LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

13th Assembly

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

Public Forum Transcript

5.30 – 7.00 pm, Thursday, 27 September 2018

Litchfield Room, Level 3, Parliament House, Darwin

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

Witnesses: Paul Tolliday
Vicki Borzi – Somerville Community Services
Kerry Boswell – Somerville Community Services
Michael Borzi
Nicola Coulter – Amity Community Services
Georgie Mumford – Fong Lim Electorate Office
Matt Stevens – Menzies School of Health Research
Tomoko Okozaki
Jennifer Jenkins – Remote AOD Workforce, Department of Health
Peter Burnheim – NT Primary Health Network
Alan Graham – NT Primary Health Network
Leon Gailitis – Banyan House
Rikki Fisher – FORWAARD
Bernie Dwyer – Team HEALTH
Maxine Atkinson
Paul Dent – Private Consultant
Katie Flynn – Association of Alcohol and Other Drug Agencies Northern Territory
Natalie Sarsfield – CatholicCare NT
Marie Fox - DCIS
Belinda Davis

CHAIR Mr Jeff Collins: For those I don't know, I am Jeff Collins the Member for Fong Lim and the Chair of this Select Committee. As you are aware, we are here tonight for a public forum on the harm reduction strategy for the Northern Territory and we would like to hear your input, your ideas and the like. I have a script that I am going to run through because there is some information in here that you need to know about the processes here tonight. Before I begin that, bathrooms are out that door to the right just near the lift, and there is tea, coffee and refreshments there, so please feel free to help yourselves.

On behalf of the committee, I welcome everyone to the public forum into reducing the harms from addictive behaviours. We appreciate you taking the time out today to discuss this important issue with the Committee. This forum will be an open discussion on harm reduction for addictive behaviours and what can be done about it. We will be holding similar forums and public hearings in Tennant Creek, Alice Springs, Katherine, Nhulunbuy and the Tiwi Islands and the Committee is due to report back to the Legislative Assembly by 31 August 2019. We will run this forum in a fairly relaxed manner, however, it is a formal proceeding of the Committee and the protection of parliamentary privilege applies, also you are under the obligation not to mislead the Committee. We are recording and what is said will be made into a transcript and if you haven't already signed in, please do so, there is a sheet that Jennifer has and that will be going around as well. Please put your contact details on there, we can then send you a copy of the transcript so that you can correct any errors in the transcript before it goes on the Committee's website.

To ensure that we capture your comments, would you please state your name each time you address the forum and if you do not want your name to appear on the transcript, that is okay, just tick the box and ask for it not to be included.

For this forum the Committee members will ask questions as we go along, but it will be largely guided by the issues that you raise. We want to hear from you and how you are affected by addictive behaviours and what you think Government can do to help. So does anyone want to start by commenting on the impact of illicit drugs?

Kerri Boswell - Somerville Community Services: I will start. Hi, I am Kerri and I am from Somerville Community Services. We support families and children for a range of services, homelessness, financial crisis, just really genuine services. Two of the impacts that we have identified impacting families in coming through their difficult situations is one, families entering rehabilitation centres, so parents who have AOD issues are sometimes hampered by actually entering, because families and children can't go with them, so that is one impact that has come up quite frequently for us and there is very often a very small window of acceptance and recognition of the issue and willingness and if there is that, a bit of hesitation, and those parents can still be really parents in their time and in that space. That is often a huge setback. The other issue is, particularly where there is ice involved, all mandatory rehabilitation is not long enough in our opinion. We see a lot of relapsing and we are not involved in AOD space specifically, but we see the impacts of that relapse happening and families not continuing on their journey, well-supported, and I think also the step down support that is put in place to maintain what they have learned during that time is not always as strong as it probably could be. So those were just two areas that we wanted to bring forward.

CHAIR Mr Jeff Collins: So treatment is provided for four months, is that it at the moment?

Kerri Boswell - Somerville Community Services: Yes, generally there are 12 week programs.

CHAIR Mr Jeff Collins: Okay, and that is Territory funding for those, are you aware?

Kerri Boswell - Somerville Community Services: I presume, I wouldn't answer that correctly I'm sure.

CHAIR Mr Jeff Collins: So, what do you think an approach could be? So you are talking about more family oriented treatment?

Kerri - Somerville Community Services: I think if the residential treatment facilities were expanded to support families to maintain parenting responsibilities, particularly where you have got single parent families and families who are up here who do not have support around them, that would help their journey in rehabilitation.

CHAIR Mr Jeff Collins: Okay. I know we have some of the treatment providers here as well, are there any comments about that?

Leon Gailitis: My name is Leon Gailitis from Banyan House. As far as residential treatment services go, I would certainly agree with Kerri, sometimes three months is not enough time and aftercare services in the Northern Territory for post treatment are probably lacking, especially transitional accommodation programs. I would certainly advocate for longer treatment programs. I think I will also add that residential treatment is the high-end of treatment. If you start at the low end of the spectrum of intensity with brief intervention or counselling services, then move through into more intensive day programs to residential rehabilitation.

Peter Burnheim - NT PHN: Peter Burnheim from the NT PHN. I think with regards to the length of treatment, quite often it is seen as an economic management tool to keep the treatment periods affordable, but there is a very false economy and that is not providing a long enough period of treatment to actually have a positive outcome for the person and you have ongoing change, then you are going to see that person again. So if you are going to have someone in five times in three months instead of just giving them a year straight off, well then they might actually get good outcomes from the treatment, and for some people, that might take a really long time. There is just a false economy in shortening the length of time to three months if there is a need for ongoing treatment…

CHAIR Mr Jeff Collins: So it's an arbitrary three months is it?

Rikki Fischer FORWAARD - Aboriginal Corporation: It's been written in our funding agreement.

Peter Burnheim - NT PHN: It's kind of become a bit of a standard for some strange reason.

Rikki Fischer - FORWAARD - Aboriginal Corporation: I can't be 100% sure, but I think it is written in our funding agreement. Even with our transitional house that we have got, it states in there three months. Now we have changed it around and we are allowing those to stay in there for up to 12 months and then hopefully move them on. But we have changed our way to say it's a minimum of three months, so if they choose to stay on, they can stay on, but I am pretty sure it's written in our contractual agreement that it's a minimum of three

months and if they are court ordered, the orders say three months rehabilitation, so once they have done their three months "Woo hoo! We are out of here" kind of thing. And the other thing to do if they did want to change it, is to stay for a period of time and possibly extend it because like they said, three months for ice isn't long enough.

CHAIR Mr Jeff Collins: So a system where you would register or monitor it as you were going along and then…

Rikki Fischer - FORWAARD - Aboriginal Corporation: Move stages. I think it is about six weeks from when they come in to when they kind of plateau and then the head is a bit more clear than what they were when they first came in. So then we have only got them for another six weeks before we are kind of opening the gates "see you later".
So it doesn't work when you try to incorporate the mental health status as well, and then if they have got mental health medication the effects of that can take up to three months, six weeks or whatever. So it is not just focusing on their AOD issues there are a whole raft of other issues that they do come in with; family, Territory Housing, Territory Families, physical primary health as well as their AOD and mental health stuff. So once you kind of get through all of that then you can get to the AOD stuff and then it is basically "see you later, goodbye", kind of thing.

