COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

FRIDAY, 20 APRIL 2001

DARWIN

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

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STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Friday, 20 April 2001

Members: Mr Wakelin *(Chair)*, Mr Andrews, Ms Julie Bishop, Mr Edwards, Ms Ellis, Mrs Gash, Ms Hall, Mrs Irwin, Mr Lawler, Mr Quick, Mr Schultz and Dr Washer

Members in attendance: Ms Ellis, Ms Hall and Mr Wakelin

Terms of reference for the inquiry:

To report and recommend on:

The social and economic costs of substance abuse, with particular regard to:

- family relationships;
- crime, violence (including domestic violence), and law enforcement;
- road trauma;
- workplace safety and productivity; and
- health care costs.

WITNESSES

Committee met at 8.03 a.m.

ANDERSON, Ms Pat, Executive Secretary, Aboriginal Medical Services Alliance of the Northern Territory

BOFFA, Dr John, Medical Adviser, Aboriginal Medical Services Alliance of the Northern Territory

BAUERT, Dr Paul, President, Northern Territory Branch, Australian Medical Association

SULLIVAN, Father Paul Gerard, Director, Alcohol Awareness and Family Recovery, and Aboriginal Islander Alcohol Awareness and Family Recovery

CUMMINGS, Ms Barbara Ellen, Chairperson, Yilli Rreung Regional Council, Aboriginal and Torres Strait Islander Commission

DUNHAM, Hon. Stephen, Minister for Health, Family and Children's Services

FISHER, Mr Peter John, Director, Anglicare Top End

WURRAMARRBA, Mr Murabuda, Manager, Substance Abuse Program, Anglicare Top End

GEE, Mrs Kitty, Needle Syringe Program and Sex Worker, Outreach Project Officer, Northern Territory AIDS Council

GILCHRIST, Mrs Denise, Director, Banyan House

WALKER, Mr James, Clinical Coordinator, Banyan House

GILL, Mr Nicholas John, Manager, Drug and Alcohol Services Association Alice Springs Inc.

JESSEN, Ms Janice, Lecturer in Alcohol and Drug Studies, Northern Territory University

KANTILLA, Ms Tarnikinga (Claudia), Community Based Field Worker, Council for Aboriginal Alcohol Program Services Inc.

SIGSTON, Mr Roger, Acting Director, Council for Aboriginal Alcohol Program Services Inc.

KITTEL, Ms Donna (Private capacity)

LEIBRICK, Ms Fiona, Counsellor, Educator and Psychologist, Amity Community Services

MILLS, Ms Barbara Joyce, Alcohol Counsellor, Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties

MURPHY, Dr Christine Janine, General Manager, Employee Assistance Service NT Inc.

O'REILLY, Dr Bridie, Northern Territory Coordinator, Illicit Drug Reporting System, and Northern Territory Representative, Alcohol and Other Drug Council

SPENCER, Mr Craig Paul, Facilitator, Drink Driver Education (Katherine)

TIPPETT, Mr Jon Courtland Arthur, President, Law Society, Northern Territory

VANDENBERG, Ms Helen, Public Officer and Community Educator, Top End Users Forum Inc.

YOUNG, Ms Leonie, Northern Territory Manager, Commonwealth Department of Health and Aged Care

CHAIR—Welcome to you all. I will make a few opening remarks and then we will go to three-minute statements. As many people will know, this reference was sent to the committee by Minister Wooldridge in March 2000. Our job is to report and recommend on the social and economic costs of substance abuse, with particular regard to family relationships, crime, violence—including domestic violence—law enforcement and road trauma, workplace safety, productivity, and health care costs.

We asked for submissions a year ago. We have received over 200 submissions from individuals, governments and non-government agencies. Most of these have been authorised for publication. If you would like to read copies of them, a list is available from the committee secretariat. If you wish to make a submission, we are open to that. If you wish that submission to be confidential, you will need to make a specific request to do that, and that will be respected.

In the past couple of days, the committee has visited many places in Darwin and Katherine and has talked to a number of service providers, in order to get a feel for some of the key issues relating to substance abuse in the Territory. Today, we are having a roundtable discussion. I thank everybody who has helped the secretariat to get to this stage today. What you have to say is important to us. It will form part of what we call our evidence, because we take it all seriously, and every individual has a view on this subject. We can refer to it when we write our final report. We will have to prepare an interim report because we will not finish the final report before the election. Depending on the electoral process and the minister of the day, we would expect the government of the day to continue with this inquiry. We expect to have the final report available in 12 to 15 months time. The committee does not swear in witnesses, but I point out that the proceedings today are legal proceedings of the parliament and, as such, warrant the same regard as the proceedings of the House of Representatives in the Australian parliament. I will ask individuals to make a brief three-minute statement. We will then have an open discussion.

Mr Gill—I start by passing to the committee two messages, as I was requested to do by a meeting of remote area night patrols which was held at Hamilton Downs the day before yesterday. Representatives of night patrols from eight or more communities in Central Australia gathered to talk about the problems that they were experiencing. One message was that petrol sniffing is killing Aboriginal people in Central Australia and that not enough is being done

about it. I am particularly relaying that at the request of Peggy Brown from Yuendumu who has, with her late husband Kunjai Brown, been running Mt Theo outstation for many years, and she was unable to get a vehicle. The sources of funding do not provide these. Peggy is very concerned about what petrol sniffing is doing to her community.

The second message that I was asked to bring to you by the night patrols was a request that there be some national strategy for funding night patrols. Night patrols have great difficulty in accessing vehicles. Usually, night patrols make application to ATSIC for vehicles, but there are many communities in which there are night patrols operating on foot. For instance, in Ali Curung in Central Australia, the ladies of Ali Curung have been conducting a nightly night patrol for three years on foot. They are unable to get a vehicle. The funding sources do not provide these. Night patrollers believe that their work for communities should be recognised by a wage rather than being done on a voluntary basis.

