LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

SUBSTANCE ABUSE COMMITTEE

Membership:

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Dr C Burns MLA
Ms S J Carter MLA
Dr R S H Lim MLA
Mr E McAdam MLA
Mr G Wood MLA

OFFICIAL BRIEFINGS

Tape-Checked Verbatim
TRANSCRIPT OF PROCEEDINGS

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Department of Health and Community Services
Northern Territory Police, Fire and Emergency Services
Office of Crime Prevention
NT Office, Commonwealth Department of Health and Ageing

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Mr McADAM: We will make a start. Marion is going to be about an hour late. I am going to chair the part of the meeting. I declare open this meeting of the Select Committee of Substance Abuse in the Community. I welcome witnesses from the Department of Health and Community Services, who are appearing before the committee today to brief in relation to the terms of reference. If required, copies of the terms of reference can be obtained from the committee Secretary. This meeting is not open to the public; however it is being recorded and a transcript will be produced which will eventually be tabled in the Legislative Assembly. Please be advised if you wish any part of your evidence to be *in camera*, the decision regarding that will be special committee deliberation. You are reminded that evidence given to a committee is protected by the parliamentary privilege. For the purpose of the *Hansard* record, I ask that you state your full name and the capacity in which you appear today each time you speak. Thank you.

Mr McLAY: Alastair David McLay, known as Ali McLay. I am the section head of the Alcohol and Other Drug Program.

Dr HENDY: Shirley Hendy, Chief Health Officer and Assistant Secretary of Health Development and Community Services.

Mr McADAM: Thank you both very much for coming in this morning. Perhaps it might be appropriate very briefly if you could give some historical background describing your experience and activity with regard to your respective areas.

Dr BURNS: We might do a person's CV in front …

Mr McLAY: Personal or private?

Dr HENDY: So you mean about us, or about the program?

Mr McADAM: You describe it personally.

Dr BURNS: Professionally.

Dr HENDY: Okay. I have been in the Northern Territory for around 25 years, with a very varied career spanning work in the hospital; work in general practice; work as a District Medical Officer in Aboriginal communities for many years; as Director of the Alcohol and Other Drugs Program also; the Health Promotion Program; the Disease Control Program; and what I have as my responsibilities now include the Alcohol and Other Drugs Program, other areas of public health, and also community services such as Family and Children Services, Mental Health, Age and Disability Services. I think that's it.

Mr McLAY: I actually started in the AOD field back in about 1988. That was a result of starting to actually work in the area as part of my psychiatric nursing training in New Zealand, in a small area that is fairly renowned for its high cannabis usage and heavy alcohol consumption. Since then, I have basically worked in and out of the alcohol field in different capacities, and managing road safety units dealing with alcohol and road crashes etcetera. I came to Australia in 1994, and worked in a variety of places around Australia, either in mental health or in alcohol and other drugs. I spent some years in Tennant Creek prior to coming to Darwin, and came to Darwin, basically, as their Professional Training and Development Advisor for the program. I am now in the position of the section head of the Alcohol and Other Drugs Program.

Mr McADAM: Thanks, Ali. Are there any questions.

Mr WOOD: First, I'd ask a general question. What's the difference between a section head and senior policy officer. Where do you fit in – fit together?

Dr HENDY: He's her boss.

Mr WOOD: Okay, that is all right. So now I know how to ask the questions.

Dr HENDY: Jo would report to Ali, and Ali reports to Cheryl Furnow who is not able to be with us this morning because she is down south. She is the section head of Social and Emotional Wellness Branch and Cheryl reports to me.

Mr WOOD: The Wellness Branch?

Dr HENDY: The Social and Emotional Wellness.

Mr McLAY: Bear in mind that it makes no reference to the fact that anyone is a greater expert than the other. In actual fact, we all have our own areas of expertise and it is the culmination of those that actually makes the program.

Dr BURNS: Look, I would like to kick off with some questions about alcohol. I know that Jo is going to be here with us a bit later, and I know that she has done a lot of the work in reviewing the petrol sniffing area and probably the cannabis area as well, with others. I think I have flagged up to this committee that, in terms of damage to the community, I believe that alcohol is the main culprit. I've spoken [inaudible] yesterday about crime. That's one aspect of it, but I think overall, you wouldn't get an argument with me about alcohol.

So I've received the briefing document here and I suppose some issues for me – and it's there up in lights about the damage of alcohol. I suppose I've shared the concern of some people about the dismantling of the *Living with Alcohol program*, so you just want to address that issue, some of the rationale or why that occurred and how those resources that were[inaudible] used - formerly used by *Living With Alcohol* are now being efficiently used to get better results in this area.

Mr McLAY: Okay. I think that under the concepts of contemporary and, I suppose, evidence-based way forward for the provision of services, you can't see that you can deal with - one substance doesn't necessarily stay in isolation so you actually need to address more than one substance. What we're finding over time is that there are more and more people who are using more than one substance, and there is more than one substance being used in particular communities.

The rationale, I suppose, then is that we need to be able to provide services that provide an integrated approach to dealing with a number of different substances and a number of different approaches. The initial part, I suppose, that people go back to with the *Living with Alcohol program* was the hypothecated. A tax that actually allowed for money to come direct from alcohol to alcohol work. That very much locked us in to a process of that. With the case from down south where it was then to be unconstitutional for states and territories to impose their own taxes on tobacco, it then brought that into question. This also gave us an opportunity to progress to a more integrated approach and it freed up some of that money to actually work on some of the other issues as well.

The focus of …

Mr WOOD: Could I just interrupt you there - is that all right?

Mr McLAY: Yes.

Mr WOOD: You said that it brought it, the tobacco issue, the constitution brought alcohol into focus, but was the alcohol - did that say that you couldn't – that the state couldn't raise a levy on alcohol?

Mr McLAY: I think it was actually stated actually it was unconstitutional to do it on tobacco. But that allowed for the same premise on alcohol as well.

Interestingly, the issue of actual hypothecated taxes has started to arise again, and the discussions that I've had with Treasury are that it was never probably really unconstitutional the way that the Northern Territory was doing it. The tax on alcohol went specifically to alcohol. If you varied from that, and the money went into general revenue or to be used for additional work then, yes, it would be then unconstitutional.

Treasury is saying that it may be possible to actually still have a tax here, but - and it may even be possible to have a tax along with the $8m compensation that we get from the Commonwealth for removal of the tax - but the bottom line really would be that you really need to work out what you want to achieve from additional money gaining and maybe there's other ways to get it instead, and we haven't followed that through at this stage.

Mr McADAM: Just to clarify this. In place of the levy, the figure that you referred to is $8m from the Commonwealth?

Mr McLAY: That's what Treasury told me that we get from the Commonwealth.

Ms CARTER: Every year?

Dr HENDY: I mean, really, probably it would be a good idea to check, to as Treasury very directly, someone from Treasury, to really give you a concise - we know what we were told by Treasury. It wasn't our - we weren't involved in making the decisions is what I'm trying to say. The decisions were made at Treasury level and then we were given the amount of money that they then indicated was received in lieu of the previous *Living With Alcohol*, in effect.

Ms CARTER: And what was the Living With Alcohol's levy? How much did that raise for you? Is $8m a significant loss or is it roughly the same?

Mr McLAY: I think we have to be clear about one thing; what was raised was not necessarily what we got.

Ms CARTER: Right.

Mr McLAY: So, the figures that we have provided are based on expenditure and that's the figures that we have.

Ms CARTER: Right, and does the $8m - do you now get it in total?

Mr McLAY: In the back somewhere I have actually slipped a budget sheet - here it is. They have a copy of this.

Dr HENDY: This is in draft form at the moment only because we just want to make some final checks of figures and polish it up a bit. I think that …

Dr LIM: The last page of these Health figures headed 'On the desk', you say …

Mr McLAY: They are also in the back of the cannabis one, I think you will see there was the same figures, and we have basically provided the figures - the budget - we had over the 1999-2000 and 2000-01, 2001-02 years so that was going from $14 673 000 to $12 895 000 to $12 397 000.

Mr McADAM: Of which the Commonwealth contributes $8m?

Mr McLAY: That is the understanding that I have. We just get money …

Dr LIM: Yes. It's not a Commonwealth grant; it is a Commonwealth compensation because the states and territories were forbidden to impose taxes on alcohol and tobacco, and what happens is the Commonwealth was actually taxing those industries on the states and territories behalf and collected the money, and then they apportion money back to the states and territories. So it is not the Commonwealth giving the territories - it's in fact the Territory's money that the Commonwealth collected first and has given back to us because we are the collecting agency for the Commonwealth …

Mr McADAM: I think we know that.

Mr WOOD: Could I just get it clear in my mind; there would have been money collected under the Living With Alcohol scheme, that you – the Health Department - didn't entirely get; is that right?

Dr HENDY: I was the Director of the *Living with Alcohol program* when it was first set up and it was set up in the Department of the Chief Minister in the first instance where it could then have a more coordinating role across the whole of government. I would honestly have to go right, right back to the figures from those days and I would get them from the Treasury about exactly what was raised and what wasn't raised. We don't keep records in the Health Department going back to 1992 essentially.

There was a point, from recollection, and I just want to make it dear - this is my recollection, all right - and it would have to be checked – I am not making a definitive statement - it did raise in the order of $9m to $10m in those first few years, and this is definitely my recollection. When you are establishing a program, you can't spend all the money that you get in the beginning; I mean the amount of money - you did some research in the first year, you are negotiating with community-based organisations etcetera, and you are bringing things on stream. In the very first year we spent I think in the region of $5m or $6m and again this is my recollection, right.

The following year we spent in the region of $7m. The following year we spent in the region of $8m, and it was agreed with Treasury that the *Living with Alcohol program* could be managed over the years and we could spend less in the early years and conserve money for out years rather than having to close off at the end of each financial year and spend the same amount every year. So that's where some of the figures can get a little confusing because if you go on expenditures, we expended obviously a great deal less in the first few years than we did in out years, and I think the maximum expenditure we ever got up to was about $9m.

We had then some funding which was conserved, and at some point in time and I don't remember the exact year, this was when I - from recollection - we had in fact returned the program to Health and Community Services and integrated the Alcohol Policy Unit back into the Alcohol and Drugs Program directorate that there were - there was a substantial amount of money now being held in balances, and in fact, the government made a decision that would be used to assisting funding renal dialysis, and $1m was taken to contribute to the renal dialysis unit. In the first year that that decision was made, if I recollect, it was $2m per year after that. Then of course the amount of money held in balances from the

Living with Alcohol Levy ran out, they moved to the new arrangement with the $8m coming in from the Commonwealth and the money for renal dialysis would then no longer have been paid for out of those conserved funds and was paid for from consolidated revenue.

Mr McADAM: Can I just – I am not sure

Dr HENDY: No. Those are facts which need to be checked with the Treasury and the exact year in which they were under. There was a clear decision by the Cabinet to have those funds then pay for the very substantial increase in renal dialysis that was occurring at that time, and that was the conserved funds, it did not come off what we were spending in that particular year.

Mr McADAM: Can I just refer to page 12 of the …

Dr HENDY: Yes.

Mr McADAM: You have a list here of the May 2000 [inaudible] referring to. That total there would be just – what? In excess of $1m-odd.

Dr HENDY: Yes. We have always had this issue of, we did not keep all the money in Health and Community Services, it went to a number of departments.

Mr McADAM: But that was probably in excess of $1m-odd.

Mr McLAY: $1.2m.

Mr McADAM: $1.2m.

McLAY: And that is, about two paragraphs down below that, it will say $1.2m there.

Mr McADAM: Okay.

Dr HENDY: $1.2m.

Mr McLAY: Now, they are off the bullet points, and I think there is also the $439,000 that went to the Family Violence program as well. So there is probably about $800,000 and something there plus the extra four.

Dr LIM: How do you define what is *Living with Alcohol program* and what it is not. I mean, domestic violence - it could be seen as a separate program completely, but you can have a very tenuous link from that through to alcohol, or even, for instance, treating burns patients in Alice Springs, particularly in the middle of winter where alcohol is so much related to people getting themselves burnt and where do you draw the line.

Dr HENDY: There were very clear decisions made by the Cabinet on where funding would go, or by the minister of the day. Now, the original Cabinet decisions on paperwork that came from Cabinet were very clearly focused so that the money was only spent on – and I do not remember the exact wording – but there were very clear words around what the money could be used for so that it could not in fact be used in the hospital to treat burns cases. It really had to go to treating, very directly, only things that you could very directly attribute to alcohol.

The family violence issue in the Northern Territory, we were in the Department of Chief Minister's at the time and, in fact, it was Carmel O'Loughlin, who is actually next door in the Office of Women,

she is at the ministerial meeting now. She and I got together, and there were some statistics at the time that the police collected which showed that almost all family violence in Aboriginal communities, frankly, and Aboriginal people told us this, was integrally linked with alcohol, I mean in a way that they would actually say it is the cause, recognising that causality is a complex thing but there was no doubt in their minds that if you do not have alcohol in a community you get a great deal less family violence than if you do. There was also some research that the police did which showed that, if I remember again correctly, this is from my recollection, something in the order of more than 60% or 70% of domestic violence instances in town were also linked with alcohol and it was felt that it was therefore not unreasonable to provide funding for family violence strategies from the Living with Alcohol allocation. That decision was made by the minister of the day, not by us as officers, and that had to be very clearly an argument put to the minister and that was then agreed to.

Mr McADAM: Thanks, Shirley. It might be appropriate at this point in time to welcome Jo Townsend from the Department of Health and Community Services. And just for the purposes of the *Hansard* record, Jo, perhaps if you could just state your full name and capacity in which you appear today.

Ms TOWNSEND: My address?

Mr McADAM: Your full name and capacity in which you appear.

Ms TOWNSEND: Oh, good. Jo Townsend, and up until the very end of May this year I was the Senior Policy Officer in the Alcohol and Other Drugs Program. I have very recently moved sideways into the Aged and Disability area.

Mr McADAM: Thanks, Jo.

Dr BURNS: I will just pursue the questioning I have about *Living with Alcohol*. If I could play the devil's advocate, I suppose, reading success of Territory Health Services as it was in annual reports, and looking at the *Living with Alcohol program* and the achievements that I thought were substantial achievements in that they were measurable in terms of road accidents. I know that is a complicated thing but I, for one, was convinced about the merit of the *Living with Alcohol program*. I am just wondering, since it has been dismantled - that be an emotive word - but since it has been reorganised and refocussed, have we any idea about – are we still monitoring these alcohol-related outcomes, and is there a snapshot you could give the committee, or do you think it is a little bit too early yet?

Mr McLAY: One of the things that we are very clear on is that, over the last couple of years we have not had the emphasis on some of the research that we, in actual fact, should have had. So, some of the figures that we probably would like to be able to provide, we cannot. I suppose if you wanted to take one snapshot, you would have to go back to some of the figures that have just come out recently, and that is relating to alcohol consumption between metropolitan and non-metropolitan areas. If you just bear with me for a second, I have it here somewhere. I think I actually put it in the briefing as well, but did I keep it separate?

Dr HENDY: While Ali is doing that I will say that there was an actual overall reduction to the program, and that does appear on page 12. So that, there was funding that was in, if you like, *Living with Alcohol program* that had passaged through the Department of Health and Community Services. It then went directly to those departments instead. So, there is an issue about how much of a whole-of-government approach do you still have that is coordinated. When you talk about the dismantling, I think that is what people think about when they think about the dismantling, to a certain extent.

The funding that was going to family violence was paid then directly into the Family and Children's Services Program because, again, one felt that if the money is not actually being spent directly in the Alcohol and Other Drugs Program, it looks like the Alcohol and Other Drugs Program is incredibly resource rich, when in actual fact there are monies in there that are clearly directed to be spent on other things. It creates a false impression of what there is. But there was - and it is very clear on page 12 - an actual reduction in funding of $1.279m, if you like, to the Alcohol and Other Drugs part of the program. That reduction was not to be spread into the non-government sector, which is a very significant sector for the Alcohol and Other Drugs Program. Most of the service really is through community-based organisations. Their funding was to remain intact, so that reduction was absorbed into the Department of Health and Community Services part of the program. That did result in the loss of a number of positions, and a loss in some of the research factor. We had to make cuts, basically. So, in answer to your question in terms of reduced monitoring, yes, there has been reduced monitoring and reduced research, because we had to absorb that fairly substantial reduction of …

Dr BURNS: I suppose what you …

Dr HENDY: So while Ali is looking for that, I think that is the answer to the question that you asked.

Dr BURNS: I suppose what concerns me, I must give credit to the previous government, I suppose Marshall Perron, in particular, who was the driving force for this *Living with Alcohol program*. I know it has, in terms of AODCA - Alcohol and Other Drugs Council of Australia - which is a peak body for those who work in the field. The Northern Territory got big ticks over *Living with Alcohol*. I suppose I am just concerned that we have done away with something that was showing that it was getting results. I suppose, in my mind, there is still a big question mark about where we are going with this.

I always felt that the *Living with Alcohol*, it was very clear what it was about and it was very focussed. I, for one, like things at face … I am all for a whole-of-government and an integrated approach, but sometimes with big issues, I think you do need a particular focus.

Mr McLAY: One of the things, though, with *Living with Alcohol program*, at least it did provide for that concept of a whole-of-government approach. But, you have to remember also, that it was the dollars that helped provide that. By being able to purchase or be able to fund things that were happening in other departments, it also gave us the key to negotiating with, and to try and bring these things together and work on them collaboratively.

One of the things that happened was that the money now goes direct to those agencies. That, in all honesty, has reduced some of the ability to actually have that collaborative whole-of-government approach. Yes, the *Living with Alcohol program* was reviewed by the [inaudible] Report and it did show a number of significant achievements. And - I can't find the figures; I thought I'd put them in here somewhere, but they're escaping me - but over the period from 1991-92, there was a significant drop in alcohol consumption in the Northern Territory. Clear and simple.

Over the period from 1992 through to 1999, there's actually been a little bit of a lift up; it then started to even out and now it's increasing, been increasing over the latter period of that time in metropolitan areas. In actual fact, metropolitan alcohol consumption in the Northern Territory at this stage is higher than it was prior to the introduction of the *Living with Alcohol program*.

Ms CARTER: Is that on a per capita basis or do population numbers affect that?

Mr McLAY: That's supposedly the figures with - I think it's called tourist adjusted or something, so yes.

Ms CARTER: So the fact that Palmerston and all those areas have grown might have impacted on that?

Mr McLAY: That's possible. There's a number of factors with that. The other interesting trend, though, is the non-metropolitan area and while the Northern Territory metropolitan area is the only part of Australia that's increasing in its consumption, the non-metropolitan area has continued to go down, down, down, down and it's something like I think about 4 litres or something per year less than…

Dr BURNS: Maybe they've moved to the city, Alastair.

Mr McLAY: Look, there's a number of factors and I think that it's quite relevant that some of the things that have been very useful are the fact that remote communities have obviously decided that they've had enough; they want to make a stand on alcohol and they have worked with strategies that are going to give them relief and can actually start dealing with some of that issue in the interim.

Dr LIM: Your increase in consumption in regional centres, you're talking about aggregate increase rather than per capita and the like. Now, your tourist adjusted - you're talking about tourists in the sense of - is a person who comes from, you know, from the bush to Darwin a tourist? Are you talking about tourism intrastate or interstate and overseas tourists if that's what you - defining as?

Dr HENDY: Yes, because otherwise people say that the per capita consumption - if you take the total consumption and divide it by the population, you get a higher per capita consumption because we have a disproportionately high proportion of tourism compared to our base population, and so the figures have always been adjusted for that.

Mr McLAY: And yes - I mean there's probably a whole range of reasons why it's happening. There may be – maybe some of the dry areas are the fact that people then drift urban to drink, but it's not to say that they shouldn't be there and it's not to say that they don't work because, quite clearly, I think they do make a significant contribution.

Ms CARTER: [inaudible]

Mr McLAY: Sorry?

Ms CARTER: To what?

Mr McLAY: To - I think there's a number of things. Some, people to – are tired of the effects of alcohol in their community; they need something that can start to deal with that issue. One is the ownership of that - of dealing with that in the community. The other thing is, though, having something that is going to give some immediate respite to the community.

Dr LIM: Yes, that sort of statement applies to the bush, but I think regional centres, too, say: 'Look, enough's enough', you know, and where's the respite for the regional centres? And there's no answer to that. Look, this is a rhetorical question - statement but, you know, people in cities would like to have some respite also.

I want to come away from the budget issues and finance, too, just, you know, page 2 of your submission where you talk about [inaudible] principle of harm minimisation. I'd like to understand what the department means by harm minimisation.

Mr McLAY: In the early days, I think a lot of the programs that were actually - the services that were purchased were pretty much around the concept of abstinence: you had a choice. You either drank or you didn't drink. For some people that's fine, but for a lot of people what we really want - we're not saying people have to stop completely - but what we really want is to get people to a level where the harm is reduced. Alcohol isn't necessarily the evil of all evils, but it certainly creates major problems. It can also be used in ways that don't necessarily create problems. How do we get people to that stage? We need strategies that can promote harm minimisation. It does not mean in any way that abstinence is not one of those options, and that would be very, very clear over the years that there is still a major option in harm minimisation.