And I also think there will be some of us that would need to change the treatment model that we have got here in the Northern Territory, from just doing your rehabilitation, to try to find them the education to have the ability to focus on employment, as well as all that kind of stuff.

Jenny Jenkins - Remote AOD Workforce: I agree with what you say, it is the standard. I am a nurse. My background is nursing, and the standard minimum is 12 weeks, so that is what everyone seems to adopt. I want to touch on your point that there is huge need for family places, do you still have a family?

Leon Gailitis: We do, we have two family units.

Jenny Jenkins - Remote AOD Workforce: Yes and CAAPS have some for our Aboriginal mob, but there is a real need. I send people in from right over the Territory and the waiting lists are huge and the waiting time is, if one of my mob want to go into rehab. They have basically made that decision if it gets to the payday and nothing has happened, they are on that cycle again. So once they make the decision, they feel that it should be relatively quick so if we can get that down, sometimes it is up to 7 months, but if we can cut that down, that would be fantastic but the only thing is, then they say "you can't take your baby with you" or if there is nobody safe in community to look after their child, they won't go!

CHAIR Mr Jeff Collins: Yes.

Jenny Jenkins - Remote AOD Workforce: And then it is just a roundabout circle. So more family places and, I agree, I think to get off alcohol in 12 weeks is fine but any of your illicit drugs, we are not seeing that too much in communities, but definitely done during alcohol.

Kerri Boswell - Somerville Community Services: Just on what you were saying. Just in general counselling on general trauma, six weeks is the briefest form of intervention and that is not talking about deep seated rooted problems. So to consider over the 12 week period, you have only got really six after the plateauing, it really doesn't allow you to address what

are in-depth complex needs, because there is so much more to sustain in what they do on the outside, than just learning how to cope with those sorts of coping strategies. But the other point about not being able to take families is, if they don't take that window of opportunity while it presents, you are putting those children at risk because the children are experiencing the same environment that is surrounding them, they have got them to that point in the first place. So it is more than just the people, it's the children involved as well, it's going to help Territory Families as well and child protection.

Nicola Coalter - Amity: I'm Nicola from Amity. So we are talking about treatment, but what I am hearing a lot about it is what Leon has acknowledged from Banyan, that we are talking about residential rehabilitation which sits at the pointy end of the spectrum and it is only one option along a treatment journey and a treatment continuum.

So when we kind of think about treatment, at Amity we start first of all with public health and health promotion campaigns raising awareness, and then we go maybe to the brief interventions, self-help goes into alternate kind of services, like your GP or your primary health network.

And then we have got more along the ebb where we are talking about counselling, and counselling comes in many forms now, whether it be face to face or telephone, there is eHealth, there are lots of those treatment programs as well. So while I acknowledge that for lots of people in the Territory who are struggling with home, housing, shelter and all that, residential rehabilitation is a really important component, but it is only one part of treatment, and it is at the pointy end of the spectrum. So when we talk about treatment beds, are really attractive to governments offer, but there is so much more that goes on in treatment other than residential rehabilitation.

CHAIR Mr Jeff Collins: Yes, and ultimately the more you put in there, you are hopefully avoiding or reducing the number who need the beds treatment.

Nicola Coalter - Amity: So if we kind of think of harm minimisation or harm reduction as a three legged stool, if we put all of our money into supply there is going to be an unbalanced stool, if we put all of our money into harm reduction and the treatment continuum at the pointy end, we are still going to have the stool that is not really solid.

So, essentially, unless we kind of do that continuum and invest appropriately along that continuum and follow the evidence as well, then we may end up with a lot of resources for a small amount of our population that aren't achieving good outcomes in the changes.

CHAIR Mr Jeff Collins: Yes, Okay.

Natalie Sarsfield - Catholic Care: Just to add to Nicola, this is Natalie from Catholic Care. I also work in a non-residential community based AOD service and I think what is unique or is something to consider in the Northern Territory around, we have got funding for "beds" but looking at our whole lifecycle of substance misuse, we often see residential rehabilitation as a pathway to abstinence and that is where it should end. That is treatment success, which is often not the case, people come in and out of rehabilitation quite a few times and every time they go, they take a new message, which is fantastic and it is something new with them. But I think it's actually really important for us to acknowledge that in and out of community based non-residential and residential, is actually a holistic pathway, so it's not around people

coming into a service and us expecting that they're never going to abuse or misuse or use drugs at all, it's around that pathway.

I think looking at it, rather from than just one avenue, that we actually play a part together and really acknowledge that we actually do need to have equal amounts of each service, because they will come to counselling non-residential, potentially first from a GP. We might refer into a rehab and they might exit before they are finished or they might think that they are okay and then two months later relapse, and then there is this gap period where there is no service. Everything turns on its head again, and people are in distress and then we do that whole process again, but it's an opportunity for us to relink this circle, acknowledging that one treatment episode or one treatment stream is not going to work for everybody all the time.

Nicola Coalter - Amity: Because, essentially, if at the heart of policy, we have the aim of reducing harm and not reducing use, then it would be more effective. That's what the evidence says in harm reduction. The aim has got to be in reducing harm not in reducing use.

So we have talked a lot about alcohol and drugs, and essentially illicit drugs, but we are also missing a whole range of behaviours along this continuum and another one that is highly prevalent around the Territory, and I am hoping Matthew Stevens across the room from me can add to that, and it's gambling.

Matthew Stevens – Menzies School of Health Research: Yes, it certainly is and I put in a submission and I guess a lot of it was focusing on pokies, electronic gaming machines up here and over the last few years, there have been some particularly big changes in the policy space where we have had a doubling of the number of pokie machines in pubs, we have got a 20% increase in clubs. Certainly one of the other changes they made was allowing note acceptors on to the community venues in the pubs and clubs and this has led to, after five or six years it pretty well plateaued revenue growth in the EGM market up here, it has gone up 30% in two years. So it is pretty well double the amount of money being lost in community venues since 2014.

And I guess what was disappointing with that, changes were made and as far as I know there was no consultation at all with community counselling services or myself as the primary gambling researcher up here.

So certainly, the other thing I looked at, was the revenues and then also matched that with data we have collected in the prevalence surveys, and looked at how things have changed from 2005 to 2015 and what it sort of show is, the people classified as having trouble with their gambling, and poker machines are the most addictive form of gambling. It has been known for over 20 years basically and they are designed to make you keep gambling basically. The amount of losses amongst that group of people has gone up around 40% since 2005, so about the same number of people are playing these machines as in 2005, even though our population has grown about 30% and they are losing twice as much, so the losses are concentrated more. Also in the last 2015 survey we collected information. We asked people if they had been harmed from other people's gambling, and 13% of Territorians had been, so we are talking about 25 000 to 30 000 adults had been negatively affected by someone else's gambling.

Amongst our Indigenous sample in that survey, the Aboriginal and Torres Strait Islander sample it was up around 28%, so it was significantly higher in the Aboriginal sample of that survey. In other work we have done a little bit with Nicola, we have found that the harms from others gambling are actually double that again in remote communities, and mostly in the remote communities it is card games. There is a bit of people travelling to town and pokies are still the preferred commercial form of gambling for Aboriginal Territorians.

