roads.

Road safety policy and strategy is developed through the Road Safety Executive Group which consists of our Chief Executive, the Police Commissioner, the Motor Accidents Compensation Commissioner and the Under Treasurer. The Road Safety Executive Group provided oversight on the development of the latest Northern Territory Road Safety Action Plan, Towards Zero.

The department was pleased to make a submission to the inquiry which focused on the terms of reference item 36 in relation to drug driving programs. Drug driving programs are administered by our department while roadside drug testing in the Northern Territory is undertaken by the Northern Territory Police. They would be the best point of contact for the committee to discuss the level of testing and the technical and operational aspects of any testing regime.

As background to the current drug driving legislation though, on 1 July 2008, legislation commenced which created the offence for driving under the influence of drugs. This legislation provided police with powers to:

- collect blood samples to test for drugs from persons involved in crashes
- saliva screen test a person whose driving behaviour was not related to alcohol or in the case where a police officer had reasonable cause to suspect the person is driving under the influence of a drug
- arrest persons returning a positive saliva test or refusing a saliva test
- conduct random roadside saliva screening and required blood tests for drivers of heavy vehicles over 4.5 tonne
- require a blood test where an alcohol test and a saliva test are inconclusive or where the police officer reasonably believes that an offence has been committed and the person poses a danger if allowed to continue to drive, and arrest the person for the purposes of a blood test, and
- where arrested for the purposes of a blood test, a police officer may suspend the driver for 24 hours following the test.

Random testing of drivers of light vehicles are often not included in those reforms however on 1 February 2016, the drug driving testing regime was broadened to enable random saliva testing for all drivers. Police now have the power to direct any driver of any vehicle to pull over and submit a random drug test similar to a random alcohol breath test which is consistent with the approach of other jurisdictions. The expanded regime provided for saliva testing to confirm the presence of a prohibited drug.

As you would be aware, the road trauma we see on our Northern Territory roads can be the product of broader social issues including drug and alcohol use. Our community attitudes towards alcohol and drugs need to change before significant progress can be made in reducing road trauma.

Unfortunately the incidents of drug related driving and riders involved in fatalities is increasing in line with increased use of drugs through our society. Alarmingly, the National Drug Strategy Household Survey revealed that 15% of illicit drug use reported was while under the influence of an illicit drug in the last 12 months.

I have a copy of the survey if you have not seen it and would like to make reference to it. We did not make four copies because it is a big document but if you are interested I am more than happy to hand it up.

Mr CHAIR: Thank you very much.

Mr PAPANDONAKIS: In the Northern Territory on average, 20% of fatalities involve crashes where at least one driver or rider had an illegal drug in their system. Over 40% of fatalities on our roads are alcohol related. A detailed breakdown of drug related road trauma including fatalities and serious injuries was included in the department's submission.

We did not know how far you wanted to go with alcohol as well in relation to road safety but we have created similar information in terms of alcohol related fatalities if you would like that.

Mr CHAIR: We are happy for any information that you have. Please provide.

Mr PAPANDONAKIS: From a national perspective, all Australian jurisdictions acknowledge this increasing problem in our society and on our roads. Looking at more effective approaches to road drug testing and reducing the risk of mobile phone use were identified as priorities by transport ministers at the road safety forum held in November 2017.

The recently published National Road Safety Action Plan 2018-2020 identified nine priority actions including action five being to increase roadside drug testing significantly in all states and territories. I have a copy of the National Road Safety Action Plan 2018-2020 if you would like it.

The department's submission to the committee mentioned the national work on drug testing underway at that time through the National Drug Driving Working Group. The work is now complete and the National Drug Driving Working Group's report, Australia's Second Generational Approach to Roadside Drug Testing, was endorsed by the transport ministers in October 2018. The Northern Territory was represented on this group by NT police.

In summary, the key findings at the national level were that: Australia is the world leader in drug driving enforcement and deterrence: there was no convincing evidence to justify a shift away from the current focus of general deterrence; jurisdictions should develop a more proactive role in dealing with manufacturers and product developers; and the most important find was that there are two pieces of technology that would significantly benefit road drug testing. They are a one-minute road screen and a roadside evidentiary test which then stops the need to have an expensive blood test.

The report considers strategies in working towards national best practice models of roadside drug testing and general deterrence. Jurisdictions are now considering these recommendations through the working group and the working group is ongoing, with police input.

From a Northern Territory perspective, the department's submission provided detailed information on the programs currently delivered by the NT to educate people on the risks and consequences of drug driving. These include the Back on Track drug driving course, DriveSafe NT Remote and a number of road safety programs including presentations and workshops to organisations.

Worthy of mention is the role the department plays in delivering transit safety officers as this may relate to the committee's terms of reference in relation to the impact on drug, alcohol and law enforcement activities. The transit safety unit team consists of 17 and provides an important service to the community and passengers on the Darwin bus network. Of the 30 000 jobs attended by transit safety officers in 2018, 7125 or 24% were related to drugs or alcohol.

I would be more than happy to organise for members of the select committee to view any of our programs we promote. I very highly recommend the Choices program, which is delivered by ourselves, police and

ambulance to high school students who are just about to get their licence, which clearly identifies drugs and drink-driving and the consequences thereof.

Ms NELSON: A very good program. My son has participated.

Mr SAUNDERS: Oh, fantastic.

Mr PAPANDONAKIS: As you are all aware, road safety remains a key priority for the Northern Territory government. Hence, the release of Towards Zero in March 2018. We have provided you with an electronic version, but if you would like hard copies, we have them. Towards Zero outlines the actions to improve road safety outcomes in the Northern Territory over the next five years, and was developed through an extensive community consultation process.

It recognises the growing community concern over drug- and drink-driving and the increasing numbers of drug- and drink-driving involved in road trauma. Key future actions to address drink- and drug-driving in Towards Zero include:

- in drug-driving, increasing penalties for drug-driving and reviewing the process for prosecution, which is Action 2.2
- delivering a targeted drug-driving community awareness campaign that is aligned with NT police enforcement. That is Action 2.4.
- developing a repeat offender regime for consideration by government which will include drug- and drink-driving offences. That is Action 1.1
- in drink- and drug-driving there is the repeat offender regime introducing a blood alcohol content limit for supervising drivers
- developing options to increase the accessibility and uptake of drink-driver education programs.

Again, I thank the committee for the opportunity to provide a submission to this inquiry and to appear today and welcome any questions you may have.

Mr CHAIR: Thank you very much for that, all that reading you have done.

Mr PAPANDONAKIS: You are welcome.

Mr CHAIR: A couple of things. I read that section of the report you are talking about with the two items they want to develop locally. I want to preface this by saying that we completely understand that driving under the influence of alcohol or drugs or texting are the things that are important for us to get the message across to drivers about being in control of the vehicle.

If you want to punish people as a deterrent, what do you say about the issue of drugs—cannabis in particular? With alcohol we know very clearly what the blood alcohol content is and how it affects your cognitive abilities. As I understand, we do not actually know with accuracy what effect the different levels of cannabinoids in your system have on driving.

Why do we not look at a cognitive test for drivers to work out their physical impairment so when they are pulled over on the side of the road—I will go on with something else... Maybe we set the bar incorrectly when we said that you can drive with 0.05 alcohol. Maybe we should have always said zero. But …

Mr PAPANDONAKIS: In fact, there is a pretty strong movement to go from 0.05 to 0.02.

Mr CHAIR: Yes, I understand that.

Mr PAPANDONAKIS: The fundamental difference between drink-driving and drug-driving is that you start from the premise that drugs are illicit drugs. You should not have them in your system to begin with because they are illegal to take.

Mr CHAIR: That is why I asked this. If that is what the basis is, it is beyond the driver safety.

Mr PAPANDONAKIS: It was an issue that was considered by the working group. They strongly came to the conclusion that we should not be working towards an impairment-type regime for drugs. Drugs are illicit. They should not be in your system from a drug-driving perspective. The tests should be 'is it there or is it not?'

There are different levels of offences as well. In the Northern Territory we have an offence for driving with it in your system, but then we also have the driving under the influence offence, which is a stronger penalty, if in fact the police are able to ascertain through the activities that you were driving under the influence—and there are stronger penalties for that. It is not a low range and a high range, but it is …

Mr CHAIR: It makes sense though. Personally, I have that thing, particularly with medicinal cannabis coming—not many people use it now but it is legal now. It is now legal to have cannabis in your system.

Mr PAPANDONAKIS: We will have to deal with that issue of …

Mr CHAIR: That is right. That is one of the things that I have a real concern—if somebody is using medicinal cannabis and they have smoked it last week, and there is still cannabinoids in their system, they are clearly not impaired at all. Why should they be punished? Under the current system they would be.

In North America and a lot of other countries use very—they seem old fashioned—the old touch nose, light—they apply those tests to drivers, and there are plenty of studies which show they are very accurate in telling your level of impairment. I wonder why, in Australia, we never seem to have gone in that way.

Ms NELSON: Nicholas has raised a really good point which goes back to what you and I were talking about earlier in regards to drug tests on work sites. The laws we have right now are contradictory. They are working against each other in some cases.

We have medicinal marijuana—it is accessible to people, it is legal. If they go to work and test positive for cannabis in their system, because they use medicinal marijuana—the burden of proof that it is for medicinal purposes is there, right?

It is like your 15-year-old saying to you—'I want to tell you something. I smoked marijuana this weekend and I really liked it', and you said, 'well I am disappointed to hear that. My personal opinion is, there is not really a lot I can say or do to change what has happened. My opinion is the marijuana has nothing to do with it, but it is an illegal substance.'

Mr PAPANDONAKIS: The other thing in terms of road safety: I am not particularly concerned whether your son or child or you smoked marijuana, but when you are on the road you are sharing the road with me, and I am concerned about your ability to drive because it may impact on me.

Mr CHAIR: I fully understand that. I preface those comments. There is no doubt that road safety is paramount, and for the safety of all of the road users. It is one of the issues that we are looking at with this process is the potentials of decriminalisation of illicit substances.

It is that conflict between what you were saying about the punishment—the punishment for impairment, and trying to drum that message in to people about not using substances and then going driving. That is not being carried through enough in the media.

I went to Kuwait many years ago on a trip, and there were cars smashed up and rolled in the middle of freeways, and I was asking about them. It turns out that people drive over there incredibly drunk all the time and there is no alcohol breathe testing. There is nothing because alcohol is illegal there. They just completely ignored it. They crashed their cars drunk and they would run off.

Acknowledging that you—that the substance is there and is being used—we need to deal with it. Perhaps it might help how we conceptualise the message.

Mr PAPANDONAKIS: I think it is the issue of general deterrence and specific deterrence. We have specific deterrence in terms of the penalties we impose and the increasing level of penalties for repeat offending. We are looking at that. There is also general deterrence which I think has positively worked with alcohol. In the 1970s everyone would get behind a car and drink and drive. Now, you would be pretty crazy to do so because there is the perception that you will get caught. That general deterrence, the ability to do a one-minute test and decreasing the cost of them so that we can do thousands of them is the way forward.

Mr CHAIR: I agree with that. I understand that in terms of deterrence. The thing I have with the way the North Americans do the cognitive test, before we get to that point, if we can get to that point that is great. If you can do a cognitive test on the driver and work out whether they are impaired—if they are impaired you then proceed along and do the expensive test. If the cognitive test shows they are not impaired …

Ms NELSON: … but they would have to change the limit then. Hypothetically, I can have one glass of wine and be falling over. That is my threshold.

Mr CHAIR: I do not think this—with the cognitive test it does not matter. You are showing a level of impairment that says you cannot drive. Your driving is impaired, so it does not matter what your blood alcohol level is or your drug level is.

Mr PAPANDONAKIS: I suppose it is an issue for police, but I would expect them to be doing that as a matter of practice.

Mr CHAIR: We have a number of questions here but I think we have covered the issues that are in here. Is there anything else you would like to add?

Mr SAUNDERS: I just had a note regarding—we were talking earlier about drugs and medications and things like that. Doctors are mandated to report drivers who are medicated that may be impaired because of their medication for their ability to drive through the registrar of motor vehicles.

Mr CHAIR: Is that if they still think they are going to drive?

Mr SAUNDERS: Yes, if they are a licenced driver and they are medicating them to a certain degree where they think it may be an impediment, they are mandated to advise.

Ms NELSON: So they have to advise regardless of whether that person is going to drive or not drive, because they hold a drivers licence. Has that happened frequently? Is that happening in the NT? Are you getting that?