Now, whether people stay abstinent from alcohol for six weeks while they are on a treatment program, at least their physical status, their emotional status increases and it gives them a build up, or whether they stay abstinent for the rest of their life, at least you have a period of time in there where people get a chance to: (1) have their health status increased; (2) have an opportunity, if they are in a program or in care some way, that they get options to have access to other services. That is also important for them because while we are also dealing with the alcohol issue, you actually end up with access to people so that you can refer them to a variety of different agencies as well. It is not just dealing with one thing, and be very clear that that is useful.

But the concept of just dealing with one substance and one issue with one person, just does not work. Yes, it's fine, you can deal with somebody to get them to stop drinking, but what about their housing? What about their education? Their lifestyle? Their community? Everything else fits into it. So, these things have to fit together.

Ms TOWNSEND: Can I just add something? Because Ali's really focussed on the treatment end of things and I think the program made a very conscious decision right at the very beginning, in relation to harm minimisation, that if we are going to have a broad, population based approach, we could not go in a tell people like you and I that the few drinks that we enjoy through the week is not on; that we have to have a much more moderate stance.

In actual fact, a lot of the harm that we were seeing was not caused by people who were long term, dependent drinkers. A lot of that harm is the harm caused by drink driving, caused by accidents, illness that really is a result of alcohol consumption that is certainly harmful, but not necessarily by the highly dependent drinkers. The program was very proactive in the beginning about trying to redress that perception that we are talking about a certain population group, or talking about a certain level of dependence. We were talking about the fact that across the board everybody in the Northern Territory was pretty much drinking a lot harder and a lot heavier than everyone else. That might not necessarily be causing problems for us as individuals as yet, but it was certainly causing problems for the community.

So that harm reduction approach was certainly much more palatable in terms of the community education strategies, but also it was emerging internationally and nationally as a much more effective approach because it did encompass abstinence, but also allowed for that other kinds of drinking.

Dr LIM: Did the program address the issue of supply? You know, you have your treatment, your community program regarding accessing rather than excessing over the supply. What was happening there?

Ms TOWNSEND: In actual fact, I think that is one of the things we did very well very early on. I think some credit should go to the Liquor Commissioner at the time because he was ..

Dr HENDY: That was John Maley.

Ms TOWNSEND: Yes. John Maley was adamant because of his experience, I think, in the police force, that the supply of alcohol was a contributing factor to the harm, and he very much embraced a harm reduction approach within the Commission. They worked very closely with the Health Department, and the *Living with Alcohol program* at the time, to make sure that those things were done with synergy. A lot the very early successes were directly attributable to changing of licensing practices, to supply practices, and to things like the promotion of light beer as an alternative. Those early years, where we talked about dramatic success, in my personal opinion were actually attributable to that relationship.

Now, in recent years, not just in the Northern Territory but across Australia, there has been this embracing of National Competition Policy, which is totally at odds with – it sits uneasy with the harm minimisation approach and in actual fact the Commission is very much about promoting business, and there is still a mission for – the Mission Statement of the Liquor Commission includes harm reduction but in actual fact the legislation does not really.

Ms CARTER: Can you explain that in more detail? Like is it a concrete example for use in the Territory.

Ms TOWNSEND: Of competition?

Ms CARTER: Of how the National Competition Policy …

Ms TOWNSEND: The National Competition Policy states that, the basis of National Competition Policy is that you should allow market forces to determine whether a business survives or does not survive, basically, and I have had senior members of the – when we have tried to negotiate the number of licensees around and the number of licenses available, because that was one of the things that was very much talked about very early on, was the very high per capita number of licensees per individual.

Ms CARTER: So are some applicants for licenses now using the National Competition Policy as an argument as to why they should be given the license.

Ms TOWNSEND: No, because you cannot argue on commercial grounds, but you could say that the commission is arguing that that is not the grounds for them to not grant a license and, in actual fact, it has been said to me, , that the Commission would be happy to have every shop front on Mitchell Street operating with a license and let market forces decide who stays open and who does not.

Ms CARTER: That is the Liquor Commission though, not the …

Ms TOWNSEND: Sorry, the …

Dr Lim: It is the ACCC.

Dr HENDY: However, Peter Allen himself, personally, sitting at a meeting of the alcohol group on the itinerants strategy, has made it very clear that the Commission is committed at this time to taking very much into account the needs and wishes of the community, and that it is not easy to get a license if there is not a good reason to have one at this point in time. He actually made a statement to us in the meeting of the Alcohol Strategy Group around the itinerants.

Ms TOWNSEND: It is also not easy to prevent a licence…..

Dr HENDY: That is right.

Dr BURNS: I would like to pick up on something that you just said, Shirley, and I guess it follows on from what Sue and Richard were talking about and, I guess, itinerancy, drunkenness, rehabilitation, alcohol counseling, I mean, can you tell us where we are headed in that direction – and I suppose even if you answer on a couple of things. It appears to me that we do have some models of trying to treat people, particularly the odd Aboriginal people mainly with alcohol problems, and I am just wondering in your answer whether you could comment on the adequacy of those models and whether we probably need to develop other models. In terms of that, and I am thinking here about briefing, as we know Maggie wrote that excellent book called 'Giving Up the Grog' gives, the most concrete example was a doctor, a medical person advising people: 'Look, you know you keep on going and you are going to die' and that has even been the spur for a lot of people to actually give up the grog.

So I guess wrapping the question up, can you answer broadly in this area where we are going in terms of trying to reach some of these people in Darwin, itinerants, drunks and whether we need more resources there, whether we need more models developed to effectively deal with treating people with their alcohol problems.

Dr HENDY: I am just trying to – what is going through my mind at this point in time is that there are things that have been talked about that are not yet in the public domain, and so if I talk about them I may need to say that strictly speaking if we are going to discuss the things we were discussing about itinerancy that I think my situation at the moment is that that should be in-camera because it is not in the public domain. So that is really what I am trying to say. Not that I have any reticence about talking about it, I am just trying to get the official channel business that I am concerned about. If I say things now that become public when they have not actually become public in other ways, that I can be in breach of my position.

Dr LIM: Yes, but by the time we print our current project, it might be well and truly out by then.

Dr HENDY: But they might be out in a different way from what I say them now, so …

Mr McADAM: What I am saying is that we are prepared to hear that evidence *in camera*.

***IN CAMERA* EVIDENCE**

Mr McLAY: Over the last few years we've probably done quite a lot of work with brief intervention, not just by actually providing training and providing access to people to have access to brief intervention, but it's also promoting the concept that there is opportunity out there.

I had a session in Alice Springs a couple of years ago and I was trying to get through to people: follow the McDonald's model. Every time you have a service, ask if there's something else that you can provide with that. You do not leave McDonald's without the chance to have fries or a drink or something else, you know. So, to me, brief intervention quite often is that McDonald care, you know. No matter where you come in - in reality, in the Northern Territory, you cannot work basically anywhere without coming into contact with people who are in contact or having some effect from alcohol.

So, it really broadens out quite substantially the amount of different places where we can actually start to put in these things called brief intervention. We have a brief intervention training course which is actually a 20 hour course. It's been actually upgraded to an accredited course now, and after quite

substantial negotiation it looks like it's going to be part of the new - a new unit of competence within the Community Service training package which will be trained Australiawide. So, that's going to actually: (1) provide for a lot of people to have training in brief intervention; it's also going to actually provide for a course that was developed in the Northern Territory to be used Australiawide, and we're actually in the process of negotiating with a company at the moment that we deal with for training products to have a self-directive learning package developed so that we can use it in the Territory and it can be purchased from interstate etcetera as well.

The drive is really on to promote brief intervention as much as possible because if we can get early intervention - even if it's just raising the issue - at least it's pricking away at people's memories and their thoughts that, you know: 'Maybe, maybe, maybe I have to think about something here', or seeding that information that 'Well, maybe I will deal with something'. It may be that people just need some information, just need to think about it; it may be that they need something else. But if you raise the issue through a brief intervention, at least it gives validity to talk about it.

Dr HENDY: And we've basically done training for - just why don't you tell the Committee the sorts of groups that we've actually done the training for and that it's available for.

Mr McLAY: There's been training in a variety of areas from health workers to frontline workers and we have this thing called a 'frontline worker' - and it was sort of devised within the National Drug Strategy and it's in the National Alcohol Strategy as well - that the definition of 'frontline workers' that we have in the Northern Territory that we're working on is quite broad. We consider anybody who is working with people, where you come into contact with people who have got alcohol - affected with alcohol is a frontline worker. So that can be doctors, it can be nurses, it can be AOD workers.

We've also, in our training, actually had dealings with people from Power and Water, from Housing because they are also dealing with people who don't pay their power or don't pay their rent because alcohol takes precedent. It could be the store owner in a community – whatever. It's pretty broad.

We've provided training in, I suppose, a self-directive process so that a whole variety of people who are doing the Alcohol and Other Drug certificates through us can have access to it. We've also actually provided training across the Northern Territory by - we actually brought Dr Paul Williamson up from South Australia and he actually did a couple of sessions; one was alcohol and the new pharmacotherapies; and the other one was brief intervention. So it was actually promoting brief intervention, particularly to doctors and to people working in the health area as such.

That was actually done through all of the health clinics from – well, actually it was Tenant Creek, Alice Springs, I think it was King's Canyon, Jabiru, Katherine, Darwin. So there was a whole variety of them put in there.

Dr HENDY: We can probably give you a list, actually, of all the training that's been done.

Mr McLAY: It is definitely one of the things that we have been focussing on. We are trying to make it – look, it is okay to talk about it, it is not okay anymore to sweep it under the carpet. We need people who have the skills and experience to actually deal with it, so we can keep providing training before then.

Dr HENDY: We have also built it into something called the Public Health Workbook and we have built it into an alcohol handbook that we have also designed for people out in the bush. The other sort of model that we should probably talk about is kind of treatment that is not exactly is the 'family coping' work that has been done. Most of the focus of alcohol programs nationally and internationally has been on the drinker or the drug user. The drinker is the one that we – I keep using them a bit

interchangeably but the drinker, we started off talking about alcohol and it is alcohol that was the main focus and we participated in a World Health Organisation auspiced program which – and you do have some descriptive words in here about a family coping study and this is where a couple of people said: 'Look, instead of always focusing on the drinkers habits, let's actually focus on the family shall we and on the relatives'. I know as a DMO when I worked out bush, I would constantly see people coming through the system, literally you would sit there and a woman would come in with a broken arm and you would say, 'He broke the other arm last month didn't he?', and it would get rebroken, and there was this continuing cycle of violence - and I do not have to tell people here about it, you know about it yourselves.

But one always had this kind of sense of not really knowing whether one was – what is the process. There is a process of brief intervention. There is a very clearly set protocol for how you do a brief intervention, the kind of questions you ask, you are trying to set up cognitive dissonance; there is a whole theory that sits underneath it. There was nothing really in any kind of manual or anyway of helping you, what do you do when it is a relative or a person in the family to help them to know that when they leave the consultation, wherever you sit, you did the best that could be done, recognising that you cannot resolve someone's alcohol related problems in five minutes or the family's. So we participated in this research program and that has actually been quite an interesting – and the idea is that you are not – when you look at the programs that have built around the concept called co-dependency, the focus is always with the other family member - on how you can work with family members to modify the behavior of the drinker.

The focus of this project was how do we work with families and make sure that the kinds of strategies that they are using to protect themselves are best for them. So let's take the focus away from the drinker and let's look at some of the other people around the place who are being damaged. That is not a common focus that is being taken. In fact, in the research process that has actually been received very well. I should say that the sites where this study was being done in were Mexico and England. We were a third study site then and it was specifically the Aboriginal community in the Northern Territory, and alcohol that was the focus of the study here. There was getting quite a lot written up about it but there have now been some workshops and people have responded very well to this different way of approaching how a community deals with minimising the harm that you get from alcohol.

Dr LIM: Is that related to the law and justice program that is being …

Dr HENDY: It is not, in fact. That is another strategy that is also being used which they showcased on the *7.30 Report* last night.

Dr LIM: Where does Holyoake fit into all this?

Dr HENDY: You go there about the individual programs…

Mr McLAY: Holyoake provided a variety of services, but one of the things that they do say that they provide is 'family first', okay? A number of – and to some extent they are not much different from other people in some respect, because people talk about we provide family services but quite often what they provide is a service that is actually around supporting the family to support the drinker. Now I am not sure quite how far Holyoake have gone but they definitely are family oriented.

We have been very clear that the family coping project is very much around providing for interventions for family in their own right as opposed to providing an intervention for family to support the drinker or the drug user. One of the things that actually came out of the research that was done in the Northern Territory and the rule pretty much that the Northern Territory is somewhere quite unique, it is quite special, that is why I am here, it is the piece that felt like Australia when I came to Australia,

after being in Queensland and everything like that, so I came back to the Territory. But everywhere you go here, we have to have strategies that are different to everybody else because we are so different. What you want to do there can't be used here. And one of the things that came out of the report and the Orford study was that yes, that may be true to some extent, but between the study that was done in Mexico, and in England and here in the Northern Territory, there were also some things that were coming up the same. Now, these were populations that had never spoken to each other, but some of these things were starting to come up. And one of the things that started to come out of it was that people actually, in situations, deal with things in a similar way, and some of the coping mechanisms that they're using out there now, although they're saying we're hopeless, we can't deal with it, we're not doing anything, in actual fact they're using quite good coping skills.

One of our strategies is to consider how do we pass these coping skills and these strategies on to other people. Maggie Brady, in her books, actually took that same process and actually provided a whole lot of stories about how people had given up the grog. We've also used those books for sending out to remote communities, to health clinics, in fact I've blitzed about every library I think in the Northern Territory with copies of both of her books so that they would be available; that's through local councils, etc, as well, because there are some very good strategies in there, but it's in story form, it's what people can understand. It's down to roots stuff.

Dr HENDY: We think that's a very promising model about how we can minimise harm in the Northern Territory by refocus - it's not a new focus - but I guess we've got an increased focus in the alcohol and the drugs program, which incorporates *Living With Alcohol* at this point in time, on family and on young people right across the program. This training area is probably the one area where one does need a more integrated approach. It is very difficult to focus just on alcohol, or just on cannabis, or just on a specific area there, and that area does have to be integrated, and we do broad alcohol and drugs training, if you like, and teach people techniques that they can use and they can actually apply to a variety of settings.

Mr McADAM: I was wondering, given we've only got about 40-odd minutes left, there might now be some consideration about just general …

Dr LIM: Could I ask one last question? If they flag this - of the delegation - whether it's possible for them to construct for us a flow chart of how THS funds alcohol-related programs so that - for instance, do you fund [inaudible], or what, where this money comes from THS to the programs?

Dr HENDY: We can certainly provide a list of the organisations that we fund, and you can have a list of how much we fund them.

Dr LIM: That will be useful.

Dr HENDY: No problem at all.

Mr McADAM: Okay, thanks very much. We can now turn to abuse, or perhaps cannabis …

Ms CARTER: I'd like to ask a question with regard to cannabis. We keep hearing comments nowadays, in the last couple of years, that there is a cannabis crisis in the Northern Territory, that the cannabis is much stronger than it's ever been before. What are your views on that?

Mr McLAY: To start with, the issue of cannabis being stronger. This is actually a document which was done by Hall and Swift. It is an NDARC publication and it is being quoted in the information that I provided anyway, and it talks about the THC content of cannabis. You know, it has been quite clear that there is no Australian data to support this claim that there has been a 10 to 30 fold increase in the average THC content of cannabis in Australia. There are probably some interesting

reasons as to why they got to that stage of thinking that but, in actual fact, they are quite clear that there is no evidence that it is actually higher than it used to be.

Yes, it may be a little, and some of that's hydroponically grown.

Ms CARTER: I understand that, but there wasn't a lot of - you call these young 20, 30 years ago, anyway.

Ms TOWNSEND: I think what certainly is the case is that people are smoking the better quality stuff. With the advent of hydroponics, you don't need to smoke the leaves, you just go for the quality, and people are quite savvy about - you know, I am not too expert of this …

Ms CARTER: You are the expert. You are with friends, Jo.

Dr LIM interjecting.

Dr BURNS: That is why you have to read the *Hansard*.

Mr WOOD: Yes, that is why Elliot wanted your address.

Ms TOWNSEND: But certainly, people are being a bit more selective about what they are smoking. The evidence about THC content is interesting, because the evidence is collected from police seizures. Their forensic labs across Australia actually do test stuff that they seize. It is that evidence that is not showing an increase. So, either it is highly unlikely, but it is possible, that the police are not intercepting the people with the good stuff, but what is much more likely that that is a certainly a myth. What I do suspect is happening is that people are smoking in a very different way than they did. People are much heavier smokers, and that is where you are seeing some of the attributed problems. They are smoking the better quality of the plant …

Ms CARTER: They are using bongs more than joints, that sort of thing.

Ms TOWNSEND: Yes, and they are smoking for a much stronger effect; they are smoking a lot more. The other part of your question, Sue, was is there an increase? The difficulty with cannabis is that as a substance, people tend not to volunteer information about their use. I think it is fair to say that certainly in the four, five, six years that I was in the program, it went from being one of those harmless, 'Let us not worry about it' substances, to something that they are much more concerned about. That is not something that is specific to the Territory. I think it is across Australia there was this recognition, and the research trend that was making that very clear link between mental illness and cannabis, but was not there 10years ago.

So certainly, the concern about cannabis is there nationally and locally, but we just do not have very good data about whether there is a dramatic increase in the Territory or not. Certainly, there is an increase nationally and we would be part of that. But, for the first time, we had remote communities actually putting their hand up and saying: 'We have problems, you must help us'. That is quite significant and quite unusual for a community to want to go to a coronial inquiry about a substance; to open up their community to that level of interest in and shame and introspection is quite - it means that certainly, for that population, it was a significant problem. That is when we started to think: 'Hang on, this East Arnhem region certainly was becoming problematic'. We did some kava sentinel monitoring with the restrictions on kava. It was about that time that, because it was probably some of the only research that was being done, we thought 'Well hang on, we are really starting to see something here and people were becoming vocal about it'.

Mr WOOD: Jo, you have been looking at the combination of those in this case. Marion is not here at the moment, but I am sure she would be the first to tell you the problems on Tiwi Islands. Are you looking at cannabis on its own, versus cannabis with other …

Ms TOWNSEND: No, and that is part of the complexity of it. When I talked about it is the way people - it is the poly-drug use. Certainly poly-drug use is a problem in urban centres as well. But, when you start to mix your drugs, you are talking about a whole different level of intervention; you are talking about different effects, different harms. I have this real sense that there is a group of people out there who, when we have, through bans, removed other drugs, they are certain groups of people who will do anything to get that effect, and they will replace it with anything.

So, there is some unusual mixing of cannabis. Some of the scary stories about mixing cannabis and amphetamines and stuff, I do not think is as big as the stories that precede them. Certainly cannabis and alcohol are the problem there. Cannabis, alcohol and kava, and there has been some recent research over in East Arnhem about the use of those drugs, and also petrol in there as well. Which is unusual, for petrol to be thrown in with those other more classier drugs, so to speak.

Ms CARTER: Just hypothetically, alcohol is legal, tobacco is legal, a lot of money spent keeping marijuana illegal. Do you think there's an advantage to the community of keeping it illegal? Do you think it's worth all the dramas? Given that it's relatively easy to obtain anywhere in the Territory, Is there any point to all of this prohibition?

Ms TOWNSEND: Well, there's lot of research about the benefits or otherwise of prohibition. I don't actually have a view because I think for some of those communities in east Arnhem alcohol is illegal in a sense, because they are dry.

Dr HENDY: I guess what we'd have to say is that it's very complex and you don't do things of that nature without considering very carefully and doing some very careful modelling about what the various options are. And you do have - I mean, you know, Jo was talking there about the dry areas legislation, and there's been various talk - and I think we are very happy to make a statement about the dry areas legislation: we would not feel that the dry areas legislation should be weakened. It very clearly allows the communities who have the fewest resources to deal with drug or alcohol related problems to actually take some sort of action that does give their communities a modicum of respite and rest. I know that there's a great deal of discussion about it just shifts the problem to town, but that, again, doesn't recognise the complexity of the situation.

The complexity of the situation is that when a community goes dry, a lot of people choose to give up alcohol it's too much hassle to chase it. So you in fact get some people giving up and staying in the community. You do get some shift to town of the people who do want to chase the grog, but if we're going to say that we want respite in town and we can't cope with it in town where we have far better resources - we've got more treatment centres, we've got police, we've got far more things we can do in town to contain it - then we couldn't possibly think about changing legislation in a way that would actually put the problem back into the communities who have even fewer resources to deal with it.