Nicola Coalter - Amity: And also what we don't know, and there is no real hard evidence and data to back it up, is the changing landscape of gambling and sports betting wagering. So we are coming into a peak time now where gambling advertising is just everywhere. I picked up the NT News, I think it was on Tuesday, and the amount of full page ads for betting companies coming into the finals was huge.

Rikki Fischer - FORWAARD - Aboriginal Corporation: At 7.24 yesterday morning I was watching the news and there was a gambling ad on and then they did one segment and the next ad was another gambling one. At 7.24 in the morning.

Nicola Coalter - Amity: So when we talk about normalising behaviour, advertising is very much normalising behaviour and if we look at tobacco control over the 40 years, it was a big part of changing behaviour. So when we think of public health and not focusing on the individual but whole of populations, these are the measures that we need to follow with the evidence, whole of population measures, and then test them for being effective.

Matthew Stevens – Menzies School of Health Research: Just to finish up, I guess with a comment on the electronic gaming machines/pokies, is things government can do and regulate these things a little bit better is, we have actually increased accessibility by adding more machines in, we allow people to put $1k in a machine and the Productivity Commission recommended in 2010 that $20 be the maximum amount you can put into a machine in one go, and that way, the person playing it is aware how much money they are feeding into these things. I mean, thankfully we are not in New South Wales, you can put $7500 in a machine in one go down there, so certainly reducing that loading amount to some sort of reasonable amount, whether it be $50 or $20, would certainly be a help. Reducing access, so maybe don't have them open the whole time that the bar is open in these venues.

Certainly aspects of the code of practice need tightening up and there is currently a review of that going on at the moment. I mean, I saw a fellow playing three machines at once the other day in a venue, and I sort of told the gaming manager, and yes, they didn't like being told.

But in that legislation, it says it is up to the gaming manager whether that is okay, it is a game of chance, he is losing three times as much money if he is playing three machines, and that is outrageous!

Some other things, certainly maximum bets, at the moment the maximum bet up here is $5 which is not too bad, it is $10 in some other jurisdictions but reducing that again. The Productivity Commission has recommended they go down to $2, so that slows how much money people can lose. Basically it reduces the amount of losses, so it is another harm reduction measure. That is all I can think of at the moment. I have got a paper with the government at the moment, I am just checking some of my policy facts.

CHAIR Mr Jeff Collins: Yes we do have your paper and there will be a public hearing, and undoubtedly you will be asked to come along and we will ask some more questions and we

will have the full Committee there as well. So it would be a great opportunity to hear more from you.

Matthew Stevens – Menzies School of Health Research: Sure.

CHAIR Mr Jeff Collins: Anyone else?

Kerri Boswell - Somerville Community Services: All this stuff is really great, and I guess I just wonder about intergenerational patterns and this young generation that is being influenced, and we talk about that three legged stool, which is a beautiful metaphor, and that early intervention and prevention, more prevention space like what is being done with the young people in the schools around this. I, for one, don't know a whole heap of what is being done but it is certainly a huge impact that is going to have generations and years ahead of us creating issues, about what is being done for youngsters to learn how to manage their money, their finances, around these sorts of things, but also about all the impacts and influencing factors around us. What are they learning in schools, at the start of school?

Paul Tolliday: I am a practising teacher, and there is education about things, but it is like a lot of stuff you can be shown, all sorts of facts and figures, but whether it's the peers, the media, the social culture, there is a whole range of other things that are at students, all the time. And I guess having been in this area for about 30 years now, both here in Darwin and interstate, as well I have taught here for about 24 years, and I find that the amount of use of drugs in schools at the moment is the worst I've seen.

A young lady in Year 10 at a different school than where I am, I know the family, I spoke to her and when she makes comments like she is only aware of one friend who hasn't used drugs, that concerns me. So education is important but there has got to be the whole balance thing because often when… It's just cold hard facts that bounces off when it is someone who speaks from personal experience, that can have more of an impact on some. It's finding that right balance and then you have got to have the right people to go in, that are going to do it in the right way and it really does become a messy sort of situation.

So my concern is the prevalence, the amount of abuse, also the social acceptance of it amongst students to say that it is okay, it is something to joke about "what did you do last night"? or "how many cones did you have last night"? It's just like saying, "Hi, how are you going?"… They are introductory statements almost.

Nicola Coalter - Amity: I would like to bring to attention that there is highly skilled researchers in this area around drug and alcohol education. Professor Robin Room is a co-author of a book called *Alcohol: No Ordinary Commodity* and at the back of that book, there is a table that talks about evidence and it categorises evidence from strong evidence, to suitable evidence, to weak evidence. Providing alcohol and drug education in schools to children is actually weak evidence. What they say is strong evidence, and we submitted to the Ice Inquiry and we attached the Icelandic study to that, is actually keeping young people engaged in school. So the latest research in this country that is coming out around alcohol is, for the first time in many generations, young people are drinking much less than they ever have before and actually abstaining. The number one substance consumed by young people in Australia is the easily accessible one, and it is alcohol, and it is found in the home. So when we think about the evidence and being evidence informed, we really do need to kind of follow the evidence. As we have stated in many submissions repeatedly, the evidence supports keeping people in schools, not necessarily attending drug and alcohol education.

Peter Burnheim - NT PHN: I made a comment in our submission regarding the quality of education is another issue around drug and alcohol. I acknowledge what Nicola is saying. There was a study done of about 50 different alcohol education programs done in schools around Australia and I think only two of them were shown to have had any impact or effectiveness on reducing alcohol usage by the people that are being delivered to.

So at the moment, I am not aware of any sort of evaluation of any of the education that goes on in schools. I think the curriculum is pretty broad in general and it's left to the principals to decide what actually gets taught in the school. So I think some stronger guidelines of the actual drug and alcohol education that is going to be delivered might be necessary.

Jenny Jenkins - Remote AOD Workforce: Again, I have worked in urban, my work is all Aboriginal communities across the Territory and it is a huge, not so much alcohol children, but definitely ganja and marijuana. I have counselled and assessed people as young as 8 smoking marijuana, and it's a cycle that just keeps going and around and around. There is nothing in that space at the moment, well there may be in communities that I don't go to, but the ones I go to, there is nothing in that space between the 10 and 20 year olds. Matthew and I were talking about this today. In regards to what they see it, they witness it, they do it. I don't think it is up to the education system to fix that. I think if you go and spend any time in our remote communities there is nothing else for these kids to do. If you live in town where you have basketball courts or whatever, but in a lot of remote communities, their football is even gone. There is nothing for those children to do, they see their parents do it and my worry is that we are going to grow up with a generation of children that are just going to be in the same cycle, especially in our remote district.