Mr SAUNDERS: We certainly do get notifications. That is again mandated from doctors for people who may have physical or other issues that they are required to notify.

Mr CHAIR: I did not know that.

Ms NELSON: I did not either. If the police pull you up and you test positive for whatever …

Mr SAUNDERS: … That could also be the fact that if it is still a case where they are medicated or there is an issue where they are going to be unsuitable to drive, we will then take action against their driver licence to suspend it for a period of time until such a time as we get medical advice that they are suitable to drive.

Mr PAPANDONAKIS: If you went to a doctor and the doctor formed the view that it is not appropriate for you to drive, they are obliged to notify the registrar.

Ms NELSON: What do you guys do with that advice then, that notification?

Mr SAUNDERS: We suspend the driver's licence.

Ms NELSON: And you let the licence holder know that their licence has been suspend while they are on that medication?

Mr SAUNDERS: Yes, we advise them accordingly. Then they can certainly get medical advice to reinstate the licence. Again, it is that risk to the community.

Mr CHAIR: Stay away from doctors.

Mr PAPANDONAKIS: I suppose our colleagues in Children and Families spoke about them being the end of where—we are right at the end in road safety because we pick up the consequences.

Ms NELSON: Of course.

Mr CHAIR: Thank you very much for your information, gentlemen. It is a pleasure.

The committee suspended

DEPARTMENT OF EDUCATION

Mr CHAIR: On behalf of the committee, I welcome everyone to this public hearing into a Northern Territory harm reduction strategy for addictive behaviours. I welcome to the table to give evidence to the committee Vicki Baylis, Susan Bowden and Sue Beynon.

Thank you all for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

If, at any time during the hearing, you are concerned that what you will say should not be made public, you can ask the committee to go into closed session and we will take your evidence in private. That being said, could each of you state your name and the capacity in which you are appearing.

Ms BAYLIS: Thank you, Chair. My name is Vicki Baylis. I am the Chief Executive with the Department of Education.

Ms BOWDEN: Susan Bowden, Executive Director, Education Policy and Programs, Department of Education.

Ms BEYNON: Sue Beynon, General Manager, Student Wellbeing and Inclusion, Department of Education.

Mr CHAIR: Thank you very much for that. Would you like to make an opening statement?

Ms BAYLIS: I will make a brief opening statement, Chair.

The Department of Education, as we stated in our submission, provides education and training options from birth to Year 12. That is something we have a lot of opportunity with, in thinking about the implications of this hearing.

Our services are delivered by about 4218 employees in the early childhood sector, as well as our schooling sector. Of that, 87% of them are school-based positions. We service and provide education and learning opportunities for approximately 34 000 young people in the Northern Territory in 152 government school settings and a full range of early childhood education and care programs.

Seventy-one percent of our government schools are located in our remote and very remote locations—which bears some context to the hearings' submissions you have heard from other agencies—and 44% of our students live in those locations.

Fifty percent of our schools in the Northern Territory are classified on a national level of socioeconomic disadvantage as very low, and about 44% of that cohort in those low socioeconomic schools are made up of our Aboriginal students.

We have been working hard with our communities, kids and staff over the last 18 months to develop a very clear strategic direction, with the ambition that every child in the Northern Territory has the best start to life and, through early learning and education, gains a bright future. For us, this aspect of it fits nicely within our portfolio. We see that we have a critical role in education and learning, both with parents and families, in the early years, and also with our young people through the formal years of schooling.

Our submission outlined a number of opportunities where we are actively engaged. We have also provided some detail—but we are happy to take questions and talk further, as you have now been talking through and looking at the submission—to explore more fulsomely what it is that we do so that you can frame your thinking into the future of where this whole process goes.

Over the past three years, this is the 2016-18 period, we have data that would indicate that the level of substance use or possession that has resulted in suspensions for young people in our government schooling sector has reduced in number and slightly in proportion of the student population. I am happy to table that data.

The overall proportion of students who ended up being suspended in our government schooling setting was 0.3% in 2018. A small number but still a number that matters and that we spend time working with and understanding.

Ms NELSON: That is reassuring it is reduced.

Ms BAYLIS: We would like to think it is strategies but we also understand population will also be a part of what goes on. We need to look at the trend data over time and have been collecting that data for a while. It is a slight reduction. When you look at the numbers, that is a better population indicator because we have enrolment growth and reductions.

The percentage gives an overall perspective but the number of students is what we spend our time looking at more fully than the overall broad percentage. It becomes an individual case management process when we have to work with young people.

Mr CHAIR: What is the policy around suspension for use or possession of illicit substances? Is it better to suspend them, punish them and get them out or to keep them in?

Ms BAYLIS: It ranges on what was actually happening on those sorts of things. We have had experiences—I will get Susan and we can table our policy and guidelines for you as well.

Mr CHAIR: So it is not an automatic thing?

Ms BAYLIS: It is not automatic and it is not a zero tolerance situation because a young person turning up with something they found at home, for show and tell, is not necessarily the person you would go to a zero tolerance. We have young people who have been engaged in providing and selling which is a totally different process. We have young people who have arrived under the influence of substances, whether illegal or volatile substances or alcohol. It is not acceptable for them to be on the premises for their own safety and the safety of others at the time.

We need to then wrap around the support needed for that young person for their wellbeing, and how long it will take to best return them into a learning environment. So there is a range of answers to what is often an individual question.

Ms BOWDEN: The Department of Education has a Drugs in Schools policy as well as drug education guidelines. In reference, Mr Chair, to your question, we have guidelines for the management of drug related incidents in schools.

In the first instance, if a young person or any people on school grounds are found with any form of illegal or illicit drugs, the police are contacted immediately. There are other supports that are provided to young people. Suspension is an option and it is a last resort option but schools work with other agencies to ensure that there is appropriate supports in place for those young people.

We have school counselling services in our schools. Young people have access to counselling support if they are suspended for an incident that might be for possession or in relation to being under the influence of illicit drugs.

I can table those policies if you wish.

Mr CHAIR: I am not sure if you were here when Territory Families were here.

Ms BAYLIS: For some of theirs.

Mr CHAIR: We were talking to them as well and this is where education comes in because you work with kids from babies through to young adults.

They have a lot of services that wrap around people with other departments as well. With this process we would like to achieve improving early intervention with as many young people as possible or anybody. In your instance it would be getting to young people and providing them with guidance, pathways, information and education so that they make better choices for themselves.

Ms NELSON: Is it part of the curriculum for the Department of Education and what age?

Ms BAYLIS: I will ask Sue Beynon to elaborate more fully but yes it is. It is part of a national curriculum. In addition to the national curriculum, under health and physical education, and there are elements that start right from Year 1 that start to build around making positive choices around wellbeing and health. It builds all the way through.

We have also been working to develop and implement a social and emotional learning curriculum that is more explicit in the Northern Territory. We have added that to our submission. We have been fortunate to work closely with the Department of Education in Victoria with their resilience, rights and respectful relationships curriculum.

Ms NELSON: That is a great curriculum.

Ms BAYLIS: It is and they start the formal drug education and other substances activities from about Year 5. There are a lot of things that you do that are general and protective around ensuring that people are making right choices, they have positive coping strategies, they know how to socialise safely and there are things as they get older around gender and identity, all of the things that start to—if it has not worked well and you do not understand it, potentially sets you up to engage in activities that are risk taking.

Those activities include how you make choices and making the right choices and having the ways to think that through to being able to be assertive and say no and how to do that and to set your boundaries. As they get into the older age levels, it is about the appropriate socialising and what that looks like because risk-taking behaviour is not always around alcohol, gambling and other drugs. It can get into a lot of other activities as well.

It is then about giving them really clear statistical information as young people progress into the secondary education area so they have clear information—the social narrative is not always the hard reality and you have heard from some of the other submissions of programs where the reality and impact of choices impacts and the road safety message is one of those and the importance of understanding the impact on health and decision-making if you engage in these sorts of behaviours. We can provide that but Sue, do you want to add to that?

Ms BEYNON: So the resilience, rights and respectful relationships is new. It is a program that we have implemented this year right across from transition through to Year 12. Added to that, we also have our own documents that are supplementary activities to the activities here.

Ms NELSON: Great. Was that launched? It was supposed to have been launched in October.

Ms BEYNON: Yes, the minister has done all of that. In the resilience, rights and respectful relationships, Year 5 and Year 6, there are three activities that are exactly around drug education. In Year 7 and 8, there are two direct activities; in Year 9 and 10 there is only one activity; and in Year 11 and 12 there are six activities. We are still writing our Year 11 and 12 document and we will ensure there are a lot more activities there for people to tap into to supplement what is there from Victoria.

In many of our schools, they are doing a lot of work around petrol sniffing and AVGAS sniffing and a lot of that is in language so that the assistant teachers are working with teachers and promoting no to all of that kind of sniffing in communities and the posters in classrooms and education as well.

Ms BOWDEN: Just to build on the resources for social and emotional learning, Vicki Baylis mentioned the links with the Australian curriculum. The health and physical education curriculum is the particular key learning area that focusses on drug education. That is from the transition year of schooling all the way through to Year 10. For example, in the transition year, there are elements of the curriculum that focus on protective behaviours and children keeping themselves safe and healthy in different activities.

If we move then to Years 5 and 6, it is around decision-making and problem-solving skills and their own health, safety and wellbeing, moving through to Years 9 and 10 which is more specific around decision-

making and problem solving skills around their own and others health, safety and wellbeing. It is focussed on both an individual, family and community perspective when it moves into Year 9 and 10.

Ms BAYLIS: That includes help-seeking behaviours. If I do, or if somebody that I mix with and socialise with that I care about—what do I do? If I know somebody else is doing this, how do I help?

As adolescents get into a higher level of social engagement with their peers, they are probably often the first people aware of what is going on with some of the risk-taking behaviours, and it is absolutely essential they know where to go to get help—whether that is online help, whether that is phone help, whether that is a local school counsellor, any of the range of sources around the help-seeking behaviours. If things are going on, where do you go to get more information and to get the appropriate advice and help?

Mr CHAIR: We have heard a lot about where the problems arise and lack of housing, lack of adequate housing, lack of nutrition and food. What does the Education department do about identifying at-risk young ones, and what can be provided for them in those circumstances?

Ms BAYLIS: The first and primary relationship is that teacher-student relationship or, in an early childhood settings, the educator, family and child relationship. They are the most likely and the most immediate ones to see changes in behaviour or to note and notice a lack of food, neglect—those sorts of behaviours.

There are things that are mandatory that we are required to do about reporting requirements that every teacher participates in—in six-monthly training—that is absolutely essential. At school levels then there is what classroom teachers do, but then there is also what a whole school and a community does.

We have in a number of our schools relationships with Foodbank or with other providers around nutrition programs that enable schools to provide those meals to young people or access to food so that they are able to participate fully in their learning.

In some of those cases, school councils choose to implement something that is very simple of their own, so there is a range of strategies around just being able to make sure a young person is well positioned during the hours of learning to fully engage.

And then what we have in our schools is through our school counsellors, through our remote school attendance strategy support workers, through our partnerships with health, through our partnerships with Territory Families and a significant number of our non-government organisations who interact with our schools in various ways—they provide a range of services.

The other particular areas in our secondary schools—and we are moving to some of our primaries, but only a few at this point in time—are the programs for engagement like our Clontarf stars and role models programs, where the adult relationship with those young people and our adolescents is different to a classroom teacher, but there is another significant adult who is able to ensure that they understand what is going on in a young person's life, and then they are able to do the work with the relevant agencies.

The other component is, besides the formal teaching of what we do in a classroom, as part of a core curriculum—that is the teacher's job—it is around then being able to access the appropriate services through the system.

Sue's team in the role being an engagement, inclusion team—critical for if we are seeing things that we think are ones where education is the appropriate agency to follow up—they have a range of support services there. If it is an engagement issue, we have another group of people as part of the agency who can support schools working with families. Then we have the relationships as part of the children standing committee, and I heard Territory Families talk about their crossover relationships of which we are a member of that particular specific case management process on those things.

Our local coordinators are increasingly picking up the systemic issues that are often within our communities where—we have an accountability about learning and schooling and education, we need to do that in partnership with the whole. Things like housing matter; safety and security matter; health matters. We need to be at the table and play our part, but we need to ensure that we support and inform with other areas that need addressing as well.

Ms NELSON: I just have a couple of questions specifically about the social and emotional learning program. When you are talking about alcohol and other drug substance abuse and addiction, do you also talk about 'if you smoke marijuana, this is what it does; this is how it changes you'? Is that part of that conversation?