So I'm quite happy to make a statement to say that it would be my professional view, most certainly, that the dry areas legislation, which has been hailed as one of the most enlightened pieces of legislation and a very modern and - a piece of legislation that gives Aboriginal people some determination over their situation - should not be weakened in any way.

Dr BURNS: I'd agree with that statement.

Dr HENDY: I think it would be disastrous.

Dr BURNS: It's my own personal belief, and I think I put this forward when we talked to the Liquor Commissioner, that by putting wet canteens in a lot of these dry communities would not only exacerbate problems on the community, I think you'd propel more people in town. Now, that's a view; I haven't got any evidence to base that up, but that's just through my experience knowing people and knowing situations and it does seem an attractive option to some to do that, but I think the number of people that actually come to town, I would say, honestly say, I think it would increase.

Dr HENDY: Also, that doesn't mean also, by the way, that we think that communities shouldn't be able to have a good community consultation process and put in a social club that has very careful rules and regulations around it and over a period of time, but it has to be a community choice and there has to be careful consultation; it has to be done very carefully and monitored very carefully. So we're not saying we want to deny, you know. I mean it's something that has to be done very carefully.

Ms TOWNSEND: Just on that prohibition issue, though, the Northern Territory was one of the first jurisdictions to introduce on the spot fines for cannabis. So we actually - we were ahead in that sense, but I actually agree with Shirley in that for some communities, you know, remote or otherwise, who are significantly affected by cannabis, I would be very nervous about advocating for a decriminalisation approach if there wasn't significantly - if there weren't other things available for them.

Mr McLAY: It's not actually going to stop the effects by decriminalising it.

Ms CARTER: No, but it stops the waste of money police and all of that.

Dr HENDY: Better you shifted that into diversionary activities for young people and made sure that you spend it on that, in my opinion.

Mr WOOD: I suppose the other side of the coin is that you say we said cannabis was a legal drug, what are the consequences to society from a health point of view and from a domestic violence point of view, from an economic point of view, like young people not turning up for jobs etcetera? How would you think that side of the coin - how much do you think that would cost our society then?

Dr HENDY: I guess my comment on that is that it's just incredibly complex and you wouldn't want to do it without considering all those things very carefully. And we do know that you've got this view about cannabis that it's harmless. And we know that a lot of our young people smoke it, and it is harmless as far as they are concerned. And that is the issue - that the vast majority of people who do smoke small amounts of cannabis at the weekend suffer no obvious ill-effects from it. But then you have a group of people who if they take it, suffer very severe and serious ill-effects from it. We know that that is happening in some Aboriginal communities actually, where people who have mental health problems, there is no doubt even though we are not able to quantify it, and I do think you know, we talk about anecdotal evidence, we have to take notice of what people say, it is a different kind of evidence. Just because you can't count it, it's just as valid – they are very clear, and the evidence would support them from the literature that when someone who has a mental health condition, certain kinds of mental health conditions, also then become heavy cannabis smokers, they will get precipitated into episodes of quite severe mental illness then, and it certainly exacerbates these conditions.

So you would want to be, and I think all health people who have anything to do with mental health problems and with a real spectrum of these kinds of issues, would be very concerned if there was any move to legalise cannabis in such a way that it suddenly became freely available. I think we would expect to see those problems worsening, so it would have to be approached with great care. That does

not mean there are modifications that don't need to be made in particular ways, but we would not be able to comment on which way you should go.

***IN CAMERA* EVIDENCE**

Mr McLAY: The data that we do have is what we have put in there on page 8 which is the number of admissions that have actually gone in through mental health. And we are talking about 15% of total admissions through mental health and key services. Yes, the Western Australia stuff, they do have some figures there, and they are associated with youth suicide. It is not saying that that's the total reason. I mean, this is one of the difficulties with drugs - it is so complex, there are so many reasons and there are many different links. You can't necessarily just hang on one label and say this has been the absolute cause.

Clearly though, for a long time there has been an understanding that there is some link between cannabis usage and those who turn up in mental institutions or mental health care areas. As for the percentage, well we are not sure on that but, because of that, we have invested something like $20 000 for this year coming up on running a specific training course on co-morbidity basically. We are quite clear that there needs to be far better training and far better skills for people to deal with the issues between mental health and AOD field as well, so there has to be that link.

As part of this, is why are we not *Living with Alcohol* any more? Why are we Alcohol and Other Drugs? And we can't deal with things in isolation. We keep coming back to that that, but we have to deal with all of these things together. But there still needs to be that additional step on to being able to deal with the mental health stuff and with the other whole-of-government approach to this.

Mr WOOD: Whilst I agree, society overruled – the Aboriginal society - alcohol is the main social drink, or the main social drug, and when you look at all the licensed premises you can go to, the emphasis today on promoting alcohol, and one of my concerns is the manner in which alcohol is now promoted, especially for the bodgy drinks, that type of promotion, where I see families sitting down, you think they are just having cordial, they are drinking 5% vodka tasting like blueberry, there are about 10 different varieties. So, whilst I agree that other drugs create problems, I think there is a perception, especially a lot of the youth today, that abstinence is not an option. You are cool if you do not drink, and I think, whilst it is certainly important to look at what effect of other drugs has, I still think a major focus has to be on what effects alcohol and society. I am really talking about my society, and not Aboriginal society, I think that has a major influence on the way Aboriginals perceive how they should approach alcohol.

Mr McLAY: We are very clear that there are three major drugs in the Northern Territory, tobacco, alcohol, cannabis, then quite a way down, there obviously are the others that are starting to increase. The majority of that effort has definitely been put into tobacco, alcohol and cannabis, far less of the cannabis, but definitely alcohol and tobacco.

Mr WOOD: Would you say, generally speaking, it is then put into tobacco. It is all a form of no advertising. I mean, there were restrictions on advertising. That was a big effort. It is the same effort for a drug that causes drink driving, domestic violence, you name it, but it was not that same emphasis due to advertised alcohol until the cows came home. So what I am saying is, the emphasis to stop promoting one drug.

Dr LIM: And the smoking campaign is much stronger.

Mr Wood: Yes, that is right.

Dr HENDY: No, that is quite true, and that is true nationally.

Mr McLAY: And if you looked at our media at the moment, what you will see clearly very strongly is that we are really pushing the tobacco stuff in the outlets, it applies nicely with the approach of the environmental tobacco smoke review but it is also fitting in with World No Tobacco Day and those sorts of things.

One of the things that we are actually looking at, at the moment, is that we have had a number of resources that were developed over time, some of them maybe useful, some of them may not be useful to use. We have a process where we want to buy national adverts that are going so that we can actually value add to some of their stuff. To some extent also, we have to go back and really have a look at what are the communities actually hearing, and what is the most effective thing out there, what is the most effective use of our media dollars to get them out there. And it may not just be television advertising and radio advertising, because in remote areas it is worthless putting money into cinema advertising because people do not go to the cinema.

So we would have to be a bit smarter, and we have to sort of revise what we have got and get, definitely taking stock this year as to what that is, and we are definitely taking stock as to what other strategies that we can use to get the information out there. Things like the BRAX radio systems and things like that. I mean, there are so many different other options that…

Dr LIM: Let me put this proposition to you: I want to hear comment from probably all three of you. If we get tobacco and alcohol and the other illicit drugs. The magnitude of the problem with alcohol and tobacco is very significant when compared to cigarettes. The conclusion from that is prohibition does work. That could be the logic behind it. So, would you suggest that maybe we should now start looking at whether there should be a national prohibition on tobacco and alcohol sales?

Ms TOWNSEND: Is that prohibition does not work, or that active marketing and campaigning with legal drugs work?

Dr LIM: No, tobacco is no longer actively marketed.

Dr HENDY: Oh, but it is.

Ms TOWNSEND: In many ways it is, that's the thing.

Dr HENDY: Absolutely very actively marketed.

Ms TOWNSEND: You might not see it on the billboards anymore, but you walk into your corner store and you will be overwhelmed with advertising. If you go to the movies, you will see your favourite movie star suddenly lighting up a Marlboro, there is …

Dr HENDY: Or a Winfield.

Ms TOWNSEND: It is very clever product placement.

Dr HENDY: Absolutely.

Mr McLAY: I think if you actually look at the movie stuff especially. I was not a movie goer for years, I guess …

Dr LIM: But there is a trend, there is a trend?

Mr McLAY: It has very much gone back to …

Dr LIM: Yes, well …

Mr McLAY: … that is where they are getting, it is that …

Dr LIM: … for 20 years or so, there were no movies - there was not a single movie that portrayed smoking

Mr McLAY: Yes.

Dr LIM: … and suddenly it has come back onto the screen again.

Mr McLAY: Graphic association.

Ms TOWNSEND: Gerry's point is a very valid one. The alcohol lobby groups, hotels association and the brewers, they are very powerful corporate citizens. I think things like – I am interested that you noticed the vodka drinks, because that is actually based on research that found that people did not like the taste of whiskey and bourbon …

Ms CARTER: Funny that.

Ms TOWNSEND: … and so they do not like it, well, what do they like? So, there has been some active marketing and development of products that are actually designed for the youth market.

Dr HENDY: To make them drink alcohol.

Ms TOWNSEND: Who is going to take on the Liquor Industry?

Dr BURNS: Gerry.

Mr WOOD: I think it is one of the issues for this committee to look at.

Ms TOWNSEND: Absolutely.

Mr McLAY: One of the things that I was involved with a few years ago was I was managing a road safety area, and we actually had money that allowed us to work, basically, at the level with media that some of the alcohol industry was working at. It made a significant impact because we were actually able to provide, per ITF media opportunities, that we had seen as being: 'Oh yes, the daggy health messages'. 'Oh, another health message, turn it off'. I got into major strife because one of the things I portrayed was: 'Let us get away from health messages. Yes, let us get it out there, but take the tag off the bottom. Why do we have to say all the time: "This is from the Department of Health".'

So I took those tags off, and when the research was done at the end, unfortunately, the police were actually attributed to most of that advertising, so it was not such a wise move. The reality was people remembered it; people did not turn it off because they thought it was a health message. We have to be smarter. We only have a certain amount of dollars, we need to be smarter in our research.

Dr HENDY: I was wondering, Mr Chair, I am actually a bit concerned that we will not get to talk about petrol at all in the time available, and so I was just …

Ms CARTER: Can I just conclude then, we have …

Dr HENDY: … starting to feel anxious about that.

Ms CARTER: … one cannabis question. What do you think comes first, the chicken or the egg? Is it mental health evidence first, and exacerbated by cannabis, or does cannabis cause mental health problems?

Ms TOWNSEND: You have just tried to preempt thousands of - nobody knows. And that is why they talk about a relationship. Nobody research has made a definitive causal relationship …

Ms CARTER: And it is that …

Ms TOWNSEND: No, it is about a relationship. It suggested that if you have a preexisting condition, cannabis use will exacerbate that, not cause it.

Dr HENDY: There are not any simple things.

Dr BURNS: There have been studies which have demonstrated cognitive impairments with chronic cannabis use.

Dr HENDY: Oh yes.

Ms TOWNSEND: Well, you know people, surely.

Ms CARTER: Yes. I mean obviously, if you bong on and party for 10 years, you are going to be crazy by the end of it …

Ms TOWNSEND: And there is that amotivational syndrome, which is basically where you sit on the couch.

Dr HENDY: But for all mental health problems and drug problems, what you find if you look in the literature these days is that they'll say that the antecedents, the reasons for all these kinds of self-harm or mental health problems, are common; they tend to be common They're about what happened to you during early childhood, they're what happened to you during your middle childhood period, and they're about what happened to you in your teenage years. They're associated with parenting, they're associated with your social environments as well as your genetics and, in many cases, they're as - the social effects are inherited in just the same way as the genetic factors are inherited.

So, there's not very much in the literature about these very complex issues like substance misuse and mental health problems that says that this is caused by that. It says, look, there are a whole of things that actually increase the risk that these things will develop, and there are a whole lot of protective factors. And what we have to do a lot more on is the protective factors: things like good parenting programs and so on and so forth for kids and decent education, decent educational opportunities. Those things are as important as this drug or that drug in the genesis of all these kinds of social ills that we're essentially talking about.

Dr BURNS: But still we shouldn't be surprised if we're talking about an relatively powerful drug that alters mood, behaviour, perception, there's also an hallucinogenic, and basically also associated with dependence, precipitating episodes in people's lives, particularly people from other cultures such as Aboriginal culture where witchcraft and sorcery are quite, you know, they're real. I don't think we should every underestimate the setting in which cannabis, in particular, is used in the Northern Territory.

Dr HENDY: Absolutely not. They're all factors.

Mr McADAM: Shirley, do you want to just perhaps touch on the substance - the [inaudible]substance?

Dr HENDY: Yes. I mean, that is Jo's particular area of – and, again, a lot of these principles are going to come out in here again.

Ms TOWNSEND: Ask away.

Mr WOOD: Can I just ask a general question on petrol? Can you give us a rundown on what forms of petrol, you know, from diesel to avgas to super to unleaded, or whatever. Is there more – I mean, can all those substances be used?

Ms TOWNSEND: Not diesel. Avgas has been a supply reduction strategy for a number of years in a number of communities; it works particularly well if you're on an island or you're in the middle of nowhere and you're not going to have people driving through. It has been particularly effective in some communities in tandem with other things, but there are some stories about people who will - young people who will sniff Avgas which is a concern because it's high lead content but it does make you feel pretty sick.

Diesel is another option as a supply reduction strategy, but generally leaded and unleaded is what you would be sniffing.

Ms CARTER: And how do they feel when they've sniffed?

Ms TOWNSEND: It's similar to alcohol, apparently. It lasts, you know, it takes about 15 minutes, lasts about four to five hours. You tend to feel kind of a bit invincible. You can hallucinate. You know, you get that dizzy, woozy, bit drunk effect. Unfortunately, it does tend to make people violent and aggressive and that's the particularly frightening thing about petrol, and people in communities will talk about being quite - very much afraid of young people who are sniffing because they are violent and unpredictable.

Mr WOOD: What is the chemical? Is there a specific chemical in it?

Ms TOWNSEND: It's a – well…

Mr WOOD: It's a refined – fuel is a refined process.

Ms TOWNSEND: There's a number of things. Obviously the lead that's in it is particularly harmful because of brain damage. They say that it's the volatile hydrocarbons, the benzos, toluene that cause the intoxication and they are also implicated in respiratory and cardiac problems as well. So a lot of young people in urban centres who will sniff paint thinners, it's the toluene and the benzine and the hydrocarbons in it that they're getting the intoxicating effect from.

Mr WOOD: And the damage is not just brain damage? You just mentioned about…

Ms TOWNSEND: No, there's a whole range of health effects, and I won't profess to be an expert, but obviously brain damage is the one that they're worried about, but if you could take the lead out, there's still significant respiratory problems and heart problems associated with the hydrocarbons as well. As well as, like, the toxic mixing of them which people don't actually know a lot about. Okay, you mix this and this and this, what does it cause? I mean, the real harm is the short-term stuff generally. It is, you know, often you are covered in petrol and you're around a camp fire, so there are burns; it is accidents because you are high as a kite and you're trying to break into the community store, so it's lacerations; disturbed mental state, so a lot of people end up over-hallucinating and can end up in hospital, and just the dangerous things that they will do once they are high.

Mr WOOD: So there is the direct effect, the mental - the secondary …

Ms TOWNSEND: There is chronic long-term damage which comes from people sniffing petrol over a period of a long time, and that is only a proportion of people. There are a group of young people who will experiment or use it for a short period of time. But they are certainly at risk of the same kinds of at risk behaviours of young people who drink alcohol, who smoke cannabis, unsafe sex, burns, falls, accidents, those kinds of injuries as well. I suppose a recent example in Central Australia is that it is – you are in the middle of nowhere and you have a significant burn; that ends up being an air-lift for you to the nearest intensive care unit with a relative. The costs associated with that – it is not like, 'Ah, I burned my arm, I'll go down to A&E'. It is thousands and thousands and thousands of dollars, not to mention the effect in the community of having those kinds of things happen in a small population.

Dr LIM: Can I summarise that - perhaps more for Gerry, talking about that indirect effects of intoxication, the direct effects of the volatiles that you inhale may cause tissue damage in the lungs and the heart, and the long-term effect of lead accumulation in the fatty tissue. The fatty issue is the brain and all the nerves, and that causes nerve damage in effect which produces the major long-term stuff which causes mental deterioration, fitting, and …

Ms TOWNSEND: And that characteristic unsteady gait that we see.

Dr LIM: So that's the three [inaudible] in a short paragraph.

Mr WOOD: And you said unsafe sex, would you - from the unborns' point of view, could have an effect on …

Ms TOWNSEND: Yes, I mean, Richard might be able to tell you more, but Alice Springs is probably leading the world in that kind of research. There were two infants born I think last year to mothers who were sniffing, and they still don't know what the long-term effects are. But there is a paediatrician in Alice Springs who would be …

Dr LIM: Until the children grow up, you know, you've got no research …

Ms TOWNSEND: No real knowledge of what effect it has had.

Dr LIM: All the theory [inaudible] that group finds the placenta will let lead through and the babies will get lead [inaudible] as well.

Ms CARTER: I heard that in Oenpelli this week it is estimated there are about 20 active sniffers, and one of the other comments was that some young mums are soaking nappies in petrol and holding them to the babies' faces.

Ms TOWNSEND: That's actually a story that has cropped up, and it's often …

Dr LIM: Repeatedly?

Ms TOWNSEND: Yes. I think it's one of those statements people use for effect. I would suggest that possibly it has been done but it is not the epidemic that it has been suggested. And I know in the - they did a national hearing and it came up there again and it was quite …

Dr LIM: I think it was an urban myth. I mean, petrol sniffing is what, 20 years, and …

Dr HENDY: It undoubtedly happens, and we would like it to not happen anymore. We don't want to wait until it is an epidemic before we do something about it.

Dr LIM: In the last 20 years there has certainly been an increase in physical numbers and your childbearing population is coming into problems now. That is where I think the anecdotal reports about you know, babies being sedated by petrol sniffing needs to be pinched in the bud now before it becomes a reality and an epidemic.

Ms TOWNSEND: I think it is an emotive story and it is one that shocks people, but I don't think it's a true reflection of what is happening.

Ms CARTER: And when a young person – I assume there is a link between the fact that a young person wants to get out of it, escape mentally from their reality – cannot get alcohol so uses petrol, but then once they can use alcohol, get access to the club or come into town.

Ms TOWNSEND: Often that is what happens. What we are starting to see – I mean you have to think of inhalants, petrol, all of them, they are basically poor people's drugs. They are drugs you use when you cannot access the better quality stuff, and that is why in remote communities it is about accessibility and often you do see people replacing it with other drugs as they get older, but I think we are seeing a cohort of older sniffers.

Certainly, I looked into prevalence levels about three years ago, and I looked into it again recently for this purpose and found that there was a small but growing group of sniffers who were older, in their thirties, like not like 15, in their thirties, and who had not given up other drugs, and then those users are on a fast track to a disability.

Ms CARTER: Had they been users when they were teenagers and just kept doing it, or had they taken it up?

Ms TOWNSEND: It is hard to know because one of the problems with petrol is we have got no idea about prevalence. In fact, the figures that I have got from 1999 came about because I actually went through a process of contacting every health service, every remote police station, every school and saying: 'Right, tell me what is going on' because one person from the community will say: 'It is thousands, it is huge', another person will say: 'It is fine'.

So I had to collect all that information together and make a reasonable assessment based on what people were saying, and what was a reasonable figure. I did that again recently, but that is probably the only monitoring that is done. That is really very much about patterns and prevalence and not really very good at tracking individuals.

Mr WOOD: Sorry, I was just going to ask Graham a question and perhaps this is in camera.

Mr WOOD: Well perhaps if we can in to camera.

IN CAMERA QUESTIONS AND ANSWERS

Ms TOWNSEND: Well there are success stories, and Dr Burns will be able to talk about those – it is very much associated with - strong communities that take decisive action early to prevent problems escalating have a much better success rate. Maggie Brady has also made some suggestion in her research that those communities with a strong association with meaningful employment and the pastoral industry are much less likely to be affected by petrol sniffing. There is something about that – if a community has a strong sense of community – if they have that relationship with work and employment and meaningful occupation, that tends to be a protective factor.

***IN CAMERA* QUESTIONS AND ANSWERS**

Mr McADAM: The point I am trying to make is that the interaction between the Commonwealth and the Territory is not improving; it is not addressing, it is not coordinating that response.

Ms TOWNSEND: I suggest that it is. That is what I am saying. I think historically it has been a poor relationship and I think that that relationship is improving. We have been very proactive in the last couple of years about being involved in the decision-making about where money goes, and trying to build the things that we're funding to …

Mr McADAM: Through the zones? What about the future?

Ms TOWNSEND: Alcohol and drugs won't go through the zones, at least initially.

***IN CAMERA* EVIDENCE**

Mr WOOD: Just a quick one. Have you approached the petrol companies, the fuel companies, at all about one is whether substances could be put into petrol to try and reduce its attractiveness? And do you think they have a responsibility as a great corporate citizen - and I'd argue the same with the breweries - to come on board to help try and solve some of these issues?