Natalie Sarsfield - Catholic Care: I have looked into this area quite a bit because we have a component of one of our youth programs which is delivering AOD education to the public schools up here. And I guess I have always kind of weighed up, what is the effectiveness of this, because as Nicola was saying, there is not a lot that is being evaluated and Peter was saying as well, around really concrete "what is working"? We have got what doesn't work, and things like ex users coming in to talk has kind of proven as not successful, and scare campaigns are fairly proven as not successful, and they are the two things that seem to be utilised the most, and having a presenter come in alone without any other context around it, is also proven not to be a successful approach.

What is successful is a whole of school community approach, which is teachers delivering content around this throughout the year, having presenters in at certain times when you need it to reinforce those messages, but also getting parents on board, getting your wellbeing coordinators on board and also really promoting healthy campaigns throughout a whole community. So the only way school drug education, so far as what they have evaluated, is that it has to be a whole school approach and it is the only way that it works. There is not one thing that will work, it really needs to be quite holistic.

I guess when we think about young people in general, their retention rate is pretty limited if it's not interesting to them. So they might go home after witnessing a car crash advertisement around drink driving but that impact is only going to last for a couple of days until they move on to the next thing.

So what we really need to be looking at is long lasting messaging and the only way that can be done is through consistency and through a lifespan. So starting young, we start with

poisons as a kid, we start with Panadol, we start with the things that are relevant to their age group and move up as their risk factors to what they're going to be exposed to, moves through. But it's a consistent messaging whilst also creating a safety around having that conversation. So we need to do a lot more work around how parents and teachers and important community members feel comfortable having that conversation around young people potentially wanting to experiment with drugs, the "just say no" doesn't work, so let's look at actually opening that conversation and start educating our young people and not be afraid of the conversation that might come out of it.

Bernie Dwyer – CEO Team HEALTH: I used to be at Amity. Now I am with Team HEALTH at the moment.

The other thing that came out of the Icelandic study was over 20 years, the reduction was quite extreme in the amount of drug use with young people, but it was also exactly what you were saying about engagement in healthy activities. So there was after school activities, there was sport, so it is actually about the broader activities that are available and the healthy lifestyle development and also that engagement of the families in those activities, so the better the family supported it, the more likely the young person was going to develop strong healthy habits. They also had curfews there but my understanding was the kids can get into trouble, the parents were not protecting their child, the child is wandering late at night rather than… So it was back to a health perspective rather than punishment.

Nicola Coalter - Amity: I believe it maybe Dr Carmen Rose Cubillo at CDU, I think there is a study going on at the moment about resilience in schools and it's from the start to finish, to rollout to baseline study to evaluation about how it goes. I think drug and alcohol education is in there somewhere but the overarching aim is teaching resilience. So it is not on the deficit model, it is not sending the message "not even once", which was an Australia wide campaign around a substance, that young people said that it didn't mean anything to them and they know it wasn't reliable.

So when we talk about young people and experimenting, we know that humans have always, and will always, continue to seek to change the way we think, feel and behave. So harm reduction says that we have got to make it safe. Deaths from overdose are 100% preventable, and I think if it's a nice segue, and I am going to lead into because I heard a conversation over here before – pill testing. The evidence supports its harm reduction. Australia 21, led by ex-federal police officer and NT Commissioner Mick Palmer, says we are killing and criminalising our children if we don't implement these measures. So I think there is enough media attention given to death because of pills and then we respond and we react emotionally and we say "we need to stop this", we can stop it with pill testing.

Bernie Dwyer – CEO Team HEALTH: I agree with that.

Peter Burnheim - NT PHN: I think, with the pill testing especially, we probably need to be a bit more broad minded than the current narrative around festival based testing. The NT is not a particularly large festival place to work in. We need to think about how that can be implemented in a more structured way. The other element with the pill testing at festivals, is you wait until people are there ready to take the drugs and it is a very limited timeframe to have any impact on influencing them around drug education or doing some change management with their mindset around taking drugs.

If we are going to look at pill testing, I think it needs to be looked at in a broader context and it needs to be built in with some structures where there is opportunities for consistent pill testing or drug checking, and it needs to be able to be fed back to the wider community quite effectively. So you might have something like a place where you can drop off a sample and then it gets published on a website or something later on that you can refer to, I think would be more effective than setting up a pill testing station.

CHAIR Mr Jeff Collins: Just commenting on that, what I understand about the Canberra trial back in March was, the benefit of having it at the music festival is that you do have a lot of people going there who are likely to be taking the pills. You have people there who are selling the pills, as well as these altered pills. You have medically trained staff who are able to provide information to the person with the pill. One of the benefits for supply reduction was that the people who had their pills tested, actually provided information to the police about who was supplying the pills. You wouldn't have got that in another circumstance and that was a real bonus for the ACT Police in being able to chase up traffickers.

So we are looking at inviting both Mick Palmer and Matt Noffs from the Ted Noffs Foundation to come and give some evidence when we have our public hearings. I think we are looking at the 14th December, so if you interested in coming along and listening then yes.

Peter Burnheim - NT PHN: I can certainly still do the festival based testing. I remember pushing about 9 or 10 years ago to try to get any sort of harm reduction into Bass in the Grass and getting flatly refused by Paul Henderson's government.

Jenny Jenkins - Remote AOD Workforce: We weren't even allowed to give away free water!

Peter Burnheim - NT PHN: Well I was working in sexual health at the time, and we were not allowed to give out any sexual health education, and I remember him making a comment; "I don't want my daughter coming home from a music festival with a condom". Well, how about an STI or an unwanted pregnancy!

So I think it's amazing that we are actually having these conversations now.

CHAIR Mr Jeff Collins: Well hopeful the worm has turned and my feeling is that attitudes are on the change at the moment, apart from the NSW premier.

Peter Burnheim - NT PHN: I think there is a great quote from sex education or reproductive health education, "If you think education is dangerous, try ignorance" and it applies just as well to alcohol and other drugs.

CHAIR Mr Jeff Collins: Absolutely. I have said that in a number of interviews. I am a supporter of pill testing, an unashamed supporter of pill testing. As I said yesterday, my music festival days are behind me but I do have an 11 and a 13 year old daughter and they are about to enter into that period of their lives and I absolutely agree that education is power and my message to them will be not to take pills but they are not necessarily going to listen to me, that is just the experience that we have…

Nicola Coalter - Amity: Jeff, they are going to have sex as well!

CHAIR Mr Jeff Collins: I have resigned myself to that fact, just have a condom, that's much better.

Matthew Stevens – Menzies School of Health Research: This is a growing phenomenon. It is found to be successful and people are more likely to seek out information and help if they know they are not going to be punished. It's crazy that we are punishing people for personal use. 90% of people use these things perfectly safely. Alcohol is same, we get the same percentages across drugs, so it is not like we are dealing with… There were two people that died, out of 50 000 people going to a festival! Two people die every night from alcohol related causes or accidents. So I think you have got to give a little bit of perspective looking at the full blanket personal decriminalisation would be a real good step in the right direction. We have now got five or six countries that fully legalised cannabis use. Over half the population of America can access legal/recreational cannabis use, yet here we had a case just up in Alyangula or Groote Eylandt recently, and the police were getting pummelled by the community residents with rocks because they busted this guy with 25g of ganja, which is below the decriminalised limit up here, we are a 40g limit here. Obviously this person had it all bagged up, so he is a dealer. I mean this is just ridiculous! They have got five police there, three sniffer dogs to bust someone with 25g of pot.

