LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

13th Assembly

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

Public Hearing Transcript

12.30 – 4.15 pm, Monday, 10 December 2018

Wurli-Wurlinjang Board Room, Community Services Building, 9 Second Street, Katherine

Members:
Mr Jeff Collins MLA, Member for Fong Lim
Mr Paul Kirby MLA, Member for Port Darwin
Ms Sandra Nelson, Member for Katherine
Mr Gary Higgins, Member for Daly

Witnesses:
Darrell Brock - Wurli-Wurlinjang Aboriginal Health Service
Elijah Sherman - Wurli-Wurlinjang Aboriginal Health Service
Michael Taylor - Wurli-Wurlinjang Aboriginal Health Service
Eric Thomas - Wurli-Wurlinjang Aboriginal Health Service
Sid Moore - Wurli-Wurlinjang Aboriginal Health Service
Gardner Shaw-Francis - Wurli-Wurlinjang Aboriginal Health Service
Bridget Hutchinson - Wurli-Wurlinjang Aboriginal Health Service
Catherine McArthur - Sunrise Health Service
Dr Louise Harwood - Top End Health Service
Jane Hair - Top End Health Service
Paul Gibbs - Top End Health Service
Jacqueline Rimington - Katherine Women's Information and Legal Service
Mary-Anne Philip - Katherine Women's Information and Legal Service
Harley Dannatt - Katherine Doorways Hub
Casey Bishop - Venndale Rehabilitation and Withdrawal Centre

The committee commenced at 12.40 pm.

Wurli-Wurlinjang Aboriginal Health Service

Mr CHAIR: Welcome. I am Jeff Collins, I am the Member for Fong Lim and the Chair of the Select Committee. We have Gary Higgins, the Member for Daly and the Opposition Leader; Paul Kirby, Member for Port Darwin and Sandra Nelson will be along shortly.

On behalf of the committee, I welcome everybody here to the public hearing of the select committee into harm reduction strategies for addictive behaviours. I welcome Darrell Brock, Elijah Sherman, Michael Taylor, Eric Thomas, Sid Moore, Gardner Shaw-Francis and Bridget Hutchinson to the table to give evidence to the committee. Thanks for coming in and meeting with us. 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 applies. This is a public hearing that is being recorded. A transcript will be made available for use by the committee and it may be put on the committee's website.

If at any time, 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. Can you each state your name and the capacity in which you are appearing?

Mr THOMAS: Eric Thomas, Strongbala Justice Program Coordinator, Wurli-Wurlinjang Health Service.

Mr BROCK: Darrell Brock, Executive Director, Community Services, Wurli-Wurlinjang Health Service.

Mr SHERMAN: Eli Sherman, Team Leader for KISP, Katherine Individual Support Program for Wurli-Wurlinjang Health Service.

Ms SHAW-FRANCIS: Gardner Shaw-Francis, Counsellor at Wurli-Wurlinjang Health Service.

Mr TAYLOR: Michael Taylor, Case Worker in AOD.

Mr MOORE: Sid Moore, Counsellor with a specialty in Mental Health and AOD.

Ms HUTCHINSON: Bridget Hutchinson, I'm a Registered Nurse for Wurli-Wurlinjang Family Partnership Program.

Mr CHAIR: We have had some problems with our recordings in the past. We have a couple of microphones in front of you but if you could speak up, that is all we can ask so we can actually get your evidence on the recording.

Thank you everybody for coming. This is a great team. Mr Brock, would you like to make an opening statement.

Mr BROCK: Yes, thank you. I would like to acknowledge the Traditional Owners of this land that we meet on today. I would like to pay my respects to elders past, present and emerging.

Introduction to Wurli really; it is a well-established ACCHO, Aboriginal controlled health service. It has been around now for nearly 38 years. We have a quiet population that we see of about 11 000 which consists of 7500 clients. We have a substantial number of visitors coming to Katherine as well, so a total of 11 000.

We service Katherine and surrounding communities. We are governed by a board of sixteen directors and we have been around for 38 years now with a staff of about 100 currently employed. We deliver a comprehensive and complex health service. We address primary health care needs for the clients we meet and that works across the clinical component, which is the main clinic over at First Street, but also in the new building for community services where we deliver the mental health programs.

We have a very strong skill mix here and I will introduce you to a couple of them. We have the AOD program. These are all small teams but they have education information sessions, talk about FASD as well, AOD counselling as well. Sid has a new role as a specialist counsellor dealing with the mandated clients that are coming through the system as well.

Eric runs the Strongbala Justice program which deals with the clients that we are trying to get out of the justice system. They come into a 13-week professional development program. That is aligned to having a better way to deliver their lifestyle. They are mandated through the Magistrate to come into this program. We have had some really good outcomes from some of the clients that have come through that program.

One of the new programs, which is quite unique other than Strongbala—is the KISP program. It is a new program, the Katherine Individual Support Program. That is addressing the needs of the homeless clients that we have identified here in Katherine.

The initial focus was those who had presented to the Katherine District Hospital more than six times per annum. Some of those were presenting seventy-two to seventy-six times per annum for general ailments and things that were not relevant but they kept presenting. One of the things they wanted to focus on was trying to see what was going on with those clients and see what we could do with them. I will let Eli talk more about that after.

We also run SEWB, Social and Emotional Wellbeing, that is what Gardner is involved in. We have a team of counsellors in that, we have a dual diagnosis counsellor, a psychologist. We are dealing with mental health counselling in that program.

We have AOD, which Michael heads up and an apology from Philip Butler today, he heads up that program as Coordinator. We have Sid Moore, who is a specialist counsellor who has been brought in on the COMMIT funding program and is addressing those clients that have been mandated through corrections.

We have a comprehensive skill mix in the community services area. We have grown from 11 staff this time last year to up to nearly 30 now. With that skill mix, our approach not just for community services but for Wurli to have an integrated approach. We have a skill mix that can look at that client holistically. They come into Wurli, we assess them and see what their client journey is going to be like and how we are going to deal with them.

You can have a number of programs dealing with specific issues but when you get everyone together working and seeing that client as multiple-need... that is our mission at the moment which we are well on-track to meet.

Mr CHAIR: Thank you for that. As you can see, Sandra has joined us. I believe most of you know Sandra.

We have a number of questions that we will ask but it tends to lead us onto different paths so feel free to add anything or go in any direction you like. I will kick off with the first one we have here and see where we go from there.

Ms NELSON: Before you go onto the first question, I actually wanted to get a quick brief from Elijah on KISP for the benefit of everybody else on the panel. What they do is really relevant to this first question and will give us a broad understanding of the wrap-around services. Elijah, do you mind—just introduce yourself for Hansard and your role.

Mr SHERMAN: Eli Sherman, I am the Team Leader for KISP. It kicked off end of November 2017 and was fully running January 2018. At present we have 100 clients. We link those individuals who suffer from chronic disease and/or homelessness to the services that they require to assist them. That can range anywhere from payment types to emergency accommodation to shelter permanently or just respite, food, security and things like that.

We are even branching off into environmental health now, so cleaning their properties and homes. We have pulled some pretty great stats of late with the engagement. (Inaudible) reduction in presentations to ED and also the influx of presentations to Wurli which has been good. What else do you want to know about that, Sandra?

Ms NELSON: How do you support the people that are presenting themselves that have addiction to alcohol and other drugs? What support mechanisms do you have?

Mr SHERMAN: Because I work in community services, we have those direct services available at hand. We are not silos here at Wurli in community services; we are all linked. I deal directly with Michael and/or Philip and we will make the first contact, take the initial assessment, see what benefits we can possibly meet and relay that information onto the other case managers to work directly with that person.

We do not just leave that person. We also assist with anything else that we can help with and refer onto other services.

Ms NELSON: So that is the whole ethos behind KISP, is it not? It is not just looking at one issue, it is a holistic approach to all of it. What challenges have you guys faced in Katherine when you are supporting clients that have addiction to alcohol or other drugs? Not just within the Wurli context but overall.

Mr SHERMAN: It is hard to just identify one problem because there is not just one problem. There is a multitude of problems. I feel education is a large one. Personally, I feel having that lifestyle for so long and not knowing that there are better avenues and not knowing that there is actually support there. That brings it back down to education. Providing that service, which I feel is paramount to these people.

Ms SHAW-FRANCIS: I have KISP clients too and one of the challenges is locating the clients because they are itinerant. That is a difficulty we face. It is just built into the nature of the problem.

Mr CHAIR: You talk about education. What is your ability to get out—you are talking about identifying clients—I take it you get them referred to you?

Mr SHERMAN: We only accept referrals from Katherine Hospital if they present more than six times in 12 months. We get that direct. We usually make the initial assessment first up at Jack Roney, if they have presented there and are admitted. Then we break the ice, explain who we are, where we are from and what we can do for them. We go from there.

It is not so much a service where we are telling you this is what you need to do and this is what you cannot do. It is this is what we can provide to assist you and then you can steer us in the right direction.

Mr CHAIR: And what about your education? What about your ability to provide information and education to these clients?

Mr SHERMAN: Just going back to the multiple services that we have within community services. I just direct them into the right area and just assist them and advocate for them. A lot of these clients do not like engaging with a lot of people.

Having you there as their back up provides that safety net for them and that is a good outcome.

Ms NELSON: So it is intense case management that you are providing and a one-stop-shop essentially. You only get referrals to the KISP from the hospital. Part of the thing that we are trying to address with this select committee as well is harm minimisation but it is also about treating addiction as a health issue as opposed to a criminal issue or a legal thing. Is there scope in something like KISP to get referrals from the courts?

Mr SHERMAN: I cannot answer that.

Mr BROCK: Yes, there is scope for that. I would like to add that one of things we have identified is that these clients have been presenting six and seven or eight times but they have been presenting for things that have been quite insignificant. What the KISP has found is a huge, complex need.

We have some really high palliative care needs that have come out of this program. We have had quite a few clients pass away and these are forgotten health needs, chronic disease issues. Katherine District Hospital has been putting the band-aid on that stuff but we did not realise the can of worms we were opening when we saw these clients that were entering the system.

The fact that it has the case collaborative management system, the wrap-around support is great, and they are having some really good outcomes. We have to pull back on all of those social determinants. You look at a KISP program and say these people would like to be in housing. That is not necessarily what these people want to do. These people may not want to return to country. We actually have to get their health back on track first which is what we are endeavouring to do.

Mr CHAIR: How many of them would have contact with the criminal justice system before presentation at the hospital?

Mr SHERMAN: Based on the client load that I have, I would be speculating. I would not have a clue.

Mr CHAIR: As Sandra was saying, one of the concepts that we are looking at is removing the criminal justice aspect, taking people out of that system but putting them into one where they get referred to service providers such as yourself so that you can have that contact with them hopefully before they get to the stage where they need hospitalisation.

Mr BROCK: I would just like to add, with these KISP clients as well, they have lost a lot of their ID so the first point of contact is to make sure we have—there is no drivers licence, there is nothing and they have gone off the grid. Some of them are not even

accessing Centrelink or anything like that. They have no idea. Like Eli said, there is nothing that we can really say about their history, we just start addressing that.

Mr CHAIR: You just get them and start dealing with it.

Mr BROCK: Correct.

Mr CHAIR: You have been quite successful.

Mr BROCK: Yes.

Mr CHAIR: That is great.

Ms NELSON: It is a great program.

Mr CHAIR: I might come along and have a look at it at some stage, see how you operate.

Illicit drugs: how much work do you get? What is your case load like?

Mr MOORE: I have been here about six weeks and each day I am getting a new client from Strongbala, and I understand there are a couple more coming across from the COMMIT program so I am getting busier, which is a good thing. Like Gardner said before, tracking the people down, doing a home visit and the people are not there. Or 'yes, I will be here at 2 o'clock'… I am there at 2 o'clock and they have gone. That is the problem. I do not think they understand orders sometimes. Brother, you have to come. Sure, see you later.

Ms NELSON: That leads into some of the challenges that we have heard from other service providers that there has to be a more culturally appropriate and linguistically appropriate approach to alcohol and other drugs program. Obviously from what you guys are saying, it is the same thing here. Is that correct? It is difficult to engage with people if we are not meeting that need. Is that a fair enough assessment?

Mr MOORE: What I find pretty successful too—I worked at Mutitjulu, at the rock there for a while and I learnt Pitjantjatjara Yankunytjatjara. That was a big plus. Coming here, it's Kriol and I think there are four different types. That is going to be a bit difficult for me to do. Learning language and learning culture is a huge step towards gaining people's confidence. I have been here six or so weeks so it will take a little bit longer.

Mr CHAIR: I have a question here about the Strongbala Justice Program. Do you want to talk about that?

Mr THOMAS: A bit of background about our program. We have been funded for about nine years now. We are in our last cycle of funding. We are funded to provide support services to 40 to 60 men a year through referrals from the Magistrate, courthouse,

NAAJA, corrections, NT Legal Aid, alcohol rehabilitation centres, self-referrals and other agencies.

Our program supports men on a daily basis. We provide them with a 13-week program every day. Through that program we provide referrals to support services for the men to gain access to health checks, AOD counselling, social and emotional wellbeing counselling, follow-up health checks.

We have engaged our service providers internally at the health service; we bring them in to deliver education sessions to our men. We try and run that personal development program daily for the men so that they have a wide range of educational resources that are introduced to them. That could be Relationships Australia brought down from Darwin delivering sessions on relationships and better management of how they live, CatholicCare doing domestic violence sessions. We have had Red Cross come in and do mental health first aid. Of course, our internal programs do all the nutrition and health topics, AOD, social and emotional wellbeing.

In general we support our men over those 13 weeks to come in and try and improve themselves in the way they live. Outside of those sessions, we also provide support for those who do not have housing. A lot of our men find it difficult when they get a referral or the Magistrate wants to send them to a justice program, they do not have accommodation if they are visiting from remote communities. If they have accommodation in town then we will accept them to our program.

If they do not have accommodation or access to that, and they are referred to our program, we will try and support them in gaining accommodation. One big issue with our clients is the lack of accommodation in Katherine. Referrals to the hospital, Corroboree or Warman House takes a lot of their income. Some men do not already have an income when they come to us, they are not on Centrelink, so we have to manage that for them and that takes a few days. Some of them are homeless until they get accommodation.

I would say that 99% of our men referred through the justice program are alcohol-related. That would be domestic violence, assault—minimal driving offences—and breach of domestic violence orders. They are the main referrals to our program. That is an area that we try and do a lot of work in with our clients. We try and engage them straight away with counselling services.

We support homeless people. There are a couple of homeless people that have been through our program that have been in the KISP program but a lot of the homeless men around town that are visiting from remote communities generally access our service for support to get on Centrelink or for breakfast or a shower or washing facilities, which we have. That sits outside of our justice program but we have implemented that to support our men in gaining access to those support services.

With our walk-in men, or homeless men, they are required after five or six visits to our service to participate in the program. We try and get them access to a health check straight away. If required, we provide counselling sessions also. Any questions?

Mr KIRBY: So with housing, as you were saying there, the lack of access to short-term accommodation, how do you work around that? What options have you got available?

Mr THOMAS: As I mentioned, with the hostels we have Warman house. They are sometimes difficult to get into due to funds, it can cost a bit of money to get into those services or they are too full. This time of the year, wet season, a lot of our men will try and access rehabilitation centres. They will do a self-referral to our Strongbala program and come and ask us to assist them in getting into rehab. We will either do that or we will access support through AOD or clinical services. That is where a lot of our homeless men try to access accommodation over the wet period.