We acknowledge that the level of alcohol consumption in the Territory by the whole population remains the most significant problem in relation to drug and alcohol. The average consumption of pure alcohol in Australia is 9.67 litres per year. The average in Central Australia is 16.4 litres. In the Northern Territory as a whole, it is 15.3 litres. We know that harms are statistically correlated with overall consumption of alcohol. The Territory has attempted to address this problem; so far it has not succeeded in solving it.

CHAIR—Thank you. Bridie?

Dr O'Reilly—Drug use and abuse are global issues which translate into differentiated local patterns. The first step in attempting to understand and address drug use is acknowledgment of its global and local nature. This allows for a glocal perspective, which is a global outlook at different local conditions, leading to tailored glocal approaches.

Generally, patterns of drug use are not significantly different in the Northern Territory. There is some local differentiation, but the overall lack of significant uniqueness must be acknowledged having regard to the insight and farsightedness required to develop and implement glocal initiatives.

The success of any initiatives in the Territory relies on an overarching Northern Territory government drug strategy, with clear goals and objectives based on current empirical evidence. This glocal strategy would provide leadership for all sectors involved in drug issues. It would be committed to cooperative and transparent processes for developing and expanding strategic initiatives to reduce drug related harm. An independent research and evaluation framework would provide the objective evidence and information base which are essential for informing drug policy and strategic direction and determining the effectiveness of various initiatives.

The illicit drug reporting system in 1999 and 2000 identified priority areas for glocal drug strategy. Some of these, but not in order of importance, include research into and development of interventions from those experiencing harm from amphetamine use. There has been a four-fold increase in amphetamine admissions to alcohol and drug services, but this has not been matched by the development of effective glocal interventions. Some services do not have the resources or trained personnel to adequately deal with the complex issues of drug use.

Acknowledging the key role of the non-government sector in harm minimisation and reduction is absolutely critical. Appropriate resources, training and ongoing support must be provided to NGOs in contact with drug users. The continuing increase in non-users seeking assistance because of someone else's use, particularly amphetamine use, indicates the need to develop and implement services for these people.

Research is needed into the health and social costs arising from the marginalisation of illicit drug users. The deteriorating health of illicit drug users results from poor hygiene and nutrition, inadequate or inappropriate housing, lack of access to health services, limited treatment options and diminished social opportunities. Marginalisation is linked to many health problems and increasing this marginalisation will exacerbate these.

Research is needed into the impact of amphetamine, cannabis and polydrug use of those at risk of developing mental health and behavioural disorders. There is a distinct service gap for dual diagnosis users who have unique treatment and health issues. We need an analysis of the Northern Territory government's policies and strategies aimed at reducing consumption of schedule 8 narcotics and other opiates. This would mean monitoring changes to the cost and availability of morphine and heroin; identifying market factors; and quantifying the health and social costs associated with the doctrine of particular strategies.

We obviously need research into patterns of and trends in substance use among Aboriginal and Torres Strait Islanders, particularly in relation to polydrug use and intravenous drug use. We also need to look at factors affecting the transition between drug types. There is little local evidence to support or repudiate claims of transition from cannabis to intravenous drug use and local research is required on transition.

Ms Jessen—As well as lecturing in drug and alcohol studies at the Northern Territory University, I am the Northern Territory representative on the Australian Professional Society for Alcohol and Other Drugs. I am also on the board of management of Banyan House, which is a residential drug treatment service based in Darwin. My comments largely relate to drug and alcohol use in the urban context. I wanted to focus particularly on the availability or lack thereof of treatment options for people with drug and alcohol problems, certainly in the area of opiates. I am sure you are going to hear from others today.

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Ms Vandenberg—... done by volunteers, and that limits our provision of peer based education. At the moment our volunteers do approximately 20 hours per week in educating other users. Amity Community Services allow our group to access their building and we hold monthly meetings there.

TEUF believes that new needle and syringe projects are needed and clean injecting equipment and support provided to drug users. One of the other difficulties in Darwin is that it is a small community and there are many costs to users and their families if they identify or are identified as users, are not dependent and use socially and occasionally. One of their biggest concerns is being able to access uncontaminated drugs.

TEUF believes that medical cannabis needs to be made available to those in the community who are affected by HIV, arthritis and cancer, and whose legal therapies are not always effective.

Mrs Gee—I run the Darwin needle exchange program and we run it as a harm reduction program. Our clients are educated in the safe use of syringes. They can get new syringes here all the time. Because of the distances, as Helen has already mentioned, that some of these people have to travel to get into Darwin it is very difficult for them to carry big yellow bottles on the bus, so we have other methods of teaching them what to do with their needles and their used equipment.

My job is actually twofold. I work both with the ID users and also with sex workers. It is a very good joint project because a lot of the sex workers here are drug users. So I virtually see the guys at the bottom line when they come in to get their equipment to use. I refer to agencies if people want to detox, and there are very few agencies in Darwin. I refer clients to treatments but there are very few treatments to refer clients to and the waiting list is huge. I also refer clients to marriage guidance counsellors because, as you are all aware, the use of drugs in any area is prone to bring on family problems and destruction of families.

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Mrs Gee—For the 2000 financial year we distributed 440,686 syringes.

Ms HALL—In what period?

Mrs Gee—In the financial year of 1999-2000. Those syringes were distributed to clients living in Darwin and Palmerston. Then we have a group of unknown clients and they are our clients that identify as clients travelling through Darwin. That client number is 39,000 plus. Out of those clients, 556 live in Darwin; 131 live in Palmerston; and 157 live in the rural areas. I must admit that these figures are the number of needles that we supply. The client breakdown of those syringes is what I have just given you. Clients made 8,314 visits. The 932 distinct clients that are accounted for had 7,407 visits. This left 907 visits by uncoded clients. On average, the 932 distinct clients made up 7.95 visits a year. This leads us to believe that the 907 uncoded visits amounted to 114 clients that frequent our service. This makes a total number of clients that frequent the service in a year 1,046. The Alice Springs project gave out 37,600 syringes in that period of time.

CHAIR—Thank you. We will come back and discuss that.