Peter Burnheim - NT PHN: I reckon it's almost backwards where, we are arguing for why we should change to support the evidence based sensible approach to this. I think put the actual ownership back on parliamentarians to argue why we should maintain the status quo that has not worked for 40 years and continues to put all of our residents at harm.

Matthew Stevens – Menzies School of Health Research: And the decriminalised thing, it is very inconsistently applied up in the Territory I think. What happens if you have got a house with 20 people and everyone wants to grow two plants? You have got 80 plants in the backyard! There is nothing saying they couldn't do that, but really, would they be allowed under our legislation?

CHAIR Mr Jeff Collins: It is very difficult. The Northern Territory approach to marijuana and the decriminalisation is not applied as you said. It is only to circumstances where you are caught with it in private not public, so if you are caught with minimum limit in a public place, well it is still a criminal offence and the reality is that 99% people are going to be picked up in a public place, not in a private place.

Peter Burnheim - NT PHN: They have to get it to the private place somehow.

Jenny Jenkins - Remote AOD Workforce: I agree with what you said. That is not the whole story though, are there any police in this room? Any policeman in any community in the NT will tell you, when there is no ganja in town, they have trouble, domestic violence goes up, BSA goes up, all the dangerous risk taking we have go up. If there is a level of ganja in town, everything is fine.

Natalie Sarsfield - Catholic Care: Makes sense.

Jenny Jenkins - Remote AOD Workforce: And if you want to know the rest of that story, the police have had the dogs out there to bust the white people for the amphetamine use. That is going on, and they have got a fair amount of it, it just so happened to dry up all the town's ganja but they were fine the next day. Because after rioting, and I know this because I have got workers and people out there, they took the rioting to an area where the police

would attend and they flew a plane load in and they find it the next day. Not a plane load of amphetamines, a plane load of ganja!

Nicola Coalter - Amity: So it just demonstrates how resourceful we are to get what our needs are, and if we think about addictive behaviours at Amity, we kind of believe it is just really an overuse of a coping mechanism. So the Territory has lots of vulnerable populations. We have got a long history of alcohol. I think in the Reilly review, we quoted the Hansard from 1915 where they were talking about our alcohol use. So I think if we looked at a harms model, and I believe New Zealand have attempted to, and we put the substances along the harms, what we would see is we would need quick action around alcohol and tobacco, the most harmful substances and easily and readily available.

In all the others, the harms kind of taper away in the scheme of things. Scientific evidence is not saying that drug use is safe. In saying that again, if we have harm reduction at the heart of the policy and remember that this is about families, not just individuals, because we don't stand alone in our society as individuals. Then we are probably going to be able to test effectiveness around our policies, around our interventions and around people's challenge.

Matthew Stevens – Menzies School of Health Research: There are certainly the flow-on effects of being criminalised too, it's not just the stigma that comes with it in the future, every job you apply for.

CHAIR Mr Jeff Collins: For most of the personal drug use or offences, you don't end up with a custodial sentence but it does effect everybody's future, as you said. It stigmatises them and marginalises them. It will cost them $5k if they want to get a decent lawyer.

Matthew Stevens – Menzies School of Health Research: Yes.

Nicola Coalter – Amity: Jeff, on that, shame and stigma that will actually continue to put up barriers for people seeking treatment. So there is lots of evidence now, that with common community perceptions are labelling addicts, druggies, problem people, we have even heard our government call them problem drinkers. These are not problem people, these are people who have problems and they are only using coping mechanisms to manage their lives.

CHAIR Mr Jeff Collins: One of the comments that the architect of the Portuguese decriminalisation has said, one of the main issues that has come from the decriminalisation is the fact that users and abusers of illicit drugs are now more likely to come forward and seek treatment because they know that they are not going to be criminalised. So it opens the pathway.

Paul Tolliday: In the same time, the use has also increased in Portugal as much as well…

CHAIR Mr Jeff Collins: Very marginally, that's actually not true.

Paul Tolliday: The usage rate in Portugal.

CHAIR Mr Jeff Collins: Last year when I was there, it was up about 4% on 2001, but over that 17 year period it had sort of gone up and down a little bit, roughly stayed the same. But what the benefit of the system is, is that you now have three times as many people presenting for treatment, so they are coming forward and seeking the treatment that they need, that is the benefit of it.

Nicola Coalter – Amity: I think one of the key outcomes is people are experiencing less harm, so that is one of the key outcomes. They are more likely to seek education, they are more likely to seek treatment and they are experiencing less harm.

CHAIR Mr Jeff Collins: Any other areas somebody would like to touch on?

Paul KIRBY: I am the Member for Port Darwin, so we are close in with Jeff on this, and understand your points and view around there should be perhaps a reverse onus in these sorts of situations. I can guarantee of Jeff having butted in his head against a pretty solid brick wall at a time when the Reilly report is coming out, and there is a lot of focus around the abuse of alcohol through the Northern Territory, which is a massive problem for use. He has had to be extremely brave to get this off the ground and I really do appreciate everybody coming here and being very open and honest with us because it will help us to destigmatise and encourage some different thought patterns.

Most people, most families have had people that they know, there have been politicians in the previous establishment that have spoken about their own families. It touches everybody. But are there states and jurisdictions locally that understand the proactive treatment or the proactive approach that we are discussing today?

A bit further down the track, the reactive and the treatments and things like that, are there states and jurisdictions that are just doing it much, much better than us? Is it because they are better funded, are there better ways that we can be doing some of those short term measures that you experts know of?

Natalie Sarsfield- Catholic Care: I think in every state there are elements of prevention and early intervention, and minimisations that are working. I don't think as a country we have got it all together but I think that somewhat comes downs to not having a national resource tool for this stuff, so what is working, let's share it.

For me, I have worked in four states in this country now, so I pull a bit of experience from what research I have picked up there or what was happening, but if you are just sitting in one place, you wouldn't know where to start.

So I would always encourage that we look at Australian evidence based practices when we are looking at what we want to implement in the city, obviously taking into account the difference between regional, remote and urban. But there are things that are working but I don't think any one state has got all of it together.

Peter Burnheim - NT PHN: I think we are talking about rehabilitations. It is not that we do rehabilitation particularly badly. I think where the changes really need to happen is the parameters of alcohol and drug management that we are talking about. If we continue to work within the parameters of the drug war and that is the only area that we are going to consider our change within, we are not going to change anything. We need a drug revolution, we don't just need to change a few little tweaks here and there. We need to change the way we think about and manage alcohol and drugs in the country in general, and take harm reduction as a lead.

Georgie Mumford – Fong Lim Electorate Office: Yes, I think you are right but we need to do harm reduction properly. Now a harm reduction strategy back a few years ago is still a

strategy, now I see it all the time, is sniffer dogs. Sniffer dogs, it scares the shit out of you! I mean if you have got something on you, it scares you.

Peter Burnheim - NT PHN: That's a harm minimisation decision.

Georgie Mumford – Fong Lim Electorate Office: No it's not!

Peter Burnheim - NT PHN: It's a supply reduction strategy.