In general, our justice clients, if they have DVOs in place from their family or their wives, they are not allowed to stay at that residence so if there is no room in their family members' houses where they can go and stay while they have a DVO in place, they are basically homeless unless they can get into one of the hostels. A big issue there is a lack of men's accommodation and hostels. We only have that one in town.

Mr HIGGINS: When you talk about this, one of things I find all the time and I think it has come out in some of the submissions, is statistics. A lot of statistics are missing from out in the communities on how they are affected. I have heard you are covering 11 000 clients over a large area from a group that has started at the beginning of the year and gone to 100 staff. There is another one here that is getting one a day. All of these have been referred by the courts, or the hospital or people here in town.

When we talk about that 11 000 clients, how far out do you think you can go and I do not mean that as a criticism, but if you have statistics on what we are doing here in town, how can that be reflected across the bigger problem which is then out in the communities that we are not even seeing.

Mr BROCK: We can only talk for our catchment area and that is aligned to some of our funding program areas. Our catchment area is a 40 kilometre radius from Katherine. We have the outlying communities and we go out to 40 kilometres. The figure of 3900 visitors fluctuates as well. Our annual figures fluctuate but that is a guesstimate around that figure which is quite static at the moment. The referrals are coming in from so many different areas.

A lot of our referrals come through the main clinic, through our GPs. That is where we have a lot of those referrals as well as what the other program areas have mentioned. We are finding now that where I am sitting in community services, because we have the capacity to build up that more complex client profile, those numbers are only going to increase for us because we are able to start—especially around the SIF program

which I forgot to mention—Strong Indigenous Families, that is around domestic violence. We have a team of workers delivering that program as well.

All our programs are inter-linked, they overlap. That integrated approach that we do is able to pick up those clients that are in that catchment area as well. In answer to your question, it is a 40 kilometre radius from Katherine.

Mr HIGGINS: Do you think it would be good if you could get out to some of these communities outside of that. In other words, not just based in Katherine. I am not being critical here, do not get me wrong, but to actually have people out there. Do you think that is going to find a bigger problem than what we are finding now?

Mr BROCK: I am mindful of the fact that there are other health services around that meet that need. There are some health services that focus more on the outlying communities for that.

Ms NELSON: So Wurli is a town-based Aboriginal health service and like you said, you have a 40 kilometre radius, but you do get a lot of clients at Wurli that have come from communities to access the health service here. Do you capture that data?

Mr BROCK: Yes, it is all captured.

Ms NELSON: So it is all captured, the community that they are from. You can provide a breakdown if needed. A lot of the work you are doing as well, you are funded specifically for that work, you are actually doing quite a bit that is outside the funding scope to meet the demand and the need.

Mr BROCK: Definitely. KISP is a classic example of that in a program. The brief on that one was to identify the needs of someone who was presenting at the hospital more than six times a year. The significant savings that has already effected in the program that Eli is running at the moment is over half a million dollars in CareFlight for these clients not being flown up to Darwin every five minutes. The recurrent presentations to the hospital and what that costs.

We are already starting to see data coming out of that but it does not take away those complex needs that these clients have. That is where we need to involve all our key stakeholders in Katherine because it is too big. We only have a very small team on the ground for KISP that are employed by Wurli. We are really a referral point into those other pathways that these clients have to go through to get their needs addressed. It is quite a complex program but a classic idea of what you just said. We build services outside what we are funded to do.

Ms NELSON: Through the Chair, can I ask a question of the AOD program. For the AOD program, did you do outreach work?

Mr MOORE: In the closer communities, yes.

Ms NELSON: So the communities that you service are Rockhole, Binjari–oh Binjari has its own health—but you do go out there.

Mr MOORE: Kalano.

Ms NELSON: Kalano, Rockhole, Binjari and some Warlpiri. In the AOD program, do you get referrals from the court system?

Mr MOORE: Yes, under my program.

Ms NELSON: And then you tie that in with the other service providers?

Mr MOORE: If needed. If I identify that there is a need, absolutely.

Ms NELSON: And it is individualised case management, very intense case management and it is all centred around that person.

Mr MOORE: Person-centred, exactly.

Ms NELSON: Okay.

Mr MOORE: A strong focus on recovery. I tried to introduce motivational interviewing, to see if someone is pre-contemplative, get them to contemplate and then actually actioning it. It is a slow process, I know. I cannot give you outcomes overnight. It is a slow process.

Ms NELSON: Generally, what do you get most of? Is it alcohol-related or other drugs?

Mr MOORE: I think it is across the board. What scares me though is ice coming into Katherine.

Ms NELSON: Has it become more prominent?

Mr MOORE: I have not seen any evidence of it yet but it is on its way. Nobody is talking about it.

Ms NELSON: On average, I do not know if you are able to tell and you can take it on notice, how many clients are referred to you because of ice addiction.

Mr MOORE: Well I do not have any ice addiction but alcohol and marijuana and some methamphetamine use.

Ms NELSON: But not overwhelming?

Mr MOORE: No, not overwhelming at the moment.

Ms NELSON: One of the questions that was asked as well and Mr Higgins just asked about capturing the issues that are happening in remote communities, because you are getting people referred to your services that are not Katherine-based, are you able to provide a good picture of what is actually happening outside of the Katherine catchment area?

Mr MOORE: I cannot at this stage. I have been there a short time but I cannot at this stage.

Ms NELSON: Overall Wurli would be able to do you think? Do you have a good idea?

Mr BROCK: No because like I say, our funding arrangements are to capture those clients within that range.

Mr HIGGINS: I only asked that specific question to make the point that there is a whole area out here that government are missing. Not you people. Purely saying you are getting a picture of here, but there is a picture outside of that. I have Wadeye in my electorate and there is nobody that covers that.

Ms NELSON: We are going to be hearing from Sunrise today as well so it would be good to ask that question of them.

Ms HUTCHINSON: I am the only person on the panel here that works with the clinical services at Wurli. I have worked there for a few years so I can tell you a little bit about our outreach services. We have a mobile clinic that goes out to communities. We do after-hours clinic and we go out during the week as well.

There would often be a doctor, an Aboriginal health practitioner and registered nurses providing complex services to people out in those communities. If we had people from out of town and they had a drug or alcohol issue, we could refer them through our services.

For my program, my program is a Commonwealth-funded program working with pregnant mothers of Aboriginal babies and up to two years old. It is a very intensive supportive program. We have had some clients who were previous amphetamine users. We have a lot of very vulnerable clients and quite a few of them smoke a lot of cannabis as well.

Again, it comes back to the social determinants of health and some of these clients might be 16, have a lot of difficulty accessing Centrelink, ID, education and from complicated backgrounds. There are all sorts of issues that come up so our program works really closely to support them and work with community services of the other services in town and the women's services as well.

Mr CHAIR: Do you get to contact the other young ones when you are out in the communities servicing your clients?

Ms HUTCHINSON: So the mother is our client and we work with the family as well so we do not really say no; if they need support, we do that. Often there will be a mother or father or mother-in-law that has problems that they need assisting with and we will try and help them be referred to some of these programs as well, whether it is Venndale for rehab or just a doctor to assess them to do home-based withdrawal type program in the community. There are different options for each client.

Mr CHAIR: The ability to provide information; do the schools do it out there? Teaching kids about the dangers of marijuana.

Ms HUTCHINSON: Our women and children's service does some work in the schools. That is more about growth and development and relationships and stuff like that, with a little touching on drug and alcohol use. But not (inaudible). A lot of our young mums leave school early so they tend to be the ones who have missed a lot of the services that are provided in the school anyway. The same with other services. We go out to Binjari, Rockhole, Gorge Camp (inaudible).

Mr BROCK: Just to add to that, from a community services perspective, all our programs have KPIs around the deliverables in education and information. A core component of what all our programs do is go out there and do some really good education and information to the schools and we are very much involved in community events so our programs, although we have the one-on-one counselling, the group counselling, we also do the education at community level as well. That includes children.

Ms HUTCHINSON: I would also add to that: we also have a health promotion unit as part of Wurli and that is newly established so they will work with the youth in schools and they will be doing a lot of that engagement stuff. It is under that same umbrella.

Mr CHAIR: Alright. How do you think it would affect you, for argument's sake, if young people or anybody—somebody picked up for possession of drugs was referred to you as a first instance, so provision of some education to them, consideration of whether they need treatment or recommendation for treatment. With your understanding of the levels of problems in the local community, how do you think that would affect your ability to do your job? Do you have that capacity to do it?

Mr BROCK: We have already started to have that capacity, especially around the AOD team where we are involved in the youth justice diversion. We have some clients that have been identified that have some one-on-one counselling with the teams. Not in large numbers, but it is something we have started to look at. With the more complex team we have now and the skill mix we are going to be able to do that. We have already had the NT police come and talk to us about that with some identified clients that have that need.

Mr CHAIR: That leads to another question. You spoke about Commonwealth funding. What is the rest of your funding? A mix of Commonwealth and Territory?

Mr BROCK: Yes, we know it is not enough.

Mr CHAIR: Have you moved to five-year funding with Territory funding?

Mr BROCK: Yes.

Mr CHAIR: You have. Commonwealth? Is that a five-year funding as well?

Ms HUTCHINSON: It is ongoing.

Ms NELSON: It is generally three- or four-year funding agreements from the Commonwealth are they not?

Ms HUTCHINSON: The program has been running for 10 years. It might be on an annual—it is believed to be ongoing.

Mr HIGGINS: You would think those short-term funds—I would even classify five years as short-term—are a hindrance?

Ms HUTCHINSON: Yes, I think previously this program was five years. I am not actually sure.

Mr HIGGINS: What about moving to something where you have five years but it is reviewed after two and you know you have three years to go and you give them the next two on top. So in other words, rolling funding. Has anyone had any discussions with you about that? As opposed to waiting until the end of the five years and having to do your submissions. Halfway through you say you have been doing really well, we now want to increase our funds back to the five years.

Mr BROCK: That is a good point because some of the funding we get, because we have slow start ups and KISP is a classic example of that. Whereas we have a lot of issues around retention and getting a skill mix of staff that we need so of course you have a slow start-up with a program. You still have to report against that and if you have not met those KPIs in that interim period then all those questions are asked. Remembering that we are classified as remote here so we have all those recruitment and retention issues.

Mr HIGGINS: Do you think that would be a good model?

Mr BROCK: Definitely.

Mr HIGGINS: Five years and then after three years you submit your five year funding so you submit for another three years on top of your two.

Mr BROCK: And it is clearly accountable because you have some evidence-based stuff happening there and if you are looking at the bigger picture which we are trying to do. We are on this mission to have a client journey and pathway that is sustainable and going to have some outcomes. That comes with a lot of underlying work that you just do not do overnight.

Mr HIGGINS: Do you think short-term funding, even at five years, leads to a lot of your staff turnover. It must towards the end of the funding period. People must think am I going to have a job?

Mr BROCK: There have been incidents where the funding has not come in until after that period so you would have lost staff because of that and our funding is only aligned to the funding agreement.

Mr HIGGINS: I am a firm believer in having rolling funding.

Mr CHAIR: Some sort of surety going forward.

Ms NELSON: I do not think you are going to get any argument on that one Gary.

Mr HIGGINS: I will have to speak to the Treasurer.

Mr CHAIR: We probably need to move along. Would anyone else like to add anything else? I would just like to say that your presentation has been great, really interesting, but would anyone else would like to say anything else before we finish?

Mr MOORE: Just from the AOD perspective, that compulsive AOD use, despite the warnings, can be put down to two things I think: an excessive desire to use substances, or a strong craving to use substances for whatever reason; but also impulse, lack of impulse control because of a neuro-cognitive impairment. Understanding that with marijuana, the more you use the less chance you are given to have impulse control.

It needs early education; really early education.

Mr CHAIR: That is why I was asking about getting into those families early on. Absolutely agree with you.

Mr HIGGINS: Do you see a strong connection with foetal alcohol spectrum disorder? I sat on that committee and one of the things that came out of that very clearly was that addictive behaviour is one of the side effects of that.

Ms SHAW-FRANCIS: Prior to coming to Wurli, I ran a men's group in Yirrkala in East Arnhem Land and I think a lot of men in our group had FASD which would account for not understanding authority figures like police and ending up in jail because of that.

Ms NELSON: Were they diagnosed with…

Ms SHAW-FRANCIS: No.

Ms NELSON: Because it is difficult.

Ms SHAW-FRANCIS: It is very difficult.

Mr HIGGINS: You have a whole spectrum and it becomes very hard. That was one of the things that came out of that report.

Ms SHAW-FRANCIS: I am a nurse and I have a nurse's suspicion; put it that way.

Mr CHAIR: And there is not enough work going into identifying it as well as we understand from others.

Mr HIGGINS: You cannot come up with a standard test.

Mr CHAIR: Thank you all very much for your time. It has been very interesting.

The committee suspended.

Sunrise Health Service

Mr CHAIR: On behalf of the committee, I welcome everybody here to the public hearing of the select committee into harm reduction strategies for addictive behaviours. I welcome Catherine McArthur to the table to give evidence to the committee. Thanks for coming in and meeting with us. 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 applies. This is a public hearing that is being recorded. A transcript will be made available for use by the committee and it may be put on the committee's website.

If at any time, 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. Can you state your name and the capacity in which you are appearing?

Ms McARTHUR: Catherine McArthur, I am here for Sunrise Health.

Mr CHAIR: Over there is the microphone. We have a bit of problem sometimes with the recording so if I could get you to speak up when you are speaking. Would you like to make an opening statement?

Ms McARTHUR: No I am fine.

Mr CHAIR: Well Sandra has already been telling us about Sunrise. She has been banging your drum. Can you tell us a little bit about Sunrise and the services you provide?

Ms McARTHUR: I work in the AOD and tobacco field, in the Tobacco Team. I am the Team Leader for that and above me is our coordinator Chris Cookson who could not be here today. Below me, I have a mentor and below her we have our team of AOD and tobacco support workers.

AOD and tobacco support workers give advice, assist people with AOD problems in community. Our workers are based in the communities that we service. We do not employ people from out of community, we try to employ our workers in community to work with their people. We have found that has been really successful for our engagement with community. That is a short summary of what we do.

Mr CHAIR: Do you ever find any difficulties with the closeness of those people in community?

Ms McARTHUR: Yes. We find that a struggle but we have employed a mentor out of the communities. She is a well-known lady and when she goes into community, our workers will address issues with her saying we cannot go and see this person for cultural or family reasons and she will go in and talk to them instead of the family members, so there is no conflict. We have found that really great to help with those small issues.

Mr CHAIR: And what areas do you cover? We heard from Wurli before and they were in town to about 40 kilometres out.

Ms McARTHUR: We cover the communities of Ngukurr, Beswick, Barunga, Mataranka, Jilkminggan, Minyerri and Bulman.

Mr CHAIR: So you go out to the broader range.

Ms McARTHUR: Yes, in all communities at the moment, except for Beswick, we have one or two staff in each community working on a day-to-day basis on all these things. We do not do any clinical things, we just do health promotion so we go to schools, we have referral lists and we go and provide one-on-one help, help people create pathways and talk to them about the risks and things like that.

We are trying to lean more towards group work, focussing on families or a whole household due to crowded housing and things like that. We are trying to focus on addressing the whole household because we are finding that working individually with one person is working really well when they are with you but when they go home to someone that is smoking, we are finding that they are just going straight back into that. We are trying to focus on working with the whole household and whole families at the start of next year. We are going to see if that works better. You can only try.

Mr CHAIR: That is right. It is worth giving it a try. I can imagine the difficulty of trying to work one-on-one and having them go back to the problematic …

Ms McARTHUR: Yes and we have really long referral lists as well. There are a lot of people who smoke and drink and that is what we have found. A lot of these people live together or hang out together so they are happy to come as a group and talk to us about the same thing because they know it is a problem so we thought if we addressed it as a group situation, it might help us tackle the big situation a bit easier.