Father Sullivan—I represent two organisations: the Alcohol Awareness and Family Recovery as well as the Aboriginal Islander Alcohol Awareness and Family Recovery. As the names of the organisations suggest, the focus is the family. My hope for the outcome today would be that the role and the place of the family appear not only on the national agenda with regard to drugs and alcohol but also that it would be translated into strategies and funding.

About 40 per cent of our clients would be the parents of teenagers or young adults. We would put as much energy and attention into the partner or the concerned other within the drinking circle. Our belief and hope would be that that person is entitled to a right to help and assistance

in their own right. Because they are living in a situation which is fairly chaotic, often the focus is on the individual person with the problem. We treat the person with the problem, but as well as doing that we would treat the partner or the other family member or the relation who is concerned or worried about the person with the drinking problem.

The Aboriginal people describe the partner as someone who is experiencing 'worry sickness'. I think that rather beautifully captures the impact on the family members. In Darwin, the family member who is worried about the drinker may go to the doctor with anxiety and depression and then be prescribed medication without necessarily having the capacity to identify the issues around the problem. As well as dealing with the partner, and more recently with the parents, we would also work with the teenager as well as the parent. I think that is a fairly critical issue to raise. When a young person is bombing out on marijuana and they are experiencing a marijuana induced psychosis or fairly dramatic behaviour at home, there is the dual diagnosis issue or there is an uncertainty as to where to treat the person and what to do with the problem. The parents are left confused. They do not know enough information about the drug and the various systems, whether it is the mental health system or the medical system or if the police are called in. There is often a lack of information about referring people on and offering support to parents and family members.

I think one of the difficulties in supporting families is getting beyond shame and blame. The recent national publication is very helpful for people to begin some discussion around the issue of drugs and alcohol. We have found that, once people experience the problem of drugs in their family, they are not too sure what to do. They feel that they are blamed for their teenager's problem and they have a sense of shame in presenting for help.

I would just like to refer to a booklet—*Understanding the key issues of drugs.* Page 1 of that booklet identifies the people that we may come into contact with. It may be a relative, a workmate or a colleague, but it does not mention the fact that the person with the problem might be a partner or a family member or a teenager. I think nationally we have great resistance and a reluctance to acknowledge the fact that the person with the drinking problem may be a partner or a family member, and that family member is entitled to equal support and help as the person with the addiction problem.

CHAIR—Thank you very much.

Dr Murphy—I would like to talk about alcohol and drugs and the impact on the workplace in the Northern Territory. We know that Territorians consume twice as much alcohol as the national average. We also had research in 1991 that indicated that the cost of alcohol to the Northern Territory community was $150 million per annum in relation to lost productivity. I believe this is just the tip of the iceberg. I think that we are not seeing the true cost for productivity in the Northern Territory due to loss of productivity. What we do need is better data. We also need better data in relation to smoking in the workplace. We know that in the Northern Territory, 36 per cent of people smoke, compared to the national average of about 25 per cent. In the Territory we need to look at, for example, legislation in restaurants which impact on employees and, of course, also the consumers. We also need to be looking at illicit drug use in the workplace. There is not enough data or research on the impact of illicit drug use in the workplace on productivity.

We do know that alcohol and other drugs do affect performance in the workplace. We do know it impacts on absenteeism. We certainly do know that it impacts on health and safety risks. As we know, we have testing in the mining industry in the Northern Territory. However, testing is not the answer. The answer is more data. We need more data, for example, to look at policy introduction in the workplace. There is a lack of workplace policy on alcohol and other drugs in the Northern Territory. There are very few policies in organisations, except the large organisations, and certainly not in small organisations. We need to look at research to the extent of working conditions, which there are in the Northern Territory, particularly for remote area workers, and this is not done.

We need to look at the bottom line to ensure that employers and organisations in the Northern Territory implement policy, not just testing, because we need to show them that on the bottom line, as we have in many years of occupational health and safety, good policy works. If you have good policy, you will not have as many problems in your workplace.

We also need to be looking at issues of workload. One of the things that we need to be researching is the increases of workload in organisations at the moment. That has an incredible impact on people. For example, they will turn to alcohol and drugs as a coping mechanism. We have no data on that. If we can show employers that workloads impact on the bottom line, such as productivity and performance, then we can actually implement some policies in workplaces and that obviously has a carry-on effect.

Also, we need to be looking at why people are turning to alcohol in the workplace. One of the things that we see in workplaces is fridges full of alcohol. We go to workplaces and there is a culture in workplaces to indicate that you have your Friday afternoon drinks or you have your afternoon drinks. There is a real culture. We need to be looking at that in workplaces.

CHAIR—Thank you.

Ms Leibrick—Good morning and welcome to Darwin. Thank you for the opportunity to be a part of these proceedings. Amity Community Services is a Darwin based non-government, independent, non-religious, incorporated community organisation. Our staff of nine professionals make up a multi-disciplinary team with expertise in youth work, education, psychiatric nursing, social work and psychology. The business of our organisation is addressing community information and intervention needs in the area of problematic habits.

We do this through, on the one hand, intervention services which include non-residential individually focused assessment counselling and skills training and also drink driver education and, on the other hand, through our early intervention and prevention services which include an information education service, a training service and a consultancy advocacy service. Our principles of practice are informed by social learning theory, harm minimisation, adult learning principles, behavioural change theory and the Public Health Model.

Amity's client group consists of people experiencing problems with either their own or someone else's patterns of behaviour, and those at risk of developing problems. Ranging in age from at least 12 through to 80, and generally representative of Darwin's complex cultural and ethnic mix, our clients are mostly socially stable, more likely to attend for earlier intervention and frequently self-referred.

Our use of the term 'problematic habits' covers a wide range of behaviours, and while the most commonly recognised are those relating to substance use, we also include any problematic and recurring behaviours or experiences such as problem gambling, problematic eating patterns, problematic anger, anxiety and depression. In doing so, we recognise that habits occur on a continuum from necessary and useful through to extremely problematic, or what is also known as addiction. We follow the definition of addiction provided by Saunders and Allsop that 'addiction behaviour is characterised by an individual repeatedly behaving in a way which, although enjoyable and beneficial in the short term, can accumulate adverse consequences...over time.' There is considerable research and clinical experience that shows there are more similarities across problematic habits than differences, and that the basic principles of change are the same despite the behaviour to be changed.