Ms BEYNON: Very much so. I would think that even more so in our communities, it is a very strong focus where our Aboriginal assistant teachers really come on board and give the students good examples of that, help them to draw up posters in language to put around the school and really understand that within their own language and culture. In our town schools that is certainly happening, where people would go quite into detail around what effects this will have on you.

Ms BAYLIS: Young people know a lot. I was in a classroom at the end of last year with a Year 8 cohort. I learned more from the kids, in spite of knowing the curriculum content, because they could describe what they had witnessed.

They were quite clear as Year 8 students in the framework of conversation in that class, which the teacher was facilitating incredibly well—this was in Central Australia—around the choices and impacts and negative health outcomes as well as the other problems that it created in terms of maintaining supply, becoming addicted, positioning themselves where they are going to cause injury and accident to not only themselves, but others.

From that particular cohort of kids, there were things that I didn't know I needed to know, but they had access to information. It is creating that safe environment to help young people process information they had some access to, but giving that a more fulsome understanding around the totality of the impact, not just 'this is what happened at the party on the weekend', but 'this is the longer-term impact if you make this choice'.

Ms NELSON: Something we heard earlier this morning was that just telling kids it is illegal is really effective. No …

Ms BAYLIS: We all know we should brush our teeth, but if you asked everybody if they do it three times a day—we actually need to explore why and engage in those conversations to create the deeper level of understanding. Yes, we need to understand that it is illegal. There is no question about that, but you also need to understand the impact.

Ms BOWDEN: Just to build on those points, it is about how we work with young people around how they self-advocate, their resilience and how they self-direct what they do in making some really important choices. The other thing I would like to add is that the Families as First Teachers program that is run from birth to four years old engages families and is also a critical point in prevention.

Literacy and numeracy is very much a focus of that program. It is about literacy and numeracy and building those important skills and foundations for children. It is also about enriched caregiving and for parents around the sorts of choices they are making that will have positive impacts on their children as well. That is also a critical program we run that can have a positive influence in this space.

Mr CHAIR: Is there one thing that we could improve?

Ms BAYLIS: I think for us the improvement needs to be around the frequency with which we get families to connect with the opportunity. If we are talking about the content of the program, the evidence is all there. It has been evaluated on numerous occasions around its impact. Like anything, the frequency with which people participate in a program increases their capacity to understand and learn.

Mr CHAIR: What would improve your ability to do that, though?

Ms BAYLIS: For us, some of it is our work about helping families understand that we need to see them regularly and ensure they are there with us on those things. Some of it is our messaging to say, 'Yes, you have enrolled and you come once a fortnight, that is great. But we would really like to see you every time the program is operating, or at a minimum this', and to use the data to help them understand that, because that builds the understanding for schooling and getting kids to school. But we start that in the early years.

The second component in all of that is that everybody else around them needs to encourage them. At the clinic, it is, 'Have you been to FaFT?' If you are connecting in, it is about helping other people have that conversation to say, 'This is valuable and worthwhile, you need to continue to connect in through the program so that you get the benefit'. Where we are able to have that whole-of-community response, we get much stronger commitment in a family and a connectedness.

For us, the second part of that is we need to increase our reach to the dads and the males of that community. We are just starting some of that work because it is both mum and dad or grandma and granddad, and not just the aunties. We need to have the uncles there too, so that they continue to connect.

We are finding different ways in our communities to start to create those opportunities so we can grow strong men to be strong parents in that process as well. They need access to the same information as the women. That is where we can strengthen and it is a really important part we need to play.

Mr CHAIR: Anything else? Have you any other questions, Sandra?

Ms NELSON: No, I do not.

Mr CHAIR: Anything else you would like to say?

Ms BEYNON: Would you like copies of the …

Mr CHAIR: Yes, please.

Ms BEYNON: Yes? We are really proud of the social and emotional learning stuff is my concluding comment. We have an early years primary and middle years package but we also have the senior years one that is just about ready to be …

Mr CHAIR: I will have a look at what my two daughters are up to.

Ms BAYLIS: You can triangulate the data.

Mr CHAIR: Thank you very much for your time. Cheers.

Ms BAYLIS: Thank you.

Ms NELSON: You are most welcome.

Ms BOWDEN: Thank you.

Ms NELSON: I have read the Victorian one.

Ms BAYLIS: Oh, it is a beautiful piece of work. We are so privileged that they have just given us access to all of that. We are very grateful.

Ms NELSON: Australia has a pretty good one as well.

Ms BAYLIS: Out of all of them, Victoria's was the one that best fitted with where we needed to be right now.

Mr CHAIR: Someone else has raised this with us, though, the Victorian report. It might have been some of your people earlier on, was it?

Ms NELSON: Yes, there was—it was just today actually.

Mr CHAIR: No, no, it was one of the other hearings we have been to. It might have been at the forum.

Ms NELSON: I thought somebody raised it also today.

Mr CHAIR: Anyhow, thank you.

Ms BAYLIS: Thank you for the opportunity.

The committee suspended.

NORTH AUSTRALIAN ABORIGINAL JUSTICE AGENCY

Mr CHAIR: On behalf of the committee, I welcome you to this public hearing into a Northern Territory harm reduction strategy for addictive behaviours. I welcome to the table to give evidence Beth Wild and Julian Murphy. Thank you both for coming before us. We appreciate you taking the time to speak to us and we look forward to hearing from you today.

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

If, at any time during the hearing, you are concerned that what you will say should not be made public, you may ask the committee to go into closed session and take your evidence in private. That being said, could each of you please state your name and the capacity in which you are appearing.

Ms WILD: I am Beth Wild. I am the Managing Solicitor of the Criminal Section of the North Australian Aboriginal Justice Agency.

Mr MURPHY: Julian Murphy. I am Criminal Appeals Manager of the North Australian Aboriginal Justice Agency.

Mr CHAIR: Thank you for that. Would either of you like to make an opening statement.

Ms WILD: Mr Murphy is going to present our opening statement.

Mr MURPHY: The interaction between substance addiction and contact with the criminal justice system is both simple and complex. It is simple in the sense that substance addiction exponentially increases a person's likelihood of coming into contact with the criminal justice system.

It is complex in that it demands a multifaceted response that addresses not just the substance addiction but also the factors feeding into that addiction such as mental health, cognitive impairment, education disadvantage, family fragmentation, intergenerational trauma and lack of employment and training opportunities.

The complexity of the problem is no excuse for inaction. In NAAJA's written submission to the committee, we address structural changes that need to occur to make sustainable and long term change. We hope the contents of our written submission will be discussed in questions from the committee. However, in addition to structural long term changes, there are small changes that could be made tomorrow and will begin to have an impact. We propose five quick innovations, each of which would involve minimal or no changes to funding.

First, introduce therapeutic bail options. Everyone who works in the criminal justice system knows criminal matters often take weeks, months or even years to be completed. If a person is on bail in the community, they should not simply be waiting. That would be wasted time. We should introduce incentives to encourage a person to address their addiction while they are on bail. The easiest way to do this is to introduce regulations specifying certain alcohol and drug rehabilitation programs that would make a person more likely to get bail.

There is also a legislative mechanism in place to do this. Section 7A (2A) and section 53 of the Bail Act allow the Administrator to make such regulations. For a reason that is not known to NAAJA, no such regulations have yet been made. This could happen tomorrow.

Second, programs for prisoners on remand. Some people do not get bail and will wait in prison for their court matter to finalise. This is called being on remand and 29% of prisoners in the Northern Territory are on remand. Unfortunately it is very difficult for remand prisoners to access programs including drug and alcohol counselling programs. This makes no sense.

We should immediately give remanded prisoners access to the same programs available to sentenced prisoners. While we are at it, we should improve and expand the programs available to sentenced prisoners, especially female prisoners, which is the fastest growing prison population.

Third, services hub at court. Around Australia and internationally it has increasingly been acknowledged that a person's attendance at court provides an opportunity to engage that person with other support services including services relating to addiction. For this reason, neighbourhood justice centres and justice hubs are

being developed, where courts are grouped together with medical centres, social work providers and housing assistance. This should be happening in the Northern Territory.

Every day—I can say I have been down at court today—a huge number of people attending Darwin Local Court need help with addiction. They should be able to get that help within the court building. We should have rostered health workers available to speak to people and refer them to services that already exist, with NGOs such as Anglicare, who can provide wrap around services and intensive case work.

Fourth, remove the mandatory sentencing provisions in the Misuse of Drugs Act. These provisions create a presumptive sentence of at least 28 days in prison for a person who is found guilty of certain drug offences if they have one drug related prior.

To put this in real terms, a person arrested in the street with a gram of cannabis for personal use faces the prospect of at least 28 days in prison if they have one prior conviction even from years ago. Locking people up for low level personal use drug offences is not the solution to addiction. The mandatory sentencing provisions in the Misuse of Drugs Act should be removed or at the very least they should be amended so they do not apply to low level personal use offences.

Fifth, abolish the differentiated penalties in the Misuse of Drugs Act. These provisions almost double the penalty for people who supply certain drugs, usually cannabis, in Indigenous communities, as compared to people who supply the same amount of drug in a non-Indigenous community. About 90% of the people caught by this heightened penalty provision are Indigenous people.

There is no evidence to show that the increase in penalty has deterred people from supplying drugs in Indigenous communities. There is no doubt that the supply of drugs in Indigenous communities is a problem but the solution to that problem is not to lock more Indigenous people up. We should abolish the differentiated penalties and start focusing on the real underlying issue, which is why people are turning to drug use and supply in the first place.

Thank you. We look forward to your questions.

Mr CHAIR: Thanks for those, they were great. You will not get any argument from either Sandra or I on any of them. I cannot agree more on everything you said.

Speaking of your submission and going to some of those issues. You mentioned shame and stigma that can prevent Aboriginal people from seeking treatment for substance abuse. What are some practical strategies that can be incorporated into a harm reduction effort here in the NT to remove such barriers?

Ms WILD: If people are able to participate in programs in a way they feel comfortable—and it may not be in a group setting, we have identified that in other submissions, then it could be on an individual level—in circumstances where a relationship of trust has been built with the person seeking assistance with their addictive behaviour and the relevant health worker.

Throughout our submissions, we talk about cultural competency and that can either be by employment of appropriately qualified Indigenous people and health workers or it can be that non-Indigenous people have the appropriate cultural competency and then apply that in an individual setting rather than what is often the group talk therapy which may then further cause shame to the person that is trying to get help in the first place. It might have a negative impact on their path towards rehabilitation.

Mr CHAIR: You spoke about some statistics on personal use and second offences. In your experience, how many Aboriginal people, in particular, are incarcerated simply for possession-type offences? Are there many or does it generally lead to something else?

Ms WILD: I do not have the statistics so it is only an impression of what happens. I had a client this morning who had a very low level personal possession charge and we had to argue particular circumstances. In that case we had a sympathetic judge who saw that the possession of that drug was indicative of a small relapse on the path to rehabilitation.

As long as we have a sympathetic judge, we are able to side-step the legislation but because it is there in the first place, if you have a non-sympathetic court, then it is very easy to start at that point of imprisonment. The provisions under the *Misuse of Drugs Act* effectively reverse the presumption of imprisonment which is that prison is the last resort and becomes the first port of call. Then you have to argue around that provision

so people are certainly caught on a regular basis by these legislative provisions that do not provide any assistance to a person that is usually and often a low level…

Ms NELSON: Sorry, so your client, that was not his first offence?

Ms WILD: That is right. He had…

Ms NELSON: Because it was not his first offence, we have the mandatory sentencing law. If we did not have a sympathetic and common sense judge, he would have automatically been sentenced, is that right?

Ms WILD: That is right. The presumption is that unless you can show that particular circumstances apply, that a 28 day term of imprisonment is to be served.

This was a man who had a previous addiction to methamphetamine 12 months ago. In the 12 months, he had managed to almost completely rehabilitate himself but he had a small relapse in a time of stress and was found to have a very small amount of drugs on him as well as an implement for using, which is also a criminal offence. Even if it were just that, without the drugs, that would also trigger those mandatory sentencing provisions. Having a bong or pipe triggers mandatory sentencing provisions if you have a prior conviction.

Ms NELSON: We have had people talk as well about drug courts and how effective they have been in certain jurisdictions. I had read up on that and they have been. If we still have laws like mandatory sentencing laws, that completely negates the effectiveness or the benefit of having a drug court. Would you agree with that?