Mr CHAIR: Alcohol and tobacco are the two main issues?

Ms McARTHUR: Yes and sometimes when we have been in the schools, we have been asked to talk about ganja and things like that. When we do our school sessions, a lot of the communities that we service do not really say that there are any other kind of drugs other than ganja going into the communities at the time, so we do not talk about those other things unless we are asked to. Mainly we focus on alcohol, tobacco and marijuana.

Mr CHAIR: Do you think there is any under-reporting?

Ms McARTHUR: We have a pretty good connection with the community and they say if they do it, they go to Darwin. If they bring it back, it is a sort of taboo thing. They do not want it in the community so they say no, get out, take it out, we do not want it here. To date, we have not had any referrals or anything from people with it.

Mr HIGGINS: Who gives you the referrals?

Ms McARTHUR: They are through our clinic. If you go for a health check, they will ask if you drink. Those are the sort of questions they ask. Then they ask if they want to be referred to our program and for one of our workers to come over and to talk to them about these issues. When we provide pathways, we try to do it so we do follow-ups with them but the biggest problem we have is that they go to outstations for months and months and we do not see them so we cannot do a follow-up because they are not there.

Mr CHAIR: Nobody goes around to those outstations?

Ms McARTHUR: A lot of them you cannot get access to. A lot of the community members that we have live in the community for certain times of the year and live at the outstation certain times of the year. We deal with a lot of that.

Mr HIGGINS: When you talk about your education, going into the schools and stuff like that, how is that initiated? Are you initiating that or is the community? When you talk about going to the houses, is that you just have one person in the house and you decide that it should be everyone or are they coming back to you? Or is it both?

Ms McARTHUR: We ask the individual client. We give them the option of us coming in to talk to their family about these things. A lot of them when we talk to them say they would like their family to hear this. We have taken that feedback on board and said if we can go back and talk to your family or do group education, would that help. If they allow us to come in and do it, we will.

Mr HIGGINS: How big a problem do you think it is? You might have seen me asking the last lot of people how big a problem all of this stuff is out there. How big a problem do you see it is?

Ms McARTHUR: It is huge. It is massive.

Mr HIGGINS: Do you think what we see in town is just the tip of the iceberg, so to speak?

Ms McARTHUR: Yes and no. Some communities are really good and others are just crazy and you are thinking, how do they deal with this? I think a lot of it is alcohol supply. If they can get the supply there then it goes in stages. That community will be terrible for a couple of weeks with fighting and things like that because of the supply that they have. Other communities might be great at this time.

Everyone travels to the supply. That is how we find it works. We find in Barunga, one week it might be really great but it is really hectic in another community but that community is doing really well and all the people that drink have travelled into town or Darwin for that. We find that it is wherever they can get it that is what they will have.

Mr HIGGINS: Do you find a difference in the communities between having alcohol in it and ganja?

Ms McARTHUR: A lot of them do not talk about it. They see us coming and decide not to tell us about things. Because we have community members working they will say we have had a lot of ganja come in this month. It varies with the supply. If someone can get it straight through to the community then it gets through but a lot of people get caught up in Darwin or a car breaks down and it does not get out there.

Mr CHAIR: Those broader social problems, when you say it turns up in one place and they all go there and they end up fighting, is that associated with ganja as well or just the alcohol generally.

Ms McARTHUR: They say a lot of—I do not know—they say when the alcohol comes in is when the ganja comes in as well because they all bring it in at the same time. That is just what we have gathered. They do not tell us that directly so that is just what we have gathered from afar.

Mr HIGGINS: It is hard to tell sometimes if you have problems in a community if it is alcohol or ganja. The police will quite often say alcohol has come in because there is an increase in say, domestic violence. With ganja, you do not have that domestic violence but you have other sorts of problems. So they know what to look for.

Ms McARTHUR: Exactly right. They say the ones that are closer to pubs, have more alcohol problems because it is easier to get the alcohol to the communities. We find Mataranka, we have a lot of clients there because there is a pub there. A lot of our clients go as soon as the pub is open, they are in the pub. We cannot go into the pub and drag them out and say look we are going to do alcohol prevention with you today because we cannot look in there because they have already been drinking all day.

Then you see them on the streets and they are blind drunk and laying everywhere and you cannot go and talk to them then either. It is either get them right in the morning and then half of them do not want to talk to us either. We have a huge refusal rate for clients. People swear at us and say they do not want to talk to us, that they do not have a problem. We get a lot of refusals to our service.

Mr HIGGINS: Do you think you get more benefit if you are speaking with younger ones than older ones? To convert an older person, old people die hard. We know everything whereas the younger ones you can manipulate a bit. Do you think that area should be an area that is concentrated on?

Ms McARTHUR: We do school visits and we engage in a lot of the community sporting things with NT Sport. This year, we did a thing in Ngukurr with NT Sport and they had all the kids doing all different kinds of sport and then we had two different rooms so we were talking about smoking and marijuana in one of the rooms and we were doing alcohol education in the other. All the kids rotated through both of those different sessions.

Afterwards all the kids were saying I am going home to tell my mum that she should not be drinking anymore because this is what is going to happen to her. They all took flyers and everything. It sparked a lot of ideas for all of our staff to want to attend all of these things because we see it in the kids. They say this is wrong and they go back to their parents. That is all we can hope that they do.

We try to do all the education in schools and run sporting events for the kids and we did Barunga Festival this year as well and we had a lot of kids come through our stall. Not many adults at all, 20% of adults to kids. The kids came through, picked up all the things, read them. We had a whole side for alcohol and a whole side for cigarettes.

They had a look through it and you can see them, they just cannot believe it. Especially when you say the effects of the lungs, you cannot breathe, they just cannot believe that can do that to you. I found that is something that we really target, the school visits, and make sure that we are doing education but trying to make it fun for them so we are not drumming straight into their head. We are doing activities to try and make them remember the activity as well as the facts that we are trying to provide for them.

Mr HIGGINS: I think manipulating kids does work. Put signs on their doors: smokers not welcome. Their parents did end up giving up smoking so it does actually work.

Ms McARTHUR: They cannot believe that you cannot smoke in cars with kids. The kids could not believe that is a law now. They were like, my mum smokes all the time in the car. You have to tell her that is illegal. You cannot do that anymore.

I found that educating the kids really helps and they come back. When we have group sporting stuff they come back and sit down and they want to listen to what you have to say. With the adults, when we try to do group things we just do not get as much engagement at all.

Ms NELSON: I have a couple of questions. How many communities does Sunrise service that are dry communities? Let me rephrase: how many communities do you have a clinic in that has alcohol in the community?

Ms McARTHUR: Only Mataranka. Barunga is a dry community and they were looking at getting permits there and Minyerri, Bulman, Ngukurr and all of those are all dry communities. When they get caught with alcohol in community, it is illegal and the police know when the alcohol is there because there are so many people drawn to that area.

We find a lot of our clients from the other communities go to Mataranka. If our clients are in Mataranka and our AOD mentor, that is where she is based, she will go and do the one-on-one work with them if she sees them there. We try to pick them up from other lists as well.

Ms NELSON: With the education program that you were talking about earlier, Sunrise has a nutritionist, a physical activities coordinator or program officer, so do you all work collaboratively, it is all linked together?

Ms McARTHUR: For the Barunga Festival we did that. We had nutrition things and all of that. We work together.

Ms NELSON: When you are delivering education sessions in communities, do you all go together then?

Ms McARTHUR: No not always. Sometimes they will invite different programs and we all just go to the ones we are invited to or we ask if we can tag along.

Ms NELSON: We heard from Wurli that there is an overlap with clients, obviously when clients are coming in from communities they are accessing Wurli while they are in town. Do you work collaboratively and do shared case management?

Ms McARTHUR: We do not really know where the clients go and we cannot follow them either so it is really hard for us. We have such a big client base. If we cannot find them on the day, we just say attempted visit and then we will look for them again. We will ask family members where they have gone and they will say, 'they went here but I think they are gone'. We cannot really follow them so it is hard for us to do that shared case management because we have no idea when they are in town and no idea when they are back in community.

Mr KIRBY: You were saying that there had been some discussions about permits in one of the communities?

Ms McARTHUR: Yes, in Barunga. I am not sure where that has gone because I did not attend the last community meeting but they were trying to make it so that a person could get a permit and they could have alcohol in their house. I am not sure where that got to but I do not know how it would work.

Ms NELSON: Do you guys have input into those?

Ms McARTHUR: I know Chris attends a lot of the meetings but we do not have much input. It is a community's decision. We take anything we would like to do to our board and they address it.

Ms NELSON: It is a huge area.

Mr CHAIR: And are there any social clubs in any of those communities?

Ms McARTHUR: Beswick has a social club but I am not sure if it is still functioning.

Ms NELSON: Beswick is serviced by the clinic at Barunga.

Ms McARTHUR: No there is a clinic in Beswick as well. We do not have a worker in Beswick at the moment. We are finding it hard to employ somebody there. That is another thing we have problems with. Because we try to employ in the communities we find it hard to get workers that want to work in this field. A lot of them say they are not doing it. That is where we struggle. We get some really great workers in and they

will go into Darwin and we will never see them again. It is hard. We try to work around all of it.

Ms NELSON: It is a common thread is it not? Recruitment and retention in remote communities.

Mr CHAIR: Is it tied in with funding as well?

Ms McARTHUR: We are pretty okay with our funding so we do not really have an issue with our funding. We just have the issue of not wanting to just sit bums on seats to fill numbers. We want to get people that actually want to learn and want to work for us. That is why we find it really hard to recruit.

We ask the board members who we could ask to come and work for us and they can suggest to us who would be a good idea. Also with applications, we ask the board member for that community and they will tell us if they are good or if they are not a good idea.

It is good to have that community knowledge as well to help us otherwise we could have been employing someone that is not even going to show up.

Ms NELSON: I have to say that Sunrise's youth engagement and education is really great. I think it is one of the more successful and effective programs I have seen in communities in regards to alcohol and other drug education, with kids and getting them engaged and that sort of thing as well. The feedback with the kids going to the parents and getting the parents involved is done really well. That coordination between the different programs and putting it all together; you have done well.

Mr CHAIR: Just before we move on, on your website you echo views expressed by several other witnesses that we have had about the community's need to be actively involved in controlling their own health. How would you suggest communities could be better involved in that delivery of AOD harm reduction?

Ms McARTHUR: If we had a lot more of this community engagement with our programs, it would make it a lot easier for us to be able to run programs. I use our team to help with their community's program involvement because they are community members as well. I ask our team what they think would be effective and they tell us what they think about what would work or not work. We ask them and attend community meetings if they want to do something huge and ask the community at those kind of meetings as well.

It would really help if we had parents that were wanting to come into the school and sit and listen in the education sessions and things like that. When we are doing the other sessions, the kids are not dragging them and it would help if the kids did not have to say come on let us go down here. We try to do things that they like. They love football. We want to try and do camps but the organisation of it is so much work.

Mr CHAIR: What sort of population are you talking about across your 10 communities?

Ms McARTHUR: The population for a couple of them is a couple of thousand. I know for our referral list, our population is nearly 400 in each community but I am not sure on the actual population of the communities.

Ms NELSON: Mental health support out in the community—does Sunrise have a mental health team?

Ms McARTHUR: Not at the moment but we are recruiting.

Ms NELSON: So what happens right now in community if someone presents at the clinic with mental health issues?

Ms McARTHUR: I am not sure but I know if it is alcohol-related, they will get referred onto our team but I am not sure about the mental health side at all. I know that they are trying to fill those positions again. That is all I know about it.

Ms NELSON: Thank you.

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

Ms McARTHUR: No.

Mr CHAIR: You have been very informative, thanks. It has been a pleasure. Cheers.

Ms NELSON: Thanks, Catherine.

The committee suspended.

Top End Health Service
Katherine Hospital, Alcohol and Other Drugs Treatment and Community Services

Mr CHAIR: You have heard this spiel a couple of times, but I will go through it again. On behalf of the committee, I welcome everyone to this public hearing into reducing harms from addictive behaviours. I welcome to the table to give evidence to the committee Paul Gibbs, Louise Harwood and Jane Hair. 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. It is a public hearing that is being recorded. A transcript will be made available for use by the committee and may be put on the committee's website.

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

For the recording, can you each state your name and the capacity in which you are appearing?

Mr GIBBS: My name is Paul Gibbs. I am the Acting Operations Manager for Alcohol and Other Drugs, Top End Health Service.

Dr HARWOOD: I am Dr Louise Harwood. I am the Director of Medical Services for the Top End Health Service, Katherine Branch.

Ms HAIR: Jane Hair, Manager for the Katherine region for mental health and AOD.

Mr CHAIR: Thank you all. We have a bit of a problem sometimes with our recording, so if I could get you to speak up when you are talking and state your name when you give evidence. Would someone like to give an opening statement?

Dr HARWOOD: We are aware that the Northern Territory Department of Health has already made a submission to the committee. We understand our contribution will need to be simply a local perspective. We have outlined some dot points in relation to the question.

Those points are that in our opinion addressing harm reduction should include due attention to the antecedent causes of addictive behaviour. Measures to reduce access such as pricing and age restrictions are important because of their selective effect on young people, but these should be used in conjunction with the previous point about antecedent causes.

We believe that education should be prioritised for the school-aged group and that strategies that have been demonstrated to work need adequate and reliable funding. Whilst there should be accountability for results, paperwork should not overwhelm the process.

We think that the best place for investing in these strategies is in the frontline primary healthcare sector and that non-government organisations and Aboriginal community-controlled health organisations are best placed to provide initial interventions in the Northern Territory and they should be supported in that role.

When issues are identified, there needs to be easy access to secondary services and advice, and in particular, waiting lists for residential services. We have been aware of situations where people seeking voluntary treatment have been unable to access services because of those undertaking mandated treatment.

We believe that individual-based treatment models which have been developed in the Western paradigm do not work for many people and, in the Northern Territory, family-based programs are important and need to be researched and developed. Family-friendly accommodation and residential treatment facilities is an important part of that.

We believe that attention to healthy lifestyles includes cultural and spiritual values as a high importance. This requires a community development approach with sustained and genuine community engagement, which will allow strategies to develop from within, rather than being imposed.

We draw your attention to a particular innovative approach we are aware of that has arisen in the Lajamanu community. It is not specifically aimed at harm reduction in this context, but it is looking at a strategy to reduce self-harm and youth suicide. That is the Lajamanu Milpirri Festival and the Kurdiji app which they are developing.

That is all I have to say on that.

Mr HIGGINS: When you talk about the family approach in addressing some of those underlying problems, in how to look at it differently, have you ever looked at what ATSIC was doing—I do not know when they got rid of ATSIC. It had an education stream and they used to do that family-based. One of the places was at a place called Five Mile outside of Daly River. It was very successful and then stopped. Have you ever looked at how successful that was, or may have ever looked at modelling of that? Or were you aware of that one?

Dr HARWOOD: We have not. One example I can describe is Borroloola. That community has funding through the PHN to provide mental health services. The team there includes a mix of AOD and mental health workers, but they also have employed a nurse who is called a Family Support Nurse. She essentially works as a nurse navigator and solely works with families of at-risk individuals. They have said that role has been a very helpful addition to the community because the problems that arise obviously affect a wide range of people within the family.