Ms TOWNSEND: I think there's been some work quite a few years ago. There's two things: the strategy has been tested and skunk juice has been added to the fuel which basically makes you very sick. That was found to not work.

A member: [inaudible]

Ms TOWNSEND: Well, I'm trying to remember what happened, but I think what happened was …

Dr LIM: [inaudible]

Ms TOWNSEND: Well, they sniffed it anyway. And the other thing was that something happened in a community and for some reason it wasn't added at one time and then it all just kind of fell apart.

Dr BURNS: What happened a couple of times were people didn't like going out fishing and being trapped in a small boat in the middle of nowhere with skunk juice fumes.

A member: That's right.

Dr BURNS: And also what you say is right: that petrol sniffers found ways of sort of letting the skunk juice, or the majority of it, evaporate and I remember …

Dr LIM: Well, it's not that. I mean, our noses accommodate this. You know, you sit in a dump for five minutes and after that, you don't smell it any more whereas somebody in a boat, you know, you can get lots of whiffs of it so it constantly irritates you. But we are going to visit Mt Theo in a couple of weeks. Can you tell us anything about it?

IN CAMERA EVIDENCE

***END IN CAMERA* EVIDENCE**

Mr McADAM: I am very aware that we have Commissioner White outside. On behalf of the Substance Abuse Committee, we just wanted to thank you three for coming in this morning. It has been really enlightening and to Shirley, Alastair, and Jo, thank you very much for your time, but also your commitment over a long period of time which I think is [inaudible] is very inspiring. I just hope that the outcome of this will serve justice to [inaudible] people within the department over a long period of time.

So thank you all very much.

Dr HENDY: We'd like to thank you for the opportunity. These are very important issues and very complex, so we're immensely please to have the opportunity and that in fact the opportunity is here to look at a whole-of-government approach to – which is the only way; a whole-of-government and whole-of-community.

Mr McADAM: Thank you.

THE WITNESSES WITHDREW

Mr McADAM: I declare this meeting of the Select Committee on Substance Abuse in the Community open and welcome Commissioner Paul White and Scott Mitchell from the Northern Territory Police, Fire and Emergency Services who are appearing before the committee today to brief it in relation to its terms of reference. If required, copies of the terms of reference can be obtained from the committee Secretary. This meeting is not open to the public; however, it is being recorded and a transcript will be produced which will eventually be tabled in the Legislative Assembly. Please advise if you wish any part of your evidence to be In Camera, and the decision regarding this is at the discretion of the committee. You are reminded that evidence given to the committee is protected by parliamentary privilege. For the purposes of *Hansard* records, I ask that you now state your full name and the capacity in which you appear today and, where possible, perhaps you could repeat you name each time you wish to speak during the proceedings.

Comm WHITE: Thank you. Paul Cameron White, Commissioner, Northern Territory Police, Fire and Emergency Services.

Snr Const MITCHELL: Edwin Scott Mitchell, Senior Drug and Alcohol Policy Advisor to the Commissioner.

Comm WHITE: So we're not connected to the internet?

Mr McADAM: No, not today.

Dr BURNS: Commissioner White, is it a general lead-in? We are generally asking people appearing before the committee a little about their background and, specifically in relation to drugs and substance abuse. If you could give us a bit of a snapshot.

Comm WHITE: Yes, thank you. I have been in policing for many, many years - all my life, in fact. So, active service with policing is around 33 to 34 years. More recently, as the Assistant Commissioner for Crime in the South Australian Police, I worked at local, state and national levels on various issues to do with drug and alcohol misuse. I was a member of the Intergovernmental Committee on Drugs which reports to the Ministerial Council on Drug Strategy, and played a part in a number of policing-related drug operations in South Australia; and presented an illicit drugs strategy for the South Australian Police. So, I would say that I have a reasonably good knowledge of illicit drugs and alcohol abuse as they relate to policing and to crime.

Dr BURNS: We had heard evidence from Scottie Mitchell and Mr Daulby, and they are very pleased to come along today. Obviously you probably have some thoughts and some issues that maybe you would like to put before the committee.

Comm WHITE: Certainly, and I thank you for the opportunity. What I would like to do is provide some scene-setting information and then link it back to my principal areas of concern; and that is the relationship between drug and alcohol abuse and crime. So, if I can do that.

Dr BURNS: Absolutely.

Comm WHITE: I would start by pointing to some national survey material that paints a picture of, particularly, illicit drug use in Australia. The 1998 National Drug Strategy Household Survey provides information on a state and territory basis and that information relates to lifetime use of drugs and recent use of drugs, both licit and illicit.

The lifetime usage rates are generally higher than the recent use, and it's an important distinction to make. I generally refer to recent use, and the reason is that the lifetime use…

Dr BURNS: If I could just intercede, when you say 'lifetime use', just – it doesn't mean you're using it all your life; you mean you've just used it at some stage in your life previously. Is that…

Comm WHITE: That's my point. Often people will experiment with a drug and they'll leave it there and that's it. But in their lifetime, they've used a drug. Recent use is, I think, a better indicator of where we're heading as a community and what the challenges are for us all.

So the recent use percentages aren't as high as lifetime use, but I think they are a better representation of the current state of play. So there are statistics which will indicate that for the Northern Territory. Recent use of illicit drugs is higher than the Australian average. For instance, recent use of any illicit drugs in the Northern Territory is around 40% whereas for Australia, it's around 23%. And amongst that recent use, the tendency is for the age group aged 20-29 to have disproportionately high levels of use. So to us, that's an area where we need to think about policing strategies.

Ms CARTER: When you use the term 'recent', what does that mean?

Comm WHITE: The last 12 months. That's having used the drug some time in the last 12 months. So having set the scene for -nationally and for the Northern Territory, I guess what I'd want to do is turn to some other studies that indicate the relationship between drugs – and perhaps my emphasis today is on illicit drugs, but I don't want to understate the importance of licit drugs such as alcohol.

Ms CARTER: Paul, can I just go back to that – just before we move away from it – the recent drug use statistic? When you said 40% with regard to recent use, was that 40% of Territorians who'd used an illicit drug in the past 12 months?

Comm WHITE: Yes.

Ms CARTER: 40% of Territorians…

Comm WHITE: Yes.

Ms CARTER: …have used an illegal drug in the last 12 months?

Comm WHITE: Yes. This was the 1998 National Drug Strategy Household Survey, so the data collection would have probably been 1997, but that is the most recent data available. This is a regular survey and I would expect the next survey will be released in the next six to 12 months, I would hope. But that is the most recent information available.

Ms CARTER: And obviously, it's illicit drugs so it's not including alcohol or anything like that.

Comm WHITE: No, and if I can perhaps – if I can give some comparisons: for cannabis, recent drug use in the Territory was 37% against the national average of 18%; for amphetamine use it was 7% against a national average of about 4%.

When you look at other drugs such as heroin and cocaine, it's not safe to use the report because the percentage base is so low that it's very hard to be accurate. So it's a very small base and very hard to draw a conclusion from that data.

Dr LIM: This is done through the ABS…

Comm WHITE: The ABS, yes. The report is in fact produced by the Australian Institute of Health and Welfare based on ABS data.

Dr BURNS: We'd have to acknowledge that there could be methodoligical difficulties with such surveys in the Northern Territory because, you know, we do have – we do have a significant population living remotely who might not necessarily be surveyed. But I think what you are saying is in line with what Dr O'Reilly – out of all those she had a very specific population that she was doing but it certainly seems to parallel it, doesn't it?

Comm WHITE: Well, surveys are indicators. Obviously at the proportion of the population they survey is relatively smaller, and they can draw some correlations and they have statistical methodologies for extrapolating the data. But it is indicative and indicative only and, yes, you do need to understand that most environments or markets that varies from location to location, but it is an indicator of recent drug use in Australia and on Australian territory basis.

Dr LIM: I suppose [inaudible] that the 40% [inaudible] rings bells in all of us and all that, so it is a concern that we need to have – whether there is a requirement to qualify the statistics in terms of the demographics of the Northern Territory and use the age of the population versus the age groups in some states, you should say you have a higher group of people just because of [inaudible] and the older age group are not.

Comm WHITE: Yes, all those thing do need to be considered, and it might well be the younger age groups have a greater tendency to experiment and use illicit drugs. But the fact remains that that is what the survey is saying and showing.

If I can perhaps turn to some evidence which is more relevant to crime. There is a study called 'Drug Use Monitoring Australia'. It is only conducted in three states and therefore it is not truly representative of Australia as a whole, nor the Northern Territory, and it is up to the reader to draw their own conclusions. However, this project is designed to improve the empirical data on illicit drug use by people detained by police and charged at a police station.

So it is a systematic monitoring program designed to give us information about people who are arrested by police and what drugs they have in their system. It is conducted in Western Australia, New South Wales and Queensland. Now, what the survey shows – and I should say that it is based on crime analysis and one clarification is that it only relates to those persons arrested and detained by police who agreed to subject themselves to urine analysis, but those who agreed to do that, what it shows is where the major charge was one of violence, for the male detainees 65% proved positive to any drug.

Ms CARTER: Any drug? So that could include alcohol?

Comm WHITE: I am sorry, illicit drugs. Illicit drugs – there are six drugs they test for: cocaine, amphetamines, benzodiazepines, cannabis, opiates and also methadone. So methadone is the one prescription drug amongst it, but it does not include alcohol.

For those offenders whose predominate charge was a property crime, 82% tested positive to any drug. And for drink driving – and again I say these are figures for male detainees – but for drink driving, interestingly 58% had any drug in their system and almost 50% tested positive for cannabis. So, although they were arrested for a drink driving charge, it clearly shows there are other drugs in the system.

The point to be drawn from that, of course, is that for people arrested and charged with an offence, there are very high percentages of illicit drugs within their system. That doesn't mean to say, of course, that it was illicit drug that caused the crime, it simply shows that quite high percentages of people charged by the police at those three locations, or four, in fact there are two testing sites in New South Wales, so that's four locations in Australia, have quite high percentages of illicit drugs in their system when they are arrested by the police. But again, I stipulate, that doesn't mean that that was the cause of their offending behaviour.

Another study worth noting is one conducted by the Australian Institute of Criminology …

Dr LIM: Can I just stop you before you go there? So, you would say that they were the ones who volunteered for your sample, or compulsory testing?

Comm WHITE: They were the ones who volunteered, but I am told and I understand that around 80% or 85% agreed to urine analysis.

Another study that, now I suppose I want to say, people might argue, well, what is the relevance of this information to the Northern Territory? Why not say, it's probably a good reason to develop a site in the Northern Territory so that we can get a better picture of drug use and offending behaviour. But the other thing that I would want to say is, although it's not representative of the Northern Territory, if you examine the data on recent use from the National Drug Strategy household survey, and see that recent use of illicit drugs is higher in the Northern Territory than the Australian average, then you might conclude that similar results will be drawn from a drug use monitoring study in the Northern Territory. Which means that it's more than likely you would get similar percentages amongst the offending population in the Northern Territory.

Dr BURNS: So, in terms of funding for the sites, who funds them? The hosting jurisdiction, or are they funded federally?

Comm WHITE: Funded federally by the Commonwealth. I understand DUMA was a three year trial and as to whether it was ongoing or not, I am unsure. But from a policing viewpoint, of course, we would be interested in these types of studies that helps us develop our policy in terms of responding to drug offending behaviour, whether it is licit or illicit.

Another study that is worth reflecting on is one by the Australian Institute of Criminology, it is the National Homicide and Monitoring Project. Their most recent report for the year 2000-01 provides statistics on homicides from a victim and offender perspective. It contains data on offender and victim racial status, but it also, for ethnicity, provides information on the number of victims and offenders affected by alcohol. What that report shows is, that in the year in question, there were 17 homicides in the Northern Territory which, by national standards, is not high, but it is high for the Northern Territory, that around 70% of victims were affected by alcohol at the time, and around 90% of offenders were similarly affected.

I have looked at the report and I am not quite sure what alcohol means, whether it's toxicity from blood samples or other evidence to demonstrate that their behaviour was alcohol related. I would suggest that there are extremely high percentages of harm being caused through alcohol use and, tragically, almost all of the victims and the offenders where indigenous.

Apart from those studies, the New South Wales Bureau of Crime, Research and Statistics conducted a study in the late 1990s in relation to the stolen goods market. They did a survey of 267 imprisoned burglars. What they found was that 70% of those burglars admitted to swapping stolen goods for illegal drugs - mainly heroin and cannabis. So, that is over two-thirds of that small group indicated that they committed crime to purchase drugs. The survey also showed that heroin-using burglars offend at

a much higher rate than non-heroin using burglars. So, the conclusion to be drawn from this is that drug use underpins a lot of criminal offending for burglars, and that those who do use drugs commit many more burglaries than those who do not use drugs.

Dr BURNS: Commissioner White, based on your experience in South Australia - and you have obviously had the very keen interest in drug-related crime issues - do you have a view on methadone programs on offending and offenders?

Comm WHITE: Yes, I do, Dr Burns. There is no simple solution to a complex problem such as illicit drugs, or any drugs in fact. But we must recognise there is a need for a multi-sectorial approach; there is no one approach that will work. The police, in recent years, are very much committed and have been very much committed to working closely with their health and education partners to producing collaborative outcomes.

What I am, therefore, saying is that the criminal justice system alone will not solve the problem. You have to look to education, you have to look to health. Treatment plays a very legitimate part in reducing problems associated with illicit drugs because, if drug use is the cause of crime, then it makes sense to treat the drug use to stop the crime. If the offending behaviour is the cause of drug use, then you might not necessarily get the same result and the criminal justice system is the best answer. So, you need both.

Interestingly, a recent research project by the National Drug and Alcohol Research Centre called the National Evaluation on Pharmacotherapies for Opioid Dependence showed that expenditure on heroin reduced significantly once the participants entered into a methadone maintenance program. It also showed, based on self-reporting - I need to qualify that much of this is based on self-reporting of the participants - but it indicated that their criminal offending reduced substantially once they entered a methadone maintenance program. For instance, before entering the trials, a participants - involved in property crime at 20%, 23% drug dealing, 8% fraud - after entering the trials, 5% were still engaged in property crime, 8% in drug dealing and 2% in fraud. The conclusion you could draw from that is that methadone maintenance has a legitimate role to play in treating drug dependency and reducing crime.

Ms CARTER: Depending on how long a period you look over, a lot of the studies show that if you go back 12 months later, many of them have gone back on the heroin and are re-offending.

Comm WHITE: Look, I – yes, that is quite true. What needs to be understood is that methadone maintenance treatment doesn't work overnight. It's not a solution that gives you an instant successful outcome. Methadone maintenance is a treatment program where, I'm told by health authorities, it can take some time for a person to actually reduce their dependency overall. It's like any other program; they're not always 100% successful. One person might respond to treatment in three to six months; another person might take two to three years.

Dr BURNS: And that someone else might decide that they want to return to drug use and that lifestyle.

Comm WHITE: Yes, and I don't think the health authorities would pretend for one moment that entering into a methadone maintenance program completely removes a person from their drug milieu and behaviour.

Dr LIM: There are many advocates of the methadone program who quote that by going on a methadone program you're drug-related crime decreases. I mean, if you supply the heroin user with methadone or heroin at tax payers cost, a lesser need of funds to fund their illicit drug use and naturally they'll end up, you know, committing less property crime because they do not need to fund their drug habit whether they're using heroin or not or any other drug.

Comm WHITE: Look, that's – I'm not a health practitioner. All I can do is point to this study that I've just cited to say based on that, there is some evidence to suggest that methadone maintenance is an effective treatment program in reducing a level of crime.

Dr BURNS: I think – I certainly agree with you that it's a part, but I don't think it's healthy or fortuitous for people to over-estimate or over-emphasise the part it can play. It's just one part, as you say, of a bigger picture, and I think that's a pretty sober view of the way things are.

Comm WHITE: There is some other research which is worth noting, and it's Northern Territory Police figures. The Northern Territory Police do collect data on the number of incidents that are alcohol-related. Now, much of this, of course, is based on the personal observation of a police officer or their opinion. But with that qualification in mind, the figures for 2001 show that overall for the Northern Territory, 67% of incidents were alcohol-related. If you exclude Darwin, the figure is 84%. So, again, what we're seeing is quite an extraordinary amount of police time is taken up in responding to both licit and illicit drug use.

Mr WOOD: Is that incidents of criminal or any…

Comm WHITE: That's all matters. It might range from a disturbance through to a violent crime. So what I've wanted to do is convey to the Committee some empirical and survey research which helps us all paint the picture of the relationship – well, firstly, the nature and extent of licit and illicit drug use, but also its relationship and nexus to criminal behaviour.

So with those things in mind, we need to perhaps ask ourselves, in searching for solutions, what comes first: does drug offending come first, or does criminal offending come first, or is it both? Because they hold some answers for policy makers. For instance, if drug offending comes first, it means that a person, through their intoxication or dependency, finds themselves in crime either as a victim or offender. Or they might find that because of their drug dependency they have to commit crime to maintain their habit. Or they might find because they are drug dependent they get involved in the criminal environment. And so if you take that view, then that might hold some answers for the priority you place on treatment.

As I said beforehand, if you take the view that offending comes first, that is, offending behaviour leads to a drug dependency, then it might be that we need to look to the criminal justice system. And it may well be the case that a person engages in a life of crime and through the criminal environment or for whatever reason they enter into a drug dependency. So, they are two things to consider.

The third one of course is that both drug dependency and the criminal environment have similar causes, that is to say, they are based upon the personal psychology or the social circumstances people find themselves in. So there might be an element of truth in all of those. That is to say that for some people, they are drug dependent and commit crime; for others, they are criminals who engage in drug taking. But the other solution - or the other effect is that criminals and drug dependent people have similar aetiologies and causes such as personality or social circumstances, whether that be low self-esteem, lack of education, illiteracy, dysfunctional family backgrounds, impoverishment - all of those things.

Mr WOOD: Can I ask just one question? Sometimes people talk about when the key yuppie group that involves itself with drugs, do you see that - are they a problem or does that exist? You just mentioned the lower socio-economic group - is that really the main people that use drugs, or do we have …

Comm WHITE: My comments are based upon drugs and crime. Now, yes, the drug use happens at all stratas of society; sometimes some stratas can hide that drug use better than other stratas in society. And certainly if I understand you correctly, the yuppie group would probably be inclined towards cocaine or amphetamine type stimulants, and certainly …

Dr BURNS: Or cannabis?

Comm WHITE: Or cannabis, and certainly you know, from time to time they come to notice. I suppose what I want to say is that not all drug users commit crime, and probably the reality is the percentage is quite low. But nonetheless, it is very disturbing. And for many who are drug dependent, they commit a disproportionately large amount of crime.

Dr BURNS: I think it's important for us - I mean, as a community we are looking into substance abuse and I guess there is substance use which is technically illegal, I suppose, or illegal - it's not a technicality like cannabis use that as you say there might be some people - cocaine use or whatever that really doesn't affect their lives or the people around them or drive them into crime to do it. So I have always really defined drug abuse as something that adversely affects the individual or the people around them more than the society or community that they are living in. Maybe that is an artificial distinction; it doesn't remove the illegality in what people do or the potential I guess for health harms in the longer term. But that is probably …

Comm WHITE: Yes, well, most of what I have been saying is drawing that nexus between drug use, particularly illicit drug use and crime. I don't want to underplay the illicit drug use, and that is why I cited the figures about alcohol and homicide, and alcohol and police-related incidents in the Northern Territory. But certainly, as I said, for many people they can engage in drug use without committing crime. I have often this morning also used the term drug dependency, and there is a difference between drug use and drug dependency.

So I suppose with those few things in mind, I would advocate a multi-sectorial approach to this, to the problems of drug misuse. You need to combine educational strategies with health strategies with enforcement strategies. It is probably worthwhile understanding that there are a range of risk factors and protective factors in both families and communities that lead towards or prevent drug use and so we must focus on, that is often called primary prevention, getting in before people engage in drug use, particularly young people, because they are our next generation. So my view is it is very important to target those families that might be at risk in the way I have described, and look to improve the protective factors. It would be important to intervene early in a young person's drug taking career to prevent them from entering into a life of drug use, because the evidence does suggest, the younger you start the more likely it is that you are going to develop a drug dependency throughout your life course.

Mr WOOD: Can I just ask a slightly political question without meaning to be, are you keeping the DARE program?

Comm WHITE: I can answer the question without referring to the DARE program. What I am saying is there is a very important role where we come to responding to drug use, to engage neighbourhoods and communities, including school communities. But questions on who is best able to deliver drug education is a matter for the current review team. But, certainly, any approach to dealing with drugs needs to consider detection and deterrents, and that is very much a police role, and need to consider how we reduce opportunities for offending. We need to look at, as I said, neighbourhood and community based approaches. We need to engage the community, and we need to look at developmental approaches where prevention is the key.