Ms WILD: They do not work hand-in-hand because the ethos and principles behind the drug court, which would recognise addictive behaviours and that a path towards rehabilitation is not a linear one, does not work in any way with mandatory sentencing provisions. Instead what can work—we have previously had drug courts in the Northern Territory that have been subsequently abolished.

My understanding is that they had a high rate of success. I think they were perhaps resource intensive and were abolished. They worked well and people came to court every two weeks. They were closely case-managed by a judge and a qualified psychologist. They worked very well.

At the moment what we have is a commit court program. It is based on the HOPE model. The Honourable Justice Southwood implemented that. It is working well in the Supreme Court and it very much acknowledges that the path towards rehabilitation is not a linear one and will often involve relapses.

Mr CHAIR: I get that. As you are probably aware, I am an advocate for decriminalisation, which does not work with that, in terms of just possession charges, but we are not talking about sending possession charges to those sorts of courts. You would be looking where you have other assault-type charges or other charges in conjunction with drug use or addiction.

Ms WILD: That is right, when addictive behaviours lead to other criminal offending.

Mr CHAIR: Gambling and illicit drug use in Aboriginal communities—what is your experience with gambling in Aboriginal communities?

Ms WILD: It could form the background to some community unrest that may lead to offending. In my experience going out to bush circuits as well as being a lawyer in town, it is not a hugely prevalent cause. It may be part of a background in the domestic relationship that has caused some issues that may lead to assault-type behaviours, but it is only in the background in my experience. Mr Murphy might have a different experience.

Mr MURPHY: I would second that. I think in the five years on and off that I have been going out to bush courts, I think there has probably only been one occasion that I can remember where it has actually been mentioned in court—that it was obviously so at the forefront of the issues that is has been mentioned in court.

That is not to say it might not be feeding into underlying tensions within a relationship, but I guess then it is also hard to disaggregate that gambling issue from money management and just healthy, positive relationships. I guess all of those things would need to be tackled together.

Ms NELSON: You talked about stigma. It is really interesting—I do not know if you guys were listening to ABC Radio this morning. They were talking about transitional housing programs and that there is some housing in Nightcliff that was part of the department of Territory housing stock. It is now being sold off.

The Prime Minister and Cabinet Office is buying it from Territory Housing and it will be used by the Department of Corrections as part of the low security prison transitional housing. They come in, fix the houses and then they are used for rehabilitation purposes for people who are low-security prisoners. The number of complaints from the residents on that street where that transitional housing will be established—these are low-security prisoners, they are not murderers, rapists, none of those offences. There is already this huge movement to not allow that to happen, 'I do not want it on my street'.

Before they have even gotten there, they already have that stigma attached. It is already there. It has happened. You know before you get there that nobody wants you here.

There needs to be a cultural change. I am raising that because we talked about the stigma here. In the whole approach to drug addiction and offences, alcohol addiction and addiction in general, there needs to be cultural change overall. It is really difficult as well to address from an Aboriginal cultural perspective also.

Do you know what I mean? It makes it really difficult when you have that stigma of being banished from community, it is a bad thing. How do you work that? If we need to change the culture overall, the way we approach it, how do you do that in community?

Mr MURPHY: I cannot answer that question. Speaking as a non-Indigenous person, I cannot speak well-informed as to how those cultural considerations impact on the stigma. I did not listen to the program this morning, but one thing that your comments bring to mind is the Venndale transitional aftercare facility in Katherine.

Having live in Katherine for about two years, that facility, I understand, has been there for some time. My experience living in that community is that there is not the same stigma attached to people living in that facility. Because it has been there for a while, they are accepted to be positive, contributing members of the community who are overcoming substance addiction.

Whether that is simply a matter of time—that is a disappointing thing—or whether it is putting in place ways to change community attitudes …

Ms WILD: I can add the solution is to be led by strong leaders, both in Indigenous and non-Indigenous communities in Darwin and so on. Similarly to Mr Murphy's experience, in the suburb I live in, we have the residential rehabilitation centre around the corner that causes no problem for all of the families that live next door. There is a primary school in the area. There is no disruption or difficulty. So, it is simply a stigma that leads to people not wanting these facilities next to them, rather than any actual evidence that it would cause any sort of disruption or danger to them or their children.

Ms NELSON: Education and awareness is a big part of that.

Mr CHAIR: It is education and time.

Ms NELSON: Yes.

Mr CHAIR: If we can do what we can to remove that stigma in the first place, then that is …

Ms WILD: In fact, the provision of this transitional housing, as well as a rehabilitative centre, leads to greater community safety …

Mr CHAIR: That is the thing.

Ms NELSON: Exactly.

Ms WILD: That should be obvious to people, rather than having people who have substance abuse issues who are living homeless. That probably places the community at greater risk than the opposite, which is to have these services available for people.

Mr MURPHY: I will say one last thing, talking about breaking down those boundaries and the stigma. The obvious advantage of having people in the community is that they can intermix with the community and they

themselves will do the educating. Once you have met someone in one of these facilities and you realise they are just a regular person—in Katherine, people at Venndale often play football with the local Tindal …

Ms NELSON: Yes, with Tindal.

Mr MURPHY: … Football Club. Sport is an incredible way of bringing people together and exposing people to each other and building those relationships.

Ms NELSON: Yes. I visit Venndale frequently and spend time there with the staff and clients. It is great. They are becoming a lot more involved in the community. They have done some amazing work at Venndale over the last five years in removing that stigma and introducing people to the work that they do and the benefits for their clients. I would love to see more of that.

Mr CHAIR: We have some questions here, but we have covered a lot of them. Thank you again, for that opening statement, those issues that you raised—just really important—things that we can work on early rather than… as you said, they can be done fairly quickly. They probably do not need to wait for us to report in August. I am sure that you and I can work away on trying to organise some of those things very early.

Ms NELSON: I certainly will be referring to it in my future speeches.

Mr CHAIR: There you go—and we will do what we can. Is there anything else you would like to say?

Ms WILD: I would like to add, in terms of funding for programs, we need more residential rehabilitation beds across the Northern Territory. We need more in Darwin and we need more remotely. We used to have one at Nhulunbuy that was defunded—it was attached to a hospital. It was a very effective rehabilitation service that people were less likely to abscond from because it was on country.

I would also think that there is great scope for a residential rehabilitation place on Groote Eylandt. There is a lot of land there, you would get a lot of support from traditional owners to have such a place there, and that is a community as well that is beset by problems that would benefit from a rehabilitation program.

For youth we have BushMob, which is culturally appropriate in the centre but we have nothing equivalent in the Northern Territory, and there is a huge gap of residential rehabilitation services for young people and we are crying out for it. We have supported bail but nothing beyond that which would provide that service.

In terms of funding, I note that it is very expensive to incarcerate a person, and that is where we seem to be putting all our money in to. If we were able to cut the incarceration rate and look at reducing recidivism then put that money in to residential rehabilitation then it would not cost a lot of money.

I would submit that it would cost less in the long-term. Crime is expensive as well—if we are reducing that—policing, crime, health—if we cut all of those that can all be achieved by the provision of greater services—be it residential, be it rehabilitation—and the Northern Territory is crying out for it.

Ms NELSON: Agree.

Mr CHAIR: There has been a number of other submissions very consistent with that. Yes, we have that message. Thank you very much.

The committee suspended

AMITY COMMUNITY SERVICES

Mr CHAIR: On behalf of the committee, I welcome everyone to the public hearing into a Northern Territory Harm Reduction Strategy for Additive Behaviours. I welcome to the table to give evidence Nicola Coalter and Tamara Laing. Thank you both for coming before the committee. We appreciate you taking the time to speak to the committee and we look forward to hearing from you.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. It is a public hearing and is being webcast through the Assembly's

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

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

Ms COALTER: Thank you, Chair. My name is Nicola Coulter. I am the CEO of Amity Community Services.

Ms LAING: I am Tamara Laing and I am the Deputy Executive Officer of Amity Community Services.

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

Ms COALTER: We are going to make a joint opening statement. I am going to start and then Tamara will talk a little and I will wrap up.

Thank you once again for having us come and talk. Amity appreciates these opportunities to talk about a whole range of things in the Territory, in particular, what we mean when we talk about evidence or effectiveness. Addictive behaviours—there does not seem to be a consensus as to the cause, prevention and treatment of addictive behaviours or disorders.

In a 2012 US Government publication, *Theories on Drug Abuse: Selected Contemporary Perspectives*, there were 43 theories of chemical addiction and 15 methods of treatment. To demonstrate this confusion and perplexity, let me explain how we see it. Many people consider addictive behaviours such as excessive gambling and alcohol consumption as diseases – the biomedical view – while others consider them to be behaviours learned in response to the complex interplay between the biological, psychological and social factors. That is Engel's biopsychosocial model. Then there are others who argue for a genetic cause.

Unlike most common diseases such as tuberculosis, which has a definite cause and treatment model to which there is no disagreement. There is consensus on what works. Everyone agrees to this. Clearly addictive behaviours is something different. This lack of agreement among experts and professionals leads to ongoing problems with prevention, protection and treatment approaches for addictive behaviours. There appears to be this constant debate in the field as to whether total abstinence or controlled and moderate use of substances—alcohol, cannabis, MDMA—or activities—gambling, sex, shopping, porn—is effective.

Others debate whether or not medication is a desirable and effective treatment method. In the area of addiction to food or exercise, of course, very few advocate for total abstinence as a solution. Many people, most of the time, manage their own behaviours and their relationships with their habits of choice rather effectively and mostly enjoy doing so.

When I look over the submissions and the transcripts, it appears for me that we are missing the mature discussion of 'people use drugs because they like them'. I hand over to Tamara now and she will talk a little about people.

Ms LAING: Thank you. We know people will always use mind-altering substances and continue to gamble, regardless of the country's policies. We know this because these are usual human behaviours that help us to meet our needs, whether that be having fun, seeking pleasure, connecting with people or coping with discomfort.

Amity advocates for keeping people at the heart of all harm reduction legislation and policies. We support the growing voice towards shifting the paradigm of addictive behaviours to align with Dr Alex Wodak AM when he advocates for redefining drugs as primarily a health and social issue, instead of a criminal justice one.

We believe that one way of shifting our paradigm is by thinking about how we understand and talk about people who choose to use drugs or engage in other habitual behaviours. Historically, our society has used language that is judgemental and disempowering, language that perpetuates disconnection, shame and stigma and reinforces the 'us and them' notion, as if only 'those people' have the problem.

When Kofi Annan wrote about drug policy, he stated:

… too often emotions and ideology rather than evidence have prevailed.

We agree that we need to set aside moral views and look to evidence. Evidence that tells us we are not talking about those people, we are talking about all of us in this room; our families, our friends; our workmates and our fellow Territorians. It is us.

When we experience harms related to our habits, Amity sees this as an overuse of the coping mechanisms we have available to us. When we use this lens, we see habits as symptoms or as part of a complex interplay between the individual environment and the activity.

This view encourages curiosity to understand a person's lived experience and it reminds us that, given the right set of circumstances, any of us could find ourselves in a similar position.

The Territory has a long history of trauma, and we agree with AMSANT's view that unresolved trauma is often correlated with addictive behaviours. We also align with Johann Hari's perspective about disconnection. As he states:

The opposite of addiction is not sobriety, it is connection.

Amity therefore supports harm minimisation strategies that include engagement activities and the development and ongoing maintenance of social infrastructure. These strategies create opportunities for people to connect and to experience a sense of belonging and community which are recognised protective factors. Pragmatism and humanity must remain central through this opportunity of policy reform.

In summary, I echo Mick Palmer who I notice presented earlier today:

We must be courageous enough to consider a new and different approach.

Ms COALTER: Therefore we see this inquiry as an opportunity for the Territory. We are a unique jurisdiction. We have so many opportunities to pilot what we already know from worldwide evidence as to what will work.

What we would see as a helpful start, or useful conversation, is about the overarching plan and our vision in the Territory because to determine what is effective or what is the evidence, we first need clarity on our view of substance and addictive behaviours. I do not believe we have that clarity yet. #BoundlessPossible.

Mr CHAIR: Boundless clarity.

Ms COALTER: That is all we have in our opening statement.

Mr CHAIR: Thank you for that. I do not know whether we will have an answer for you on how to get that clarity. That is a difficult one. What can I say?

Tell me one thing that came to mind as you were both talking. People like drugs and ultimately, they will continue to take them and continue to gamble. Something that has not really come up in a submission, but I just thought I would run it past you, is something I am concerned about—advertising and the effect of advertising.