Georgie Mumford – Fong Lim Electorate Office: Yes, to an extent.

CHAIR Mr Jeff Collins: What we were talking about before, is those three areas, so supply reduction is one of them but some people argue that that is not harm reduction, but you have an example of how it wasn't harm reduction.

Georgie Mumford – Fong Lim Electorate Office: Yes, well my best friend that I went to school with, it was Stereosonic 2014 and he went with about 10 pills in his pocket and basically saw a dog, and instead of throwing them away, he took them and he died. And if there had been a pill testing booth or something there, maybe that wouldn't have happened and he would still be here with us today and I do see the effects of his family every day and it is a tough thing.

CHAIR Mr Jeff Collins: Yes. Thanks.

Nicola Coalter – Amity: Because supply reduction without the other two arms Georgia is not going to help us.

CHAIR Mr Jeff Collins: Yes, that is what's going to happen.

Nicola Coalter – Amity: We know the evidence out there is that the majority of the money in this country and the drug war goes to supply reduction. Professor Nicole Lee said that for every dollar spent on treatment, we will get a return on our investment but for every $7 spent on policing, we are only getting a $1 return.

I think Johann Hari is a leading expert across the world and has certainly been recognised over the last few years in his work in addiction and treatment, and he is talking about how disconnected people are, and how disconnected communities are, and that is why we are reaching out for these behaviours. These behaviours extend beyond alcohol, drugs, tobacco, they go to gambling, they go to eating, they go to pornography. People could also kind of extend that across to shopping and anything else. Drinking and drug driving is another behaviour. So there are lots of spectrum here we haven't even touched on. Eating disorder and how that impacts on people in the community, and if there is even treatment out there and it is a well known addictive behaviour.

Matthew Stevens – Menzies School of Health Research: And I guess related to that, is the protective factor of being connected and feeling community connected and certainly why in so many settings, you need the whole community approach which involves getting different family groups.

CHAIR Mr Jeff Collins: And the supporting groups is just the start of that?

Natalie Sarsfield - Catholic Care: And that means investing in something that doesn't necessarily scream out 'drug and alcohol service', it's the men's group, it's the wellbeing group, the culture group. They're hard to evaluate, in that the changes are often insightful first for a long period of time before you can track a long term behavioural change, so they are not necessarily refunded, but having insight into bad behaviour and wanting to change it is huge, and that grows. So when we look at treatment, I think yes, it needs to be beyond counselling, residential rehabilitation and withdrawal. It needs to be tapping into that connection space, tapping into culture. It needs to really be, because people don't become dependent when they are happy. It is about that connection. It's about coping mechanisms, so we need to make people well first.

Rikki Fischer - FORWAARD - Aboriginal Corporation: Even within drug and alcohol treatment services you spend very little time actually talking about drugs and alcohol, it all about finding hope and making a connection with community.

CHAIR Mr Jeff Collins: I think that is a fairly common theme from some of the submissions that we have been getting.

Belinda Davis: My name is Belinda Davis and I'm not with any organisation.

CHAIR Mr Jeff Collins: That's okay, thanks Belinda.

Belinda Davis: About safe injecting rooms, I know we don't have a lot of injecting up here but it is becoming bigger and more of a concern we are talking about the police out in whatever community, doing whatever for whomever, but it's not just non-Indigenous population, it's also the Indigenous population.

CHAIR Mr Jeff Collins: Can I just say we have received about 29 submissions so far I think. We still have about five outstanding but that is fairly common thing as well. So medically supervised injecting centres is something that has had a consistent positive feedback from the submissions, so it's certainly something we would be looking at. As you said we don't have a Kings Cross or a Richmond…

Belinda Davis: But we do have shooting galleries here.

CHAIR Mr Jeff Collins: But we do, that's right. As I said, in spite of that, we have a smaller problem, it's still a problem and people should be able to do that safely, so if we can protect those people, then that's what it's all about. It is something that we will certainly be looking at.

Natalie Sarsfield - Catholic Care: I think needle exchange has come up in a fair few from who I have spoken to in the industry. So not just having a safe place to use injecting drugs, but also better access to clean needles so there is not infection, then absolutely.

Belinda Davis: So it is not needle exchange, it is actually…

CHAIR Mr Jeff Collins: Supply.

Belinda Davis: … that is the old terminology we used to have to exchange needles.

Natalie Sarsfield - Catholic Care: Oh yes.

CHAIR Mr Jeff Collins: So the Needle and Syringe Program. The Department of Health has provided some information on what we currently provide but yes I agree, we need to expand it, we need to be able to provide it to people who need access to that program.

Peter Burnheim - NT PHN: The other thing to recognise with needle and syringe programs and the pill testing or checking, is they provide an amazing opportunity to have intervention with someone. They give you access to people who you are not going to see otherwise, all these people aren't going to present to their GP and say "I've got a drug addiction problem, I am injecting drugs". It's an opportunity, especially for the young people. The pill testing, one of the prime reasons you do it, is because you have that opportunity for intervention and education.

Sandra NELSON (teleconference): It's the first step towards mitigating that harm isn't it? You know, when you do the pill testing and provide safe injecting rooms?

All questions about harm reduction, it's a creation of public health institutions or government institutions with traditional systems in the way that we address the consumption of drugs, I guess. The implication of that means that we are going to have to come up with new policies and new legislation and regulating drugs and where do you start? That is my question to you guys, where would we start? Do we start with harm reduction legislation or do we start with legalising drugs?

Matthew Stevens – Menzies School of Health Research: Decriminalise personal use for all drugs.

Nicola Coalter – Amity: I don't think we need to start all by ourselves as Matt has acknowledged, and as many of us around the room already know, there are many other places around the world who are doing this as well, who are doing it effectively.

And you know, realistically Australia was a world leader in harm reduction in the 80s. There is no reason why we can't be again, and this is a great opportunity for the Territory to implement legislation, of course if it doesn't get overturned. Because we are not big enough to do that by ourselves. And then actually have evaluation all along and alongside it as a parallel process to test and define it's being effective and if it's actually reducing harm or if there is unintended consequences.

Sandra NELSON (teleconference): Yes.

I have got tell you guys that for me, when we are talking about legislation and laws and all of that stuff in regards to drugs and criminalisation, one of the first things I always ask is "where is the harm reduction component coming into this?" Harm reduction is, as a drug policy, as it alludes to the policies and practices, it limits the negative social and public health consequences for drug users, their families and society as a whole. It is not actually being tentative to end drug use altogether. It's about harm reduction. We are acknowledging that people are users of whatever drug they choose to use but we are not going to try and end it we are just…

CHAIR Mr Jeff Collins: That's the pragmatic approach from the Portuguese model as well, Sandra?

Sandra NELSON (teleconference): Exactly, that is exactly right and you know that is what I am all about Jeff.

Peter Burnheim - NT PHN: We need to deal with the reality rather than the moralistic idealism, that would probably be a better way to go about things.