Dr BURNS: So, Commissioner White, I just get a bit of a plug in here. My son was in the Junior Boys Rangers, which I think is a fantastic initiative, it is a fantastic program, and …

Mr WOOD interjecting.

Dr BURNS: No, no, he is in the Air Force now, but it certainly made him as a young man, and all his friends, and I know the Baldwin family have been very great supporters over the years of that program and so that is just a plug, to let you know, I think there are many in the community that hold that program in very high esteem. I guess if we had unlimited funds we would be looking to broaden that out, maybe that is something that could be considered.

Comm WHITE: Yes, and of course there are other mechanisms too - there is the Police Youth Club, that is very productive too and does quite a good bit of work with community volunteers to create programs for young people in a similar way.

Dr BURNS: I was very attentive when you were talking about inter-sectoral approaches and, given your wide experience in South Australia and at the Commonwealth level, I guess being into the ministerial council, are there any models in Australia that you could commend in terms of inter-sectoral approaches to this problem?

Comm WHITE: The intergovernment committee on drugs has, in fact, produced two plans, one for licit drugs and one for illicit drugs. Both are available, and I understand that the Health Minster's taskforce on illicit drugs does have copies of those documents. They are probably worth reading because each contains somewhere between 4-7 strategies, but you will find that the strategies relate to reducing supply, reducing the demand for drugs, and reducing the harm associated with drugs.

So you will find that the police have a primary role in preventing the supply, the supply at all levels – and I would like to come back to that in a moment – agencies have a rolling demand reduction, whether it is through discouraging people who want to buy drugs from dealing with dealers, or whether it is through some kind of treatment program. Of course, harm reduction generally focusses on the condition of those already drug-dependent deteriorating. There are a number of strategies within that sort of umbrella, within both the licit and illicit action plans.

I say that there is no simple solution; it is a complex problem. We have to work together at both government agency level and with the community. There is just no simple answer to this.

Dr BURNS: I suppose I was asking whether you know of any examples in other states for this intersectoral cooperation? There would have to be some driving forces, say in Western Australia, where there is a task force and, who heads it up. Any suggests as to the way forward for the Territory to start?

Comm WHITE: Well, I think it is very important. Firstly, to begin, we need to understand the nature and extent of the problem we are dealing or grappling with. That is the very first thing. I think there needs to be a clear understanding of the nature and extent of the licit and the illicit drug use in the Northern Territory. That gives you your starting point; it tells you what the problem is. Then we need to work together. There are models in other places - whether it is at the chief executive level or a departmental level. Some other jurisdictions have developed a notion of drug reference groups or drug action teams. I, personally, believe in police/community safety plans, where you engage the police and the community, and where there is shared ownership and responsibility for common problems. There are a number of models where you can actually bring people together with the intention of them working together. That can happen at a Territory-wide level or at a community level.

I suppose another thing I want to say is that because licit and illicit drug use is widespread, we can develop either a tolerance or a complacency. We need to be careful that we do not allow that tolerance or complacency to get to a point where our future generation is going to be in a worse - well, in a predicament in which drug use is much greater than what we are today.

Dr LIM: With alcohol, you said you quoted some figures about police arrests. You found there was a high percentage of people who had been using illicit drugs, but you also said that there was quite a high percentage of people who were affected by alcohol. What are the relativities between the two? Are there more alcohol-related arrests compared to illicit drug arrests?

Comm WHITE: Alcohol abuse as it relates to crime is far higher than illicit drugs. Indeed, it is much, much higher. As I said before, if you look at the alcohol-related incidents across the Northern Territory - I have quoted the figures, they are extremely high and, frankly, not unlike most other jurisdictions. So, it is not a Territory phenomenon alone. It is common in policing that an enormous amount of our time is taken up in responding to alcohol misuse.

Mr McADAM: I was just going to say, Commissioner, I guess the real difference would be the percentage of indigenous people as opposed to, perhaps, the other states. If I might, there certainly has been a fairly [inaudible] over a long period of time, given the fact of the impact of violence in remote and bush areas with regard to alcohol, which we have known for a very long period of time, and how we have drugs etcetera. I think we've seen examples at places like Ali Curung and perhaps Lajamanu where you have really good relationship between the police, the community and its interests [inaudible] as well. But I think right across the Territory, we've got 84% alcohol related [inaudible]. As I say, a very high percentage [inaudible]. I just want to seek your views in respect to a few years back in South Australia, which you might be aware of, they established an Indigenous Police Steering Committee and I think it might have been Inspector [inaudible] or someone like that in those days who may have played a part in [inaudible]. I just want to – are you aware of that?

Comm WHITE: Not entirely. My viewpoint would be that would have related to the development of a police Aboriginal Aides. They're now called Community Constables in South Australia.

Mr McADAM: I was just going to go on to say that I was part of that back in the early days and it certainly, I believe, had a real impact in terms of relationships between the police and the community, particularly in remote areas, but also it allowed the interchange of ideas, different understanding between the police and the indigenous community. Given the high percentages of indigenous contacts with police in the Territory, I was just wondering what your views would be in respect to the establishment of something similar – not necessarily on a state basis or a territory basis, but on a regional basis. It certainly happens on a local basis. I think there is some real room there for – and if we talk about the police [inaudible] strategies, I think there is some real room there to get in early and to develop these sorts of strategies at these levels. But I guess the point I'm trying to make is that either regional indigenous police steering [inaudible] or a territory one because I really think there's a future in terms of developing strategies to combat the impacting increase in alcohol and drugs etcetera on indigenous communities.

Comm WHITE: Well, certainly. Without an intricate knowledge of your model, I wouldn't like to provide a response, but what I would say is that we need to work together; we need to look at good problem identification and good solutions. And we would be prepared to look at any approach that helps us not just reduce crime, but reduce harm in bush communities where, tragically, indigenous people are both victims and offenders of – mainly through substance abuse. And so we'd look at any model.

I might say that there are concerns about the increasing use of cannabis in bush communities. I know that the Menzies School of Health Research has done some work in East Arnhemland. My understanding is it's a predicament that's similar throughout the Northern Territory. There are some very good programs in some indigenous communities, and you cited Ali Curung, where they have a Law and Justice Strategy. At Port Keats they have an aggression management policy. What I'd like to do is get some consistency across these communities across the Northern Territory. So if something's working well at Ali Curung, why can't it work well somewhere else? And if something's working well at Port Keats, why can't it work well somewhere else? And that's something we're currently looking at.

One of the frustrations, I suppose you'd call it, is the ongoing difficulties we have in recruiting people, indigenous people, into the ACPO scheme. We understand that indigenous people are very good at dealing with their own community when it comes to potential crime problems and crime problems, indeed, and we will encourage the growth of that scheme, but we are currently recruiting and finding difficulties in recruiting sufficient numbers to fill the Aboriginal Community Police Officer positions.

Mr McADAM: From where? The communities?

Comm WHITE: From within the communities, yes. But I also want to say while I am new to the Territory, I have been to all but three bush communities. The striking observation was that where you have the less crime and less harm, you have strong indigenous communities with strong indigenous leaders, and from what I have seen, the general demeanour and where you have that, you have a good ordered society. Where that's lacking, you have dysfunction, and that's also a challenge.

So from a police point of view, I suppose to summarise where we would come from in relation to illicit drugs in particular is that we have to prevent and deter the uptake of illicit drugs particularly among young people, for good reason, they are our next generation, and if you enter into drug dependency at a very early age, then you are more than likely to enter a lifetime of drug use.

We need to reduce the supply of illicit drugs at all levels, not just the Mr Bigs, and that means the street level. You have to have a truly all-embracing strategy if you are going to attack supply, and we have to reduce criminal activity associated with the use of illicit drugs which means we have to target people with a drug dependency who, as I have indicated through the evidence, are committing a disproportionately high number of crimes. And that will be the approach that the NT Police will assume in the coming months and years.

Dr BURNS: And also you seem to be - well, you were advocating a [inaudible] site in the Territory.

Comm WHITE: Well, I believe we need to set the record straight. My view, based on the evidence both locally and nationally, that you can draw some conclusions about the Territory on the extent of its drug use, but I think that it is probably time - if the Territory had a similar site - so that we can improve the empirical evidence in respect to the issues we have discussed today.

Mr WOOD: With regard to the value-adding, I think you need the figures to do it, basically given them and see which way you go. Last night in the House, the drug house bills were passed and the property forfeiture bill was passed. I asked last night that it be evaluated annually by either independent source or [inaudible]. Now, will the policy have the ability to be able to give those sort of figures, to say now there is a reduction in the supply - less people on the street? Is there some way we can know as politicians that this piece of legislation is able to do what it is said it will do?

Comm WHITE: Well, I certainly - evaluation would be important, and one aspect of the evaluation would be looking at the police data. But there would be other ways of evaluating it as well, and so yes, if parliament or government dictates that it needs to be evaluated, then that would give you an indication of the effectiveness of the legislation.

Mr McADAM: Commissioner White, on behalf of the Substance Abuse Committee, thank you very much for your time this morning. It was very much appreciated, and we wish you well in the future. [inaudible] thank you so much for coming in and I also wish you well. Thank you both very much.

Comm WHITE: Thank you.

Snr Const MITCHELL: Thank you.

THE WITNESSES WITHDREW

SESSION 3

Mr McADAM: Marion Scrymgour who is the Chairperson of this committee is not available at the moment. I am acting on her behalf. So to Lyn, Jill and Stephen, thank you very much for coming in this afternoon. I much appreciate it.

I declare open this meeting of the Select Committee on Substance Abuse and welcome officers of the Crime Prevention Unit who are appearing before the committee today to brief it in relation to its terms of reference. If required, copies of the terms of reference can be obtained from the committee secretary. This committee is not open to the public, however it is being recorded and a transcript will be produced which will eventually be tabled in the Legislative Assembly. Please be advised if you wish any part of your evidence to be *in camera*, the decision regarding this is at the discretion of the committee.

You are reminded that evidence given to the committee is protected by parliamentary privilege. For the purposes of the *Hansard* record I ask that you now state you full name and the capacity in which you appear here today and repeat your name each time you speak.

Ms McDADE: Lyn McDade. I am Executive Director of the Office of Crime Prevention.

Ms GOODSELL: Jill Goodsell. I am the Policy Research Officer from the Office of Crime Prevention.

Mr FARRAWELL: Stephen Farrawell, Project and Community Liaison Officer with the Office of Crime Prevention.

Dr BURNS: I am aware that this Office of Crime Prevention is a fairly new initiative. What we have been doing with the people from the organisations appearing before us is just to warm up a bit, just to tell us a bit about yourselves. We are obviously engaging before hearings about where the office sits and how it integrates and how it works. So over to you.

Ms McDADE: Thank you for that. Do you want me to repeat my name? Lyn McDade speaking. The Office of Crime Prevention came into existence in February this year. You might all be familiar with the NT*Safe* concept that existed under the previous regime. The NT*Safe* concept was morphed –

to put it that way – into the Office of Crime Prevention by bringing together the people from NT*Safe* and the stats group from the Attorney-General's Department which had been formed previously.

That effectively brought together 16 people – we will have 16 people come 1July when our establishment is finalised. What we will be capable of doing once that has happened is, half of that group of 16 are statisticians, that is with a view that we will have a capacity inherent within us to evaluate programs that are implementing relation to crime prevention outcomes and the like. We will also have the ability, as agreed by Cabinet, to publish crime statistics, and criminal justice information and data from time to time. At the present moment in time, it is contemplated and it is yet to be determined, but contemplated that what we will be doing is publishing on a quarterly basis, and subsequently on an annual basis, whereby we will give a much fuller picture of crime activity and matters relating to justice and outcomes across the Territory. That does not mean for one moment that police won't have their similar role in relation to the utilisation of statistics and the like and what they publish in their own report on matters such as that.

It is hoped and expected though that, because of our capacity with the statisticians, that what we will be able to do for the first time in the Territory is have good, reliable information going out on a regular basis that is repeatable and sustainable, and that is, we can report on the same things on a regular basis. It will come from our office on the basis that it will be a little removed from the people who control the data, that being the police, therefore we do not have any agendas to run in relation to what we put out, it is going to be there for everyone to see in relation to what is happening across the Territory.

We ultimately hope to be able to get it down to locations so that we can actually see what is happening in various areas, and if there is a particular upsurge in some particular activity, that will become highlighted, that will assist government to develop programs and interventions in those locales that might turn things around in relation to particular types of crime.

Mr WOOD: Can I just ask a question while we are on that subject? I mentioned it to the Police Commissioner before. The couple of bills that have just been passed, one is the drug houses and one is the property forfeiture. Now, will you be keeping statistics to see if we can evaluate whether those bills, that legislation, is working?

Ms McDADE: That is certainly the intention. What we are hoping to be able to do in relation to drugs is to report, particularly on court outcomes for illicit drug users and the like, much like we are currently doing with mandatory sentencing. The changes since the repeal of mandatory sentencing, we report to government about the effect those changes have had by way of court outcomes, ie, what are people now getting in relation to those similar type of offences.

Mr WOOD: I was talking to someone the other day about the difficulties of getting, for instance, what the sentences are, because one of the concerns when this legislation came through was, well, if we are going to show that this will be just as effective as that, then we need to see what the level of sentencing is compared to what the crime was. Will you be able to give statistics?

Ms McDADE: Yes. When I talk of court outcomes that is exactly what we will be able to do. We will be able to indicate what dispositions people are getting.

Mr WOOD: And how long do you think before you get a reliable …

Ms McDADE: Well, bearing in mind the legislation has just gone through.

Mr WOOD: Mandatory sentencing went through quite early.

Ms McDADE: Yes it did, and even that, because it has only had a small number going through since, and you are talking about reporting statistically, you would like to be able to get a trend in the time series. Those two pieces of legislation have yet to commence, so I would not expect that you are going to get anything really concrete for at least 12 months, in the sense of …

Mr WOOD: … mandatory sentencing, you could get …

Ms McDADE: Oh, no, not mandatory sentencing, the drug legislation.

Mr WOOD: How about on mandatory sentencing …

Ms McDADE: We are still – we're doing that as we speak. That goes to the Attorney-General on a regular basis. We report in relation to what is happening there for that, that is possible now. But, again, I do not think you are going to get a good indication of trends and the like for a little while after because it is pretty new legislation, and it will take some time once the drug legislation commences. Again, it will take some time before you get any indication, statistically, as to what the changes are or how effective it is, if I can put it that way.

But, yes, that is part of what we are intending we can do across the spectrum. We are only small and we have only just started, but that would certainly be the ideal situation and part of our *raison d'etre* so that we can actually be able to assess what it would look like and why, we then put a, b and c in, what effect has a, b and c had? And have a good and realistic look to say: 'Well, a, b and c did work, or a, b and c just did not work'.

Mr WOOD: Will you analyse the diversionary programs, and what that meant? Like, there is a lot of scope in the diversionary …

Ms McDADE: You are talking about the juvenile diversionary program?

Mr WOOD: Yes. There are some complaints that sometimes the diversionary program is write down a ticket and tell them to buzz off, that's the diversionary program. In other words, does that analyse …

Ms McDADE: We haven't been asked to do that, no, as we speak, but that's not something that should be beyond the realms of possibility. We certainly have not been given that charter or request, as we speak. There are some very good diversionary programs, too. Some extremely good ones.

Dr BURNS: What I was asking, the original question was, can each of you three give us a little about your background and how that relates to your current position - in terms of professional background, I am speaking about.

Ms McDADE: Okay. Well, speaking for myself, I am a lawyer. I have been qualified to practice now since 1981; five years practice in Sydney; thereafter I joined the Australian Army for 10 years as a legal officer; did various things in relation to the national [inaudible]on military law and the like, Defence Force discipline, administrative law; subsequently became a Police Prosecutor; thereafter Deputy Coroner; acted as a magistrate for six months; then became CEO of Office Courts Administration; with the re-gigging, or flux on 13 November I became Executive Director, Courts Administration and Executive Director, subsequently, of Crime Prevention NT. That is it in a nutshell.

Dr BURNS: Thanks. How about you, Jill?

Ms GOODSELL: I am a former police officer. I actually resigned in 1994, then I worked for Nabalco for a while in Gove. When I came back to Darwin, I rejoined the public service, did some road transport prosecuting and ended up as Registrar at the Magistrates Court; the Fines Recovery Unit; and now I am working in the policy area which is something new but, yes, it is good.

Dr BURNS: That's the way. How about you, Stephen?

Mr FARRAWELL: I am actually a librarian, which does not sound very relevant. From 1994 until about two years ago, I was working with the Northern Territory Library in their community libraries program. That was setting up library or information services in remote Aboriginal communities. So, it is a lot of field work and also a lot of policy work for public libraries in the Northern Territory. We, the public libraries, brought in an innovative grants scheme - that was my main task - then I was seconded to review the NT*Safe* grants scheme and they kept me full-time. I do a lot of field work with local community groups and, because of my field work experience - and I do a fair amount of research type work as well. I use a lot of skills in a number of areas to do the work that I am doing.

Dr BURNS: Thanks a lot. So, in terms of budgetary items, NT*Safe*, I guess, is being wound up as you said. Has the complete budget from NT*Safe* gone to Crime NT. How did all that pan out?

Ms McDADE: We were very fortunate in relation to the budget that was given to Crime Prevention. We now have, effectively, a $400 000 grant scheme, whereas NT*Safe* had a $250 000 grant scheme. We are still waiting guidance from our Crime Prevention minister as to how we will go about administering that scheme. Essentially, it will commence operation in a theoretical sense on 1 July, but we still do not know how they want us to go about making it available - whether or not they want a series of small grants, whether they want some targeted grants, or whether they want some support for that money to go into the establishment of the regional councils. But yes, we have had a significant increase in that particular area.

There also has been some significant increase in personnel. As you appreciate, NT*Safe*, I think, at its height had four people. We are going to have 16 on 1 July or shortly thereafter, and we have funding for those positions. So, we have been remarkably well served and, I think, rightfully so, bearing in mind the importance of having a coordinating body that has some research and policy ability across government in crime prevention. It can put some coordination across agencies and other non-government agencies to come to an outcome which, funnily enough, from time to time, we are all trying to get to in any event; that is a safer and better Territory. It is probably important that it was appropriately resourced and not given the impossible task to do with no resources. I think we have been quite well served in that regard.

Dr BURNS: Strategically, how would you summarise the difference in strategies or strategic viewpoint between NT*Safe* and Crime NT?

Ms McDADE: Well NT*Safe* - and I was not part of NT*Safe* - did not have an evaluation capacity. For instance, none of the small grants that were given out have really, been properly evaluated as to whether or not they did anything effectively other than make reward people for effort in relation to small pockets. Again, it would probably be very difficult at the level the grants were given out, to even have a huge impact - though some of them did some quite remarkable things. NT*Safe* had none of that capacity. What we intend to do, strategically, is to develop a strategy for crime prevention across the Territory. Again, that discussion paper was with the Crime Prevention ministers as to how we go about that strategy. We've given them certain options that we'd like to pursue to develop that strategy across the Territory, and we're awaiting the outcome of their deliberations as to which direction they'd like us to go.

So I think we've got a higher – a far greater strategic focus but we've also got to [inaudible] come down to the tactical level, if I can put it that way, and have some hands on assistance. As Stephen was indicating, he attends most of the local Crime Prevention Committees' here to assist them – the Esplanade group, the Mitchell group and Cathy [inaudible] also who has a similar role as Stephen, attends those – the meetings of those smaller committees.

Tennant Creek, for instance, we attend either their meetings personally or via video link to assist them in their implementation stage and we're also charged with creating councils throughout the Territory and, again, will have a significantly hands on role in the short term to get them up and running until they reach maturing. So I think we've got a far greater strategic charter and a far significant tactical ability to actually put that strategy into place.

Dr BURNS: So in terms – I guess we're sitting here considering substance abuse, so in terms of those strategic direction or overview, I mean, can you just tie the two together?

Ms McDADE: I can. I don't know if you've read our structure. We have the Co-Ord Committee and we have a sub-committee of Co-ord which is the Crime Prevention Committee. On that is the Liquor Commissioner. He is an additional member in relation to that Co-Ord Committee. And when we talk about coming together in the sense of coordinating agencies, what our role is, is to coordinate the agencies to come together, to develop collaboratory and collectively programs that can have outcomes that are measurable and outcomes that suit not just a crime prevention outcome, but they are also their core functions because we're talking crime prevention in the wider scheme – from the moment you're born to the moment you die.

So we're talking particularly in relation to substance abuse in communities, it would be part of our role eventually to assist in relation to the development of any strategies that were likely to be implemented across the Territory or indeed in places in the Territory and be part of at least the evaluation process to see whether or not what was done was changed and it may well be that our research and policy directive can also assist in the development of meaningful strategies by looking across the world as to what's been implemented elsewhere. So I do expect from that focus…

Dr BURNS: Have you been having any dialogue with the Police Commissioner? We had him as a witness earlier today…

Ms McDADE: Yes, we have.