We have had a lot of gambling in communities. It is generally card games. There is not a lot of advertising that goes on around that, that is just a community issue. But like when you opened up the *NT News* a few weeks back—whenever it was—the first 11 pages were full page advertisements for the TAB. Do you think it would be worthwhile—personally I do, I will put that out there—ban that sort of advertising? People will take harmful substances. Should they be encouraged to take them?

Ms COALTER: It is an interesting question you ask. I think I understand what you are asking about is how we enable people to advertise a regulated product. Yes?

Mr CHAIR: Yes.

Ms COALTER: If your example is about gambling, I suggest that it is there about alcohol as well. Recently the Territory released something about alcohol—an alcohol strategy or plan. On the front page of that is a great picture of the unique Territory scenery and people in a boat. They both have a glass of alcohol in their hand. Whether it be an advertisement for a gambling product or company or for an alcoholic beverage, it says to Territorians that this is part of our culture and this is okay.

When we look at harm minimisation, if you think of a three-legged stool, demand reduction is one of the legs of that stool. Often, it is the leg that is least supported, discussed or provided resources. Demand reduction is something—for example, in tobacco legislation it has taken 40 years. Fewer people now smoke than ever before.

When we talk about advertising, it could be one strategy under the demand reduction banner …

Mr CHAIR: Yes, that is …

Ms COALTER: It is certainly something that is worth unpacking more.

Mr CHAIR: I am not talking about leaving alcohol out, by the way. I have a thing that alcohol advertising should be banned as well as a harm or demand reduction strategy. Like with cigarettes, people still know tobacco products and where to go and buy them if they want to. But over that 40-year period, there has been huge advances made in reducing the number of people who are using those unhealthy products.

Ms COALTER: Over 40 years, there has been genuine investment in all three legs of the stool—supply control. What supply control does in the illicit market is create an economy that is not regulated, taxed or safe.

When we talk about people—and people in this room—we are talking about our children. That is why I believe the Territory has a unique opportunity here to change the way we do our business about psychoactive substances or behaviours such as gambling, which are inherently risky, yet in a regulated, controlled market can be managed.

Mr CHAIR: Yes. All right. I have a few questions here to run through. We may go off on tangents as well. It has been known to happen to us.

Diversionary programs like SMART Court and Credit (NT) specialist courts—can you think of any challenges that would need to be taken into consideration in reintroducing such programs?

Ms COALTER: It is interesting to hear you say ‘reintroducing’ because, again, I go back to when we think about what is effective. If we have evaluation alongside any strategy, potentially we would know what is effective. In our submission, I drew attention to a couple of different models. Amity has had experience with both the SMART Court and the illicit drug and alcohol processes.

I do not see any particular barriers to reintroducing them other than potentially direction of current governments. From all of the evidence, and we have talked a little in our submission about it, they are shown to provide opportunities for people to either seek support or ways of changing, potentially, things that might be going on for them that they are finding problematic.

It would be interesting if we also included gambling in those type of courts.

Mr CHAIR: How would we get there?

Ms COALTER: Two years ago at a national conference for gambling studies in Australia, a lawyer presented—talking about how in different jurisdictions of Australia—if it is drugs or alcohol, drinking and drug-driving, for example, you might have an opportunity for a diversionary court process, but people she was working with around gambling as the problematic behaviour that had led to other things, there was really no opportunity for those people in those diversionary courts.

Mr CHAIR: If their gambling leads to fraud of some sort, they end up in court then they get referred through that way. Okay, I understand that.

Ms COALTER: If we apply one rule for addictive behaviours then surely that rule should be applied across the various addictive behaviours.

Mr CHAIR: We should be consistent. Consistency is not a strong suite of a lot of governments, but it should be. I agree.

Ms COALTER: If we have policy and we understand what we aim to achieve through that policy and have evaluation alongside, at arm’s length, then we might have some more hope of consistency.

Mr CHAIR: Yes, true. We have heard a lot, in various hearings we have had up and down the track, about various groups working together. There are various organisations that provide services, different levels throughout communities. To what extent do you collaborate with other organisations, both government and non-government, in delivering your AOD harm reduction?

Ms COALTER: It is an interesting question because, as I mentioned in my opening statement, first of all we have to work out which lens the treatment provider organisation, service or other is using for alcohol, drugs and other behaviours. If it is a moral lens or a disease lens then it is unlikely we are going to be able to partner with them.

Having said that—some examples of partners—we have a NT gambling project. We are the primary providers of the intervention. We call it a health promotion activity because intervention in the Territory is a really challenging word for us. We are the deliverer of that service—that activity – under the Ottawa Charter for Health Promotion, and alongside that process is the Australian National University and Dr Marisa Paterson, and also Menzies are contracted in under that contract, under Dr Matthew Stevens. That is one example.

The reason why we do that is we have provided gambling harm minimisation and education programs across the Territory for a decade, and we get a sense that the way that we work and the evidence that we use is useful for people, but we have none of our own local evidence in gambling that this is the way that we do. We are hoping from that project and that evaluation that it will be something that others will look to. That is one example.

We have a Strong Steps independent service model at Coolalinga and the Council for Aboriginal Alcohol Programs (CAAPS) hold the contract for that but we are a major contributor and collaborator in that. Before we are able to work with other services, organisations or government we have to understand the lens through which they are viewing.

Mr CHAIR: Do you have any programs that are aimed at early intervention?

Ms COALTER: Essentially from the way that we work at Amity, the public health model of protection, intervention and prevention is in all of our work. When you are talking about prevention, I find it useful to unpack prevention, as in genuine prevention, demand reduction, or prevention after the point of harm has been identified because they are separate things.

For one example of prevention, a demand reduction campaign, is that Amity takes the lead on Responsible Gambling Awareness Week throughout the Territory every year. The aim of that is to bring together key players. That can be government licensing, policy—that can be industry across many forms—and treatment agencies, Amity and others, that provide gambling services.

The aim of that is to raise awareness of responsible gambling, which is a bit funny because there are many people in the Territory who do not have a word in their language for ‘responsible’. I believe even though it has been going for about 15 years and is a national thing at different times in Australia, the Territory is still very much in its infancy because the commitment to fund genuine prevention can be challenging. It takes a long time to see results and outcomes from prevention work.

Mr CHAIR: We have here maybe a Dorothy Dixer. In treating substance abuse as a health issue rather than a criminal issue, do you believe decriminalisation of illicit drugs would be an effective harm-reduction approach in the Territory?

Ms COALTER: I will draw attention to the word ‘effective’ again. Before we can determine what ‘effective’ means, we would probably have to understand what it is that we are hoping to achieve. I do not think the Territory has to start with something that is not already known. I think the Territory has great opportunities to take from world-wide evidence and work out how we are going to implement it in a way that will be of benefit to Territorians and potentially not just in health and socially, but economically.

Mr CHAIR: Okay. It can be difficult to get an accurate sense of the extent to which gambling is a problem in the Territory, especially among Aboriginal communities. Are there any gambling-specific harm reduction initiatives being utilised elsewhere that you believe could be adapted here in the Northern Territory?

Ms COALTER: Ashley Gordon is an Indigenous man in the NSW region. He has a gambling helpline for Aboriginal people answered by Aboriginal people. That could be something—we have a helpline available in the Territory, but it is not as unique as Ashley Gordon’s. something like that—but my understanding around

working with our First Nations people and card playing, because often it is not seen as gambling; it is card playing.

We have other jurisdictions in Australia looking to us and the NT Gambling Project that has strong evaluation, being both qualitative and quantitative, next to it to see what else could potentially be done. I think the government that signed off on that funding just before caretaker mode may not have realised the power of what they gave us. I think the Territory can learn some really valuable information from that project.

Mr CHAIR: Is there anything else you would like to finish with?

Ms COALTER: It is probably a little bit dry, but because we talked about the 'them and us', I want to have on the record a brief snapshot of some of the people who access Amity's face-to-face counselling. I am happy to hand up those statistics if that is ok.

Mr CHAIR: That is perfectly okay.

Ms NELSON: I just quickly want to go to that 'them and us' language. I do not use that sort of language at all ever in my own personal and professional life. That is one of the things I have been focusing on since I have been the Member for Katherine, to eliminate 'them and us' from conversations in Katherine. When you are talking about 'them and us' you are talking about more of the addicts and the—is that what you are …

Ms COALTER: We are absolutely suggesting the same as you are. We have to remove 'them and us' from our language because it is not 'those people with problems' and 'those people experiencing harms'. It is all of us. I think it is quite obvious and evident in the Territory that we are all feeling the harms from alcohol.

Mr CHAIR: Absolutely. Thank you both. Cheers.

Ms COALTER: Thanks very much. I appreciate it.

Ms NELSON: Thank you for putting that on the record.

The committee suspended

ALCOHOL AND DRUGS FOUNDATION

Mr CHAIR: I welcome you both to this public hearing into a Northern Territory harm reduction strategy for addictive behaviours. I welcome to the table to give evidence Dr Erin Lalor and Sally Underdown.
Thank you both for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you.

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

If, at any time during the hearing, you are concerned that what you will say should not be made public, you may ask the committee to go into closed session and take your evidence in private. That being said, could each of you please state your name and the capacity in which you are appearing.

Dr LALOR: Erin Lalor, CEO of the Alcohol and Drug Foundation.

Ms UNDERDOWN: Sally Underdown, State Manager for South Australia/Northern Territory, Alcohol and Drug Foundation.

Mr CHAIR: Thank you. I just had to be reminded. For *Hansard*, would you please state your name if you are changing between speakers? When you start to speak, if you could just state your name again please.

Would either of you like to make an opening statement.

Dr LALOR: Sure. I will start.

Mr CHAIR: Thank you.

Dr LALOR: First I begin by acknowledging the traditional owners of the land on which we meet, the Larrakia people, and pay my respects to elders, past, present and emerging.

Preventing harm in Australia is the Alcohol and Drug Foundation's maxim. For almost 60 years we have been committed to preventing harm from alcohol and other drugs. We have always been an independent, evidence-based body that has advised Australians to avoid using illicit substances.

Concurrently, we have supported the harm minimisation approach supported by, and adopted by, the Australian federal and state governments since the 1980s, which recognises the reality of licit and illicit drug use.

We really welcome this inquiry and think it is the best-practice, humanitarian approaches, as well as its broad scope, which should render a significant report. It will help us address the stigma of drug use which has been identified as a barrier to seeking help.

Evidence shows us that it is often many years between the onset of substance addiction and the seeking of treatment. Medical professionals, media and decision-makers have roles to play in changing public discourse so that drug dependency is viewed as a health issue and not a moral failure.

I acknowledge the positive developments in the Territory since we lodged our submission five months ago. It has been great to see the introduction of minimum unit pricing in the Northern Territory, agreement on mandatory pregnancy warning labels on packaged alcohol beverages and the release of the Northern Territory government's proposed risk-based licensing approach for the sale of alcohol.

Today, though, I will focus on several aspects of the submission we made, including the importance of a preventative approach to the harm associated with alcohol and other drugs, looking at alternative approaches to drug law reforms and decriminalisation, picking up some of the work from Portugal and drug courts, also to talk briefly about needle syringe programs and real-time prescription monitoring. I am happy to also talk about other issues in our submission about pill testing, medically supervised injecting facilities and the like.

I will start talking about community prevention programs, which is a space the Alcohol and Drug Foundation has worked in for a very long time. We recognise that there is no silver bullet if we are to deal with the harms associated with alcohol and other drugs in our community, and that we need to take a multifaceted approach.

The programs we run in the community—we have two programs: the Good Sports program which is in about 10 000 sporting clubs across the country, with over 200 of them in the Northern Territory, and the Local Drug Action Team program, which is a program we run on behalf of the Commonwealth government.

These programs are about creating an environment where people are supported to make the right choices about alcohol and other drugs and where we strengthen protective factors that will protect us from harm from alcohol and other drugs and reduce the risk that we may develop dependencies.

The Good Sports Program has been running for 20 years. Its premise is to create an environment where members of a club are supported to avoid risky drinking. We have had it evaluated through a randomised control trial, demonstrating that we can reduce risky drinking by 37% amongst clubs that are participating in the program. More importantly, we reduce the harms associated with alcohol by 42% within the membership.

We also see the reduction in risky drinking spilling over into the behaviour of club members into their homes. People are less likely to adopt risky drinking behaviours in the home environment, as well as in the club environment. In the last two years, we have been starting to work with clubs to address illicit drugs.

We are strengthening the capacity of community sport to support their members who may be using illicit drugs and developing dependencies and experiencing harm from those drugs. We have also been helping people to see drug use as a health issue, to reduce the stigma associated with drug use if people become aware that a member of that club community is using illicit drugs, which is an important part of the program.