The perspective we take of addressing 'problematic habits' generally, rather than focusing on specific types of habits such as substance use, positions us somewhat uniquely as an agency to remain constantly aware of the varied, complex and inter-related individual, environmental and behavioural factors that lead to problematic outcomes for the individual and/or the community.

In particular, this perspective keeps us constantly mindful of the common individual and environmental vulnerabilities—such as living skills deficits and social and educational marginalisation and isolation, and mental health issues, which may be momentary or long-term—that can lead to risky lifestyle choices and problem habit outcomes. Essentially, our experience is—and a range of research mirrors this—that it is more effective to be aware of and address the complex and individually varied underlying vulnerabilities that lead to problem habits—that is, the underlying and multiple risk factors—and to see problem habits as the expression of those vulnerabilities, rather than falling into the error of assuming that just because the end behaviour appears different it needs to be addressed singly, specifically and in isolation from other problem habits. Treating one obvious symptom in isolation from others rarely leads to a return to health: it's like giving cough medicine for pneumonia. Many of our clients will present identifying a single issue as the problem—for example cannabis use—but the assessment process almost always reveals a complex suite of associated problems that can include financial, legal, interpersonal, health, family and work-related issues to name a few.

Our concern is that as a community and at the Territory level to be aware of the importance of having multiskilled professionals who feel comfortable working across multiple habit areas and that there are opportunities for them also to address individual problem areas that they might be experiencing. Also, just to highlight what we see as being the importance of an informed community that feels comfortable and knowledgeable about drug related issues, that is involved and that feels that those issues are relevant to their own roles.

A break occurred in the transcript at this point due to technical problems.

Mr Fisher—Anglicare is pleased with particularly the partnership with the people on Groote Eylandt. Our interest this morning is the community of Nguiu on Groote Eylandt and the issue there of petrol sniffing which in more recent times has become more an issue of marijuana. Referring to what Paul said, it is definitely a family problem and we see it as a family problem. I could go on further and say that it is not just a family problem—and this is stating the obvious perhaps—but a community problem. I think part of the answer is to empower the community. We cannot see the problems that exist particularly with young people on Groote Eylandt without

connecting it to the issues of the social situation, the education, the conflict of being caught between two cultures, the issues around employment and also around health and housing. It is from our point of view a matter of empowering the community to act and our partnership has been with Murabuda in that area. Murabuda's team of people on Groote Eylandt have developed a range of community services and one of the programs there is funded in partnership through us.

A break occurred in the transcript at this point due to technical problems.

Mr Fisher—The program council funded through FACS is an alcohol and substance misuse program. I think I might leave it at that.

CHAIR—Thank you.

Mr Wurramarrba—Good morning, ladies and gentlemen. My name is Murabuda from Alyangula, east of Darwin, maybe 300 or 400 kilometres from here. So I live there and I have always been working for many years in the job like this, drugs and alcohol. I know the poor ways to balanda. In the one section in Darwin area, I was the president of that alcoholic and abuse program with my own coloured people. What I was trying to say to you people here to understand Aborigine culture, it is a different culture from the white society.

The Aborigine people has got to have the culture to have this type of drink or marijuana or any other alcohol in the world today. They are very new to us, to Aborigine people. I do not know, I do not drink; I I am not a smoker, I am not a drinker. I just see my people die very fast. Maybe one man drink his whole lot; he does not save anything, you know. This is what is happening in our community.

I work and I see them, these people. I was working with the young teenagers in Darwin, Daly River, Tiwi Island, Maningrida, Oenpelli, Goulburn Island—all those people around and I know them. I was a speaker, trying to teach the way to live in the way of Aborigine people in our culture. But the culture has disappeared from me to other people from Arnhem Land, just gone away a bit. And that will just depend on the drug. It is a really shame and really sadness to be in our community.

So I just want to try to have a say so you people know, because this is what I heard from my people because things are getting bigger and wider and they are dying faster. I mean the faster dying is a death here or a death here, so we are not going to see in the world what is going on—we do not know—depending on the drugs. The drugs do not help us to have those things, you know, just to make them go into a graveyard or to somewhere else.

Anyway, that is my problem with the community. In Darwin here, my lot of people living in the long grass and I feel ashamed of it because it is my colour and because of my family. And I know Paul was, you know, we are a partnership. This man is a partnership and that man over there, we are partnership for a long time on this drug and alcoholic abuse. So I know a lot of teenage people from all over the Northern Territory, in Arnhem, even in Berrimah in gaol. I visit them, talk to them, teaching them handcraft. At least the way they try, but we still keep going like this, you know. Anyway, I know in white society too with the teenagers we can't cure the

problem. We can't mend the problem. It is still popping up, brand new. Anyway, that is my request for you people, ladies and gentlemen. Thank you.

CHAIR—Thank you.

Mrs Gilchrist—I am the director of Banyan House. James Walker is the coordinator of a program at Banyan. My following comments provide a description of the services of Banyan House and what we perceive as the priorities for action in this area. Banyan House is dedicated to providing a quality residential rehabilitation service to those affected by substance misuse and to promoting education in the wider community about related issues.

Banyan House strives to provide a holistic, proactive quality service that reduces substance misuse and associated harm in the community. Banyan House has the capacity to house up to 15 residents plus children. The residential program offered at Banyan is based on the therapeutic community model, which is a recognised viable treatment option in the drug and alcohol field.

It is based on the levels principle, which mimics the way larger society operates. Under this system residents come into the program on a low level, with few responsibilities and likewise few privileges. As the residents show that they are motivated to changing their lifestyles and are participating fully and sincerely in the program, they advance to higher levels where they take on greater responsibilities and gain greater privileges.