Dr BURNS: …and he's quite keen to see an inter-sectoral approach in line with some recommendations that have come out of, you know, ministerial councils at a Commonwealth level setting templates for dealing with, you know, crime and drugs and the inter-relationship between the two.

Ms McDADE: Oh, look, part of our role is not just the coordination, but to work in partnerships and to work together with particularly the police. They're the main provider, the main operatives in relation to crime prevention. We don't purport to usurp their role at all. And we've worked very closely with police in relation to most of what we've done, particularly the stats area, because we see that we can be of great assistance to them bearing in mind so far as the recording of crime, they own those statistics, just as on the IGIS system which gives us the court outcomes [inaudible]. But, yes, that is part of it – we're not meant to be operating on our own; we're meant to be hand in hand and forming partnerships not just with Police Commissioner and indeed other agencies, but with communities. And that's the whole idea of our structure. So it's a down-up approach or an up-down approach, whichever way you like to look at it. We're the conduit and the voice and the cement between the brick, if I can put it that way, as to anything that might be done across the Territory that can have a crime prevention outcome. That's the *raison d'etre* for us.

Ms CARTER: Lyn, you mentioned that you are – there's an entity known as the Crime Prevention Ministers. Who are they?

Ms McDADE: The Chief Minister, the Health Minister, the Attorney-General and Jane Aagaard.

Ms CARTER: So three.

Ms McDADE: Three.

Mr FARRAWELL: Four.

Ms McDADE: Four. Four. And they've got the ability…

Ms CARTER: I've got Chief Minister, Health, that's Aagaard…

Ms McDADE: Police.

Ms CARTER: Oh, and police.

Ms McDADE: So you get police, Chief Minister, Attorney-General and Health.

Ms CARTER: And you said that eight of your 16 staff deal with statistics, what do the others do? Obviously you'd have admin support.

Ms McDADE: We have one admin support. The others are essentially either research or policy or community relations officers. We haven't got a full establishment yet, I might say. That's to come in the new financial year. But we don't get our funding until the new year for the new positions.

Mr WOOD: And you're – is it the Supreme Court?

Ms McDADE: Yes, it is.

Mr WOOD: And do the statistics – are they published statistics? If I was to ring up and say: 'Can you tell me how many break ins in the rural area', can I get that, or would it have to go through…

Ms McDADE: No, we couldn't give that to you. It is not our data to release. The arrangement we have with police is that we can work with their data and improve their data with them, but we have no right of independent publication without their them and indeed most publications would come back through the process to be released in the ordinary way. But no, you probably wouldn't get an answer as Joe Blow in the street or indeed as Gerry Wood MLA, but I imagine if you were concerned about that, you could make a request across to the minister. It would come down that way and I would be very surprised if you didn't get a positive response that way.

Mr WOOD: I suppose I'm asking, sometimes there's a danger of - I mean, statistics get used politically.

Ms McDADE: Yes.

Mr WOOD: Is there any - I mean, could the Auditor-General audit what you have done to see whether the statistics are accurate or the opposite?

Ms McDADE: Absolutely. The Ombudsman I don't think has got the capacity, but the Auditor-General certainly could. I mean, the whole intention was to have us a little separate but even though we are part of the Department of Justice to avoid that type of perception. We don't have a stake, as I said, in relation to it; we simply get the data, produce the data, analyse the data and make comment in relation to the data. We have no agenda, but I appreciate what you are saying nonetheless.

Mr McADAM: I was just wondering if I could ask one question on the structural relationships. The NT government aids the program called the Crime Prevention Council and the way that it funds it. Can you just describe how they will work.

Ms McDADE: How they'll work? Well, bearing in mind that Tennant Creek is the Divisional Crime Prevention Council in Tennant Creek has not - I take that back - the Youth Initiative Strategy in Tennant Creek agree that they're happy to be a pilot in relation to being the first regional council created in the Northern Territory. So we don't yet have a regional council in place, but Tennant Creek will hopefully be up and running before the end of the calendar year. We anticipate Alice Springs and Palmerston would follow, but again for the rest of the Territory, I couldn't give you a time line.

Local crime prevention committees are being created of their own volition in relation to matters and things that affect communities. For instance, the Esplanade Action Group here has individuals who have concerns about the Esplanade; the Mitchell group, you'd be very familiar with, they work under the auspices of your office as I understand, and you provide certain support to them. We have the Wagaman Group, we have a Palmerston Forum in relation in crime. The town council also has its own crime prevention committee. So there a number of things are happening. In a [inaudible] anyway what I'd like to see is that we would have a series of small groups throughout Darwin, Palmerston and other geographical areas that fit nicely together by way of language group, or otherwise, whereby they identify at the local level what their problems are and have some say in articulating how they see resolutions to them, that they would then go to a regional council which would again be responsible for a particular geographic area, whereby they would have information fed to them as to what the concerns are with the community and how they, of their own volition, believe rectification might occur.

That may be by way of changing school times, all types of issues, but they would have the input to that group. That group would then have the input up to us and us across to Co-ord and the Standing Group of Ministers so that the communication line came up and down. Eventually I would like to see, and this is very much in the future, a devolution of control down to the regional councils even in a fiscal sense, but certainly control about what programs come in to their location, so a portal for service delivery, if I can put it in that sense, so far as programs go that relate to crime prevention. That ultimately is how I would like it to see but I honestly can't see as we sit here, that is how it will work. We are still very much in the development phase and we haven't really had any of that tested. But as I say …

Mr McADAM: Just the NT government agency programs …

Ms McDADE: The NT government agency programs - they're the core functions in relation to what they still do. As I said, we take crime prevention from one spectrum to the other; we're not just talking about criminal justice issues here. So we're talking about health and their ready interventions, talking about FACS and their interventions in families. All of these are programs which we in the Office of Crime Prevention say are indeed programs that have crime prevention outcomes. Education has attendance officers and the like and there's concepts in relation to a pilot for truancy out at Palmerston as we speak, and youth night patrols that have been developed by Health in relation to the northern suburbs; the Nightcliff youth centre and things such as that, and even the indigent policy that's being done by a collection of agencies in relation to itinerants, the itinerants program. All of those are government agency programs that are currently up and running of which we have some interaction with the people who are responsible for them.

Is that what you were …

Mr McADAM: Yes.

Ms McDADE: There's a lot of those going on. I mean, I probably have understated those, but there are numerous current programs being delivered.

Ms GOODSELL: One of my tasks at the moment is to actually do an audit of government programs, so eventually we should be able to provide people with some information about what is already in place, and also of agencies that are thinking about doing something, they can have a look at our list and have a look and see what other people are doing.

Mr WOOD: We are looking for diagrams because we get lost in this maze.

Ms McDADE: A mixed prize. I mean it is quite comprehensive what we have already got back as to what current agencies call their core delivery, but we say our crime prevention outcomes.

Dr LIM: You said that Alice Springs is still waiting to establish a [inaudible] Is there any reason why it has not occurred.

Ms McDADE: Only a question of time with the greatest respect, no other reason than that. We have had some discussions with the town council and, indeed, they have had some other discussions with other groups. I think it is just a question of time and I am not …

Dr LIM: I would have thought that you were still the second largest correctional people, you would have thought there would be an agency for the …

Ms McDADE: I think we are quite keen, but again I think the stimulus must come from the community, and these things cannot be developed overnight either. I mean not withstanding …

Mr McADAM interjecting.

Ms McDADE: It has to. It has got to be community driven. We have planted the seed in Alice Springs and they have to germinate it a little bit more, but I am quite confident they will. But it is not a question for us to go and impose anything on them, and say you must have this group come and meet, otherwise I think we have ruined it from the very beginning. This whole concept is community involvement, forming relationships and taking responsibility for the fact that crime is not just a police problem, crime is a social problem. We have all lived in society, we have all seen the development of it and it really is a time for everyone in the Northern Territory to say: 'This is my problem. This is where I live, I do not like it, I want to see things change'. But give people the opportunity and the information they need to make those changes. That is a very slow process and changes can be quite subtle, but the changes that we have been making incrementally that way are long lasting. There is no quick fix to this. I have not got a magic wand, and I am not going to change anything that quickly.

Dr LIM: And this promotion of the program in Alice Springs, the [inaudible] in the Centre, it is community based, this is available and …

Ms McDADE: As far as I understand – I have been spending a significant lot of time in Alice Springs and I am down there again next Wednesday for 2½ days in relation to a youth initiative that we have got down there at the moment. The number of agencies that are coming to that meeting in relation to addressing issues relating to youth, I think our numbers are in excess of 12, and that has been organised over the last couple of weeks.

There is certainly great goodwill and great feeling with the community in Alice Springs, there is no two ways about that, and I think people are genuinely interested in seeing change and being involved in the change process, genuinely interested in engaging and consulting, and that is why I do not think you can go down there and ride rough shod over everybody, you have got to get them engaged and you have got to get them involved, and sometimes that takes a little bit longer. There might be satisfaction

from some people's perspectives, but I think Alice Springs will do very well by having this development phase and taking their own time and going at their own pace.

Ms GOODSELL: One of the other things that emerged in the crime prevention councils was, again, you have to remember there are a limited number of people in the community that can contribute time and energy to those things, so I think part of the philosophy was to talk to groups that are already in existence and say: 'Would you like to take on this role?' rather than try to start something else, a whole new round of committees. So it is about talking to the groups that are already there too.

Mr WOOD: I know there was a fairly specific program meeting at 10.00 at Humpty Doo where a group of people – not today, Monday – concerned about some crime problems in that area. Now, could a local group start up without having the regional groups operate.

Ms McDADE: Oh yes, and that has already happened here in Darwin. We have no regional council in Darwin but we have a plethora of local crime prevention committees.

Mr WOOD: And these, about 20 of these …

Ms McDADE: See, the Chairman did not even know, he would probably have asked one of the liaison officers to come along.

Mr WOOD: Alright, I will ring, because I did not know that and I …

Ms McDADE: And we can give you some …

Mr WOOD: … a service here half an hour ago and …

Ms McDADE: We can give you lots of guidance and …

Mr WOOD: They are talking to the Police Commissioner, would there be a problem there?

Ms McDADE: No. Again, I say I think that we are not in opposition to the police at all. The whole concept is that we work in partnership with everybody who is interested in crime prevention, and certainly the police are a very good client.

Ms CARTER: When we have our meetings, Stephen and Kathy often come along, more often than not, and also senior police officers. So everybody just joins in.

Mr McADAM: One other question, if I may. In respect to the NT government agency programs, now what is the capacity or capability in regards to the directions between those agencies and the regional …

Ms McDADE: We expect that the key government agencies will be on the regional crime. We have encouraged that. In fact, in Tennant Creek, we have written to all the CEOs to nominate members of education, health, police, community welfare and development, to come on to that committee. I think they are essential.

Mr FARRAWELL: In relation to one of your previous questions with regard to the link between substance abuse and the Office of Crime Prevention; with the last round of funding that was given out - and that was through NT*Safe* - we received 83 applications which was in excess of $1m when we added them all up. We had $250 000. Thirty-one of those applications had identified substance abuse

as a major issue contributing to crime in the community. They are almost exclusively in remote indigenous communities.

Ms McDADE: Yes, and in fact …

Mr FARRAWELL: We were able to fund 21 projects and 8 of those were projects that identified substance abuse. It falls across many issues; it is not just the crime prevention – it is the health and the education. The family life is not an issue you can deal with in isolation. That is why we are trying to work together with other agencies.

Ms McDADE: Also, as part of the NT*Safe*, part of their proposals - which they never got to explore - was that a whole-of-government, across the NT, approach be taken in relation to alcohol and drug issues. Rather than to do pockets of restrictions in some areas, that we take a holistic approach in relation to how we might look at the supply of alcohol and the substances throughout the Territory. That was one of the projects they were going to get themselves into and, ultimately, we would like to think that we would get to that stage where we could coordinate an approach.

The advantage of having a Liquor Commissioner on the COAG committee makes that very advantageous. However, it is quite apparent that alcohol, particularly, in communities is causing a huge degree of grief, and substance abuse seems to be catching up rather remarkably in most communities. Notwithstanding that the research that was done under the NT*Safe*, but even in my conversations with people now, that is their main concern it seems. They would like to see things done differently. Tennant Creek in particularl is already highlighting that this is a grave concern for them. It is not just the rural communities; it is everywhere in the Northern Territory. Whatever could be done collectively and collaboratively across government to look at a better way of supplying alcohol would be probably beneficial to us all in the long run.

Dr LIM: You might want to make contact with Ian [inaudible]Crundle when you are in Alice Springs next week. He currently chairs a group, the Substance Misuse Action Group, which is overseeing the alcohol restrictions in Alice at the moment …

Ms McDADE: The restrictions as they currently are. Yes, I've seen …

Dr LIM: Talking about the substance abuse with crime, his reference could probably be one of the best groups you can get.

Ms McDADE: Yes, thank you for that. I certainly will. Yes, I think that that is the general feeling across most communities throughout the Northern Territory, that we have a problem.

Mr McADAM: Anyone else? Again, we have heard this morning about the catastrophic impact the supply of grog, marijuana, with reference to the indigenous communities in the bush. Adding that all up [inaudible] as well in the Territory. I think we have a bit of a picture seeing that there was not a lot of coordination or there was not a lot of planning between the Territory and the Commonwealth in respect of a whole range of programs. Will the office be in a position to go for-instance put up a package ie to the ministers – in the case-and I use those as an example, the CDEP at the moment. You have to be 15 years and nine months to register and you become eligible, I think, when you turn 16 years of age. There are a whole range of kids out there who are under 15 years and nine months, who are not going to school. We are talking about schooling and our youth etcetera. For instance, [inaudible]. What capacity would the office have in regards to be able to lobby or to put in position to the Commonwealth in regard to a variation to the CDEP or some other program, which links them back in the school system? Do you follow what I mean?

Ms McDADE: I hear what you say. I do not know whether I necessarily want to answer your particular example. If I can just talk of the process, and that is engaging the Commonwealth in relation to making change …

Mr McADAM: You are offering …

Ms McDADE: We have been most mindful that the Commonwealth is an important fund provider for the Northern Territory into most areas. In Tennant Creek we've got a Commonwealth representative, too, from the Family and Community Services. So – and equally with our initiative in Alice Springs, we've invited the Commonwealth and we've got two departments coming.

It would, in the fullness of time, be my perception that the Office of Crime Prevention could be the conduit for such a submission to go the Commonwealth because it could be done collectively and coordinated by the office from everybody and then pushed through the ministers and the ministers could be in a position to make whatever approach about whatever matter or thing they want to do. So not necessarily action or example, but I would see that process as being something that could be facilitated through the Office of Crime Prevention, yes.

Mr WOOD: When you said you had a background in the Army, I thought you might have written some of this: tackle property crime; attack drug dealers…

Dr LIM: Gerry!

Ms McDADE: That's all right; you just call me 'Ma'am'.

Mr WOOD: Touche. But it's – I mean, they're probably the right words to use, anyway, because I mean I think if we don't take it seriously, we're not going to get anywhere.

Dr BURNS: So when do you think the matter might be resolved about – for funding for projects. I know that for Wagaman School has got a – they got a grant from NT *safe* for some fencing and lighting to make the area safe and because of various reasons, they're about $1500 short and so they…

A member: [inaudible]

Dr BURNS: Yes, I've written.

Ms McDADE: You've written, yes, and I think we've responded as well.

Dr BURNS: Oh. I must have been in a parliament. I haven't seen that letter.

Ms McDADE: But just on that, we're contemplating, because of the success of some of that lighting program in schools and to do with [inaudible] of vandal like activity to look across all the schools in the Territory to see whether or not we can't get a best practice approach and do a collective approach for most of the schools in the greater Darwin area first, and we just need one school to be able to evaluate the effect so that we can have a justification for saying: 'These measures do work in the reduction of vandalism' and the like. We're also looking at – sorry.

Dr BURNS: And the other issue is parks.

Ms McDADE: Indeed.

Dr BURNS: And I've written to you – I think I've written to you about Borella Park…

Ms McDADE: Yes. Lighting.

Dr BURNS: …which is a bit of a trail there from the Airport Hotel through to the Jingili Shops so a few of the neighbours have asked about that. I know the lights that were installed in Amsterdam Park – my predecessor Steve Balch was very active with that group and they successfully got those lights. I think it's a great idea that hot spots like that – I think that's good use of that sort of money.

Mr FARRAWELL: I think one of the more long term outcomes that we're hoping to achieve with the Esplanade Action Group, they received funding as well for lighting on Bicentennial Park, and as it – the area is under the responsibility of Darwin City Council, that had to go back and they're looking at their lighting standards and possibly reviewing them because it's been identified that they're probably not adequate enough in terms of public safety and this has come about through the [inaudible] work as well. So in the long term, that will be an all-of-Council responsibility. They'll take that on board in terms of all their lighting in all their public parks and streets and public spaces etcetera, so these are some of the more long term outcomes that we're hoping to achieve and that's sort of – that's started to happen a little bit with Darwin City Council because what they had as a minimum standard isn't sufficient.

Dr BURNS: Can I touch on another issue? It's in the sort of lighting, environment issue and I think the environment is an incredibly important factor in crime, and certainly in the Casuarina area, the Casuarina Square. I know police have complained to me that the design of it actually – well, it doesn't encourage young vandals and criminals and ne'er do wells, but it actually provides an environment where they can hide and not be – do you work with…

Ms McDADE: Well, Kon Vatskalis has had two meetings in relation to Casuarina Square and the adjacent shopping centres at Nakara, Tiwi and Alawa on those very issues where he got all the traders together because they were of great concern, particularly if you've got a [inaudible] there. I think the Uni was there and so was Lend Lease, and Lend Lease seemed to be very mindful of the fact that they've got a building that perhaps if we had the opportunity and the money, you could probably redesign from a crime prevention perspective and indeed, I'm sure that that will become more apparent in what we build in the future, but unfortunately we have Casuarina as it is.

So, yes, a lot of work has been going on there and a lot of that is to do with the tension of utilisation of public space. People – shopkeepers for instance, like people to come and consume, where as other people like to Casuarina Square, particularly the youth, walk around together as friends. The itinerants like to go there too and they like to sit around. Generally speaking, not necessarily to be untoward and people find that very difficult and it becomes quite tension filled. And also unfortunately, what that then does, if there is one incident people become quite fearful of the crime and they start to think they are the next person, so if they are walking to their car, particularly underground carparks there and they see a group of youths, I think their immediate apprehension is, 'Oh God, something is going to happen to me' and that may not necessarily be the case. It may just be a group of kids who are walking along. But they have managed to get some community involvement in relation to those issues at Casuarina Square and as I say, the three adjacent supermarkets who are all experiencing that type of antisocial behaviour and fear of crime, particularly in relation to youth groups and the like, and a part of that is interrelated with the itinerants project. The Larrakia people have also come and spoken at the meeting in relation to what they were doing, to inform people that look, we know that there is a difficulty with itinerants, this is what we are doing with our program.

Health spoke about their youth patrol program, which they are hoping to get up in the very near future, and about their youth club with the hope to get up in Nightcliff. So a lot of information got passed because people were concerned and willing enough to come together and that was pulled together by Kon Vatskalis and his office, and that has only happened in the last three months.

Mr WOOD: Your programs to buy private land, for instance, you mentioned the parks need more lighting, but a small shopping centre where the land is owned by the owner of …

Ms McDADE: Well they involve other people that do not necessarily live on that land. We are more than happy and we have not taken a purely legalistic view in this. As far as we are concerned if it is utilised by the public or the community of the Northern Territory and the shop owners are happy to be involved, as most of them have been, and another example is the Malak Shopping Centre…

Ms GOODSELL: Could I speak about a separate – only because I am both a resident of Malak so I have been to some meetings with Delia Lawrie and I guess I am a bit of an idealist but the thing I see happening is some community people get together because they are tired of not being able to go to the shop without being harassed by drunks or having windows smashed by juveniles. So they get together and they start to look at the problem and they can do a number of things. They can talk to the council about the park across the road and the lighting and maybe look at some long term strategies. Maybe we should not have all these big parks in the middle of suburbs that are not really well used but they are misused perhaps.

The shop owner gets involved and he might do some things to help around the shop. You look at the licensing rules for that supermarket and ask if the opening times and stuff are appropriate. If you can solve some of those problems by getting agencies in and talking to community groups, getting business involved, then ultimately you might have something where the people of that community will think, yes, something happened here and the place got improved.

To my mind that is partly what the Office of Crime Prevention is, just helping to coordinate those people and allow communities to say: 'This is what we need. This is what we do not like'. Of course they cannot have the earth but they can do something that…

Dr LIM: How far does your money spread in the sense – take for instance in Alice Springs the Sadadeen Shopping Centre. It is an L-shaped shopping centre with a square in the middle and service station in one corner. Recently they had vandal problems and I had a meeting with all the shop owners there and they said: 'Look there is a perfectly good park across the street', right across 'but it is fully maintained by the council, fully lit'. There are areas of play furniture. Now would this sort of program

be part of a funding for – or even could they assist the town council in putting say a bike track, a BMX track, a small one, so that the children can actually play there rather than in the carpark of the shopping centre in [inaudible] and all that, you do it in the park, it is only across the street. It provides a good environment to play , it is a park, it is the appropriate place rather than carpark where they are in conflict with the traffic.