Nicola Coalter – Amity: That's a really good point Pete, because I think what happens in our community is we all take a moral stance because we are not informed by evidence and what we need in our legislation, what we need in our policies, is evidence. And on a note that you said before, I almost got the sense that there is a perception that the Territory does drug and alcohol badly. We don't. We do it really well, there is lots of evidence, sometimes the implementation is a bit of a challenge for us because we have very unique jurisdiction, but I think there is a lot of evidence around the Territory that says we do it really well.

Peter Burnheim - NT PHN: We just have larger scale problems to deal with, to begin with.

CHAIR Mr Jeff Collins: And some more money and large distances and all of those things.

Jenny Jenkins - Remote AOD Workforce: I came here and said I wasn't going to talk just on the harming, and one thing that is sadly lacking, and I am going to bring it up in this because it is a result of all sorts of addictions is, safe houses for men in communities. Every single community we go to asks for it. We have women safe houses, women aren't always the victim, quite commonly men are the victim and I have actually heard lots and lots of stories of; "if I had a safe place to go when we were arguing, I wouldn't have hit her". Now you have got to take away the judgement but it's true. In Aboriginal communities, I go to every community safety meeting and it comes up and everyone says there is no money for a men's safe house. We have these things for women, and if we want to talk about harm minimisation and keeping our children and our families safe and strong, we need to be really equal. Domestic violence isn't just about women, it is just as much about men. I have witnessed it, I have seen it. We need to keep our communities safe and strong and every community I go to asks for that. It's a big thing.

Belinda Davis: We have had men safe houses in a number of communities over the years and most of them, not all of them, there is one community that I know that still holds it, but most of them have fallen into disrepair due to a variety of different things.

Jenny Jenkins - Remote AOD Workforce: Is that because of lack of funding?

Belinda Davis: I don't know but I think that sometimes we have got to look at what is there, and not necessarily about the dollars that go with things, because sometimes you can find the dollars that go with things within places. I think money is important, don't get me wrong. I do actually believe that men's safe houses are very important. I think that it should be equality.

Jenny Jenkins - Remote AOD Workforce: I have communities that have got much higher suicides rates going up and it all relates back to alcohol, drugs, domestic violence. So we need to make our communities safer and it's not about money. I have got one community in mind that there are no physical buildings in that community that could possibly be used. They want to do it, the community want to do it, the Aboriginal Corporation want to do it, but there is nothing. So it all goes hand in hand. We talk about your three pillars; harm reduction enhanced by harm in…None of that money ever goes to that. At the moment, I have been up

here six years soon, it is not going now and just as many men have problems as well and it's more again I get back to the families and the communities keeping those people strong, so that their children could grow up strong.

Belinda Davis: I think a lot of the men are dumped in the big house.

Jenny Jenkins - Remote AOD Workforce: Which is not effective.

Belinda Davis: No, it's not perfect. All the stuff that you are talking about splits up the families, it is true, but we take the men away mainly, not necessarily the women. I mean we do but I can't just say that.

Paul Tolliday: Jambi, perhaps it's a place that you can talk, I don't know or some Indigenous people that are in there, it would be for us to hear from the Indigenous people about all of this that I hope, that as you go to Tennant Creek, the main trap down the road, but there is a lot of other voices. I know in the submission I put in, I sat and talked to a number of elders from East Arnhem Land and put some of their thoughts down in my words but part of our uniqueness is that we can actually fashion something that is going to be culturally appropriate and men are culturally appropriateness sort of thing as well. And I think there is a lot that we can learn, if we can find those places where we can link together.

CHAIR Mr Jeff Collins: Absolutely and I think we, just speaking on behalf of the Committee, we understand that. We are heading to Nhulunbuy and to the Tiwis. It is a bit difficult to get to all of the remote communities, but whatever plan we come up with, that isn't culturally sensitive, then it is not going to work. So we can't build treatment facilities in all of the remote communities, we have to find a way, and I think, as Nicola and some of the others have said, it's about connections. This is my gut feeling and we want to expand on this, but how we get those communities working and how we get that connection going back in those communities also.

Natalie Sarsfield - Catholic Care: I think also, while you are over there, there is a lot of that going on. There is a lot of real key leadership in communities, and there is a lot of really great alcohol management groups and local drug action groups and things like that, that are already established and I think when you're looking deeper into it they are really key. Making sure that you are going to the right people, the elders. I think because there are problems in community, it is easy to assume that it is dysfunctional but it's not. It's like anywhere else in the country, there are issues and there are strengths. I mean, Tiwi Islands is the perfect example of where there is so much strength in there and there is a lot of commitment to making changes and getting things done, but there are also problems. You know what I mean? Because I think it is really important to really look at what is going on here in the Northern Territory, because there is amazing work happening across the Territory.

CHAIR Mr Jeff Collins: We certainly can't afford to reinvent the wheel as well.

Natalie Sarsfield - Catholic Care: And there is no point, because there are things that are working and have worked, and it may have been defunded but was fantastic, and that is where it is really worth talking to people who have been in the committee forever. Historical stuff doesn't necessarily mean it didn't work. Change of government constantly, things get defunded whether they were successful or not.

Matthew Stevens – Menzies School of Health Research: Probably a bit old tune you mentioned about these alcohol reference groups and committees. I worked on a project, actually with Jennifer a few years back, and it was about developing a place based framework for monitoring and evaluating alcohol management plans and mostly community based. Government never released this report, never gave back data reports to the alcohol reference groups and community members who I had been telling them for two years I was going to bring it back and tell them, so it was very shameful for me.

The report was referred to a legislative review but this is the sort of thing that these alcohol reference groups have been crying out for for years but they were so happy when I gave them back a little bit of admin data. So we pooled together like police offences, assaults, alcohol related assaults, domestic violence related assaults, percentage female. We pooled education, attendance, enrolment. They had hospitalisations for alcohol related conditions, emergency department presentations. It was a very full mix of information. We put NAPLAN results and things like that in there as well, and what we actually found is a lot of people say "the data is not good enough", but that is not true.

These hospitalisations went up at exactly the same as assaults go up. We even had wholesale alcohol data, and you see a massive drop in that when they suddenly said "no you have not got your licence" or something like that, and assaults just dropped.

So this information is there and it is empowering communities I think, to provide it to them and to these groups. There are issues around, like it leaking and shaming, so basically every community got their profile and it would have an NT rate along with everything. So communities want to know whether they're above the average or below the average and we keep saying "no they don't" and they all ask for it, they want to know. So if they are at the bottom, they want to know that they need to work harder to not be there. So that is a way you can empower some of these community groups and give them a sense of ownership. So that comes back to that community level stuff as well.

CHAIR Mr Jeff Collins: Try and track that down?

Matthew Stevens – Menzies School of Health Research: I can send it to you

CHAIR Mr Jeff Collins: Send it to me please.

Matthew Stevens – Menzies School of Health Research: I've been sending it to people don't worry.

CHAIR Mr Jeff Collins: Send it to me. Anyone else? Anything?