Mr HIGGINS: Is that just undertaken within Borroloola, or do they isolate the family or remove the family to some sort of separate accommodation? The reason I ask that is in the ATSIC program they were using, they would bring the people to there from a lot of the communities around. They would bring the whole family there, that is why it sticks in my mind—it was a whole family issue. Borroloola …

Dr HARWOOD: At Borroloola it is not a treatment service, it is really the primary healthcare intervention. But there is this …

Ms HAIR: It is a team.

Dr HARWOOD: … nurse who works within the team to work across the whole family in addressing what happens next.

Mr CHAIR: Is it her job to identify different problems within the family …

Dr HARWOOD: Yes.

Mr CHAIR: … and then seek the support from …

Ms HAIR: And then work with the family as a whole. That team has proven to be quite satisfactory. I do not have any stats but you will find, by having that team there, including a mental health nurse and AOD workers, flying into Darwin—your admission is to Darwin. I am sure they have the stats but it makes a huge—just me from seeing it—difference on inpatients coming into the Darwin inpatient unit.

Ms NELSON: Is that done in the community first?

Ms HAIR: Yes. It is run by the health clinic, so it is Department of Health clinic. These are funded positions in the clinic. It is a social, emotional family unit within the clinic positions.

Dr HARWOOD: The AOD team would then be Borroloola. It covers Borroloola and Robinson River. They have a mental health nurse, and AOD worker who is the team leader, another AOD worker who is a local person, a driver and the family support nurse who has the liaison, coordinating role.

Mr HIGGINS: How long has that been running?

Ms HAIR: For two years at least. It started off with a mental health worker… it started off with AOD and then from AOD they implemented a mental health worker and it has expanded from there. But the programs you are talking about are probably excellent programs and should be re-implemented.

Mr HIGGINS: That is why I asked …

Ms HAIR: Yes. We do not have the statistics on that, but that is where you want to go.

Mr CHAIR: All right.

Mr GIBBS: If I could add on a point that you made. One of the issues about how programs are funded is they do not often come with money to do the evaluation

component. So, often what happens is they are delivered for while they have the funding, through two or three years, and then they drop off. Evaluation data often does not exist and that is one of the things that is different from Alcohol and Other Drugs to mental health, for example. AOD has been seen as an area that you can just fund for two years, three years, then drop off.

Mr HIGGINS: The one with ATSIC just stopped because ATSIC was gone. It just stopped. My personal view is I know what that program was doing, looking from the outside very closely. It could have evolved into something—I think about 20 years ago ATSIC was shut down. Do not quote me on that. Hansard, remember that.

But probably in today's terms, that had evolved a bit more like you are talking about. Alcohol was looked at as a problem. They had identified that it was a problem that needed to be addressed by the family. There were probably a lot of other problems in the family that needed addressing. It was going down the right path. The funding stopped because ATSIC stopped. Nothing has taken it up. We are coming back to finding the same thing.

Mr GIBBS: There is a lot of really good research into multifamily group work in alcohol and other drugs and in mental health. It is a very effective tool and it can be run in a way in which the group is empowered to take control of the process. That would be the ideal.

Mr HIGGINS: I also mention it was discussed in the report—I was interested in this—about the opioid misuse. Any comments on that? It is a new one to me in communities. This covers everything.

Dr HARWOOD: Historically in this region it has not been a big problem. It is always open to change in the future, but at this point it is not something we see as a significant problem.

Ms NELSON: Is it fair to say that—for want of a better term—the drugs of choice are alcohol, tobacco and marijuana? They are the most prominent?

Ms HAIR: And amphetamines.

Ms NELSON: And amphetamines as well?

Ms HAIR: Yes, that is pretty common.

Mr HIGGINS: What was that? Sorry.

Ms HAIR: Amphetamines.

Mr CHAIR: Amphetamines.

Mr GIBBS: We see in Alcohol and Other Drugs that it is a fairly cyclical problem. It is also market driven. Australia is quite unique in some ways because with amphetamines there is a high pick-up rate here compared to anywhere else in the world. It comes back to alcohol each and every time as the preferred substance, particularly in the NT. We know that when we look at issues like the volatile substance use, which we see the pick-up across the Top End is increasing about 20% a year since 2014. We can see that is a real issue.

It is interesting when you provide an in-depth assessment, because the volatile substance use occurs concurrently with alcohol. We might get a referral for VSA, but we also know that is an issue particularly with children. Alcohol has actually been involved in that.

Mr CHAIR: That is interesting.

Ms NELSON: That is interesting.

Mr CHAIR: I had not heard. We have heard some people talk about VSA, but I did not realise it was increasing 20% a year.

Mr GIBBS: It is for the Top End. Central Australia has had a very different trajectory since the NT introduced the *Volatile Substance Abuse Prevention Act* in 2007. That occurred at the same time as the rollout of low aromatic fuel. For a period of time we saw a reduction. That is not true in the Top End at all. In some of the remote communities, we know that is occurring at a rate that is a real concern.

Mr CHAIR: Okay. That is interesting.

Ms NELSON: It is a bit different from what we heard …

Mr GIBBS: I am aware of that. My colleague over here has been one of the people who has helped us do the research on that. It is a real issue and a remote one. Because of that, we need to develop ways of working with communities, and family groups in particular, because that is how it seems to present itself. It is a concerning issue.

Mr CHAIR: You were talking about the program in Lajamanu with the Warlpiri. Is that to do with VSA as well?

Dr HARWOOD: No, it is a suicide prevention initiative.

Mr CHAIR: Oh, okay.

Dr HARWOOD: It is interesting to look at because it is purely a grassroots generated program that has happened.

Mr CHAIR: Right. I understood they did something up that way with VSA as well.

Mr GIBBS: They may well have done. If I could give an example—nobody here in Katherine—several years ago, volatile substance abuse became an issue on Tiwi. It was a community-led response, not a government-led response. They brought the government in.

Because it was a community-led response, they developed their own plan. They effectively prevented the use from occurring. It has not been an ongoing issue for them.

We have other communities in the Top End where it seems to be a chronic reoccurring issue. When other substances cannot be found, people will start to use the volatiles again, but it is not their preferred choice.

Mr CHAIR: All right.

Mr HIGGINS: I wonder why.

Mr CHAIR: It'll give you a screaming headache.

Mr GIBBS: My understanding is it is unfortunately in the Top End an issue in which younger and younger children are starting to use. Where it was fairly common to see 12- and 13-year-olds, we are now looking at seven and eight-year-olds. That occurs in several remote communities across the Top End. It is a highly sensitive issue. No one really likes to talk about that as an issue, but it is real.

Mr CHAIR: Absolutely. Is it only petrol or is it other volatile substances?

Mr GIBBS: No, it is other substances.

Mr CHAIR: What sort of other substances?

Mr GIBSS: Everything from deodorant, fly spray, paint …

Ms NELSON: Oh, the inhalants.

Mr CHAIR: Is it really hard to get it away from young kids?

Mr GIBBS: Yes. In Katherine, for instance, we see here—thanks to people on Jane's team, who were really good at going about—where they are having the parties. There are cans, bottles and all sorts of things. It tends to be a group binge activity as well. That is how it presents itself. It is very hard to stop.

Mr CHAIR: The only way you will stop that is with education, is it not? Getting in to them early and educate?

Mr GIBBS: It is also about distractions. We do not see the same issues happening in Darwin, as an example, because there are plenty of things for people to do and much more easy access to alcohol.

Mr CHAIR: Stealing cars and breaking into houses.

Mr HIGGINS: Stealing cars and breaking into houses. We have things to steal here.

Mr GIBBS: It is an issue about distraction, social and emotional wellbeing and hopefully, engagement with the family and the community. It is one of the most underrated interventions. We have spent a lot of time in Alcohol and Other Drugs investing to see if cognitive behaviour works and motivation in the interviewing.

We know the family interventions particularly are really effective. There is just not the research base that is used to defend it.

Mr CHAIR: That is really interesting. Thanks for that. I suppose at least …

Ms NELSON: It is really disturbing.

Mr CHAIR: Yes. It is good to know.

Mr GIBBS: Yes, it is. From my perspective—I have worked in just about every jurisdiction in Australia. I have been involved in Alcohol and Other Drug Service delivery for 40 years. I have never seen volatile substance use as prevalent as it is. The Top End stands out by a long way.

Mr CHAIR: When you say the Top End, which location are you talking about? From here up?

Mr GIBBS: Yes.

Mr CHAIR: Okay.

Mr HIGGINS: You would think it would be more prevalent. I am trying to think back. When I look at the back, it is not at the fellow sitting there, but the fire extinguisher behind. Can you remember the fire extinguisher one when a person died and they were using contents of a fire extinguisher? How many years ago was that? That was when it really came to the forefront of that sort of substance abuse.

Mr GIBBS: That is right. It was the hydrocarbons that they were inhaling. That actually killed them.

Mr HIGGINS: How long ago was that up here? That was a coronial, I think.

Mr GIBBS: That has to be 20 years.

Mr HIGGINS: I am only 40 and I can remember it on …

Mr GIBBS: Yes, I can remember that. It is quite a disturbing thing about the Top End. But there is good news. There has been consistent research done. Professor Peter d'Abbs has been leading that research. He is still involved. He is working with the Menzies, so it …

Mr HIGGINS: He has been around a few years.

Mr GIBBS: He has been around for years. It was just this year that we were able to help him with the data we could pull out of the information we have had. As I said, it is really rather disturbing, particularly because of the age where people …

Ms NELSON: The age bracket you mentioned is very disturbing.

Mr GIBBS: Correct. You hear about alcohol and drugs it is about choices people make. Earlier someone was talking about what he described as lack of impulse control. I would describe it as not being able to predict the consequences of the behaviour, which is different from impulse control. Because you are not able to predict the consequences of your behaviour, that speaks to something else. We know there are high rates of FASD—

Dr HARWOOD: That is all right.

Ms NELSON: Louise and Jane will definitely butt in if they …

Dr HARWOOD: Yes.

Ms NELSON: … but you keep going.

Mr GIBBS: We know there are some really disturbing trends, particularly in remote areas when we see things like developmental disability that has not been diagnosed correctly. That occurs or is influenced by exposure to trauma. Then you layer that over with cultural and language impact and the learning disability. It is great that we will engage kids when they go to school, but we only have—what is it?—about 30% school attendance rates. So, we need to be pragmatic about that. It is great we get kids to school …

Ms NELSON: But then what?

Mr GIBBS: But then what? How do we get the kids when—it is about seeing that it is a multifactorial process. With alcohol and other drugs it also speaks to social disadvantage.

Ms NELSON: Of course, the social determinants are definitely key factors in that, yes.

Mr GIBBS: Correct, yes.

Ms NELSON: It is interesting, though. In this select committee we are talking about harm minimisation. A lot of people have talked about alcohol, marijuana, amphetamines and that sort of thing. You have just raised other volatile substances like the sniffing, the inhalants, the aerosols. This is the first time that has been introduced into the discussion …

Mr CHAIR: I agree. It has been spoken about, but not in the terms you have just told us about. It is really interesting.

Ms NELSON: Yes.

Mr GIBBS: That is correct. The reason it happened is we did not look closely at the numbers. We were not monitoring what we needed to and could have done. There were locations of staff, things that got in the way of that.

Mr CHAIR: Is it also because it is a bit out of sight?

Mr GIBBS: Correct.

Mr CHAIR: When it came up it was kids wandering streets sniffing petrol from a tin or jar …

Mr GIBBS: Well, if Professor Peter d'Abbs was here, he would be saying he does not understand why kids would sniff low aromatic fuel because we are not even sure there is any impact they would have from that. But it is a behaviour they are engaged in. There is no research that actually investigates the impact of sniffing low aromatic fuel.

But then, when you look at it, particularly for those small remote communities along the coastline, they have these things called boats and outboard engines that all run on premium fuel. That is …

Mr CHAIR: Normal aromatic.

Mr GIBBS: Yes. They are highly volatile substances that are poorly understood. This is an issue. I would describe it as a precursor. You would see young people starting their alcohol and drug trajectory using the VSA, but preferring the alcohol. Very much all the way through the continuum, it is alcohol.

Cannabis plays a part. It is a small ongoing—small! It is consistently an issue. Methamphetamines—ice if you like—I gave evidence to the ice committee two or three years ago. We know that the use of ice has stabilised, if not gone down. That is probably because the price went …

Mr CHAIR: We heard that from the police.

Mr GIBBS: Yes, because the police have really done their jobs. We know the three pillars of alcohol and drug intervention. You limit the use, you police it—prevention and then treatment. Australia's had that policy in place since 1996. It is very effective.

Mr CHAIR: We would like to see more funding into the treatment.

Mr GIBBS: We would like to see more funding, yes.

Mr CHAIR: That is something we will probably be addressing in our report at some stage.

Ms NELSON: More money.

Mr CHAIR: A different mix of the money that is spent, away from the supply to harm reduction and treatment.

Mr GIBBS: One of the differences between—sorry.

Dr HARWOOD: Go ahead.

Mr GIBBS: One of the issues about volatile substance use is the profile is different in Central Australia because of a couple of things. The community structures are different. But they also got a giant leap an investment in funding through low aromatic fuel rebate. The Top End did not get that.

Ms NELSON: No. It is only Katherine in the Top End. Katherine has low aromatic fuel. Past Katherine it is normal. That is why …

Mr GIBBS: That is right. But they got that big investment of money. With that they were able to build a prevention and distraction, if you like. They were able to build an infrastructure in which children and young people could be engaged. They funded things like halls, art classes, cars—you name it. All these thing they were able to put in place. That was a non-government organisation set up for that called CAYLUS. That has been highly successful. It has just not been replicated in the Top End.

Mr CHAIR: We have met with CAYLUS and spoken with them when we were in Alice Springs—Alice or in Tennant?

A member: Alice I think.

Mr CHAIR: Alice Springs, yes. Some of the stuff they are doing is very impressive.

Mr GIBBS: If I could point out another issue. You talk about access to treatment. Alcohol and other drug treatment is one of those areas where there is a lot of talk about it, but it is often poorly understood. It has to have a basis in harm minimisation and brief intervention in the first instance. That is where we see hospitals and GPs as being critically important. If we are not resourcing and understanding the needs, that is a relatively poor outcome in itself. Brief intervention is demonstrated to be as effective, if not more effective, than residential care.

The trouble with the Top End—and I am mentioning the Top End because I have not worked in Alice Springs—is that the focus seems to be on abstinence and residential treatment. For a while, I was on the board of a residential rehab, so I understand what that is about. It is a very expensive way. We have far more residential beds than any other jurisdiction, that is the plain fact. We know that some people cannot get in instantly, but we also know that there is flavour in this, which is homelessness. That was talked about earlier.

Ms NELSON: Yes, with Wurli.

Mr GIBBS: I will put my hand up to go into rehab now because I do not want to get wet. It is not that I want to change my behaviour, it is just that it is a place I can be dry. That is actually a housing issue.

Mr CHAIR: Yes.

Mr GIBBS: It needs to be understood that that is a very different thing. They talk about alcohol and drug as a chronic relapsing condition. It is if treatment is poorly understood. If treatment is poorly understood and all we do is engage someone in being abstinent and do not address the underlying anxiety, trauma and depression, we have just put that person into a motion of lapse and relapse. When you treat the antecedents, people do not have the preference to make a mess of their lives. They have …

Ms NELSON: So true. People abuse alcohol, they take drugs. There is a reason behind all of that.

Mr GIBBS: Correct.

Ms NELSON: You are spot on. If you are not addressing those issues at the same time as you are addressing their physical addiction—it is a moot point really, is it not?

Mr CHAIR: It is one of the takeaways I have from the various meetings we have had in Darwin and Tennant Creek, Alice Springs and now here that our funding is unfortunately so significantly weighted towards that residential treatment. It strikes me, in another analogy, it is a bit like putting a Band-Aid on a cancer.