Ms McDADE: Again, I think anything is possible but most of our grants that we have given in relation to that have been generated by the community who have indicated and identified their difficulties and done particular submission in relation to particularly NT*Safe*. But look, any organisation that gets themselves together that way are good people, and identifies matters and things such as that that are justified in a sense - I mean, certainly funding is possible but it's not something that we would just trot along and say, oh, that's a good idea, look, they're playing here, we'll go and build this park - again, it's got to have some genesis from the community, and certainly they've been told to make an application.

Mr WOOD: You mentioned here rigorous evaluation and reporting requirements to identify programs' potential. For example, the small community group of business people, they are not going to have a lot of time to be filling in some large report or forms.

Ms McDADE: Yes, I appreciate that, and you might be familiar with Business Watch in Palmerston.

Mr WOOD: I've heard the name. I live further out.

Ms McDADE: I appreciate that. They had that very problem and they were doing some very good stuff in relation to Business Watch and they expanded their recruitment, particularly in areas where they'd suffered from a lot of break-ins and they did a lot of security type audits and probably lost all their [inaudible]. Nonetheless, a lot of the owners were quite chuffed at the fact they didn't have to sleep at their premises any more.

It then became very difficult for them to evaluate the outcome. They are currently doing a sample evaluation of five people, that is the Australian Institute of Criminology, to try and see whether or not it can be evaluated across the board. Our intention and hope is, if we come up with something quite innovative like that, that we put the evaluation mechanisms in place at the very beginning and assist in that evaluation, most of the smaller grants that would be the most difficult for, but simple little things can be measured, and that means a snapshot at the beginning and then regularly looking at it and going, oh, have we seen the change? Now, change might not be a full barometer; it might be by degrees, but that's our hope and expectation, that we put something in the beginning so that we can monitor it through to the end and assist in that monitoring process and not make it too complicated, particularly for the smaller grants.

If we get the ability to give time to grants that might have recurring funding, then we would expect vigorous evaluation and part of that funding money would go towards developing an evaluation program, but the smaller ones, we can be of some assistance.

Ms CARTER: I guess the statistics unit, too, if we can get down to offences in particular areas, you might start to see trends like, we might take a number of initiatives at Malak to deal with vandalism offences, and that works wonderfully, but two months later in Karama, all the offences that were in Malak are suddenly happening at Karama. Having that statistics and that evaluation, being able to watch what happens, will probably help us to better formulate strategies and watch that we just don't shift the crime from one …

Ms McDADE: Displacement is the big issue in the northern suburbs; you appreciate you light one park, where do they go - to the next suburb's dark park.

Dr BURNS: Except I think there's …

Ms CARTER: Local members don't mind.

Dr BURNS: My own view is that there are hot spots because of the geography and what's in the area. In that Borella Park, you've got the Airport Hotel, the Jingili shops and the cemetery there.

Ms McDADE: The cemetery, yes.

Ms CARTER: Can I say that, being involved with two groups, the role of, first NT *safe* and now, Crime Prevention NT, has been very welcome. I think the joy created by the awarding of the $15 000 grant had to be seen to be beheld, quite frankly, given the scheme of things, $15 000 is not a huge amount of government money. The frustration now is in the implementation of that grant. This is to provide some extra lighting on the Esplanade, and as you can imagine $15 000 is probably going to buy very little. However, the group thought it was marvellous and clapped their hands together with glee. But now the implementation has moved over to Darwin City Council, and so although the original problem is and continues to be itinerants, essentially, that create a level of fear within the community so that people won't use the park, the idea of course is if you increase lighting the itinerants will go away to some degree, and people will actually come back and use the park after hours, but there is a level of frustration growing now over the implementation. We probably naively thought that you just pick a couple of trees in an area and bug light them and won't that be lovely.

Ms McDADE: I met with Robert Parker the other day; yes, I understand that he's …

Ms CARTER: Yes, Robert's the chair.

Ms McDADE: Yes, and we developed a strategy whereby we might be able to be of some assistance to facilitating the expedition of the implementation. You will appreciate that I am not Darwin City Council, and again, part of our process I guess is to grease the way, if I can put it that way; we don't particularly want to go to war with anybody.

Ms CARTER: Sometimes there's so much bureaucracy involved that it becomes very frustrating.

Ms McDADE: I can accept that, and that is something we are very mindful of because it reduces people's enthusiasm. Once you've engaged the community and got them motivated, they expect, and I think they are entitled to expect, your cooperation and to see something happen, and what we have to really guard against is giving false expectations; leading them down the path, getting them to work very hard and then giving them nothing at the end. That is something I am most mindful of, particularly with smaller groups and when you are talking about people who are, generally speaking, these days very busy in all matters and things, but they are able to take the time to be community minded. I think they deserve all the assistance they can get. Certainly, that is the ethos that the Office of Crime Prevention has. Most of the people who work there are imbued with that belief. I make sure that they maintain that belief and, in fact, deliver it. I think that you have had very good experience from those …

Ms CARTER: We did the audit in Mitchell Street and there were quite large numbers of business owners, in particular, and operators from the Mitchell Street area, very excited about it all. The Mitchell Street group is newer compared to the Esplanade group, but now that we have seen how the Esplanade group has ground to some degree into a …

Ms McDADE: [inaudible] has that effect.

Ms CARTER: I am watching the Mitchell Street one; we have identified a lot of issues on Mitchell Street mainly to do with lighting and excess rubbishy scrub that creates areas where people who have consumed substances might be hiding. My hope is now, that we do not grind slowly onwards now with the Mitchell Street group, because you get a lot of energy in the first six months and then it is like: 'Oh, God, what is the point of these meetings?'

Ms McDADE: You do not want for them to meet interminably, we want them to get …

Ms CARTER: We want to see some action. These are dynamic people; these are not your local losers turning up to these meetings. These are the go-getters of the community, and they expect outcomes from the energy that they put into it.

Ms McDADE: And so they should.

Ms CARTER: But anyway, we are pretty happy with the way things have gone.

Mr McADAM: Did you want to do a presentation at all?

Ms GOODSELL: Basically …

Ms McDADE: Well, I think you have probably covered it, really. I am happy to if you wish, but I think it is pretty much self-evident from this, and you have probably listened enough, but …

Ms CARTER: You were going to give me a copy of the power point …

Mr FARRAWELL: Yes, I will send that to you.

Ms McDADE: You can just e-mail it if you like. It really is encapsulated in those documents that I have given to you.

Mr McADAM: Are there any other questions?

Ms CARTER: No. That is very good, thank you. Very exciting activities occurring and I wish you all the very best with it. It sounds very good.

Mr FARRAWELL: Also with Alice Springs, we have actually been given some input to the council with regard to the implementation of CCTV in the mall - pros and cons for the argument - so that is another …

Ms McDADE: Because they are contra intents about that with the council themselves, but we decided the easiest way was to give them the research so that they could see that, really, that may not be your answer. It may not be your answer.

Dr LIM: It has taken a long time for this program to come to a decision.

Ms CARTER: Can I write to the Attorney-General or the Minister for Justice and seek a copy of that as well; a copy of your research?

Ms McDADE: No, no, you can write to us and get that. That is just research that we do. If any of you ever want research or anything, certainly there is no need for any formal process in relation to that at all. I did not mean to put you off when I spoke about statistics.

Ms GOODSELL: And hopefully one day that is what the regional Crime Prevention Councils will do. They will have someone from the council on that committee and they will say: 'Oh, we need to know about the CCTV'. They will ring our office and we will provide them with some.

Dr LIM: Again, I [inaudible] crime prevention [inaudible].

Ms McDADE: Thank you for that.

Dr LIM: That takes up the very wide representation of the community within the council.

Mr McADAM: On behalf of the Substance Abuse Committee, thanks for coming in. We do appreciate your time and your presentation. Lyn, Jill and Stephen, we wish you the very best.

Ms McDADE: Well, thank you for that.

Ms CARTER: Thank you.

Mr McADAM: Stephen, did you want to say something?

Mr FARRAWELL: I was just going to ask Gerry if he would actually like someone to come to that meeting?

Mr WOOD: Well, they are just having an initial meeting tomorrow.

THE WITNESSES WITHDREW

[Editor's Note: commencement of session not recorded].

…any questions around those areas but I would emphasise that our involvement is really very much based under the national strategies and national frameworks. What we bring to the Territory then is that national consistency so that all Territorians can be both included in whatever is happening across the country, including the suicide prevention strategies, the Aboriginal health strategies, the various projects and programs that come under those strategies, and also the national alcohol and national tobacco strategies.

Ms CARTER: How many staff do you have in the Territory?

Ms YOUNG: I have 50 staff. I have an office in Alice Springs of around 10 people and around 40, 42 in Darwin, depending on whether we have some particular projects that are short term.

Ms CARTER: And is most of the work concerning the distribution of grants?

Ms YOUNG: No, it is not. No. Some of it is around distribution or overseeing of contracts and grants and initiatives but much of it is around developing programs, developing responses under those national strategies that I have talked about and much of it is around assisting communities, around particular approaches. For example, the Primary Health Care Access Program, which has been talked about recently by Jane Aagaard, around the 21 health zones. That is Commonwealth funding that is driving that and so a great deal of the work that is done in my office is around the development of either partnership programs in health or the new development of particular initiatives, but are uniquely and particularly focused on the Territory.

Ms CARTER: When you say you are involved particularly in program development, what sort of an agency implements most of the programs?

Ms YOUNG: Usually non-government organisations, Aboriginal medical services, or, in the case of aged care, for example, individuals who are interested in providing care to their ageing relatives in remote communities, for example, community aged care packages. They would be assessed as being in a position to provide that level of care and so you do not need to have a major organisation around you for that to happen.

Dr LIM: A large part of your work would be grants supervision, grants allocation, or is that …

Ms YOUNG: A fair proportion is, yes.

Dr LIM: The programs are done in a way that THS is aware or not aware of …

Ms YOUNG: Yes. We operated in a partnership framework, that does not mean we agree on everything. As you would all know from federation, there is a healthy tension around Commonwealth/State or Commonwealth/Territory priorities and ways of doing things, but there is a great deal of good will around working in partnership, or at least having a coordinated and collaborative framework, or an approach to something, does not always mean that we would agree to go the same way. What we try very much to do is not to duplicate our services. And what the Commonwealth is very concerned about is not putting services in to particular areas where they have been identified as high need, and Territory Health and other Territory services have been withdrawn from that area so it is very much – the partnership is exactly that, where we both commit to the improvement of health in particular areas and we might agree on a way to do that.

Dr LIM: What has been on my mind is that the potential of the review that is being conducted at the moment – or was conducted and we have still got to release the report on the amounts here and all that. Is that is still not available yet, the report.

Ms YOUNG: It is still in draft form I understand. Yes.

Dr LIM: Is there any inclination that services might be reduced or withdrawn?

Ms YOUNG: No. The key focus of the reviews was to look both against, from a funding perspective whether they were delivering as they were originally intended, and it is clear that they were not. The other is to then provide some constructive advice about how they might go about it. The other thing too though, is they were funded a few years ago —I am not exactly sure whether it was three or four years ago, under a particular substance misuse strategy, but since then there has been a great deal of emphasis put on petrol sniffing prevention across the Territory and with the Prime Minister's own interest and awareness in this area, and so other programs have developed up. They have Mt Theo and [inaudible] operating in isolation from what is happening in Central Australia, for

example, under the youth link up service, means that they are not able to be part of that coordination or an integrating approach. So we are very keen, as a result of the review, that they do become part of what is happening in Central Australia.

Dr LIM: You in fact went to visit Mt Theo …

Ms YOUNG: Yes.

Dr LIM: From that perspective, how is it going and obviously you [inaudible] asked the wrong people whether the funding will be secure or not.

Ms YOUNG: Yes. The funding is secure but it is not secure in the terms of nothing happening against that funding. For quite some time there has been – well there were problems around the service being delivered, there were problems around the administration of the program, and I understand great changes have been made in those areas. I am still to see, though, an improved service delivery or improved outcome. One of the things around having the scrutiny on particular areas – though I would not consider this a best practice approach. One thing about having scrutiny in particular areas, people are conscious that people are looking over their shoulder, ie, the funding bodies or even the community, and so the numbers of people sniffing in Yuendumu are far less than there were previously, which is in itself a good outcome.

Ms CARTER: I was just interested whether there would be a reason, I noticed that Bathurst Island does not attract any funding, however it has a well known suicide problem over there which is arguably related to substance abuse. Could there be any particular reason why Bathurst would not have a program funded by the Commonwealth.

Ms YOUNG: They have many programs funded by the Commonwealth but they may not come under a substance abuse heading. They have a suicide prevention program and a mental health program. They have Exploring Together and their Tiwi for Life programs; both of those attract Commonwealth funding. They also have, under their coordinated care trial program framework, funding for mental health. They see suicide as just but one part and so, in terms of looking at the whole of health, they have really strong mental health programs. They are one of the shining examples for many indigenous communities across Australia, with the success that they have had. For two years, they had no suicides. So, they do not have a suicide problem as such at the moment. They have had three in the last little while, I know.

Ms CARTER: I was going to say, I know of three in the last …

Ms YOUNG: In the last couple of months, yes, they have. Before that, they had none for two years, and that is a very proud thing for the Tiwi people, as you would imagine. Why I know about that is we had the Tiwi coordinated care trial monitoring group meeting yesterday. They are most concerned about the incidence of suicide building again and the worry for the community around that.

Ms CARTER: I understand one of them was a woman who stabbed herself in the neck a number of times. Now, for a woman to do something as dramatic as that is bad, isn't it? A very unusual way of killing yourself. There are some serious problems.

Ms YOUNG: Yes. Yes, so it is not to say that issues are resolved on Tiwi in any way. Any death from suicide is tragic. But they are receiving Commonwealth funding and they have a number of programs. They are also providing evidence of the success of their programs in national forums, for example, the suicide prevention conference that is on at the moment. The Tiwi are not there this year,

but they have been in the past and they also got a Gold Award under The Mental Health Services Conference a couple of years ago for one of their projects.

Mr WOOD: Are these the only programs the Commonwealth gives for either licit or illicit drug …

Ms YOUNG: No.

Mr WOOD: Are you able to give us, at some time …

Ms YOUNG: Yes, I can, and I brought that along today. It is probably the one I have at the back of the report. It is an up-to-date list, but what it does not cover is what is paid to Territory Health under the health care agreements, that they can use for work in this area, and also PHERP funding – the population, health funding which is not part of the health care agreement. It is like a specific grant for population health activities that is also paid. That can be used for work in this area. The other is the $2.7m that is available under the Illicit Drugs Diversion Program. $1m of that has been the Prime Minister's interest moving to petrol sniffing prevention. However, there is $1.7m still that is part of the partnership arrangement with Territory Health and ourselves.

Mr WOOD: Are you able to give us a list of those as well?

Ms YOUNG: It is in that one.

Mr WOOD: Oh, it is all in there? Oh, right. I thought …

Ms YOUNG: Oh, in terms of the other funding?

Mr WOOD: Yes.

Ms YOUNG: I could give you a list of what the Commonwealth pays to Territory Health if …

Mr WOOD: Is that a tied advance for a particular purpose or is …

Ms YOUNG: Some of them are, some of them are more broad - broader than that, like the health care agreements which, for example, is $73m that is around a range of health areas, particularly hospitals. And so hospitals would have a role, too, in providing acute care for people affected by substance misuse. That is not counted in here.

Mr WOOD: I suppose what we are trying to find out is where everything fits into place and how many people are getting money from this point ...

Ms YOUNG: Yes. All the grants that are related to substance misuse are listed here. I have also listed the NT Alcohol and Other Drug Services, that are funded by the Northern Territory government in the format that incorporates some of the Commonwealth funds.

Dr LIM: So, yes, so that the dollar figures you have got in the second last column relates to the funding sources that is in the third last column?

Ms YOUNG: Yes, that is right. So for example LWA was *Living with Alcohol;* AOD, alcohol and other drugs.

Mr WOOD: You grant directly to non-government organisations?

Ms YOUNG: Yes.

Mr WOOD: They are the ones at the beginning?

Ms YOUNG: Yes.

Dr LIM: So where does DHSC come in? I can't see the DHSC.

Ms YOUNG: It is on the back and it is listed as Territory Health Services. It is something that Territory Health would need to update or …

Dr LIM: So when you look at funding sources, NT I assume is NT government?

Ms YOUNG: Yes.

Dr LIM: LWA is *Living with Alcohol* program. Was your initials, I mean DHSC or…

Ms YOUNG: This is not Commonwealth funding; this is Territory government funding but it could be using some of the Commonwealth funding to the Territory.

Dr LIM: Are we allowed to know which ones they are? Which are the ones that the federal government contributes to along those - if these are partnership funded programs, it would be a dual party?

Ms YOUNG: No. It's all NT funds that are listed there...

Dr LIM: The funds are given to THS?

Ms YOUNG: Yes, from a number of buckets. If you are looking at how much the Commonwealth puts in, if you move to Appendix 1, page 7, under the National Drugs Strategy, under the COAG Illicit Drug Diversion Initiative, there is an amount of $2 739 679 there. $1m of that has been allocated to petrol sniffing prevention specifically, and $1.7m is still being – it has not been spent; it is in the process of being spent. Under the National Illicit Drug Strategy Program and just going over the page, we make direct grants to non-government organisations and they are listed here and the aggregate is $339 000.

Over the page there is OATSIH funded services under the Commonwealth program. It is not just neatly Commonwealth it comes under a range of areas within the department and I think it is $15m. Then under the petrol sniffing prevention and support programs under National Illicit Drugs, the government provided funding totalling $7m over four years and out of that, some $6m went to the Territory government for a number of projects over the four years. So it is $1.93m per year.

Mr WOOD: Does your department in the Territory monitor the success or otherwise of these programs?

Ms YOUNG: Pretty well, yes. We certainly monitor in terms of the funding against the expected performance and we monitor it in terms of how many services have been provided against the funding, that sort of thing, but in terms of tracking levels of use, we have that data as well but it would be difficult to say that the amount of money spent – well, one would expect that it is contributing to keeping services flowing and people able to manage their substance misuse, but I do not know about levels of prevention.

Mr WOOD: How does that – I'll call it the NPY Womens Council – case go? I mean how is that operating?

Ms YOUNG: It has not spent all its funding and that is for a range of reasons, particularly with communities - the patterns of petrol sniffing, particularly in the areas, change and they are quite variable. So you might have your project set up in a particular area and the community most at risk or the highest number of people sniffing is not in the area that you got the service, for example.

Mr WOOD: Is it just based in any one of the Pitjantjatjara services based in Alice Springs?

Ms YOUNG: No, it is actually rolled out. It is based in Alice Springs where its administrative headquarters but on the ground it is in the NPY lands.

Mr WOOD: I did not know whether it was centred in there. So it is administered from Alice Springs?

Ms YOUNG: Yes.

Dr LIM: On page 13 of the documents you handed us, again the program is for the current year 2001-02 which runs out in a couple of weeks. So is there a similar sized program going to happen in the next year?

Ms YOUNG: Yes, possibly more funding, yes. There is no reduction in the funding that is going in.

Dr LIM: May I ask on behalf of the committee that we receive a copy of the report when it is finalised.

Ms YOUNG: Yes, yes.

Dr BURNS: Leonie, I remember listening to you on radio one day. You were in a fairly invidious position in terms of questions being asked about the $1m that had been given or funded by the Commonwealth and an apparent inability to spend it. Those of us who worked on the ground understand how difficult this is, but I gather from what you are saying that a lot of those issues have been overcome now and that there are bodies now receiving the funding for programs that are currently being developed in the petrol sniffing area. Is that a fair enough summary of where it is?

Ms YOUNG: Yes, yes, that is a fair enough summary. I was under a great deal of pressure to get the money…

Dr BURNS: You handled it magnificently, let me tell you.

Ms YOUNG: Well, being of the Territory you would understand rolling out programs is not just about rolling about the program but it is about sitting down with people and working out what it is that people want to have happening in their communities. That was taking a great deal of time.

I wish I could say that the programs are working well but we have still got problems with some of the programs delivering services because now the people who are charged with delivering the services are doing the sitting down and not everyone is agreeing with the best way …

Dr BURNS: Can you tell me – to be honest with you, I know very little about it – can you tell me the sort of nature of the service that is being developed?

Ms YOUNG: Yes. It is an exciting concept and possibly because of its excitement it is causing more ripples than it needs to. There are something like 17 agencies in Central Australia that are funded for petrol sniffing prevention, alcohol and drug or illicit drug or illicit drug servicing. That includes early intervention, promotion, prevention, treatment, respite, a whole range of things, and it flows onto Aboriginal Medical Services, for example, who get a proportion of funding for that.