We have been working in the past as well to try to understand more about what the Good Sports Program might look like in remote Aboriginal communities where the structure around club governance and structures is not the same as it is in the cities and larger areas. We have identified that the Good Sports model would need to have significant adaptation to be run well within those communities.

We also acknowledge that community sport is a setting in which people participate in social behaviours like drinking. But community sport is also an avenue for protective factors about illicit drug use. The more we can get people to participate within a healthy club environment and a community sporting environment, the greater their chances are of being able to manage their exposure to alcohol and other drugs in the longer term.

Some of our work recently has been to try to understand how we can strengthen community club capacity and infrastructure to better provide a mechanism for local members of that community to participate. There are actually some terrific examples in the Territory of clubs that are doing more than just working within their club. One of them is the Palmerston Basketball Club in Darwin.

The Local Drug Action Team is our second major program. This has been running for a couple of years through funding from the Australian government. We have 172 Local Drug Action Team communities across Australia. We are about to bring on another 70-odd teams into the program. We have always been oversubscribed. We have had four rounds in which communities are able to apply to be part of the program.

The premise of it is that we encourage a local community to identify what their alcohol and drug problem is. They either do that through community consultation or through data collection, with advice from our staff and local experts within their area.

They then form partnerships with people within that local community who are committed to achieving a change in that aspect of alcohol and drugs. They develop a plan of action and we support them to develop that action plan, then we provide funding for them to implement that. They also find funding from other sources through this program.

We have had a larger than expected number of applications from Aboriginal communities. We suspect that is because of the burden of harm that these communities are experiencing, but also because the model of the Local Drug Action Team program is about the community choosing what the action looks like, and us supporting them to do that.

The Local Drug Action Team program will run for another couple of years. We have been looking, in the last year, at drawing on some international and Australian research to strengthen the program. One of the countries we have looked to is Iceland, where Planet Youth operates a program that they have been running for 20 years. It is a program that uses data collected from youths aged about 15 to 16 that measures how strong their protective factors are.

It looks at four fields of protective factors: access to supervised extracurricular activities such as sport, relationships with parents, health and wellbeing amongst the youth in that community, and relationships with peers in an unsupervised manner, which is actually a risk factor for AOD use.

In 1998, Iceland had some of the highest youth rates of alcohol, cannabis and tobacco misuse in Europe. They now have some of the lowest rates. They have been applying that program in 23 countries outside of Iceland. They are modifying that program to suit the needs of each particular country. That is the foundation of it and we will be bringing Planet Youth to Australia in June to understand more about what that might look like in Australia.

Ms NELSON: They are coming here?

Dr LALOR: They are coming. We are not sure where exactly in Australia they are coming but we are bringing three of them over so we can send them far and wide to meet with people.

We are also talking with researchers at Deakin who have been doing some terrific work with obesity. The work they are doing with obesity is working with a community to facilitate a conversation that helps that community identify what exactly are the problems contributing to the obesity rates within their local community.

It is a more structured conversation than we have been having with the local drug action teams to date so we will be looking at doing that in the second half of the program as well.

The other thing that I wanted to talk about, recognising that prevention is one part of the puzzle but the reality is that people will continue to use drugs. They will continue to consume alcohol, it is human nature to do so. It is how we can minimise the harms from those people who are continuing to use illegal and illicit substances.

Decriminalisation is a big conversation that is happening around Australia at the moment. We are all looking to Portugal. We see the success that the Portuguese Government has had in implementing a comprehensive model of which decriminalisation is one part.

When we talk to people about decriminalisation of drug use, we are really clear to point out that changing the law alone will not resolve the problem. We need decriminalisation within a comprehensive system change and if you look at Portugal, that is what they did. They invested in treatment, holistic wraparound services for people and they acknowledged that the response to drug use is not a 'one size fits all'.

There might be someone who might be stopped in possession of personal use amounts of a particular substance and that person's relationship with that substance may be very different from someone else, so they tailor their response to those individuals.

That brings me into the conversations we have been having with people around drug courts and the success that we have seen in other states in Australia and overseas with drug courts: the history of drug courts in the Territory and the opportunity to start to understand and explore models that pick up some of the models of the Portuguese court of dissuasion versus the more formal drug courts that we see in other parts of the world.

Ms NELSON: Even the name alone, court of dissuasion.

Mr CHAIR: It is the Commission for Dissuasion of Drug Addiction. Very Orwellian.

Dr LALOR: It is. But it is about treating a person from a health perspective. Understanding what it is that we can do to support them.

Mr CHAIR: It is not as intimidating as it sounds.

Dr LALOR: So that is another piece of the puzzle that we believe in. There are some relating to needle and syringe programs. The Northern Territory has the highest prevalence of Hepatitis C in the country. Needle and syringe programs have proven to really tackle that. It is very difficult for people in remote parts of the country to get access to needle and syringe programs. There is real opportunity in the Territory to start looking at what we can do for people who are using drugs that can reduce blood borne diseases within those populations.

I will stop there. I am happy to talk on pill testing and supervised injecting facilities, naloxone provision or to talk through any of the other aspects, including real time prescription monitoring which is another piece of the puzzle that we think is at play.

Mr CHAIR: We will get onto those because I do want to talk about those. I think you have covered a lot of the stuff. We have questions here but you brought up your drug action teams; 172 drug action teams across Australia. Are there any in remote communities or are they all in…

Dr LALOR: I will let Sally speak to the Northern Territory.

Ms UNDERDOWN: We have three currently operating in the Northern Territory which is Tiwi Islands, covering a few islands around Tiwi; Palmerston and a group in Alice Springs which is working with seven remote communities around Central Australia. We will be bringing on a few more.

Mr CHAIR: I think you had mentioned the Tiwi one to me before.

Ms UNDERDOWN: Yes.

Ms NELSON: How did you pick those three jurisdictions?

Ms UNDERDOWN: It is a competitive grant process. It will go out to—anybody can apply for our local drug action team program. Then the applications are assessed by an independent panel based on needs that are identified in the community, the capacity of the organisations that applied as well as the intended activities.

Dr LALOR: In the Northern Territory we have had four rounds of applications. In the third round we had a number of communities within the Territory who we would have loved to fund but just did not have the capacity. The same thing has happened in the fourth round. We know there is interest from communities and a need and desire to do more.

Mr CHAIR: Where does your funding come from for that?

Dr LALOR: The funding comes through the Australian Government Department of Health.

Mr CHAIR: It just sounds—is there a size of community where it does not work, like it is too small? Do you need particular services available in the communities?

Dr LALOR: The key thing from our perspective is to ensure that there are strong partnerships within the community. We run a similar program in New South Wales called the CDEP program, which can actually draw in individuals who have an interest from the community as well as organisations. The local drug action team program is organisationally run.

We are still learning a little around the program. It is in its second year now of a four-year program. We have identified that there are some communities with less capacity than others. There is not a particular characteristic of those communities that allows us to say, 'It is this sort of community that struggles more.' We are seeking to trial and understand over the next two years what we can do within those communities to really encourage activity that starts to make a difference.

We have developed a series of tool kits that communities can use to do the more commonly-used activities. They are things like mentoring, peer support and supporting parents. Education in schools is one of the big issues we are seeing lots of our LDATs pick up, just trying to make sure that an evidence-based approach to youth education in schools is in place, because that is often not the case. That has made it much easier for communities to pick up and run with activities much more quickly.

Ms UNDERDOWN: The Palmerston group are actually working on a 'supporting teenagers toolkit' that we have provided, working specifically with parents around parenting and good communication with their teenagers around AOD.

Mr CHAIR: What sort of numbers can each of the teams deal with? How many kids or people?

Dr LALOR: One LDAT in New South Wales is working with 9000 youth across their networks. They are working through football clubs to start to educate their youth around alcohol and other drugs and looking at upskilling their coaches to be able to provide a stronger mentoring role within their communities. They can be as small or as big as they need to be. It depends on what the local need is. It is really important that the local need is self-determined.

Ms UNDERDOWN: The Right Tracks program in Central Australia has engaged 1600 members across those seven communities, which is pretty extensive across Central Australia.

Mr CHAIR: I do not know how much money the federal government gives you, but it sounds like money well spent on those programs.

Dr LALOR: Yes.

Ms NELSON: I am interested in the drug courts. From your experience, have you come across areas where it has been really successful and then areas where the drug courts are a complete failure? Have you seen the comparison?

Dr LALOR: I am not aware of any comparison that has been done that looks at hugely successful and unsuccessful drug courts. The experience in New South Wales and Victoria tells us that the drug courts there have been successful. The evaluation has been pretty robust and positive.

Ms NELSON: Do they have mandatory sentencing laws or legislation in New South Wales and Victoria?

Dr LALOR: I am not sure to be honest. I would need to come back to you on that one. In relation to drug offences, I am not sure.

Ms NELSON: It would be interesting to get that.

Dr LALOR: We can come back to you with that information.

Ms NELSON: That would be really good.

Dr LALOR: One of the things we have noticed in those states is the difficulty we have in regional areas and being able to try and link in people who are not close to those centralised drug courts to be able to roll them out.

Ms NELSON: We empathise. We have huge difficulties in the Northern Territory with our regional areas in accessing services, courts and that sort of thing. Logistically, it is a nightmare.

Dr LALOR: The other thing, looking at the Portuguese model, is it is considering an alternative to the justice system, bringing in the people who can do a full health assessment of that individual and understand what it will take to address the very complex factors that have led to a place where such harm is being experienced from these illicit substances, and recognising when the harm is not significant and finding an appropriate course of action in those instances as well.

Ms NELSON: Yes. You were talking about the Iceland model, the youth program. How heavily was the government involved in that program in Iceland?

Dr LALOR: With the Iceland model, in its infancy, the government was key. The former Prime Minister of Iceland is the Patron of Planet Youth now and is known to occasionally involve himself in encouraging governments of participating countries to support the program.

It is interesting, because when Iceland implemented their program, in the very early days, they implemented a number of regulations. They increased the drinking age, put a curfew on youth in winter and summer of varying times …

Mr CHAIR: It is easy when it is minus 10ºC.

Dr LALOR: That is right. It is midnight in summer and 10 pm in winter, I think.

They worked very closely with parents. A lot of it was about alcohol regulation. But in other countries, the countries are finding their own way of doing that. The country they are most active in at the moment is Chile. You can imagine there is quite a different culture in Chile from Iceland …

Ms NELSON: Yes, absolutely.

Dr LALOR: They are working with those local communities. It is a very similar model to the Local Drug Action Team program where the local communities get the information that says, 'This is where your gaps are', and comes up with part of the solution to find out how they start to close those gaps. Then they collect that information every year. It takes about five years for you to see an effect. Prevention is not a fast game, it is a committed game. They are really demonstrating those effects in countries outside of Iceland as well.

Ms NELSON: But if they do not have a buy-in from the community members, the residents—overall, in general, everybody—it is hard for it to be effective, is it not?

Dr LALOR: When we talk about a whole-of-country approach in Iceland, the Iceland population at the time was about 250 000. It was a very small country. They work in municipalities of about that size. In Chile, they do not work across the whole country all at once, and they would not do that in Australia.

When we have been speaking to them, we have been identifying that our Local Drug Action Teams are often based in a local government area. Many of our LDATs are led by a local government group. We would look at what the size of the community is. That makes sense.

They also work very closely with education within those communities. They work at the level where they will have the most impact. Yes, it takes community buy-in, but their processes have demonstrated that they can get that sort of buy-in once people start to understand the problem better.

Ms NELSON: I am sure you are aware there are some issues in the Northern Territory in our communities in regard to disengaged youth and …

Mr CHAIR: Disengaged families.

Ms NELSON: Disengaged families, yes. … drugs and alcohol—alcohol being the big one. There is an overrepresentation of Indigenous youth in our justice system. When things flare up in communities like mine

in Katherine, for example, lots of people will immediately point to Iceland. They will point to the Nordic countries that have adapted this Planet Youth model and say, 'Twenty years ago, it was this bad and look what they did'. I always say to them, 'There was a buy-in from the government. It took the government lead to get things going'. But if the communities themselves are not participating it is not sustainable.

Dr LALOR: Iceland has managed to sustain it for 20 years …

Ms NELSON: For 20 years.

Dr LALOR: It has been running it in some European countries for 10 years now. When they come to Australia, that is part of the conversation we want to have with them. We want to understand …

Ms NELSON: Absolutely. I want to be there.