Ms NELSON: Yes.

Mr CHAIR: You treat the cancer early then the chances of getting it are much better.

Mr GIBBS: Particularly if we look at the trajectory I have talked about of how this community engages in substance use. It can mean very different things all around the world. But in remote communities, we know without a doubt that it starts with volatile substance use and it goes on to something that is quite different. We then get children being born with all of the issues that comes from the substance use before. Again, it needs an investment in understanding why that seems to happen more in remote communities than anywhere else.

I can give Wadeye as an example. Earlier this year, we had a group of people start to use ice in Wadeye. There was quite a community reaction to that. We were able to reduce that quite quickly, because we were able to harness that community …

Mr CHAIR: Anger.

Mr GIBBS: Yes. That is what happened. Those people went away. That is not such a good market to sell ice anymore. But VSA and alcohol continues.

Mr HIGGINS: There are underlying problems. I agree with you that there is a stack of issues. You have raised a couple—housing and education are examples. When we talk about education, we need to educate our kids not just on drugs and alcohol, but we want to send them to school.

At Wadeye I was talking to an old fellow who had his grandkids. I said, 'Why are your grandkids not at school?' He said, 'They will learn more with me out bush'. I said, 'Hang on. They need to get an education'. He said, 'Why?' I said, 'So they can get a job'. He said, 'What job?' That is the first problem. They have this cycle.

The other thing then, of course, is you talk about housing and 20 people living in a house. The thing is the 20 people living in a house are overcrowded and do not have jobs. You have nothing else to do and that, of course, leads to substance abuse, full stop. While I agree with intervention, it is terrific, there is a stack of other problems that will take a hell of a lot of money to address. Unless we address those, we will continue. While this may improve, it will be very slow. You will never get rid of it until you fix those underlying problems. I completely agree with you. I have probably only touched on some of those underlying problems.

Ms NELSON: That goes back to what we were saying earlier, that you have to get back to the root cause of it.

Mr GIBBS: The unique thing that has happened here—and this has been explained to me by people in the community—is parents now—would that be the X generation?—who have kids in their teens are saying, 'We do not have control of our kids'. They will

go to child protection and say, 'We have hit them', and will do this and that, but we have lost control of our kids.

From any perspective, when parents are saying, 'I do not have control of my child', that is concerning. When we see that in a remote community, that speaks a lot. The way to do this is by engaging the families, health promotion and through primary healthcare. We are overinvested in residential rehab to the extent that we are underinvesting in primary health.

Catherine, who talked earlier today, talked about the value of having people living in communities who will lead and champion issues. It is building that community leadership and handing back control—it is a difficult thing for governments to do. Until we have done that, we will have a difficult time.

I am sorry, I have …

Mr CHAIR: That is all right. We are running out of time, but it has been really interesting.

Ms NELSON: Very.

Mr CHAIR: Is there anything else you guys would like to add? He has been very good, hasn't he? I know why you brought him.

Ms NELSON: This has been very insightful …

Mr CHAIR: Yes, it has.

Ms NELSON: … but valuable.

Mr HIGGINS: He has been sitting in the back there. He has been chaffing at the bit every time someone said something. He has wanted to step in there. Anyway, he has had to save himself.

Ms HAIR: Good on you.

Mr GIBBS: I am sorry. I am passionate about this stuff. It is …

Mr CHAIR: Thank you for being passionate about it. As I said, it has been an absolute pleasure listening to you. Thanks for the information you have provided because it is invaluable.

Ms NELSON: Well done. Thanks.

Ms HAIR: Thank you.

The committee suspended.

Katherine Women's Information and Legal Service

Mr CHAIR: We will start again. Welcome. On behalf of the committee, I welcome you to this public hearing into reducing harms from addictive behaviours. I welcome to the table to give evidence Jacqueline Rimington and Mary-Anne Philip in place of Matt Fawkner. Thanks 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 recorded. A transcript will be made available for use by the committee and may be put on the committee's website.

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

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

Ms RIMINGTON: My name is Jacqueline Rimington and I am the Executive Officer of the Katherine Women's Legal Service. I am here representing KWILS.

Ms PHILIP: I am Mary-Anne Philip. I am a solicitor at Katherine Women's Legal Service and appearing as a representative of that service.

Mr CHAIR: Excellent. Thank you. When you speak, if you could speak up. We have sometimes a bit of a problem with the recording. If you could state your name when you give your evidence. Would anyone like to make an opening statement?

Ms RIMINGTON: Yes, I would. KWILS is the Katherine Women's Legal Service. We are a community legal centre that provides free and professional legal services to women across the Katherine region. Our main areas of practice are domestic violence, child protection and family law. We also provide general and civil law support, including housing, employment, compensation, credit and debt.

Alcohol and drug abuse touches many aspects of our work with clients. Alcohol is a significant factor in the matters we deal with on a daily basis across all areas of law we practice in, but is particularly relevant in child protection and domestic violence matters.

With regard to child protection, KWILS often represents mothers and grandmothers in child protection proceedings where children have been, or are, at risk of being removed. Alcohol and other drug addictions are often contributing factors to children coming into care. Where children have been removed and a reunification plan has been developed with Territory Families, parents are expected to meet certain milestones and access to therapeutic services ranging from parenting programs, counselling, as well as rehab services for AOD.

Where there are barriers in accessing quality and timely rehab services, this impacts on the reunification of mothers and their children. The current wait time for intake to them now is approximately four months. They have many empty beds that are not currently funded.

We have proactive mothers seeking support from KWILS in their self-referral to Alcohol and Other Drug programs and others are being directed by Territory Families to Venndale Rehabilitation Services. The wait list is often extremely long and can protract complicated child protection matters that re-traumatises families throughout.

Wherever possible, mothers and their children should be able to attend rehabilitation services together. Unfortunately, there are no family residential rehabilitation services in Katherine and women must travel to Darwin to access this type of service. This is a significant barrier for many of our clients and adds to the ongoing trauma and separation of mothers and their children.

If there are improved rehabilitation services for alcohol and other drug dependency, there would be positive flow-on effects in the child protection space.

With regard to alcohol and domestic violence, KWILS works extensively in the DV space, which is plagued by alcohol-related assaults. The data for the Katherine region shows a consistent trend in alcohol being involved in the vast majority of domestic violence incidents attended by police. These statistics have been consistent for the past five years. In 2018 financial year, there were 2641 DV assaults associated with alcohol, compared to 1130 where no alcohol was involved. Many of the domestic violence orders we assist clients with are no-intox DVOs. Often clients want to continue in a relationship with the offender, but only if alcohol is not involved. It is clear that adequate rehabilitation services are required, particularly to reduce alcohol-fuelled domestic violence in our region.

We also come across alcohol issues touching on housing problems. Whenever clients seek assistance in housing matters and obtaining trespass notices, there are issues when tenants have unwanted visitors impacted by alcohol use in their house. When there is damage to public housing due to alcohol problems, this becomes a legal problem and can at times put people at risk of homelessness.

Another point we would like to share with the committee is our experience with the Katherine sobering-up shelter. It is consistently seeing an overflow of people who are

then transferred into protective custody, with no criminal charge. As they are processed, they become at risk of being placed on the BDR for having been processed three times. Therefore, we feel this is criminalising addiction.

Some other service gaps and barriers to recovery that KWILS has seen include social, economic and health needs of clients—particularly financial barriers are an issue. Venndale is $182 per week. If someone is paying rent or maintaining other bills, then this is an expensive treatment option.

There is a significant need for transitional housing for families impacted by alcohol and leaving rehab services in Katherine. This currently does not exist here.

There also needs to be better services for those impacted by volatile substance abuse, which often affects teenagers in our region. There should be earlier intervention services and residential therapy available here.

KWILS submits to the committee that these issues come down, in our feelings, to resourcing and prioritisation and desperately needs meaningful investment in this area. Alcohol is touching many issues that our clients are seeing us about.

KWILS wishes to submit to the committee that the police attending the bottle shops and takeaway outlets has been positive, in our view. There has been some impact and this is a good component of our whole strategy.

Mr CHAIR: Thank you.

Ms NELSON: Hi, Jacqueline and Mary-Anne. I want you to put on public record, if you could please, you are the only women's information and legal service in the Katherine region—in between Darwin and Alice Springs. What areas do you cover?

Ms PHILIP: Geographical areas?

Ms NELSON: Geographical areas.

Ms PHILIP: We cover—is it?—330 000 square kilometres. That is from …

Ms RIMINGTON: We go north to Pine Creek, to Ngukurr, Borroloola, south to …

Ms PHILIP: As far south to Lajamanu. We have …

Ms RIMINGTON: To Lajamanu. Then right into Timber Creek. We also are a community legal centre and are managed by a voluntary management committee of local people. We are the only localised legal centre here. The other ones here have head offices in other—like Darwin and Alice Springs.

We gain our strategic advice and have our ear to the ground through our members. We have also been operating for 21 years in the region. We have six staff—three solicitors, an executive officer, an admin and support officer.

Ms NELSON: It is a small community legal centre that …

Mr CHAIR: Covers half the continent.

Ms NELSON: … covers half of the Territory. Exactly.

Ms RIMINGTON: We try our best to do as much outreach as possible, but …

Ms NELSON: Funding constraints.

Mr CHAIR: Yes.

Ms RIMINGTON: Correct.

Mr CHAIR: Your funding is from?

Ms RIMINGTON: We are funded through the Commonwealth, through three main grants.

Mr CHAIR: Okay. Are they all timed at the same time? You are making those applications at the same time?

Ms RIMINGTON: Yes. Yes, they are and that has been an ongoing issue for us. It has been 12-month contracts—two-years to 12-month contracts. They all have a slip at the end.

Mr CHAIR: So, 50% of your time you have to be filling in forms and then, the other 50% you are covering half the continent.

Ms RIMINGTON: Yes.

Mr CHAIR: You are doing well.

Ms RIMINGTON: Thanks.

Mr CHAIR: Does anyone have any specific questions? Gary?

Mr HIGGINS: When you say the area you cover, have you much link with the ones in Alice Springs? Do you coordinate with them or …

Ms RIMINGTON: There is a Central Australian Women's Legal Service there. We have a great relationship with that service. They are a bit bigger than us. They go to

Tennant Creek and have a great outreach presence. We work quite collaboratively and very closely with the Top End Women's Legal Service in Darwin also. We are lucky in the Northern Territory to have three women's legal services.

Mr CHAIR: Yes.

Mr HIGGINS: When you mentioned before you are the only one that is based here in Katherine and that some others come from Darwin—is how I interpreted it—which ones are they?

Ms RIMINGTON: Sorry. When I say legal services, the big players like NAAFVLS and NAAJA have a great presence in Katherine.

Mr HIGGINS: Okay.

Ms RIMINGTON: The point of difference is that KWILS is a Katherine-based service and only Katherine.

Mr HIGGINS: Okay. So, you undertake similar work to NAAJA and all of those, but specifically women and specific issues?

Ms RIMINGTON: Correct. Also, our clients are both Indigenous and non-Indigenous, although last year 70% of our clients identified as Indigenous. We also can represent women who are perpetrators, as well as victims, in domestic violence matters.

Ms PHILIP: That is filling a significant gap that we see, particularly in the courts. We have a dedicated duty lawyer who is at court each day and goes on circuit court to assist with domestic violence matters. The gap we are seeing is that NAAJA is not funded to do domestic violence work, so they cannot represent perpetrators or alleged defendants in domestic violence orders, unless it is running with the criminal matter. NAAFLS is the North Australian Aboriginal …

Mr CHAIR: Family legal service.

Ms PHILIP: Yes, family legal service. They are only funded to act for applicants or the victim, essentially. So, if there is an unrepresented defendant for a domestic violence matter, KWILS is the only legal service to represent. Obviously, we are only able to represent women. But it is a gap we see.

Mr CHAIR: There is no legal aid for those …

Ms PHILIP: Legal Aid can only act on a duty basis if they have an available solicitor. It means that if a matter goes to hearing, if it is contested then if KWILS is not able to represent them or if they cannot afford a private lawyer, they are not represented.

Mr CHAIR: Okay.

Mr HIGGINS: There is no funding other than through you for domestic violence defendants? That is only …

Ms PHILIP: That lawyer is not dedicated to act for defendants. That is just a gap we see because none of the other legal services are able to fully represent a defendant.

Mr HIGGINS: What about males in that area?

Mr CHAIR: They are the ones who are left short.

Ms PHILIP: We then have the criminal matter that is related to the domestic violence order application. Then their criminal lawyer will usually act in the domestic violence order matter running with the criminal matter. But if it is separate, then there is a gap there.

Mr HIGGINS: It sounds very complex.

Ms RIMINGTON: It is. The funding landscape in legal aid and community legal services is a bit of a mess. But the particular group you speak of about men—in Darwin they are funding a domestic violence duty lawyer service that is specifically for perpetrators, which is often men. That has been a new service because there was a recognition that that was the group that was not being adequately supported through those processes. In Darwin, that duty lawyer service represents the perpetrators. In Katherine, KWILS is funded to represent—the duty lawyer service can be the victims or the perpetrators, but they have to be women …

Ms NELSON: Women only.

Ms RIMINGTON: Women only.

Ms NELSON: And you are a generalist community legal centre?

Ms RIMINGTON: Yes.

Ms NELSON: You are not specific just for domestic and family violence?

Ms PHILIP: Yes.

Ms RIMINGTON: That is correct. We do a huge range of things, but we prioritise domestic violence, child protection and family law.

Ms PHILIP: The other thing is there is no means testing that is required for a client to come and see us. That is particularly important where, on paper, a women might look financially stable, but in fact there might be financial abuse happening in the home or she does not have access to funds, so could not actually pay a lawyer. We have quite

a number of clients who do not meet the legal aid criteria on paper, but are able to come and see us. If they were not able to come and see us, they would not be able to afford a lawyer.

Mr CHAIR: In Tennant Creek, there was a women's service that was going out to communities and talking to women who were, generally, the victims of domestic violence and, effectively, educating them about the problems of domestic violence, even though they are the sufferers. They were quite successful in getting these women to understand the signs when domestic violence would occur—the bingeing of alcohol. Their report was really quite interesting, in the sense that they have seen a marked reduction in domestic violence because they were able to get the women to come in before it became a problem, and provide them with some short-term accommodation to see them through that period. It is probably the same sort of things you were saying before—a lot of them want to stay in the relationship but just do not want the alcohol. Have you any experience of anything like that here?

Ms NELSON: You do community legal education services, don't you?

Ms PHILIP: Yes. We provide that for the client or potential client, but we also provide it for service providers. We have a very significant relationship with the Katherine Women's Crisis Centre. They provide the type of service you might be referring to.

Mr CHAIR: Yes.

Ms PHILIP: We provide training for their workers on domestic violence and child protection because they have Territory Families coming in and wanting to set up meetings with clients. It is important that they have an understanding of what role they play in that. Equally, with domestic violence-type matters, that they understand the legal side of things.

Mr CHAIR: Yes.

Ms RIMINGTON: We try to work on that basis of early intervention and community education. As part of our community legal education strategy, we have, in the past two years, focused on other frontline service providers like Save the Children, Venndale Kalano Association in skilling up other frontline services in identifying legal—or potentially legal—problems for earlier intervention.

KWILS has been approached by a number of community organisations in accessing that community legal education, but again, resourcing is an issue. But there is a huge demand in this area.

The emphasis on early intervention in this space is vital. But it all has to link up. We can identify and move to a point where we could make a difference and change that path and avoid litigation, but there has to be adequately-funded and resourced support services to refer people.