And so one of the opportunities with the $1m for petrol sniffing, we called for applications of interest and in Central Australia there had been under the Primary Health Care Access Program, the Central Australian Regional Indigenous Access Plan, there had been a specific substance misuse plan developed under that. So there had already been a great awareness of, 'Look, things are pretty crook here in terms of substance misuse and we need a plan of action'. So there was a community plan. Using that plan, 17 of the agencies that are funded got together, formed a consortium and put in a bid for the petrol sniffing prevention funding. The minister at the time, Michael Wooldridge, personally wrote back and said: 'This is wonderful, this is really exciting and I support this'. So they got the funding, and of course, with 17 agencies one group needs to hold the funds and one group was nominated to be the auspicing agency.

Since then we have had a number of disagreements within the consortium about the best way forward. And it is a lesson in terms of selecting those who…

Mr McADAM: [inaudible]

Ms YOUNG: Yes, it is about politics. It is about local politics and it is about long-held historic agreements and grievances coming to the fore, and this is where I find it particularly frustrating. That means that those funds are not getting out to the communities that are needing them, and I find that particularly hard. So, we have been working very closely with the agencies and encouraging them to come together to see the greater goal rather than who is managing who on a particular day, and I am happy to say that that is coming together well.

There is great capacity to deliver in communities by people in communities, and recognising that and having people in positions where the funds to support that happening is the goal and the intention of this project.

Dr LIM: Would not those 17 agencies have a coordinating body which directs the fund holding body to …

Ms YOUNG: They did, they came together and organised themselves under a committee of governments for the consortium and for the project management, but it was likened recently to a description from the agency holding the money was that they have one end of the piece of rope and intending to go a particular way, and they were constantly being dragged back by the consortium on the other end of the rope, which means that the committee obviously aren't sharing the one view around how to go forward, and that is based on a number of political differences.

Mr McADAM: [inaudible]

Ms YOUNG: Yes, it is public knowledge that Tangentyere are the auspicing agency

Ms CARTER: If the money's not spent, will it be taken away?

Ms YOUNG: It can be. It could be. I would much prefer though to work through, even though it takes a little bit longer to actually getting everybody who all thought it was a good idea and signed up early. What was it that brought them together, let's capture that and then let's get out there, because places like Mutitjulu, Mt Theo and Imanpa are waiting for services, and there is petrol sniffing occurring in their communities now, and there is a great deal of community input.

Dr LIM: So if the consortium is saying yes, they should be funded, why isn't the Tangentyere council releasing the funds?

Ms YOUNG: There is a great deal of effort being taken in the recruitment of a project manager and a difference in opinion in who that should be and how that should happen.

Dr BURNS: So what are the sort of services envisaged on the ground, say, at some of these communities? What form will they take?

Ms YOUNG: Okay. Well, they can take the form of whatever is there now and existing, whether it is youth services, education, some health services in the clinics, for example, or maybe some community development work, some sport and recreation. If that is there now, and it has the community's support to actually be bigger, with some brokerage funds from this project, which can happen, then that can then occur around identifying a number of activities for the particular community that would help around youth services.

It is not so much focused on petrol sniffing prevention, but in your community if that is what the issue is, then the funding can happen for that as well. There are a number of interventions. There is a great deal that has been written by Peter D'Abbs and others, and there are a number of resources that have been put together that is like a community package around what to do if petrol sniffing is in your area.

We have the resources, we have the funding, we have got the communities, and we are waiting for this to happen. With the funding that came in, it's around coordinating those activities under a structured, like an accredited approach, but accredited in terms of good practice. It is not about imposing a particular model, but around sitting down with each of those communities and then building on what is there.

If nothing is there then, clearly, there needs to be some immediate petrol sniffing prevention, or support for those kids who are. Then where to next, what happens around that? We have some funding for some additional educational training as well. That can go into training up people in communities so that there is a skills and knowledge transfer that can occur, so that people in communities can know what to do when petrol sniffing is a bother.

But, if it is not about petrol sniffing – if it is around kids who are perhaps at risk and who are demonstrating at-risk behaviours, which can be a number of things, including smoking gunja and so on - then that could be included as well.

Dr LIM: So the release of funding - I am having difficulties in understanding. There is a consortium that says: 'Look, funds to do this, this and that for organisations'. The holding bodies say: 'No, we cannot release the funds …

Ms YOUNG: Until we get a project manager to do that.

Dr LIM: And the consortium is not helping with getting the project manager or …

Ms YOUNG: They are now, yes. Yes they are. There is a meeting on Monday and they are all coming together and they are concerned to - I know this is being recorded but – they are concerned too.

Dr BURNS: You can ask for it to be *in camera*.

Ms YOUNG: Yes, I know, that would be good.

Dr BURNS: Can we have that *in camera*, please?

IN CAMERA EVIDENCE

Dr LIM: Now, this need not be *in camera*.

Ms YOUNG: Yes, this can be public now. So Territory Health have purchased those kits. The Commonwealth has purchased those kits as well for every Aboriginal medical service and then refunded Alcohol and Drug and Indigenous Petrol Sniffing Prevention Service as well. So, there is a great deal of information and resources out there. Interestingly, some of the good work in there has been completed by people in the Territory, even though it was developed with South Australia.

Dr LIM: It is all sealed, is it?

Ms YOUNG: Yes, just pull it, lift it.

Dr BURNS: So it comes from South Australia?

Ms YOUNG: Well, they put it together, but Peter d'Abbs is the researcher. Craig San Roque was the chap who did The Brain Story with some people a little while ago under one of the Northern Territory programs funded by the Commonwealth. So, we have had long partnerships in this area.

Dr LIM: And these resource kits are left with each community?

Ms YOUNG: Yes.

Dr LIM: A whole stack of them, or just one?

Ms YOUNG: Yes, one with each community, one with each health centre. Territory Health are also training up their alcohol and drug people to be able to deliver their services using those resources, and so is the Central Australian YLUS Project being asked to use that as the resource material. So, each of those services that were funded under the $1m is being asked to use this material. It has been endorsed by ATSIC and a number of Aboriginal health agencies.

Mr McADAM: Leonie, can I just ask one question in respect to – and, again, I don't really [inaudible] with the funding arrangements - do you have a central body that you tend to liaise with in terms of recommendations with regards to funding or - and a Top End group?

Ms YOUNG: We've got a central body for the National Illicit Drugs Strategy diversions and then we have a number of committees on a whole range of things including petrol sniffing prevention and substance misuse, for example, so where they come down to specific categories, we've got a specific committee for those and that's represented by usually AMSANT, ATSIC, ourselves, non-government organisations, for example, being in-house or drug and alcohol service.

Mr McADAM: So would CARIHPC be one in the southern region?

Ms YOUNG: In the southern region, CARIHPC's Substance Misuse Committee encompasses all of those players that I've just talked about, yes. They have a Substance Misuse Committee in Central Australia; up here we don't, and so we have a number of committees on the particular issues. But at the NT Aboriginal Health Forum - which is the CEO of Territory Health, myself, the chair of AMSANT and the two ATSIC commissioners - all of the programs that are underway and all of the new initiatives from the Commonwealth and Territory Health are tabled there so there's like an overview, an over-arching group who do look over what we do so that there's a sense of it coming together. It doesn't mean it always works well, though, but there is a central group.

Mr McADAM: I just raise that because you only fund one program in the Barkly and that's the Congress. [inaudible] Borroloola, and I just wonder if the mechanisms are right in respect to access from the central – and what I describe as central; it might be Alice Springs, the central [inaudible] - as to whether indeed they're getting their share or whether they're part of the process or that the organisations aren't responding to them.

Ms YOUNG: It could be a combination of historical factors like the organisations in those areas may not have been participating early in the substance misuse planning, but that's not a reason now for them not to be included in that. The other might be that, for example, Anyinginyi in Central Australia may not have been in a position - actually, here they are. So they are funded for alcohol and drug - on page 9 - alcohol and drug residential rehab program accommodating 8 clients and staffed around the clock; a hospital and cell visitor schemes incorporate regular visits for a potential client; youth activity program targeted at men between the ages of 14 and 20 with sport and rec activities which gets some assistance.

Anyinginyi is not set up to offer programs for difficult youth and therefore would not be suitable to undertake correctional diversion activities. So they may have chosen at particular times not to bid for more funding that was available under a drug and alcohol or substance misuse program. They might have thought: 'This is as much as we can do', and much of the servicing happens as a result of bidding for grants rather than an integrated…

Mr McADAM: I guess without reflecting on myself or the department, I mean I would have thought that Alice Springs and Darwin dominate and I think your department has to have a look at that to ensure that there is an equitable and fair distribution because, I mean just personally, I can think of any number of programs in the Borroloola region and I know that they're starting now, but I'm surprised that over all these years I think people [inaudible] there, as is the case of other than Anyinginyi Congress in Tennant Creek.

Ms YOUNG: Yes. It's a fair comment. The capacity of people to deliver programs even when they're out - a quite - what's the word? - they have been operating for some time, it often depends on being able to attract staff, a whole range of reasons. It's not an excuse. You're absolutely right. There should be a better spread of services in those areas and I'll come to how we're addressing that in a minute. But very much services are usually funded to agencies with the capacity to deliver. Sometimes the community or the agency chooses not to apply because they recognise that for themselves. Other times they will apply, like the 17 members of the consortium, all well able to deliver programs and then for other reasons still not being able to follow through. So there are a number of factors there.

Mr McADAM: So out of that 17 are there any from Tennant Creek or Borroloola?

Ms YOUNG: I think Anyinginyi is part of that, I am sure it is. Yes. Yes, it is on there. On the consortium, yes.

Just in terms of what we are doing about it though, I know some of you know a little about the Primary Health Care Access Program and I did not bring any documents on that - but I can. That is around providing health services against the community's needs in a zone or area that is really about looking at what is there now and what is needed. And so that does provide great capacity to deliver not on a basis of whether you are able to be at the table or have an influential voice, but it is around the level of need in the community. Northern Barkly is one of those first areas that will be getting PHCAP funding and so that is on the edge, if you like, of being able to tap into a great deal of health service dollars.

Dr LIM: I want to come back to this – many of the publications can be directed at the crime group. Who is going to deliver it? Who delivers the program?

Ms YOUNG: Yes. Well, a dedicated workforce usually and that workforce is made up from a number of health sector, community, youth and education people, and it will not be a surprise to you to know that we have got a great shortage in many of those areas in the Territory.

Dr LIM: So the funding would have gone to developing this package, then it gets sent to all health places in the Territory?

Ms YOUNG: Yes, and for that particular package, the people who will deliver it are the alcohol and drug workers or substance abuse workers or the people working in Aboriginal medical services who are funded under particular programs already. Or there will be additional funding and they will be able to recruit new people to do that.

Dr LIM: Well now thinking of a general practitioner or medical service or the clinic nurse might be able to help deliver that, but they either have to take time off their work to do it or their own time to do it. With Aboriginal health workers, whether they have the – I mean the last one that I read was quite complex documents and I am not even sure whether some Aboriginal health workers would be able to deal with that document.

Ms YOUNG: Well, I know for myself I would not be able to unless someone took me through it who had the skills and knowledge of that particular area. That is why it is vital when you get the funding for them, and particularly let's use the consortium as an example, to get a person with appropriate skills and knowledge to be able to then train up other people, to train people in the community, and to share their skills and knowledge around particular things. That has taken a little time, but it is expected that it will take time, but it is expected that somebody with those credentials will get the job, not someone just because it suits the area.

Dr LIM: Otherwise what will happen is someone will get the funding that will sit on a shelf somewhere creating dust and that does nothing for whatever.

Ms YOUNG: And we are monitoring that closely and that is where there is a – like we were requiring a particular level of expertise and where it is not there, we are supporting it to be developed. Territory Health are with us on that as well. As I said they have just recently advertised for people to run training for their alcohol and drug workers using this kit.

Dr BURNS: Leonie, the issue arose this morning, we talked to Territory Health this morning – and it is probably a hobby horse of mine as well – in terms of useful and productive activities for young people and particularly employment opportunities – now I know it is very difficult in remote areas of

the Territory and I know it is not a health responsibility, but can you tell us whether there is any work or any sort of working groups at a Commonwealth level between departments such as Health and whoever, DEETYA and other departments and whoever rolls out the national Aboriginal health strategy monies in terms of buildings on communities to try and work in employment strategies along with the way that the Commonwealth spends its money in a whole range of areas in Aboriginal communities.

Ms YOUNG: There are a couple of things which are opportunities for us, and they have not always been taken up in the past, but with the OATSIH capital program funding, one of the requirements of that is an involvement of the community at building, training, contribution, materials. For example, we are building an aged care facility at Maningrida, and we will be using mud bricks and a number of other things that BAC and other people out there are able to provide. It says that in our contracts, where possible and within existing funding. That has not always been followed in the past, but it certainly is on the table now in terms of a requirement. We have a national program manager that oversees our projects where we are also, from a number of levels, looking at strengthening that so that it happens. I had a meeting recently on the Maningrida aged care project and it is going to be very much with the community, by the community and with young people in the community, so that there is a training program that is available as well.

That is good in itself, but it is one case, and if you look across the Territory there are a great deal of cases that are not being undertaken that way. But my department is committed to that theme, a way of operating that is perpetuated right through. So there is that. The other is that, very recently you might have heard Philip Ruddock and others talking about a whole of government approach rather than a separate education, health, employment, ATSIC and so on. There are a number of sites identified in the Northern Territory that are going to be part of – it is being called a pilot at the moment - and while we would want it to be a good practice model, there will be opportunities to test that out and there are a number of areas in the Territory that are being considered, I understand. So there is great capacity to do the identified training as something that is important and to put the structures in place to support that.

Mr McADAM: I was going to ask, who is the lead agency in this …

Ms YOUNG: I think it is ATSIC at the moment. The first meeting was held yesterday in the Territory. It is being run as a coming together exercise at the moment, and I think a lead agency will be nominated out of that.

Mr McADAM: I have only one other question, Leonie. That again, basically touches on what Territory Health does about this, and the amount of interaction that occurs between the Commonwealth and the Territory – health in this case – and I got the distinct impression that sometimes there are some discrepancies involved here, [inaudible] - for reasons you were just describing, but is there a mechanism? It is not going to fix it up, but is there a mechanism that can assist in better coordination, better – I do not know, you know what I mean?

Ms YOUNG: Yes, yes. It would be good if there was one simple mechanism, but what happens usually is the partnership occurs on a particular strategy or a particular initiative, and so that there is not a committee or a particular entity that says: 'This is Commonwealth/State'. But, it works under the NT Aboriginal Health Forum where we both do come together and set it down and we talk about all the range of programs that we have - both of us - in indigenous health. So, if you like, that is the forum where much of the partnership is developed.

But then it comes down to: well, how is this going to work? For example, under coordinated care trials we are very much a partner at the table with the Territory government, ourselves and the

community. With the primary health care access program, it is very much a four-way partnership with ATSIC, AMSANT, ourselves and so on. So, there are a number of forums where it happens where there is great goodwill and a sharing of information and planning, and everything about where we need to go, to be able to take it forward.

There is not a separate forum where it is just Commonwealth and Territory agreeing, necessarily, other than the goodwill that exists between the office.

Mr McADAM: Perhaps it is historical in terms of [inaudible].

Ms YOUNG: Yes.

Mr McADAM: Historical reasons for this.

Ms YOUNG: Yes, possibly.

Dr BURNS: Although Territory Health did say they enjoyed excellent relations locally here.

Ms YOUNG: Yes, they do.

Dr BURNS: There was no suggestion of any bad, or whatever, relationship.

Ms YOUNG: No.

Dr BURNS: I think they are probably looking for more autonomy for the local Commonwealth agency.

Ms YOUNG: Yes, occasionally yes. There are tensions from time to time around different policies, different governments, different ministers. You would be very close to …

Dr BURNS: That is our wonderful Federation, isn't it?

Ms YOUNG: That is right, yes. You are very close to that so you would understand. But, there is an absolute - not to sound too – there is an absolute commitment to share the resources and the programs that we have to enable the health of Territorians to be improved, or to have access to all the services that other Australians have - absolute commitment to that. On that, there is not a difference in terms of politics or anyone's views. So that is quite strong, yes, very strong.

Dr LIM: We do not want to hold you up too much longer. We have talked mostly about petrol sniffing more than anything else. What about other substance abuse - from narcotics, illicit drugs, to [inaudible]. Is the Commonwealth government doing anything with that in the Territory?

Ms YOUNG: Yes, we provide lots of opportunities for a number of things that are important at a national level. For example, there is a National Alcohol Strategy which is around the *Living with Alcohol* programs that come out of that. The review of Aboriginal and Torres Strait Islanders substances abuse programs; there are a number of strategies that came out of that that are funded here as well. There is the needle information and exchange that the Commonwealth funds. There is the methadone program, the Commonwealth funds that as well. So they actually fund all the methadone use in the Territory. They make that available for each state and territory as well.

Dr LIM: The *Living with Alcohol* program was praised by all authorities and agencies around the country, but I do not recall that the federal government actually contributed anything at all to the *Living with Alcohol* program.

Ms YOUNG: It contributed funds to the Territory government who then spent them on the *Living with Alcohol* program, yes. It came under the National Alcohol Strategy, but it was very much a home-grown Territory initiative, you are right. And that is what we want as well.

Dr LIM: It is recognised as a very good program. Why hasn't the federal government picked it up and run with it across the country?

Ms YOUNG: Because it was a specific targeted program for the Territory, and it was based on a number of good factors, elements, that were part of the national strategy.

Dr LIM: It could be transferred across to say, Cape York just as easily as where else …

Ms YOUNG: That's true.

Dr LIM: It could have been a national initiative in the sense of picking it up and say, Cape York you can try that, or western …

A member: The Kimberleys.

Dr LIM: The Kimberleys and all that.

Ms YOUNG: Yes.

Dr LIM: It might be worthwhile thinking about that.

Ms YOUNG: Yes. There is capacity for that to happen if it were evaluated and seen to be a model that could be transferred, yes. And you were right; it was a very good program and disappointing that it is not there.

Dr LIM: Maybe this committee can recommend that it be revived, resuscitated. Especially with an injection of some funds from the Commonwealth as well. That would be much better, more effective.

Ms YOUNG: If we could cost share it, I am sure it is possible.

Dr LIM: The committee can suggest that we give it a go.

Ms YOUNG: Yes. But you are right, the impact on citizens, on people around alcohol and tobacco smoking is not to be underestimated as well. We do focus – and I know this committee's focus on a range of substances, but the impact of licit and illicit drugs on people's health is huge, immense.

Dr LIM: I think when we talk about substance abuse we tend to lock into the illicit stuff only but I think alcohol more than any other thing features very strongly in the Territory.

Ms YOUNG: With tobacco - the results of people tobacco smoking is profound in the Territory as well and we tend to think benignly of tobacco as well.

Just one last thing and that is around the Suicide Prevention Program, the framework for the prevention of suicide and self-harm, there are particular initiatives in here also, and strategies that relate to substance use which is seen as a pre-determining factor for events leading on to suicide, so there is a great deal on that. And the other area that I would like to draw to your attention is the co-morbidity of using substances and then the impact on one's health around the mental health, suicide or mental illness, maybe schizophrenia. It also has a profound effect, too, on the use of substances. So that then brings a level of servicing needed from clinical and other health services around the person's health or well-being. That is not always factored in when you are looking at substance misuse but it actually has an impact on their greater health.

Dr LIM: Are you presenting it to us as part of your submission?

Ms YOUNG: I am.

Dr LIM: We accept that and at least have that registered as part of your submission and members here can decide to read or not to read it. The members are being overwhelmed by the amount of paper work we are receiving.

Mr McADAM: Sure are.

Ms YOUNG: There is a great deal of worrying for these things nationally and, of course, all sectors and so - there is also a great deal of funding that follows that. So there is - I think it is a very good time for us to be coming together and I commend the committee for holding the inquiry around looking at what we can do …

Dr LIM: Do you know whether the federal committee has started looking at this already or whether they have already seen this themselves? Do you know?

Ms YOUNG: Yes, they have. There's two things: there was a federal House of Representatives Committee looking into substance misuse last year and it came to the Territory.

Dr LIM: That has now started again, hasn't it? Another one?

Ms CARTER: It has been re-established.

Dr LIM: Re-established, yes.

Ms YOUNG: Yes, it's been re-established. There is also the Ministerial Council on Drugs Strategy which has been going since, I think, February '98 and that, too, has an ongoing reviewing role on all of the things that are happening across the country, yes. So you are not looking at it in isolation. As I said, a number of people at particular levels, right up to the Prime Minister, are worrying for these things.

Mr McADAM: Are there any further questions?

Leonie, thank you very much for coming in this afternoon. On behalf of the committee I thank you very much for your contribution including your report. We wish you well in the future.

Ms YOUNG: Good, thank you. It was a pleasure to be here.

THE WITNESS WITHDREW