Dr LALOR: Great. Terrific. We will send you the details.

Ms NELSON: Yes, please do.

Dr LALOR: We believe we need to trial it here. We are not recommending we go wholesale into …

Ms NELSON: Well, the population numbers are comparative.

Dr LALOR: That is right.

Ms NELSON: We have 260 000 in the Northern Territory, which is the number they had when they started 20 years ago.

Mr CHAIR: It is about the size of my electorate.

Ms NELSON: Exactly. Land size, yes. We get conversations, people talking about curfews and that sort of thing.

Dr LALOR: They have not done curfews anywhere else as far as I know. They are not using curfews in any of the other countries.

Ms NELSON: The message I am trying to get across, though, is that if you do not have buy-in from the community itself, you cannot constantly be relying on the government. There are things that we need to do as a government. My focus is to try to shift the government's approach to this from a punitive justice approach to actually a health—it is a health matter—it is a therapeutic—that is how we need to look at it.

From a community perspective, I get increasingly frustrated when the finger goes to the government—what are you doing to fix it? They have these great models that they look at in comparison like Iceland, Denmark, Sweden all of that, and I have read up on all of them and I have been to those countries, on holidays and observed it for myself as a regular person, and it is great. They work really well.

The thing that I noticed was, the number one observation, was that everybody was invested in it.

Dr LALOR: On that, I would just come back to the LDAT program—that we have communities. We have more communities than we can support. We have communities that want to participate in action to address these problems at a local level. Communities are hurting from the burden of harm from alcohol and other drugs, and they want to step up to the plate.

Somehow we need to find a way of bringing the activities that government can implement, the activities the local community can implement, the activities that NGOs and experts like us might be able to add to it, to be able to create a holistic approach to it. This issue has become too big and too complex for us to take a simple approach to it—solution. It is just not going to happen.

Mr CHAIR: It sounds like you do have a—your LDAT is—as good as the Iceland model might be and the fact that it is coming out here—it sounds like stuff you are already doing is pretty good.

Dr LALOR: Yes. We just want to make it better and more targeted.

Mr CHAIR: Do you know much about the stats—you talked about Iceland and the reduction in youth alcoholism, tobacco and drug use. Do you know what sort of effects it has had in the other countries where it has been adopted?

Dr LALOR: It has not had the same level of effect because the bar was not so high. There has been a similar type of trend in the countries where it has been applied.

Mr CHAIR: Quickly, pill testing. I just want to say something and maybe get your response. We had the statement made to us today that the statistics show that there has been no improvement—or medically supervised injecting rooms have effectively saved no one.

Ms NELSON: There is no statistics, no data that backs up that pill testing is effective in reducing numbers or saving people, and there is no data that backs up that safe injection rooms are also effective. I have to declare now—I am not overwhelmingly supportive of safe injection rooms but I have also never had that experience, I have never been around it so I am dying to hear what you have to say.

Dr LALOR: There has never been a randomised control trial looking at what happens for people who use drugs if they use a supervised injecting facility or not. If you are looking for randomised control trial evidence then no, there is none.

Every supervised injecting facility around the world is clear that when people use them they do not die from overdoses. They have not had a death in a supervised injecting facility, and they have lots of deaths outside them on the doorstep, in the streets around them.

It is not the sort of problem you would do a randomised control trial with, because what you are saying is, we have supervised injecting facilities in many parts of the world now, when people go in to those they are cared for in a way that means that if they do overdose, there is a response that means that they do not die.

Mr CHAIR: One of the comments was that, with the medically supervised injecting rooms, the evidence shows that people go in there and try different concoctions of drugs and they have had a 27-fold increase of overdoses. It struck me that exactly what you said before, there are no deaths in there. Does it really matter how many overdoses they have?

Dr LALOR: To my knowledge, nobody has looked at the number of overdoses within a medically supervised injecting facility versus the number of overdoses outside a medically supervised injecting facility.

The other thing we cannot lose sight of, when we talk about medically supervised injecting facilities, is that they create an opportunity for that person to have contact with a system that can provide information, advice and support and treatment if it is wanted. That is an important part of the recovery journey for those who are looking for it.

If you are coming in day after day and you are safe with the people you are connected with in that environment, you are more likely to engage in a conversation about a different way. I think we overlook that when we talk about supervised injecting facilities.

We say what is the evidence that it stops people using drugs? That is not what they are there for. They are there to reduce harm. They are there to support people if they want to look at reducing their dependence on the particular substance that they are using. They are shown to do that.

Ms NELSON: The locations of those supervised, safe injecting – whatever you call it – that makes a big difference does it not?

Dr LALOR: Having them where they are accessible, in places where people who use drugs are more likely to be is really important. I have recently come back from Canada where I saw them in all sorts of places. In Canada, they are now running what they call overdose prevention sites which are supervised injecting facilities, not supervised by medical personnel, often they are supervised by peer-to-peer. It is people who use drugs watching out for other people who use drugs and they can be anywhere.

One of them, I did not see it, it was not operating by the time I got there, was run out of a trailer. Some of them are in facilities for people who are in the homelessness system. It is an alternative model to the comprehensive supervised injecting facility. There is one in Calgary, Alberta in Canada that is operating 24-7 out of a medical facility. There are different models around the world that we can learn a lot from.

Mr CHAIR: Same as pill testing, so that interface thing—that ability to come face-to-face with people and, as you said, provide information.

Dr LALOR: When you look at pill testing, it is the same as supervised injecting facilities. We do not have a randomised control trial but at festivals where we have had pill testing, nobody has died. That is not to say that it is the silver bullet, but it allows people to understand more about what substances are in the pill that they have.

It gives them contact with someone who can talk to them about their drug use and this group is very often difficult to get that sort of information to. It allows them to make an informed decision about whether they take that substance or not. We know from surveys that many of them will discard the substance once they have had the results.

We have also been talking with a number of groups around some of the static sites that are being used overseas, in the Netherlands, where they have—they used to run it in music festivals there, they now have static sites within the city. People can take their drugs in there to have them checked. 50% of them have the chance of getting their results back that day. Some of them take longer.

They have collection sites where people can drop their pills or drugs off and have them sent in to be tested. That is a model that allows a broader range of people to get access to the service to make informed decisions about substances that they are taking as well as the pill testing in music festivals.

Mr CHAIR: Any other questions? You guys have been really informative. Thank you very much. If there is anything else you would like to add, feel free, but you have given us a bucket load of information so thank you.

The committee suspended

MICHAEL BYRNE

Mr CHAIR: On behalf of the committee I welcome you to this public hearing into a Northern Territory Harm Reduction Strategy for Addictive Behaviours. I welcome to the table to give evidence to the committee, Michael Byrne. Thank you for coming before us. We appreciate you taking the time to speak to the committee. We look forward to hearing from you today.

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

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

Mr BYRNE: Michael Byrne, and I am making this submission as a private citizen.

Mr CHAIR: Michael, would you like to make an opening statement?

Mr BYRNE: I will. I stress that this is a private submission and is based on my experiences working with homeless people in the past 16 years. I am currently with NT Shelter, which is a peak body for NT homelessness and affordable housing. Prior to that I was with St Vincent de Paul running all their homelessness services.

It is from the St Vinnies background that this has piqued my interest. It does not have much to do with NT Shelter apart from the fact that a lot of the submissions and evidence says that having a home that is safe is part of the whole process of recovering from substance abuse and mental health issues.

In the submission I suggested three recommendations based on the reality that not everyone who drinks wishes to, or has the capacity to, maintain abstinence. Focusing on abstinence in our responses to substance abuse is bound to be a costly exercise with little to show for the investment. I think history shows that the rates of success from rehabilitation programs are quite small.

I had one guy at Vinnies tell me that going along to do that 12-step program was the best thing in the world. He has done it 12 times, and every time he does it he gets something fantastic out of it. That is the whole process. It is a long process.

But not everyone who drinks or enters a rehabilitation program has the strength to follow an abstinence lifestyle. People consume alcohol in harmful amounts for many reasons. For some, the decline into dependence is a slow one that could be a culmination of cultural factors and influences. However, for many who frequent St Vinnies services, alcohol was medication.

Some became homeless because of alcohol, some developed mental health issues because of the alcohol, but a lot of them fell into alcohol after they became homeless. The alcohol has become a medication to deal with trauma. Living the homeless lifestyle is a dangerous thing and there is a lot of trauma involved.

With our Indigenous people around the Territory, there is generational trauma that needs to be dealt with. If I am sick, the doctor will give me some antibiotics. I will take those antibiotics until I am better. You do not stop half way through. Yet, with our rehabilitation programs it is almost like we are dealing with …

Ms NELSON: Half the problem.

Mr BYRNE: … Half the problem. We do not get to fix the problem and the rehabilitation is just an intermittent—we do not deal with the greater issue, which is what the clients are suffering from. The use of alcohol as medication—if the person drinks to cope or to forget, why would they want to stop? One of my past clients when he was getting off drugs said to me that reality is really crap. He would rather be stoned.

Mr CHAIR: He is probably not wrong.

Mr BYRNE: I guess professionals in the field would tell you that one of the biggest things for people coming off drugs or alcohol is that they face reality with a clear head and it is not real great. If we do not work on the underlying issues, will we have success? If we do not replace alcohol with something else, will we achieve change? If people cannot change, do we just cast them aside?

It is important that harm reduction programs be developed for those who drink, but do not wish to follow the abstinence path. I recommend the development of wet shelters—or for a more descriptive title, homeless hostels that permit the controlled use of alcohol. I have also heard culturally-appropriate wet shelters being referred to as healing centres, which puts it all into the right context.

We need to see the implementation of programs aimed at dealing with the underlying reasons for substance abuse developed and offered in our rehabilitation facilities, correction centres and homeless hostels. Hostels that allow drinking, or wet shelters, should be seen as part of a holistic health approach to substance abuse. In my time at Vinnie's, I can also say that wet shelters are a humane approach to engaging with addicts in the way of affording dignity to the lives of some who have no dignity and to whom the community gives little respect.

Wet shelters are a way of giving these chronic drinkers shelter. But history showed in the early days a wet shelter will give some a dignified place to live out the last months or years of their lives. I imagine if we create a wet shelter in Darwin the biggest exit will be from people dying because you are taking people who have chronic issues off the street. Even if that is all it does in the early days, it is worth it for that reason.

Providing a way to connect with a cohort is usually only engaged by the police. Eventually, it could be possible to open the doors to a path of reduction in consumption that can lead to abstinence. It is very similar to talking about the drug testing and the needle facilities. It could be just that place where you engage someone …

Mr CHAIR: You actually get them.

Mr BYRNE: … that is safe, and eventually you will, hopefully, get them around to seeing that there are other solutions. With any long-term change, people need to have the skills, or be given the skills, to change.

One mechanism to see change is a Chrysalis program. It might not be the best or only program out there, but it is one I have direct experience with. This holistic personal change program engages, inspires and compels individuals to own and drive personal change in their lives. Primarily a program run in UK prisons, it has also been delivered in schools and rehab centres.

We trialled it at Vinnie's and it had some pretty amazing results, some of which still stand today. When I was at Vinnie's, guys who might have been in and out of that place for 10 years, then one day—change—and they have never been back, except to come and tell us how well they are going.

The program inspires participants to challenge their paradigms with thought and behaviour, increasing their feelings of self-esteem, self-motivation and hope. What is evident is that such programs should be culturally sound and delivered at many points such as prison, rehab, homeless shelters—all places where people with substance issues enter and engage with the system

The Chrysalis program engages on many levels. I went along with my staff and our clients and a bunch of kids from St John's College. Each of us gained something relevant from the course. It was quite amazing. I was sitting there thinking, 'That is why that staff member does not engage with that client'. But our clients obviously got something different out of it. If you look at the results in some of those case studies, it has been quite amazing.

It meant controlling their alcohol intake. It was not necessarily about giving up the grog, it was about being sensible about the way they drank, or making choices about their drinking. They still might drink a lot of alcohol but they can hold down a job, a marriage, buy a car and live in private accommodation. They are still, essentially, the same people, they have just changed how they do it. That is, obviously, not right for everyone. It is about having those choices.

If we wish to take away an addiction we need to fill that space with something else. What is the reason to give up grog? Is it for a home, a job, a family, good health, or hope? For lots of people there will never be a job, a home, their health is shot and they do not have hope for a better future. For some of these people, programs such as Chrysalis can help fill a void and build resilience, self-control and confidence.

There is a side note. The founder of this program has just received an MBE from the Queen for his reduction in recidivism through delivering this program in UK prisons.