Mr CHAIR: Yes. That seemed to be what—the positive thing there was they had some accommodation. Obviously, it is a smaller population, but they had some accommodation for these women to come to. The women identified themselves once they all talked in the women's group. They then self-identified and came in—took themselves out of the situation and were not reliant on somebody else.

It just struck me it is one of those good example of providing education to people and where it can lead. I have heard a bit about that today and at other times, moving away from that blunt end of the treatment, the rehabilitation—this is not that particular issue—away from that link to education and trying to get into early intervention.

How much alcohol and other drugs comes into the work you do?

Ms PHILIP: It is very prevalent in many of the matters we deal with. Either it is something our clients have experienced themselves, or are experiencing. If it is not a part of their personal journey, it may be a significant part of their partner's or the children's. It is right across the board. It is very much something that comes up.

Ms NELSON: Would it be fair to say that in 80% of your cases, alcohol and others drugs are part of those cases?

Ms RIMINGTON: In consulting our colleagues about this, our principal legal officer believes that it is 99% of our …

Ms NELSON: Ninety-nine percent?

Ms RIMINGTON: … is a part of our child protection matters. Across the board, it is harder to say. I do not know. It is a high percentage.

Ms PHILIP: It is a very high percentage. It is hard to put a figure on it because we also do employment and credit and debt matters. That can be quite a different area, that social …

Ms RIMINGTON: It is easy to say that our two biggest areas are domestic violence and child protection, both of which are hugely impacted by alcohol issues. It is on the outside of those issues, but really informs how we progress with that. It is particularly obvious in child protection matters when we have a mother with a reunification plan that requires her to attend services in order to get her child back.

Ms NELSON: Regain custody.

Ms RIMINGTON: Yes.

Mr HIGGINS: In your opening statement, you mentioned figures for 2018. Can you give us what they were again?

Ms RIMINGTON: Sure.

Mr HIGGINS: I think it was 2800 or 1000 and something—I made a note here—that were alcohol-related.

Ms RIMINGTON: Yes. These statistics are just from the Katherine police for the Katherine region. From July 2017 to July 2018, there were 2641 DV assaults with alcohol involved, compared with 1130 where no alcohol was involved.

Mr HIGGINS: So, they were just domestic violence assaults?

Ms RIMINGTON: Just.

Mr HIGGINS: Yes, okay.

Ms NELSON: Alcohol involved.

Ms RIMINGTON: And not. But it is important to note that this is just that …

Mr HIGGINS: That is three to one. I did my maths wrong.

Ms RIMINGTON: Yes.

Ms PHILIP: And that does not necessarily mean that in the assaults that do not involve alcohol, that alcohol is not a broader issue in that relationship. It may just be saying that those incidents …

Mr HIGGINS: It could have been drugs.

Ms PHILIP: Yes, but just because on that occasion there was no alcohol involved, it does not mean it is not involved in the relationship on other occasions.

Ms RIMINGTON: When talking about these DV statistics, these are just reported DVs …

Ms NELSON: It is not what is captured.

Ms RIMINGTON: It is not the full picture of the …

Mr HIGGINS: Well, I think a lot of police are treating domestic violence as welfare checks. One of the things I hear anecdotally at the moment is that they are not being treated as domestic violence. I say that anecdotally, you do not have to respond to that at all. It is okay.

Ms PHILIP: There were a number of matters that I would like to add to, that Jacqueline touched on in her opening address. The first is about alcohol and housing issues, linking in with clients who are going through a rehabilitation phase. We have a client who has gone through the child protection court system and went through drug rehabilitation. She is a young mother who has been through a lot in her life and made significant progress in the rehabilitation side of things. She was then put on a reunification plan with her child and was making a lot of progress.

One of the significant drawbacks was that she resides by herself, keeps to herself. When family members who have alcohol issues were being arrested or stopped by police, as part of the police guidelines, my understanding is they must or should ask the person they have apprehended whether there is a safe place they can take them—safe family member's house they can take the person who has been apprehended to.

They were nominating her address. She is a very young mother who had been through her own journey and made significant progress. She was constantly—and this is every weekend and potentially multiple times in a weekend—having intoxicated family members who are much older than her, in very volatile situations, being dropped on her doorstep. It was getting to the point where she was repeatedly telling police—it is not that they are being dropped off by someone else, it is by someone in authority …

Mr CHAIR: Someone from police.

Ms NELSON: The police, yes.

Ms PHILIP: She was repeatedly saying, 'You cannot. Please do not bring this person to my house.' We had written letters and spoken to police and it was continuing to happen.

That, I guess, ties into a real deficit in appropriate services in the community to service that need. These are people who need to be in a safe place—they are intoxicated—but they have been …

Mr CHAIR: Dumped on somebody who is …

Ms PHILIP: The authority is dropping them off.

Ms NELSON: Why are they not being taken out to the dry-out centre—Mission Australia?

Ms PHILIP: that is the next thing I wanted to address. As Jacqui has mentioned, there has been a trend of the sobering-up shelter being too full to accommodate people who are needing to access that. I have a client who was picked up by police. She requested voluntarily to be taken to the sobering-up shelter. On that night it was full, so she was then taken to the police watch house. Purely because there was no space

she was then taken to the police watch house. She needed to be processed under their requirements …

Ms NELSON: Of course.

Ms PHILIP: … which means she, essentially, was taken into custody. She was fingerprinted and her photograph was taken. For her, the consequence—unfairly in my opinion—was that she had previously been taken into protective custody for other reasons twice in that year. On this third occasion she was taken into protective custody for no other reason than she asked to be taken to the sobering-up shelter …

Ms NELSON: And they claimed they were too full?

Ms PHILIP: That is right. She was then taken into protective custody for the third time that year for a completely different reason not her fault and placed automatically on the Banned Drinker Register. That was put on her record, in that sense, and that is purely through no fault of her own—purely because there is not enough resources to assist her.

Ms NELSON: I will challenge that claim by the sobering-up shelter that they are at capacity. I went with the police several times and have gone to the sobering-up shelter when I have been on those ride-alongs, and have not seen them at capacity. So, I challenge that. It really concerns me. We have one sobering-up shelter in Katherine. Yes, it is because of situations like this where, if they are refused at the sobering-up shelter, then there is no other choice than to take them to the watch house, and all of a sudden they have a record.

Ms PHILIP: It is really positive that clients are actually nominating to go somewhere safe.

Ms NELSON: Yes, of course.

Ms PHILIP: If this trend continues, then it is concerning to think about what impact …

Ms NELSON: Exactly.

Ms PHILIP: … how that impacts with clients.

Ms NELSON: Yes. It will mean that they will not want to nominate to go to a safe place to sober up.

Ms PHILIP: And they might end up somewhere very unsafe.

Ms NELSON: Exactly right.

Mr HIGGINS: An interesting question for me was when they took the children out of Don Dale and put them in the watch house, did they get processed, fingerprinted and photographed? An interesting question, isn't it?

Ms PHILIP: Yes.

Mr HIGGINS: Were they processed the same? What was the difference between them and your client?

Ms PHILIP: Yes. My understanding is that there are processes they must go through if they enter the watch house.

Mr HIGGINS: That is why I asked the question about the children. Were they treated the same as your client? It is an interesting one.

Ms NELSON: That completely goes against what we are trying to do, but the reason for this select committee is harm minimisation. The whole focus is that we are trying to move away from criminalising addiction and treating it as a health issue. I have real concerns and am really critical of the fact that government provides funding for a service like a sobering-up shelter and it is not being …

Ms PHILIP: Yes. And I guess that flows through in harm minimisation through rehabilitation facilities. Jacqui has mentioned Venndale as being the only service of that kind in this immediate vicinity.

We are obviously dealing with a lot of mothers in child protection matters. When there is a waiting list, like the one that Venndale has, you have mothers who are essentially choosing between, 'okay, is it my child or is it …'—because if they are having to move outside of the Katherine region to access rehabilitation facilities they do not get to have access to their child …

Ms NELSON: To their kids.

Ms PHILIP: … if they are up in Darwin.

Ms NELSON: That is really interesting because when we spoke to the Tennant Creek Women's Crisis Centre, one of the things they said was that their clients—not the women's crisis centre—who was that? One of the agencies or organisations in Tennant Creek said that their clients are always asking to be referred to a service in Darwin or Katherine—outside of Tennant Creek because they do not want to go through rehab or access support in their communities. You are saying it is different …

Ms PHILIP: Yes, that is certainly not the case …

Ms NELSON: That is not the case here. Okay.

Ms PHILIP: … here, it is the complete opposite. It is not to say that individual clients may not have reasons for not wanting to go to rehab in a particular area if there are family or cultural issues. The trend is certainly the opposite of that here.

Ms NELSON: Which goes along with the other evidence that has been provided all day today—there needs to be a whole family focus and approach—that holistic approach. It is interesting, to be honest with you, nothing we are hearing throughout this entire select committee process—that I am hearing—is new.

You do not treat addiction singularly. It is not an isolated issue. Addiction, obviously, affects everybody that the addict is in contact with. But yet, it seems that we all—successive governments—have been—I am sorry, I will get off my soapbox …

Mr CHAIR: You are right.

Ms NELSON: Thanks, Gary.

Mr HIGGINS: No, that is all right. You said before that waiting list for Venndale was four months. Is that for everyone, or is that voluntary?

Ms RIMINGTON: That has been our advice when we were trying to refer clients, or clients have been told they need to access that service, possibly …

Ms PHILIP: Most of our clients are accessing it voluntarily. I cannot really say if someone has been sentenced and part of that criminal sentence is that they need to attend a rehabilitation facility. I am sure it may be that it is different. In terms of our clients voluntarily accessing it, that is our understanding that there is a …

Mr HIGGINS: So, you do not know whether there are so many beds allocated to voluntary, as opposed to compulsory?

Ms PHILIP: I could not speak to that.

Mr HIGGINS: Okay. But those wanting to get in there voluntarily are four months waiting list?

Ms RIMINGTON: At the moment, that is the advice we have received.

Mr HIGGINS: Yes.

Ms NELSON: We have Venndale coming up next.

Ms RIMINGTON: Yes. They should be able to speak on the specific question. But we have …

Mr HIGGINS: I will ask them. It is down to me. Can you answer that question when you come up here? If we can get a …

Ms RIMINGTON: We have women also, who are proactively trying to seek treatment to mitigate any potential issues. A real-life example last week was a person coming to KWILS who had been referred by police to KWILS for help trying to get into Venndale. We are hearing positive things about Venndale. KWILS would support the increase of Venndale's resources, especially if there was emphasis on family residential care here.

Ms NELSON: That family residential care is a big need.

Ms RIMINGTON: We strongly support that.

Ms PHILIP: It is something I understand CAAPS provides. When we have clients who might be quite stable normally, but have had some trauma occur in their life which has resulted in their child being taken into provisional protection or temporary protection by Territory Families. I have sat in on quite a number of case conferences where Territory Families was saying, 'We are quite happy for your child to stay with you if you are in a rehabilitation facility'. Mum is saying, 'Yes, I want to do that'. But Venndale does not offer that because they do not have the funding for that. So, CAAPS is looked at as an option, but obviously there is a waiting list involved there. If mum has other children who are in other situations, it just means mum cannot have access with them if she is in CAAPS with one child.

Ms NELSON: Of course, yes.

Ms PHILIP: So, it can be quite difficult and stressful for the mother if she is in a position where she is having to choose again, in terms of her personal recovery and time with her children.

Ms NELSON: I have one more question.

Mr CHAIR: We might make it the last one because we have to move along.

Ms NELSON: Thank you. To go back to something you said earlier about having the police in front of the bottle shops—the upcoming police auxiliary officers. It is KWILS position that you support that program? If you could just elaborate, because it is obviously an emotive issue and quite contentious in Katherine.

Ms RIMINGTON: We do not have any specific data to draw on to say that there has been an improvement, but our feedback and the advice from my colleagues is that it has been positive. The concept of early intervention, police presence, has been effective. That is all we can way on that.

Ms NELSON: That is interesting.

Ms PHILIP: Obviously, going along with that, the way that police or security conduct themselves in that environment is paramount and important. If particular members of society are being prejudiced through that process, that will obviously end up being a negative. But if there is …

Ms RIMINGTON: If it is consistent and fair and there is no profiling involved …

Ms NELSON: It is the consistency that I have an issue with. I am supportive of any program that mitigates harm and reduces the potential harm related to alcohol, but if it is not across the board—we have police in front of bottle shops in Katherine, Tennant Creek and Alice Springs, but that same program is not extended to Darwin. I have some concerns about that. We are essentially pushing or kicking it down the street.

Ms PHILIP: Not many …

Ms NELSON: It is the consistency.

Ms PHILIP: It is consistency in the way that people are treated as well within the same area.

Ms NELSON: Yes. Thank you. I am done.

Mr CHAIR: Sandra is done. We are okay. Is there anything else you would like to say?

Ms RIMINGTON: We would like to thank the committee for inviting us to give evidence today. Thank you.

Mr CHAIR: No problems. Thanks for coming along. It has been a pleasure.

The committee suspended.

Katherine Doorways Hub – Salvation Army

Mr CHAIR: Harley, welcome. How are you?

Mr DANNATT: Good afternoon.

Mr CHAIR: On behalf of the committee, I welcome you to the public hearing into reducing harms from addictive behaviours. I welcome Harley Dannatt to the table to give evidence. Thanks for coming before the committee. We appreciate you taking 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 recorded. A transcript will be made available for use by the committee and may be put on the committee's website.

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

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

Mr DANNATT: My name is Harley Dannatt. I am the coordinator for the Katherine Doorways Hub, which is a program of the Salvation Army in Katherine. Katherine Doorways Hub is a pilot program funded by the Department of Housing and Community Development in the Territory. We have been operating for approximately 12 months, since October 2017. The Katherine Doorways Hub is a community space drop-in centre in central Katherine. We are open five hours a day, five days a week. There is no limitation on who comes through the door, but we are set up primarily just for people experiencing or at risk of homelessness in Katherine.

In our first 12 months, we have had approximately 17 500 individual daily attendances, which equates to …

Mr CHAIR: Every day?

Mr DANNATT: That was …

Mr CHAIR: You are really busy.

Mr DANNATT: That was 12 months. We see between 80 and 100 people come through the doors every day.

Mr CHAIR: Wow!

Ms NELSON: Five days a week?

Mr DANNATT: Five days a week, for five hours.

Mr CHAIR: Eighty?

Mr DANNATT: Eighty to 100. That number has slightly crept up over the 12 months. We are funded currently until the end of June 2019. We are seeking ongoing funding beyond that. Shall I continue?

Mr CHAIR: Yes, if you have anything you would like to say, more than happy to …

Mr DANNATT: As I said, primarily we are a community space. Our first priority is to be a safe, inclusive environment for anybody in the community, bearing in mind that we are predominantly targeting people who are homeless. Most of our clients are either sleeping rough or come from an overcrowded or unsuitable situation—a highly transient community and approximately 98% identify as Aboriginal.

Our second priority is to provide access to amenity and health hardware which we have at the hub—showers, washing machines, toilets, cold water and two meals a day. We have breakfast from 8.30 am, then we serve soup at 11 am with bread. There were approximately 4500 lunches served in the first 12 months. We assist with clothing if people need clothing, then referral to emergency relief for donated food.

Our third priority after access to health is support services. As a hub, we have a network. We work collaboratively with a range of mostly Katherine-based services, which either come into the hub to engage with their clients, or we are referring our clients out to the other services in a managed way.