During a resident's time at Banyan House, he or she is provided with the opportunity to improve their health: experience a drug free lifestyle; undergo further education; learn relapse prevention skills such as anger management; effective communication and problem solving; engage in full-time employment; develop new social networks with other drug-free individuals and have time out from prison and crime.

Priorities for action in this area, firstly in the Northern Territory as a whole, is acknowledgment that a drug problem exists in the Northern Territory and that it is impacting on the lives of Territorians, and increased funding to provide greater diversity of services incorporating the needs of youth, women and children and individuals experiencing the co-morbidities of major mental illness and drug addiction. For Banyan House itself, we need specific funding for the provision of a safe, waterproof and liveable complex for approximately 25 residents and their children.

CHAIR—Thank you for that. James, did you want to add anything?

Mr Walker—No, that is all, thank you.

Ms Young—I thank the committee for the opportunity to speak today on behalf of the Northern Territory office of the Commonwealth Department of Health and Aged Care. As the committee is aware, the department has already made a wide-ranging submission to the inquiry addressing issues across the spectrum of substance abuse in Australia. I will be speaking today on the issues for the department in the Northern Territory. Substance misuse affects individuals and communities on a range of economic and social levels of course, and its subsequent impact on the provision of health and aged care services in the Northern Territory is widely encountered by our office.

Overall, the rates of tobacco and alcohol consumption in the Northern Territory are amongst the highest in the nation. This, coupled with the use of cannabis, kava, petrol and other volatile substances, continues to severely impact upon individuals, communities, health and aged care services, Aboriginal medical services and substance misuse services.

As everyone is aware, direct health servicing remains the domain of state and territory governments under the Australian health care agreements in our federal system. But I would like to focus on those services and substance misuse issues which have particularly come to our attention in the course of delivery of the department's programs here in the Northern Territory and the frameworks within which we are actively working to address those issues.

Beyond implementing specific national drug and alcohol strategies and programs—and in the Northern Territory this amounts to something like $15 million per year—a key plank in our overall approach is working in partnership and collaboration with other government agencies at state and federal levels, with professional bodies, with the non-government sector and, importantly, with communities themselves.

The illicit drug use programs in the Territory are under the national framework arrangements and they are also through support for treatment programs with individual organisations. However, the Diversions Advisory Group, which was established to oversee the Northern Territory approach to the implementation of the national illicit drug strategy diversion initiative, is of the view that petrol sniffing and the use of schedule 8 drugs are considerably greater issues for the Territory than the use of illicit drugs such as heroin. The committee would be aware that while petrol sniffing in itself is not illegal, users often engage in illegal activity when under the effect of inhalation, and also run a significant risk of incurring serious health consequences as a result. Treatment programs are funded through the national drug strategy, including the non-government organisations treatment program and through direct funding to substance misuse services and Aboriginal medical services.

We have also got a community partnership initiative program underway in the Northern Territory premised on the view that illicit substances used by young people can be reduced or prevented by mobilising communities and fostering relationships between governments and the broader community. On inhalant substance abuse, petrol and other substances, the department has been actively involved in petrol sniffing prevention and intervention through the national illicit drug strategy and others. Also a number of other departmental programs, such as the Office of Aboriginal and Torres Strait Islander Health, also fund petrol sniffing prevention—something like $7 million per year in the Territory. But clearly it is not enough. It is not coordinated or integrated and we need to do a lot of work there.

On alcohol, our primary focus in the Northern Territory lies with the funding of substance misuse support services and complementing Northern Territory initiatives under the national action plan. On tobacco, the Northern Territory has the highest reported rates of tobacco usage in Australia, with over 80 per cent of men in some remote Top End Aboriginal communities smoking. As would be expected, this is accompanied by high rates of tobacco related illness, hospitalisation and death.

The department's national tobacco strategy provides for national leadership while allowing flexibility for each jurisdiction and the NGO sector to ensure tobacco control action is

responsive to their particular needs and priorities. In the Northern Territory, we support and promote the strategy through our membership of the NT Tobacco Control Coalition. Membership of the coalition is drawn from a range of community, private and government bodies.

Regarding kava, while the management and licensing of kava usage in the Northern Territory is outside the jurisdiction of the department, the health effects of kava misuse can reasonably be expected to impact on our funded services. Advice from affected communities is that this is so. We are aware of kava research being conducted at present, and will be monitoring the outcomes of that work, and seeking to respond appropriately.

Having touched very briefly on a range of specific substance abuse issues and departmental programs in the NT, I would like to conclude with a reference to the way forward. You will have heard from a number of people and organisations throughout the NT about the disproportionate impact of substance misuse on the health status of indigenous communities. This is undeniably true. The department's approach to improving Aboriginal and Torres Strait Islander health is based on a long-term partnership arrangement and founded on the principles of community empowerment and participation in the development and delivery of health services and we stand by this.

The success of the partnership approach in improvement in health at the community level is demonstrated by the outcomes and recent evaluation of the coordinated care trials conducted by the department in collaboration with Territory Health Services and the Katherine West and Tiwi health boards. I am pleased to advise that this very important and innovative work is being continued and extended throughout the NT and, in time, involving all communities via the Primary Health Care Access Program. Empowering communities to address their substance abuse and health problems at the community level, and developing strategic partnering arrangements to support those initiatives with governments and other agencies, requires strong commitment by all partners, and provides a practical and realisable framework for all our efforts on substance abuse into the future. Clearly, there is an outstanding need for this to continue.

A break occurred in the transcript at this point due to technical problems.

Mr Sigston—CAAPS did a couple of deliveries of an indigenous family violence program for perpetrators. This was a pilot project and was almost 12 months ago now. Contrary to our expectations there was a very high demand for this program. The program was full and communities were asking for more of the same long after the pilot program was delivered. There has been no further funding forthcoming for that. There is another example with the training: CAAPS is undertaking delivery of certificate 2 level courses and registered short courses in 12 remote communities in the Top End. It is one of the few organisations to attempt that. It is very difficult due to the isolation, the distances and the expense involved. That funding has now been cut back to two communities.