I have not detailed in the submission, but it is clear that housing is an issue. Although it is a private submission and not from NT Shelter, shelter is a key issue and it must be considered. Shelter must be seen as a part of the whole package of dealing with some of the issues we have today.

I will close by reiterating that harm minimisation needs to be part of the solution. Not everyone wants to or needs to stop drinking. To offer dignity and engage with hard-core, highly visible chronic drinkers in our community, hostels that allow drinking or wet shelters are vital and should be seen as a health response to the disease not a housing response.

Culturally appropriate programs should be delivered into programs, especially in remand. There are so many people on remand who get nothing. This is an opportunity to engage with them.

Mr CHAIR: Yes we heard that earlier from NAAJA.

Mr BYRNE: Rehab facilities, homeless services, places where chronic drinkers enter the system is a place to engage and such programs are required to build resilience and give people the skills to deal with their issues and hopefully prevent them from re-entering the system.

I will agree with you that it has to be community-led. We can take this one program from the UK but it is not going to work for every cohort. The community needs, and the various Indigenous communities need, to own their own problems and come up with their own solutions and work to it as a community. The government's job is to facilitate that and to build the capacity of the community to run their community how they need to.

As an example, living on Bathurst Island and since, people know who takes the drugs into the communities. The community hate the effects of the drugs and they have the capacity to ban that person from that community quite easily but they do not have the skill or the need to do it but the community would love it. Maybe there is…

Ms NELSON: They have the capacity. What they are looking for is support.

Mr BYRNE: That is right. I feel that we have taken away a lot of Indigenous peoples' capacity to be consulted because everything is being done by Bathurst Island Catholic Church, government and the whole hierarchy has broken down and it needs to be built up so that they can be responsive to their own problems like they

used to be in the old days when there was something going wrong, they would just deal with it by moving to a different area or whatever. So I agree with that. That is the end of my statement.

Mr CHAIR: Thank you for that Mike. You have given me a couple of things I want to ask you some questions about. The Chrysalis Programme; what has happened to that? Is it still running?

Mr BYRNE: Yes, it is a UK-based program and the guy running it, David Apparicio was in Sydney and we connected. He was coming through Darwin and I thought it would be great if I could grab some funds and just—his program is run over six weeks in a prison, we ran it over five days and we thought we would see how it works.

We needed something for guys that were just floating; not achieving anything. We have a 12 month Vinnies program and they had been there for 18 months. Prison is an easy place to deliver programs because everyone wants to do them because they are bored, a captive audience.

We were going to evict a few guys and it was the last chance for several of them; 'look, you have had enough goes, time for somebody else to have a go.' We said go along to this program, you have to do the first day. If you do the first day, we will let you stay another month and we will work out a better exit plan. You do not have to do the other four days. They did the whole thing because they got into it. Real change.

He was in Darwin, travelling through, we connected. He came back once, more for a holiday and to get out of England in the winter. So then he was asking how do we get this going in Australia. I told him he needed to go to Sydney, you need big money. I think he is just so taken up with what is happening in the UK.

I do not think for a moment that Chrysalis is the only program. There are probably plenty of other programs. That is just the one we connected with. I liked it because it was a lot of what anyone would have done in personal development in the corporate or business world. It is very much the same. He did not dumb it down.

What it meant is that you were not sitting there sharing your personal feelings and dramas. It was not like—we had kids and homeless people and managers all sharing from their heart—it was just a really safe place. Just like corporate training really, and it just resonated with everyone on a different level—it was just sort of fit in. Then of course, you have to have the funds to be able to continue these things.

Enzo Floreani was from Alice Springs. He was a member of parliament.

Mr CHAIR: His name rings a bell.

Mr BYRNE: His son was working for the chrysalis programme and they were talking about maybe getting a licence for Australia. I do not know where it has gone.

Ms NELSON: Way before my time.

Mr CHAIR: Back in the day. He ran it once here? Is that what I get?

Mr BYRNE: He ran it twice with some dramatic success, but a lot of the other success was just people get nicer around the place—not as cranky, they pick up things. A lot of it is about behaviour and how you talk to people. Just stuff like that.

We ran it twice and it worked. I tried to sell it to the Department of Health as part of the discussion around the mandatory rehab. You cannot just have mandatory rehab. You have to put something else in with it. They liked the idea but it just never went anywhere. People change places and move.

They actually sat there during the sales pitch and at the end of it they said, we would like to do this for our staff. They could see the worth as a personal development plan, but that is where that has gone.

Having that sort of stuff attached to things. You can go and do things and talk about people's issues but you do need something in there to break through.

Mr CHAIR: The wet shelters—just a question I have come up with—is the concept that you actually limit their drinking? Say you have people who are problem alcoholics do you just put them in there and let them drink however much they like, or do you say, come on in, you can drink, we have a limit here?

Mr BYRNE: The model I looked into was in Ireland and it was run by De Paul. I was with Vinnies and De Paul is a conglomeration of organisations that have the Saint Vinnies—follow the person Saint Vincent de Paul—and we brought the guy in to Darwin, he was once again travelling through and we did a presentation. His model was that you come in, it is your own alcohol you buy it. It is not supplied for a body or organisation. It is kept in a bar and you can go to the bar any time you like and have a drink. But it is your alcohol.

The whole point was to get the drinking out of the rooms, get in to a nice area where people can relax and have a talk and a drink rather than just sit in a corner drinking. It was not about—they had issues with the community accepting this in their area. So it was not about supplying alcohol. It is just a hostel where people can stay and drink.

The thing is it is a medical thing, so you have to have a lot of nurses and doctors. You are dealing with real chronic drinkers. Not the people that would go to the Salvos or to Vinnies. These are the people who will never get off the streets, no matter how many facilities we have. They want to drink and they will be the ones on the streets.

The whole point was that over time, through engagement, you would cut down the drinking and eventually get to a point …

Mr CHAIR: Decentralising drinking as opposed to having them drinking on their own and self-medicating.

Mr BYRNE: That is right and also managing their drinking so that they do not dry out. You go on a big binge, then you run out of money and you have nothing for a week then you have the DTs and you are crashing and burning and you are in a lot of trouble, so it was to try and smooth that out. For us it began over a fortnight—it was that interaction.

Ms NELSON: You are subscribing to that whole moderation?

Mr BYRNE: Yes, but they do not preach moderation. You can drink as much as you like, but you have to pay for the alcohol so you buy it and bring it in. they do not have a licence to sell it. It is your alcohol; they store it in their bar. You can only drink what you have purchased and you can drink it all in one day. The whole intent is that if you were to attempt that, there would be someone there to try and engage with you to say that maybe you should drag it out.

The purpose it to get them to reduce their drinking. They then get to a point where people can abstain. It has happened. A lot of the first people exiting the program were dying because the people moving in there were really chronically sick and unwell.

Ms NELSON: I really like that you have brought out that whole ‘not everybody wants to’. It is really about harm minimisation.

Mr CHAIR: Yes. And it is consistent with the message from Tamara from Amity. People are not going give up; the reality is that some people cannot. We really appreciate your …

Mt BYRNE: But the intent is not just to maintain their current patterns in 10 years’ time, but to improve it and hopefully get to that place. I think if we approached them and got some of their more recent statistics, you would probably see more success.

There has been a proliferation of these shelters opening in Ireland. The reason they started in the first place is the same things we have here, business people complaining about drunks on the street and all of these issues. The issues the drunks on the street had were massive amounts of trauma. You would think it is a fairly similar base.

I canvassed Vinnies doing this because we run a hostel; we could have said, ‘You are allowed to drink.’ The problem is the hostel is funded through Housing. If you change purpose you have to get rid of a whole lot of other people that end up on the street.

Ms NELSON: I know we are running out of time, but we have Ormonde House in Katherine, which is men only and run by St Vincent de Paul. Quite often there are—I have quite a number of men come into the office looking for help in finding accommodation because they have been there and have breached the rules by either having alcohol or—maybe they have not taken alcohol into the house, but they have had a drink with a friend somewhere and you can smell it on them.

You are right, if we are going to support them in trying to whatever—come in off the streets and get healthy, then we should be empowering them as well, to be able to make healthier choices. If a healthier choice is drinking in moderation instead of abstinence ...

Mr BYRNE: Our position at St Vinnies was that you cannot drink or take drugs on the facility, but you can elsewhere. We are not going to tell you that you cannot drink or use drugs. We manage behaviours. If you want to come back drunk that is fine, just go to your room. If you come back drunk and are abusive then you will be gotten rid of.

We thought that was a better way because so many people are turned off by that pressure of abstinence. We say to guys, if you want to drink there is a (inaudible) bar, which was a bus stop just down the road. That is where you see them all drinking. That is showing a level of respect that they are not doing it in the facility. Not everyone that drinks has a problem with alcohol.

Ms NELSON: Exactly. It comes back to that whole empowerment thing. You want to empower people to make that choice. By doing that, you are encouraging them to make a healthier and safer choice.

Mr CHAIR: It is the other judgemental drinkers who do not drink in the street who have the problem.

Ms NELSON: I do not drink.

Mr CHAIR: I do. I try not to judge.

Mr BYRNE: I chose to stop for a while, but if someone came along and said, 'you are not allowed to drink', I do not think I would be too happy. I chose to stop. That is what we are doing here. We are creating—there are so many homeless people in Darwin who have been told they cannot drink because there is nowhere they can drink. There is no pub they can go to. If they did that with the whole white community—if they made Darwin dry, imagine how bad Palmerston would be every Friday.

Mr CHAIR: I know you are not here for NT Shelter, but you did mention them. What is their sort of capacity for accommodation?

Mr BYRNE: NT Shelter, being a peak body, represents Vinnie's and Salvo's that have the accommodation. There are not enough rooms. The simple fact is we get 1% of the specialist homelessness services funding for the country and we have something like 12% of the problem.

Mr CHAIR: That come federally or from us?

Mr BYRNE: Federally. The federal government says it has to be a 50/50 split, but the Northern Territory government puts in more than 50%.

Mr CHAIR: Right.

Mr BYRNE: But it is not enough funding. You have services dealing with homeless people. Pretty much, a lot of money is spent down the spine, of course, not out in those regional areas. You are dealing with the problem as it is now, which makes it really hard to deal with it upstream.

Ms NELSON: Constantly reacting.

Mr BYRNE: That is right, yes. One of the things for Katherine—and it has nothing to do with this harm minimisation—is that it needs a crisis centre. Vinnie's is not that. You need that spot where people can go.

Ms NELSON: You are spot on. I say that all the time. We do not actually have a housing shortage in Katherine. The two issues we have is we have long-term tenancy issues, but we are in desperate need of transitional housing or short-term crisis accommodation. That is our number one need.

Mr BYRNE: It is a crisis problem. It is accommodation for people who just need something now. But these places all need culturally appropriate, affordable caravan parks, for want of a better word. A lot of people at Katherine and Darwin are just coming here for visits, health reasons, whatnot. They are not permanent residents. They are coming in and out. But they cannot afford to stay at a caravan park. Darwin caravan parks cost almost $300 a week just to pitch a tent. And it is not conducive to that group.

Yes, we are fighting for those sort of things. We need more affordable housing and programs for homeless people.

Mr CHAIR: Indeed. Thank, mate. Anything else you would like to add?

Mr BYRNE: I do not think so. I made a note before. You listen to other people talk and think, 'That is right'.

Mr CHAIR: Yes.

Mr BYRNE: Definitely programs in remand would be a great thing. It is just crazy that people are sitting in there and when they get out they have nothing. They lose their Centrelink when they go in there, so they lose their house. They are sitting there and end up going to court and getting a sentence, which is the same amount as they have already been in, and they are let out. They have had six months, or whatever, or nothing …

Ms NELSON: It has been reiterated several times today.

Mr BYRNE: Yes.

Mr CHAIR: Thank you very much.

Ms NELSON: I really enjoyed reading your submission. Thank you.

Mr CHAIR: It is a pleasure seeing somebody, a private citizen …

Ms NELSON: A private citizen, exactly.

Mr CHAIR: … having a go …

Mr BYRNE: If I was at Vinnie's still, I would have …

Mr CHAIR: That is all right.

Mr BYRNE: … made a Vinnie's submission.

Mr CHAIR: Thank you very much for your …

Mr BYRNE: Also if you look, there were only two submissions already that were online. I thought, 'Gee, I better put something in'. It is all about drugs.

Mr CHAIR: Good on you, mate. Thank you very much.

Ms NELSON: Thank you.

The committee concluded.