The hub was set up as a project of Katherine Accommodation Action Group, which is an informal network of service providers in Katherine, chaired by NT Shelter. For a number of years, that group worked towards something like a hub—a multipurpose space that could fill the gaps. Katherine works very well as a network of services. We know each other and call each other all the time. The hub is set up to be a space to coordinate those different services so they have that continuity and formalised approach to that networking.

Ms NELSON: When you have a client at the doorway hub, on the day, instead of having that client travel all the way through the Katherine township to visit you—there is Centrelink and then everybody can just …

Mr DANNATT: Yes, it is centralised. You can use the term one-stop shop …

Ms NELSON: One-stop shop.

Mr DANNATT: … if you like, yes. We may assist a person to go elsewhere. Some services come to us on a regular basis. Some will come as needed. That is legal services, KWILS, who you just spoke to. They come on a regular basis. The Women's Crisis Centre comes on a regular basis, CatholicCare, financial counselling through Anglicare, more legal services from NAAJA and more.

What is relevant to this committee is that the hub is an engagement space. We see it as a friendly, safe, inclusive space. I do not have the figures or a way of recording this information, but I can say with confidence that our regular cohort—and we have a range of people, approximately 60 to 100 people who attend four to five times a week. We also have new people come in regularly. A vast majority of our regular client group

have long-term substance abuse addictions. That is across all age ranges from younger clients through to older clients who have onset, very developed health issues.

As I mentioned before, many of our clients sleep rough or in bush camps. Many of our clients could be identified as people who are, at other times of the day—noting that we are open in the morning from 8.30 am—associated with public drinking. Our clients are largely high-needs, very complex cases. The purpose of the model of the hub is to engage with this cohort of the community who otherwise are very difficult to engage with.

Mr HIGGINS: Just a quick question. The age group—you said a variety. What is the age range?

Mr DANNATT: Actually, we did a snapshot two weeks ago, where we actually recorded that. In that snapshot week, we had 285 individuals come, with a total of 480—I did not bring the exact numbers, but this is …

Mr CHAIR: Yes, roughly.

Mr DANNATT: … not an exact number—285 individuals and 50% of those individuals were aged between 35 and 55. We had 29 children under the age of 18 and most of those children are younger children coming in with families. Then again, the balance are the more elderly, older than 55, then younger people between 18 and 35. Predominantly, it is that middle age group. Sadly, a lot of our clients do not reach a great age and many of our clients who are over 55 present with health complications which might mirror a person in their 80s. I am not a doctor, that is just an observation.

Mr HIGGINS: What percentage of the addictions, roughly, would be just be alcohol?

Mr DANNATT: The vast majority is alcohol addictions, some cannabis use, rarely any other substances. I should also note, for the purposes of this committee, gambling is significant, particularly poker machine gambling in Katherine. Cigarette and tobacco addiction is close to 100%. That is an observation, again. It is not something we record, but it is significant.

Mr HIGGINS: Do you think a lot of that addiction—say, with the gambling—can lead to a lot of them sleeping rough because they are spending their money there? Or …

Mr DANNATT: This was something I would have come to. The financial component and any financial lever needs to be really looked at pretty closely with this cohort that come through the hub. I am not in a position to say whether people put their addictions first and that is why they have no money, or if there are any other factors at play. It is certainly very complex.

What I can say is our clients who are addicted to alcohol will spend what money they have—if a client is addicted they will source what they require. It regularly means that

clients go without and feed their addictions before meeting other needs. We do not doubt that. But it certainly is a complex situation.

That is one of the main reasons the model of the hub is to form relationships with people and unpack a very complex set of circumstances. Addiction is generally a factor to ongoing intergenerational financial hardship. Trauma, legal and health issues are generally all closely tied together. Any individual presenting at the hub, it is difficult to treat or suggest a strategy that would only deal with one of those. You have things that you consider to be effective.

Mr HIGGINS: Do you get many clients you are able to refer to some of the other services?

Mr DANNATT: Yes.

Mr HIGGINS: Yes, go on.

Mr DANNATT: We tend to have a very good relationship with Venndale and VTAC, through the K.I.S.P. program, which, I believe, may have been presented to you earlier.

Mr CHAIR: We know them, yes.

Mr DANNATT: We work closely with the K.I.S.P. program. Through that program we have a Venndale rehabilitation worker attending the hub most days to support K.I.S.P. clients who might be living at VTAC and presenting to the hub as part of their daily routines. Out of that relationship, we enjoy a very fortunate position of that Venndale worker being able to accept immediate referrals from our clients who put their hands up and say, 'I want to go into rehab'. That has been highly effective. Almost the day it began, clients who would otherwise just be coming for their breakfast, immediately started putting up their hands.

I understand too that Venndale's capacity is probably not something it would be able to extend to every service in Katherine. We are very fortunate in that regard to have that pathway. If I compare that pathway of having a worker who comes regularly to the hub people will get to know and see as a familiar face, they can immediately say, 'I am looking for help', and immediately have that contact to another rehabilitation's intake pathway—say, a Darwin-based service, which we refer to from time to time as sometimes Venndale is not appropriate—it could not really be more different. I strongly support a pathway with effect immediately—first to get to know someone and speak face-to-face, particularly with this cohort, and then have that immediate response. Many of the other rehabilitation centres are quite bureaucratic in their intake.

Form filling is fine for me. I am happy to help people with forms, but there is often a call-back and the client may go away, they might leave messages with me. That is the sort of work we do with our case management. But that is where things fall down.

Yes, I guess there are two different experiences there. One is often not effective and by the time somebody is accepted into a Darwin-based program, their circumstances might have changed and it might not be appropriate, compared to that face-to-face.

Mr HIGGINS: Some measure of your success should not be in having people rehabilitated, but more in how many people you are able to refer successfully.

Mr DANNATT: Yes. Part of the fluidity of that relationship is that we have not necessarily been able to provide that as a firm statistic. I do not have that statistic …

Mr HIGGINS: No.

Mr DANNATT: I can investigate it, but …

Mr HIGGINS: It would be very hard to get …

Mr DANNATT: Yes. As I am sure the committee is aware, we do not consider one stint in that rehab to necessarily be likely to be effective. Again, where the hub sees itself fitting in this, is that a person may go to rehab, then come back and see us and we still have that relationship. So, that is okay. We will try something different. For whatever reason it falls through, the hub remains there as place to come back to, and then to go off …

Mr HIGGINS: Better than the legal system.

Mr DANNATT: Yes, in looking at the pathways that lead a person into rehabilitation and which are the pathways that will be effective, if you could compare somebody being perhaps ordered by the court to attend, compared to, over time, getting to know your case manager and then, in a holistic way, whilst other areas of their lives are being addressed, going to rehabilitation, possibly not completing it, coming back and going again, my submission is that will clearly be more effective in the latter.

Having said that, some people probably benefit from the immediate cold-turkey approach of ‘off to rehab’. Perhaps they rehabilitate immediately, but for the cohort we are talking about who have been drinking for a very long time, it is difficult to see that a one-off mandated stint will make—it does not make it, not for the long term.

Mr HIGGINS: Someone this morning said mandated abstinence is not necessarily the solution, you have to find the underlying problems …

Mr DANNATT: Yes.

Mr HIGGINS: … which you have the potential to find, building up that relationship.

Mr CHAIR: Does that give you access as well to other family members? By the sounds of it, you are getting some hard-core, problematic drinkers or addicts. Do you ever get the opportunity to get to some of the ones earlier in the process?

Mr DANNATT: Yes. Everyone is different. Certainly, when you see a younger person who is drinking heavily, there is a strong impetus to really try to help them. I was working with a young man in his 20s. He actually had a seizure from drinking too much alcohol at the hub and went into hospital. That is something for a young man to have that sort of seizure. We see it from time to time with older people. After that episode, he came and said, 'I want to stop drinking. I will stop drinking if you can enrol me in a literacy and numeracy course. I really want to change my life. I really want to do this.'

Mr CHAIR: There you go.

Mr DANNATT: I said, 'Yes.' Then, unfortunately, he had to go to Alice Springs for a funeral and has not come back.

Mr CHAIR: Yes.

Mr DANNATT: It is just a very windy, windy road.

Mr CHAIR: You have to keep trying.

Mr DANNATT: That is where the hub fits in. It is windy road for people, but it is a stable point. When you are in Katherine, you can come and take a step towards getting back on the horse, on the cart …

Mr CHAIR: The straight and narrow, whatever it is called.

Mr DANNATT: That is the only way you will really engage with those people whose lives are very chaotic.

Mr CHAIR: You probably said this, but how many case managers do you have working with you?

Mr DANNATT: I am the coordinator of this program and I case manage as well. There is one other case manager. The program also funds half of a support worker position.

Mr CHAIR: Right. Okay.

Mr DANNATT: The Salvation Army also has an officer who works at the hub …

Ms NELSON: So, 17 5000 individual attendances with two full-time workers and one part-time.

Mr DANNATT: Yes, 2.5. I would …

Mr CHAIR: When do you scratch yourself?

Mr DANNATT: Our funding process is going forward and we are seeking an increase for an additional case worker and additional support worker.

It is a pilot. We never knew what the demand would be. It kind of makes sense at the same time. In Katherine, we know there is a high need, but we opened the doors and everyone came in.

Mr CHAIR: You said it was the Department of Housing …

Mr DANNATT: Department of Housing and Community Development.

Mr CHAIR: That is the Territory Department of Housing?

Mr DANNATT: Yes.

Mr KIRBY: Would there be many clients you were seeing at the start of the program 12 months ago that you are still seeing regularly?

Mr DANNATT: Absolutely. Yes. Some of the case management pathways have continued the whole length of the 12 months. Some people are in and out more quickly. As I said, we do not see complete—we rarely see—solving of all the person's problems. We are looking at making small steps and supporting healthy living. That is the realistic benefit.

There is a client who is a man in his late 50s, a long-grasser drinking all of his life. He is also a K.I.S.P. client. When he initially came to the hub, every two weeks he would ask for a new set of clothes. He would just wear his clothes until they were absolutely soiled, and then come in for a new a set. We got to know him. We did not think he spoke, we thought he was unable to speak. But over time, we slowly built up to a point where he stores his clothes. We have storage lockers and he stores his clothes. We showed him how to use the washing machine. He now has three sets of clothes and cycles through them. He washes his clothes and changes them every couple of days. We consider that an achievement. We have a range of successes. That man now presents and talks to us every day. He is wearing clean clothes and his demeanour has completely changed.

Some people might consider that not much of a success, but this is a guy who had those patterns for a very long time. He also stores his medication with us, so he takes his medication regularly.

Mr CHAIR: That is good.

Ms NELSON: That is great.

Mr DANNATT: Yes. It is as small thing, but …

Mr CHAIR: It is important in someone's life.

Mr DANNATT: Yes, but it is not necessarily—he has a long way to go …

Mr CHAIR: Yes.

Mr KIRBY: It might not be Nirvana, but it is a long way from where he was.

Mr CHAIR: We will have to move on. Is there anything else you would like to say? What you have given us so far has been really interesting.

Mr DANNATT: No, that is it.

Mr CHAIR: That is it? Excellent.

Mr DANNATT: Thank you very much.

Mr CHAIR: Thank you very much for your time.

Ms NELSON: Thanks Harley.

The committee suspended.

Venndale Rehabilitation and Withdrawal Centre (Kalano Community Association)

Mr CHAIR: On behalf of the committee, I welcome Casey to this public hearing into reducing harms from addictive behaviours. I 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 will be recorded. The transcript will be made available for use by the committee and may be put on the committee's website.

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

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

Mr BISHOP: Casey Bishop, Venndale Rehab, which is a program of Kalano Community Association Aboriginal Corporation, which is a section of Kalano Community Association. I have been the program manager there for 12 years.

I did not prepare an opening statement like the KWILS ladies. They did very well.

Mr CHAIR: Yes, they did well. Some do, some do not. It is okay. You do not have to. We do not expect you to have something prepared. But if you would like to tell us a little about Venndale, please.

Mr BISHOP: Sure. Venndale is a residential facility with 35 beds. Twenty are funded mutually by NTG and the feds for 20 health-related beds, as we call them. Another 15 are by the Northern Territory government Department of Corrections for correctional obligated clients. They are supposed to be for general leave permit people, but that leads to a lot of red tape at the prison end, so that does not happen very often. We only have two in there. We agreed to fill that with people with correctional obligations while there were not any GLPs.

The program is 84 days long, at a minimum. To get a certificate, you have to be there for a minimum of three months. But we take people out to 12 months. We have had one guy there for 18 months now through both programs. Harley mentioned VTAC. That is one of my programs as well. That is our care facility funded by PMC for about the last five or six years.

We have a good program out in the sticks. It is probably the ideal location for any rehab in the Territory. I think we have the best location. We have all the rehabs. We are not two minutes from the pubs. You have a good 40 kilometre walk if you are that thirsty. Yes, it is a good spot. We only recently got phone service out there. We have been fairly primitive in our setting for a long time, but it has allowed us to do better things. Our statistics are attributed to our location in most cases.

We are full all the time. We have statistics—not recent ones, up to 2015—where we can justify the need for about 58 beds at a time based on how long our clients stay versus how long the waiting lists were from 2009 to 2015. We could justify 58 beds. We had 48 at one point, then thankfully, mandatory rehab was canned, so we lost 12 beds there and did not get them replaced. Now it is just 35 and 14 at VTAC. Four of those beds are funded through the K.I.S.P. program, which they have spoken about. I believe K.I.S.P. is or will be made fairly evident to you. We now have plans to keep it going.

It is the first time in my 12 years that Katherine services have worked so well together. It is really good to see orgs not worrying about who is getting what and not competing

for dollars and more or less everyone getting on with supporting the issue of the clients. It is really good.

For someone who did not have an opening statement, I could keep going.

Mr CHAIR: You have done well.

Mr BISHOP: There is so much …

Mr CHAIR: It is easier than you think.

Mr BISHOP: In answer to Gary's question, we never say no to a self-referral. A self-referral is someone who comes through a non-legally referred system. An argument we continuously have is that people who come from KWILS or NAAJA are not self-referrals. They are self-referrals, they decide to come to Venndale. But we do not classify them as self-referrals in our acceptance side of things. If someone comes through the K.I.S.P. model—I do not know if you noticed Harley said we would always make room for his group, but then the lawyers are saying there is no room.

That is how we segregate as far as the waiting list goes. Any self-referral—which are very few and far between—are given immediate beds, whether we are at capacity or not. The legal referrals are the ones who are sitting on that waiting list for four months.

Mr HIGGINS: So, your self-referrals would be the ones that will walk the 40 kilometres out to you.

Mr BISHOP: Yes, they will come …

Mr HIGGINS: As opposed to someone who will drive out there, get the lawyer to drop them off and say, 'Go in there and tell them you want a bed'.

Mr BISHOP: Yes, that is a good analogy of one …

Mr HIGGINS: Yes.

Mr BISHOP: That is good.

Mr HIGGINS: You said earlier that the mandatory treatment, thank God, was got rid of. Why?

Mr BISHOP: Because it was mandated. The funding was a little iffy as well, from a financial standpoint. It was not funded well, which was hard for us. We are seeing the same thing with the NTG corrections funding. It is about half what Health give us.

We are always faced with those battles. Unfortunately, there was a feeling back when we took this on. You just want to keep doing what you can as far as helping them with

their AOD issues. We had to say yes, we felt. I notice another rehab has knocked it all back, as far as mandatory rehab goes and also the COMMIT funding and all that sort of stuff. I know some people have knocked it back, but we felt it would be irresponsible for us to turn that down.

In answer to your question, just the mandated side of things …

Mr HIGGINS: If you do not want to be cured, you will not be cured.