CHAIR—We might be able to explore some of those in our general session.

Mr Sigston—They are just some examples of that. In short, CAAPS respectfully suggests that family based services be evaluated and supported accordingly. It is important to realise that we cannot continue to increase services. The other end of this needs to be looked at; that is, the

regulating or policing the supply of alcohol and other drugs in the community. For example, in one remote community, the average consumption of heavy beer reached 14 cans per person per day. The Northern Territory Liquor Commission knew of this and there was no action. It seems that if each person in a community wants to drink 14 cans a day, that is fine, despite the health and social consequences. Another issue is the anti-social behaviour that has come right into focus around Darwin and other Territory towns more recently.

CHAIR—We will come back to that.

Mr Sigston—They were the main points that we wanted to bring forward, thank you.

Ms Kantilla—I work for CAAPS. Part of my job as a community based field worker is to work around the town area—the three camps. In my job I have seen a lot of people wandering around, sleeping in the bush camps and everything. Part of my job is to deliver cultural and education awareness about alcohol and drugs in the community. I also do a lot of referrals. I work closely and liaise and network with detox hospitals. I visit people around the camps and tell them that there is somewhere for them to go to fix their drinking problems. I do assessments and refer them to CAAPS. I also promote CAAPS around the Darwin areas and Palmerston.

Mr Spencer—I am a service provider in a number of areas in the alcohol and drugs services. Today I am mainly representing Katherine's Drink Driver Education. I mainly want to put a concept together because alcohol use and abuse is an ongoing problem in terms of road safety in the broader community. There are substantial cost implications financially, emotionally and socially. Currently, the restriction on blood alcohol concentrations for initial licence holders or drivers of certain vehicle classifications is the only restriction we have in terms of zero readings.

Unfortunately, the level of knowledge of alcohol in the community as a whole, and by individuals, is fairly low. People who are convicted of drink driver offences in the Territory have to complete a drink driver education course prior to relicensing. Interestingly, such courses are not required Australia wide. Some jurisdictions have them and some do not. These drink driver education courses provide education and information about alcohol—its effects as well as alternative behavioural and drinking strategies.

Levels of alcohol involved in motor vehicle accidents within the Northern Territory consistently appear to be in the 15 to 20 per cent range. In fatalities it does vary from year to year, but it seems to be around 30 per cent. The statistics do vary at times, depending on who you talk to. That is the problem with statistics. Sometimes you hear various figures quoted, 'That two to three hospital beds are filled by persons directly related to alcohol use or abuse.' So it is a reasonable problem for society.

A large percentage of the Australian society do have drivers licences. Where we are coming from is that it may well be an option to use that as a means to try to tackle some of the problems that we have been talking about this morning. If we can educate people about alcohol and other drugs—not just alcohol as such—we may have a very effective means of reducing the harm associated with the alcohol and other drug use in the community. We have to start somewhere—the sooner the better—particularly with teenagers and young adults. I do not suggest for one moment this is a cure-all. I do not put it up on that basis, but I think it is something to start with.

I suggest that in certain terms drivers licences could still be obtained by people. I am not saying we should stop drivers licences for people. However, at the moment we do have a zero blood alcohol concentration level for new drivers and for people who go back on P plates, et cetera. We also have it for people with certain driver classifications. What I am suggesting is that we do not change that part, that we should still allow people to have drivers licences. However, if people wish to have the luxury—and remember that licences are only a privilege and not a right—if people want to have the privilege of being able to go up to .05, then from that point of view I believe they should have to do some sort of education course such as an alcohol and other drugs awareness course. By doing that, I think that would then actually encourage people to be more aware of alcohol and other drugs—and the implications on them—and aware of other strategies. Numerous governments have put out various programs in the past to try to overcome things like that. Going back in Queensland a few years ago, one was the Plan and Save Strategy—PASS.

The type of thing we could do in terms of an alcohol and drugs awareness course would be something similar to the one that has been developed by Amity Community Services here in Darwin for alcohol abuse. There could be additional information about a few extra drugs and those types of things that are used on a recreational basis. With respect to this, we have a chance of actually allowing people in the community to be more aware of alcohol and other drugs. When you do the drink driver education course, you find that people do not have a lot of knowledge about it. They have been around for a long time drinking a lot of alcohol. This would be a starting point to try to reduce alcohol involvement in road safety but across a broad range of health related services and activities. From my point of view, I hope this may generate and stimulate some discussion and action.

CHAIR—Thank you.

Proceedings suspended from 9.12 a.m. to 9.27 a.m.

A break occurred in the transcript at this point due to technical problems.

Mr Gill—…guilty of avoiding our responsibility to mankind. The emphasis of Australian work on alcohol and other drugs needs to be firmly focused on supporting Aboriginal culture in its own ways of dealing with alcohol and drug problems. Aboriginal people know what the answers are. We need to listen to them and we need to do everything that we can to support them.

CHAIR—What are two or three of your priorities, Nick? You have mentioned the patrol. I will outline a scenario that occurs to me. We have got a patrol. They will end up in a sobering-up centre or they will end up giving somebody a hard time in the cells for the night. They go to detox and then they go to rehab. What are the priority areas?

Mr Gill—I am talking specifically now about remote communities. That scenario is the scenario of what happens in Darwin, Alice Springs, Tennant Creek and so on. That is not the scenario for remote communities.

CHAIR—With respect, Nick, it is a scenario for a significant group of people which we have to consider.

Mr Gill—It is indeed, yes.

CHAIR—So I need a response from the meeting about what is the balance and the appropriate response and how we do it better, as well as the isolated communities.

Mr Gill—With regard to the in-town scenario, it is vital, first of all, that sobering-up shelters have a significant health focus rather than a crime or public disorder prevention focus. All sobering-up shelters need to be funded to have Aboriginal health workers on staff and to be able to conduct appropriate interventions in language, if necessary. The prevention activities are absolutely vital. Education and prevention throughout the community—

CHAIR—What is the most effective education prevention process at the moment? How should we advance that?