Nicola Coalter – Amity: So I was just thinking back to the flyer that was advertising this and it has got something treatment and I think the Territory needs a genuine and long term investment into trauma informed care. It's a specialised skill set. There is lots of evidence that shows that if we are just dabbling in this area, that we are traumatising people. Given the nature of the Territory, and it's not just Aboriginal and Torres Strait Islander people, we have got fly-in fly-out, we have got defence people. We have a history of trauma and I don't think we have really unpacked that and I don't think we work with it very well. We know the evidence of alcohol and drugs generally is that is someone is having significant problems with their drug and alcohol behaviours and choices, and as an adult they've usually experienced childhood trauma. So there is strong evidence out there, and I think drug and

alcohol try their very best to build our capacity but again, I think we need a genuine investment across the whole of the Territory, and not just the drug and alcohol workforce. I think we are talking about a whole workforce to able to understand working this space.

Sandra NELSON (teleconference): I think we are failing miserably on the trauma informed anything, to be honest. I mean people are addicted to alcohol and they are addicted to drugs and other things because there is something there and they are seeking either comfort or solids or whatever. They are using something externally to forget about a trauma or a problem, and I don't think we do that very well addressing the past traumas, especially when it comes down to Indigenous population.

Jenny Jenkins - Remote AOD Workforce: So a lot went into that recently Sandra, by not only AMSANT, but Remote AOD and it is something that we are looking at rolling out.

Sandra NELSON (teleconference): Yes. There would certainly be a bit of focus here in Katherine in regards to trauma informed counselling and different strategies, and there are a lot more organisations in Katherine that are doing training and opening themselves up to that sort of training and gaining that insight, which is great to see, but it in the greater scheme of things, it is pretty minimal. Again, you know when we are talking about harm reduction strategies, I totally agree with you. We need to be looking at that sort of thing as well that needs to be part of the discussion, it needs to be part of the strategy.

Peter Burnheim - NT PHN: Yes, I think the move in health towards the social and emotional wellbeing structures in Indigenous communities is a really positive one. I think it would be great to see NT Health get more on board with funding towards models that support the social and emotional wellbeing structure and concept. The PHN has rolled out funding through our Indigenous Mental Health and AOD stream from the Department of Health. They are all part of the Health, Mental and Social Wellbeing which has come out of formation from the Aboriginal Health Forum, and I think it is really important that we see NT Health get on board with that model being rolled out and a lot more support given to the structure and embracing practice frameworks that support that. Because if you want to see some real changes in health in the Indigenous sector, we need to start working in models that are supported and developed by Indigenous people.

Matthew Stevens – Menzies School of Health Research: I am not sure whether Nicola wants to comment on this but I will start anyway. I wonder if it should be AODG workers.

Nicola Coalter – Amity: Thanks Matt.

Matthew Stevens – Menzies School of Health Research: Because the research we are doing in communities, it is showing the people who gamble more frequently have worse Kessler five distress and things like that. So I think, from harms arising, we found 60% of people are being harmed by other people's gambling, we are talking about kids missing out on school, people running out of money for food, having verbal and physical violence towards them. So it is up there at the same level with these AOD things. So the NT could be leaders in this space. Gambling is one of these things that sits at the bottom you know, "He was drunk and he hit me and he hit me because I ran out of money from gambling" or whatever, you know. We don't often dig down to that bit of it, so I would like to try at some point get Health to take it seriously. I mean I have been working in this space for quite a few years at Menzies, and yes, I used to get laughed at basically "Oh it's not a health problem, it's gambling". And we know it is a health problem, both physical and psychological.

Nicola Coalter – Amity: It is Matt, and it extends beyond card playing and remote Indigenous people in our community, it extends across everything. We can think of front page news stories of high prominent people with NTG fraud and that, so absolutely. The evidence supports the way that we work with addictions, or habits as we like to call them at Amity, for drug and alcohol and gambling. Makes sense to include that, working with that with people is the same process. In relation to a model of working with gambling in remote with Aboriginal and Torres Strait Islanders, with people across the Territory, we have a public health framework and the Ottawa Charter that is currently halfway through the project. It's a pilot project, Matthew Stevens is one of the evaluators of it, and the Australian National University. So we think it is really interesting that when we invest with our money in the Territory for these things, that we actually complete them, release the reports and then use that as our own evidence to continue to build. All too often we do these things in the Territory and reports end up on shelves, so pilot projects get in.

Jenny Jenkins - Remote AOD Workforce: I agree with you 100% because I am out there every day of the week, but I am not Health, I just sit there. We are actually Commonwealth funded for AOD. So our program is we, myself as a nurse, I train Aboriginal people in their own communities to look after their own people and I oversee that model. So we are just funded for AOD. We have got funding for another four years. It was a 15 year project, we probably will get refunded but it doesn't exclude we touch on gambling in our models. Where we have a PHN psychologist, they do a lot of work, like I know our psychologist down at the Tiwi Islands is doing a lot of work around that too. So there are those positions in some of the bigger ones, I think they go hand in hand.

CHAIR Mr Jeff Collins: Can I just assure you that this Committee has been set up as a harm reduction strategy, bearing that in mind it sort of came about from a trip that I did to Portugal last year to look at their decriminalisation law. That started with their *National Drug Strategy on Drug Addiction.* In 2012, they changed that to their *Addictive Behaviours Strategy* because after 11 and 12 years of sending people through to their treatment facilities, they realised what Nicola was saying, that the treatments are very similar and so they have expanded their strategy over there to include gambling, pornography, online gaming and all those sorts of areas. So they recognise that those behaviours are harmful to individuals to families and to communities.

So the concept behind setting up this particular select committee was to bear that in mind from the beginning.

Kerri Boswell - Somerville Community Services: Just as a little bit of a spinoff in terms of the current government has been good with five year funding agreements and moving in that space which is great. Talking from personal experience, I have seen services that used to perform in the early intervention space, where anyone from the street can come to your service and get counselling, has been changed in the funding space with changes of government to go to the crisis end and take all that funding that used to be open to anyone and restrict it into a space of saying 'child protection' for example. So you have got what used to see anyone walk in through the door, you could reach them before then getting into that high end space. So let's say there was an organisation, three general counsellors that is no longer there, it is now the high end of crisis, preventing children from being removed. I just wonder how much of that is happening in the funding space, just a thought.

CHAIR Mr Jeff Collins: We might decide if we can make that inquiry.

Kerri Boswell - Somerville Community Services: Yes. This government is pro early intervention and prevention, which is what we are hearing all over the show and that is great. But I think when we look at funding programs and organisations, I have certainly seen that happen.

Leon Gailitis: Just a final comment on decriminalisation discussion. I think it is really refreshing to see Australian politicians talking about decriminalisation. It is something that hasn't happened all that often around Australia.

CHAIR Mr Jeff Collins: No.

Leon Gailitis: I have always thought that the real criminal act, is that we continue to lock people up for what is essentially a health and wellbeing issue. That is great to hear.

CHAIR Mr Jeff Collins: Yes look, it has been a position I have had for a long time, so I am grateful for the opportunity to bring it forward in this forum. There are other people around though. Victoria has done a committee and provided a report. Daniel Andrews, the current Premier down there, has indicated he is in favour of moving towards a minimisation approach as well, so there are people around. As I have said before, the worm has turned, and I think that there is momentum behind a change in approach, and it's a growing momentum.

Well I think that is about our time.

The committee concluded