Mr BISHOP: Not under the circumstances. The people who were put in for the mandatory treatment were often quite difficult, with very complex needs, and often very ill as well, health-wise. Homelessness was really the main reason they were coming to us, because they fell down drunk three times, whereas my inmates had fallen down drunk four times, but they are inside a house when they do it. There were all those issues.

Our biggest issue is the social problems that surround treatment—all the housing issues, kids in welfare. There are 100 different issues that contribute to someone relapsing over and over.

Mr HIGGINS: Do you only do alcohol?

Mr BISHOP: AOD, alcohol and drugs. One thing I would mention is we do not do withdrawal. We are not a withdrawal centre. We used to be years ago.

Alcohol and cannabis is the bread and butter, so to speak. Alcohol is nine out of 10. Sole cannabis is one out of 10, but most people drinking smoke cannabis as well as a poly-use system. It is very common. There are very few methamphetamines, probably two at a time and VSA—one every six months.

Mr HIGGINS: Any ice?

Mr BISHOP: Yes, methamphetamine, that sort of thing. We always have two at a time there.

Mr HIGGINS: When you say your program is 84 days. I have forgotten. It might have been Banyan House I went to. One of the problems they highlighted with funding for their rehabilitation-type program is—do not quote me on this—they may have been funded for, say, 90 days—three months or 12 weeks. They said that for ice people, you may feel that has overcome their problem, but there is some sort of relapse after that. Have you found that with any other drugs?

Mr BISHOP: Every drug.

Mr HIGGINS: Yes, okay. Righto.

Mr BISHOP: The analogy …

Mr HIGGINS: The temptations is always there.

Mr BISHOP: Yes. How many times have you tried to get on a diet?

Mr HIGGINS: Do not talk about …

[All members speaking]

Mr HIGGINS: I have struggled with this all my life. Next you will bring up my gambling problem.

Mr BISHOP: No, well, it is for anybody.

Mr HIGGINS: I know exactly what you mean.

Mr BISHOP: I am a former addict and I was 175 kilos once, so I know exactly what it is like.

Yes, quite often the first question we are asked by people who do not understand is, 'But you keep getting people come back through the system'. Well, that is how rehab works, unfortunately.

Mr HIGGINS: That is why I asked the question.

Mr BISHOP: Lots and lots, with every drug

Ms NELSON: It is very rare to find that one person who went to rehab the first time and stayed clean forever after.

Mr BISHOP: Very rare, yes.

Ms NELSON: Exactly.

Mr CHAIR: You mentioned COMMIT. Do you find any difference between the old AMT and the COMMIT program?

Mr BISHOP: Okay. The COMMIT thing is a bit strange for us because we are not really funded to take more people. We were given funding for two positions, with COMMIT money. We then found out later it was COMMIT money. So, we have never really had an arrangement to take COMMIT clients.

One thing with Venndale is we do not care how they come in. We do not categorise them at the start process. I know that sounds very cliché. We have had probably 10 COMMIT clients in the last 12 months. As far as the difference goes, yes, they are

painful—very painful—clients. They cause a lot of grief. I have never been subpoenaed to court until I took a COMMIT client. I have never had a contested breach of bail until I took a COMMIT client—very difficult clients to work with. However, they deserve treatment and our model is about keeping people out of gaol.

We are happy to work with anyone. Our motto is, basically, we do not care where you have come from, we care where you are going. A huge difference. I understand they are a troubled client for the prison, so I get it.

Mr CHAIR: All right. Anyone else? We have some questions pre-prepared.

Mr BISHOP: Good.

Mr CHAIR: Sometimes we ask them, most of the time we do not.

Mr BISHOP: Better to send them through last night.

Mr CHAIR: Sometimes we just go off on tangents.

Mr BISHOP: No, that is all right.

Mr KIRBY: You have been in the game quite some time. Have you seen patterns with drugs—I guess ice is very prominent for people's discussions at the moment about how difficult it is and the destructive behaviours. You have been in the game a number of years, you would have seen it.

Mr BISHOP: As far as Venndale goes, alcohol has not changed. Alcohol is, in my opinion, on the increase as far as people being younger and drinking. Cannabis is now into 10-year-olds, 11-year-olds, 12-year-olds. The same thing. The use is not changing, it is the age demographic that is changing, in my opinion.

However, methamphetamine, no. We are very lucky at the moment that a lot of our mob on communities are scared of it. Thankfully, they are scared of it. Yes, there are some economic issues as far as people are making money from sly grog before they are taking a risk and selling sly drugs, so to speak. There is a lot of that stuff going on that would contribute to it. As far as I am aware, it is hard to come by as well. That is the message I am getting.

Mr KIRBY: We have had similar feedback in Tennant Creek and places like that. They did not think it had infiltrated communities very heavily …

Mr BISHOP: It is a non-Indigenous problem, to be honest with you. I do not want to categorise it by skin colour, obviously, but we are finding most of our people being referred for methamphetamine use are non-Indigenous and are being sent away from their centres. My finding is 50% are people with parents who can afford the treatment

and would rather hide the issue than face it, and will send their kids away to get it treated.

None of the methamphetamine users—because I have a close relationship with Banyan. When I have gone there, quite often they have had to leave me outside and hide people first because they are from Katherine and it is a small town. I am aware of the fact that there are a lot of Katherine methamphetamine users in treatment in Darwin. That would be for the simple reason they do not want to be seen here.

Mr KIRBY: Yes.

Mr BISHOP: You cannot blame them. It is a stigma they will have for the rest of their lives. But now, alcohol and cannabis has not changed and thankfully, methamphetamine is not... There is more knowledge about aerosols amongst the kids. I do not treat kids yet.

However, prescription stuff is getting bigger. People are understanding the value of tramadol and codeine-based stuff. It feels good to take it. Voiding memories and trauma issues and all that sort of stuff is something that these mob have to deal with a fair bit and do a fair bit.

Yes, there is no real increase on the main drugs, though—alcohol and cannabis and nicotine, but that is a third one down the road for us. Alcohol and cannabis are our main …

Mr KIRBY: If you had the opportunity to try something different with those substances that are continually abused, what would you do?

Mr BISHOP: You do not have all day. You do not have enough time. It will sound a bit silly, but personally, I would open licensed venues more—24 hours a day if need be. I would make controlled environments for consumption of alcohol. I will not say I would legalise cannabis. I will never say that, although I see the benefits and the disadvantages as well.

We are taking a prohibition approach to some things that I would not do. Police on the bottle shops is a fantastic idea as a deterrent. However, I do not think the Banned Drinker Register makes an inch of difference to the people who are on the Banned Drinker Register. They still access alcohol. You are cutting off one way of accessing it, but there are plenty of ways to get it.

Yes, I would do things a lot differently, but that is just me, from what I have seen Takeaway is a bad element and problem we have to deal with because the consumption is unsupervised. If you could supervise all consumption, it would be fantastic. I am sure there are people who would disagree with that.

The main positive thing I am hearing—because, obviously, in a small town I get other people's opinions given to me a lot as well. The one I agree with really is that if you are not employed, that would be the takeaway barrier, as in employment or some sort of application process to purchase takeaway. I have said a thousand times, I do not think licensees should be punished, they are running a legal business. I also believe that because of the climate at the moment, licensees are too scared to sell alcohol to anyone intoxicated because they are scared they will be shut down. I do not think they are doing it intentionally. I am not a drinker, but when I was I could fool my way into eight or 10 clubs if I needed to, just by walking straight.

There are lots of things we are doing very differently at the moment that I find hard to comprehend, but that is just me—the strike rules and where did you have your last drink and all that. It does not ask where you had 15 before that, which is usually on someone's back verandah at home, because people cannot afford to drink all night in the pub so they do not come out until 10 pm. They have had 10 before they get there. As I said, you can fool your way into a venue. Until there is a legal measure of intoxication, it is really hard to police that.

I do not want to can the policies that are in place. You guys are doing some productive stuff at the Menzies Research that will hopefully bring everything to fruition and shed some light on what is missing. It is good at the moment, it is very proactive.

Yes, police on the bottle shops is keeping people away. I have seen it. I have seen when they will come out of Last Chance, which is the Crossways Hotel, and run back in and say, 'Police are not there yet', and you will see the place just evacuate until the police get there at 2 pm. It is evident it is happening. But it all boils down to the fact that they are waiting for that 2 pm bell to go off. What is happening after is what disturbs and upsets me. It is a win/win for businesses, in my opinion because the mark-up over the bar is huge compared to takeaway, I imagine.

I do not see how it would be an issue, but then again, we all have the right to have a drink if we want to. It is not illegal. How do you do it? The permit system is really—and an application process. I do not know how you do it. That would be what I would do.

Mr KIRBY: Yes, there are a lot of people we have spoken to who are heavily bogged down in reactive behaviours and programs and this thing that they will enjoy the opportunity to do, but just do not have the people, the funding or the capacity to try to get their business in the black.

Mr BISHOP: There is a lot of goodwill going on too. There are a lot of organisations that do a lot they are not funded for, especially around this K.I.S.P. program. We are funded for one position, but we dedicate about four positions to it—not dedicate, we make K.I.S.P. part of four or five—five if you count my role. There is a lot of goodwill because there are a lot of people who want to see the problem end. We will not see it end in the next 50 years, I believe.

For us, the big issue now is the approach to families and youth. We have put a proposal to the youth justice investment group which, hopefully, will promote it up the line to you guys—to government. We would love to see a youth facility like BushMob in Katherine. We would love to see a youth patrol system, a youth outreach system that operates 24 hours a day. We have a lot of youth services that shut their doors at 4.30 pm. This is when the kids are getting out of bed. Kids are not up during the day. They have been up all night.

A lot of these kids are Kalano mob, so we would like the option to put our hands up and say, 'Let us try to help'. BushMob has a really good program and we would like to replicate it here in the centre of the two so kids do not have to go away. That, in turn, will allow us to do mum and dad at Venndale, and kids at Venndale as well. Even if they are not together for a start, the facilities are side by side and you can have regular meetings. The idea is to get the Territory Families' kids out to Venndale, because at least 50 of our clients this year have been told, 'If you could take kids at Venndale we would reunite you now.' I do not remember what the term is called, where they start the process to get you back together.

Mr KIRBY: Reunification.

Mr BISHOP: Reunification, yes. That is what all my work is going into at the moment, trying to find that youth approach, get someone funded. Hopefully, we will get there.

Mr CHAIR: Yes. Are you making that application?

Mr BISHOP: We got through our first draft, which has been given to the 30 organisations who are on the youth justice. Now they are all critiquing it. My spelling and grammar will be corrected, I imagine, and it will be given back to us to submit as Kalano, but with support from the youth justice. The benefit for us is we have a place to put it. We have land and somewhere to build it and it is out of town. I understand it works in line with Territory Families' five criteria—the youth camps, the case management. We really want to contribute to the next generation. We need a bridge between the two, but we need to acknowledge and start burning one end of that bridge and say, 'We cannot fix anything from this point backwards, but we can fix from this point forwards'.

Mr CHAIR: You can make it better going forwards.

Mr BISHOP: Yes.

Mr CHAIR: Yes, that is right. That is one of the fundamental things with issues of this committee. We do not expect to be able to fix everything. As you said, you will not fix it in the next 50 years, but if we can make it better. This is about harm reduction so we are about trying to reduce the harm going forward. What you are talking about fits in very closely with that.

Mr BISHOP: Yes. I do not know if anyone has any other questions.

Mr KIRBY: Not for me.

Mr CHAIR: Sandra?

Ms NELSON: No.

Mr CHAIR: I do not believe that.

Ms NELSON: I have spent lots of time with Casey at Venndale.

Mr CHAIR: Oh, yes, okay.

Mr KIRBY: Must have, because it is the quietest I have ever heard Sandra.

Mr BISHOP: She knows all about it, so it is good, yes. If there is anything I can add, it is mainly I heard the chap from mental health speak. I am alarmed that there is the thought that there is too much going into residential care. There is an emphasis on the money that is dedicated to the alcohol problem going into residential care, but if you look at our financials, you will see that it is nowhere near enough as far as the demand on our treatment centres. The fact that we are scratching and going without, no training budgets—all this sort of stuff. We ran out of repairs and maintenance money in the first half of the year. I do not know where we will find our repairs and maintenance for the last quarter—all that sort of stuff.

I understand what people are saying and that there is a huge focus on it. I also do not agree that it is a primary health issue. The co-morbidity and the mental health side of things is definitely prevalent in our industry and we need to work better together. But the Indigenous organisations are the ones that have to deliver this treatment.

Wurli is an Indigenous organisation—given—but I would like to see medical centres concentrate on general health medical side of things, and let the social side of things be left to the NGOs that are working on social issues. Once we get them crossed over, it confuses things for the client, but—with all due respect—there seems to be some bedazzlement of the medical model from government as well. They are bedazzled by the medical model and that is what I have seen in the last 10 years as far as trends go.

I would like to see that organisations like Wurli were resourced enough to be able to—I know they find it hard to attract—but have ample doctors and diabetes staff and the other chronic disease side of things that support people in our treatment centres and people in Aboriginal hostels and the women's crisis centre. At the moment, we get Wurli out to Venndale for a half a day a week, which took 10 years to happen. They finally came out to us, but they can still only stay until 11 o'clock in the morning. Then they have to come back because it puts so much pressure on them back here. I know

getting doctors is a big issue. I would like to see the two separated and more emphasis go into residential treatment which works. In Katherine, residential treatment works.

The biggest problem with a lot of our services here is that they are not residential. There is no one helping that person after 4 pm or 2 pm. It is frustrating. A lot of services finish up with clients when the pub opens or the Bottle-o opens. People are just going straight from day programs down to the hotel to find family and then are encouraged to drink. But I am sure you probably do not have enough batteries for me to keep talking.

Mr CHAIR: No, you are right. Just on that issue, I do not think it is a matter of taking money away from the residential treatment facilities. There is an emphasis on residential treatment. We do not get enough, is probably the bottom line. We do not have enough for harm reduction …

Mr KIRBY: Anything, yes.

Mr CHAIR: That is right. When you talk about the three pillars of harm reduction, supply reduction and demand reduction, it all goes into supply reduction. So, the 90% of the funding goes into supply reduction.

Mr BISHOP: Yes.

Mr CHAIR: Something like 2% goes into harm reduction. If we could get a better representation for the harm reduction pillar, then you could be funded better, and that other end of harm reduction could be dealt with as well. That is what I would really like to see.

Mr BISHOP: I do not envy the position you are in, I am sorry.

Mr CHAIR: Yes.

Mr BISHOP: Good on you. I do not know if it is a voluntary position, but well done if it was.

Mr CHAIR: Yes, it was. I dragged them all in. They all came in voluntarily.

Mr BISHOP: The single biggest issue in the Northern Territory, I am afraid. Our town is built on the problems that alcohol has caused. You have a conundrum, as a government. If you fix the alcohol problems, our town will not exist, because all the issues caused by alcohol supply the tradies with work, the supermarket with stock. It is such a conundrum for you guys. I do not envy the position you are in.

I would love to make myself redundant. That would be fantastic.

Mr CHAIR: I do not think we will do that, as much as we hope to make the situation better.

Mr BISHOP: It is a reality though. What do they do once we finish all the problems? Where does everyone work?

Mr CHAIR: Yes, exactly.

Mr BISHOP: It would be good if you did, yes.

Mr CHAIR: Thanks for your time.

Mr BISHOP: No problems at all. Thank you. Catch you later.

Mr HIGGINS: Catch you. Thanks for that.

Mr BISHOP: No worries.

The committee concluded.