Mr Gill—The most effective ones are those carried out by Aboriginal people themselves in conjunction with the elders of each community and in the traditional context.

CHAIR—What about for non-Aboriginals—the European society? They constitute three-quarters of the population of the Territory. Are you going to consider those as well?

Mrs Gee—I definitely think that is a very valid point. The statistics that I have show that, especially for hard drug use, it is the European part of society. I am not denying that there are gross problems within the communities. Certainly, the majority of Aboriginals are now not using hard drugs. So there is a problem there. But I would like to see it addressed as a general problem. I think you would have to take the community problem as a separate problem but I would like to see the overall problem of drug abuse taken as a group—not two separate groups.

Ms Kittel—I think the government is dividing people by making it two separate issues.

CHAIR—Donna, we will allow a spot at the end or as we go through, but we need to listen to the other people who have come here to speak.

Ms Kittel—Okay.

Mr Sigston—Can I follow through on what Nicholas was saying. There is a positive move that has come from the Territory Health Services. In our service plan with them for our funding, they are insisting that we do follow-up and after-care programs, which ought to connect back into remote communities and families, whereby those families have the education and support that are necessary for them to cope. That follows through, no matter who is involved. Other people have mentioned teenagers. That support is essential. It is our strong belief that if families are equipped to cope, that will be much more effective than increasing external services.

CHAIR—How do we best do it, Roger? The strong family theme is one of the first in our terms of reference. So there is no debate about its importance, but we need to know how that should be done.

Father Sullivan—One thing that Roger is doing is providing training programs for Aboriginal people. Often that training program is for both the drinker and the non-drinker, or non-user, after some kind of treatment program. In my 12 years of involvement of working with remote area people, those people who are trained then go back to their remote community and they become a bit of a filter in the local community. Those people are on the council, they are in the women's group, they are in the stronger women/stronger babies group, our culture for life group. They are like the yeast in the community, as it were. They carry the burden not only for their family but for the community. So supporting those people is the beginning of building up confidence and an ability to work.

CHAIR—Paul, with respect to the balance of the community, the Europeans in the community, how do we do that better?

Father Sullivan—I think we work on a systems level as well. I would very strongly support this workplace system where we are up front in dealing with alcohol and drugs in the system of the workplace. So rather than treating the individual person in isolation, the person is treated within the system and the system is very proactive in taking policies and procedures. Whether it is in the workplace or the family—

CHAIR—The union movement, etcetera?

Father Sullivan—Yes. The system takes on responsibility for occupational health issues in the workplace and you have got the policies and procedures to deal with issues as they arise. They are normal issues, so let us treat them as normal in responding to them, either in the workplace or within the families.

CHAIR—Murabuda, how do you see it—the white fella and the black fella?

Mr Wurramarrba—This is what I can see everywhere in Arnhem Land today. For example, if we are standing in water that is this deep, we can stand. But beyond that, you sink or swim. You can't see the land; you can't see the way. That is what the black man is doing today—he can't see the way because there is a lot of boxed land and he can't see the clear picture. We can't understand what drugs are doing in our community and we can't handle it. Where are we going to get the tablet from? We have not got any tablet in Australia; or a needle to stop the drug. It is only the words that we can teach them—the people. And we lost our way. It is not up to the doctor, the champion of the world in drugs; he can't fix it. Only we can fix it, in our hearts and mouths. This is what I believe, because we are lost—black and white. They are both the same, and we can't fix it. How are we going to fix it? We can't fix it. We can't mend the soul. The boil is inside. We can fix it, but other disease comes out —grows again. This is what we see, among Aboriginal people and the white society. How are we going to fix it with this? Just by sitting here and talking about the diseases that we have? We might as well see what we can do, and work together—black and white. That is what my thinking is, and the thinking of leaders of the community in the remote areas.

CHAIR—Thank you.

Mr Sigston—One of the reasons that I emphasised the training and the lack of it was because of people like Murabuda and families of people, especially women. You might have noticed the

media in the past have focused on women in Central Australia and what they are trying to do. These people are highly motivated. Bringing them together, supporting them, sharing with them and providing them with that little bit of information is really effective. It fits with what Murabuda was saying.

Mr Gill—I want to quote a little bit from the Territory Health Services' submission. It talks about front-line workers in drugs and alcohol. The point is made that front-line workers in Aboriginal society are not paid workers; they are family members and the whole community—the elders of the community and so on. There is a training front-line workers initiative under the National Illicit Drugs Strategy. It is vital that funds from the training front-line workers initiative be addressed to non-traditional front-line workers. I think this is a recommendation that should be adopted.

A break occurred in the transcript at this point due to technical problems.

CHAIR—…the impression of trying to tease out the abstinence discussion; that it is an option for everybody and that other options may have certain consequences. I agree with you: we do not have to go into it in a culture of fear, but we can go into it with the full range of options.

Ms Leibrick—Absolutely.

Mrs Gee—The committee has been travelling around Darwin for two days. What is your overall impression as to how much people admit that there is a drug problem within the Territory? I refer to drugs overall—alcohol, cigarettes, petrol sniffing and hard drugs. Quite often, when we go to government here, it gets swept under the table: 'It's not a problem.' One famous article in a newspaper about 18 months ago stated, 'We don't have a drug problem and if we had, put them on a bus and move them on.' I was wondering what impression you got about how open the community was about people who are injecting drugs, drinking or whatever?

CHAIR—It is an excellent question, Kitty. I will certainly invite my two colleagues to discuss it. We came here on Wednesday, visited Katherine yesterday and we are now here this morning. There is an acute awareness of it. If we go to Banyan House, for example, you would expect a focus like that. At Katherine yesterday, which was our first broader community contact, there was a very real concern. They were quite open and we ended up having quite a positive discussion about some of the negativities that can be around the issue. As you know, your government was a little reluctant, but we feel privileged to be able to meet here in the parliament this morning.

Mrs Gee—That was what I was trying to tease out, actually.

CHAIR—The Territory government makes its own decisions and I do not want to get into that because our role is from a national perspective. We are going to all the other states. We have been to most of the states, including Sydney, New South Wales. It was a remarkable experience to visit Cabramatta and talk with the Fairfield City Council. We also visited the Goulburn jail; we were at Berrimah yesterday. So in terms of your people in the Territory and the people that we are talking to—not just the specialist people working in the field—it seems

to me that the broader community has a concern and they have been very open and helpful to us. Menzies is another great facility that you have here.

Ms ELLIS—Without repeating what Barry has said, there is absolutely no doubt—it does not matter where we go in the country—that the awareness on the part of the community, with whom we have meetings, discussions and informal talks, is incredibly high with respect to the problems and the need to do something about substance use generally. This area is absolutely no different. I am a little less reluctant than the chair to get into the other side of the debate, because it needs to be said publicly, and I am happy to say it. In my two terms in parliament, with respect to all the inquiries I have been involved with—including a very long inquiry into indigenous health and a range of other issues—this is the first time we have ever experienced obstruction from government in terms of what we are attempting to do. Any government of any colour, of any level anywhere, which adopts an attitude of not wishing to participate in something like this is very seriously accused of letting down the community that they purport to represent. There is absolutely no doubt of the reality of the problem, the seriousness of the community view of this and the absolute willingness by the community right across the board to attend to it, despite their varying views about how to attend to it. I think that our trip here, whilst frustrated to some degree, has been enhanced by the commitment of the community people and the organisations with whom we have met.

Mrs Gee—Bearing in mind that that is where our funding comes from, too.

Ms ELLIS—I understand.

Ms HALL—I endorse everything that both Annette and Barry have said on this matter. Everywhere we have gone within the Territory, the communities we have visited; the people that we have spoken to in the communities, have been very free in identifying a number of major issues that relate to drugs. Unfortunately, your government here has not adopted the same approach and has, in actual fact, put out a very strong message that there are no problems with drugs in the Territory. I would like to address that by referring to the submission that we received from Northern Territory Health. It runs through the incidence of substance abuse of various kinds within the Northern Territory and then compares the figure to that for Australia as a whole. Just look at cannabis. In 1995, the figure was 52.9 per cent in the Northern Territory and 30.9 per cent in Australia as a whole. In 1998—these are the years that were given—the figure was 58.3 per cent in the Northern Territory, and 39.1 per cent for Australia.

If we look at heroin—which we have been told is a problem that does not exist in the Northern Territory—the figure was 1.8 per cent in 1995; 1.4 per cent Australia-wide. Once again, the Northern Territory is up there. The figure for 1998 in the Northern Territory was 4.4 per cent; 2.2 per cent for Australia. It is the same with amphetamines. The only one that seems to be consistently down in comparison with the rest of Australia is cocaine. I find it really sad that the community has got varying problems with drugs, be it alcohol, nicotine, amphetamines—which I hear is quite a problem—or cannabis. With all these problems existing in the community, the government's response is to attack a committee that has received enormous cooperation throughout Australia and deny that the problem exists. There has been fine research work done here, by Bridie and the people at the Menzies School of Health Research. They have identified the problem, yet once again we have got this denial factor. You have got a community that is committed to high quality programs. All the providers that are

here understand the issues, yet we have got a government that denies it and really frustrates the process. I think it is very sad.

CHAIR—We need to move on. I invite AMSANT—Pat Anderson and John Boffa—to provide a summary for three minutes. Then we will have a discussion.

Ms Anderson—First of all, we need to apologise for being late. In fact, we thought we were early. We got our times a bit confused, so we apologise to the committee and other participants. For the benefit of the committee, we need to explain a little bit about AMSANT, Aboriginal Medical Services Alliance of the Northern Territory. We share all the concerns that Annette and Jill have raised. This is a serious community health problem, in our view. AMSANT is the peak advocacy body for all of the Aboriginal community controlled medical services in the Northern Territory. We have 15 members, ranging from the larger services in town, like Congress in Alice Springs, where John Boffa works. We have a large delegation who have come up specifically from Alice Springs to be part of this process.

Just to give you some further information about AMSANT, our services have helped to pioneer a joint needs based health planning process between governments and the community sector. The processes are based on the models of Aboriginal community control and comprehensive primary health care.

A break occurred in the transcript at this point due to technical problems.

Ms Anderson—Substance misuse is a major problem in Aboriginal health in the Northern Territory. It is the leading cause of premature death such as homicide, motor vehicle accidents and pneumonia. They are all strongly related to substance misuse. The devastation of family violence is directly related to substance abuse and total misuse. There have been recent articles in the *Weekend Australian*, which we have contributed to, about this issue. We have spoken publicly about the unacceptable levels of violence against Aboriginal women and children which, in our experience, also happens as a result of substance misuse and abuse. Because of this appalling situation, we have collaborated with the government to develop planning processes. This involves us, ATSIC, the Commonwealth and the Northern Territory government—all of the partners. It is also very disappointing for us because the substance misuse plan we have developed in the centre was done in partnership with the Northern Territory government, the Commonwealth and ATSIC. We are hoping to have that same process happen here in the Top End.

So we are in this partnership arrangement with the Northern Territory government as well at the Northern Territory Aboriginal Health Forum, where we try to look and act strategically and plan for introducing access to primary health care across the Northern Territory. So it is really disappointing that they have chosen not to participate in this forum when we already have a partnership arrangement. We have what is called a framework agreement, which we have all signed off on. So maybe they are panicking for unnecessary reasons.

What is extremely disappointing about this whole situation is that it is absolutely vital that all of us participate in trying to solve this community health problem and it is extremely disappointing. It is a terrible problem, and the Northern Territory government has chosen not to participate. What I am going to do now is hand you over to John. I think he might have a bit

more time to perhaps talk about the main points of the substance misuse plan that has been developed with all of those partners for the centre of Australia.

Dr Boffa—We are going to table a copy of what is a draft plan because it has been signed off by ATSIC and AMSANT. At the moment it is with the Commonwealth and the Territory government, and we expect them to sign off within the next few weeks. You are here slightly too early to get the final copy. We expect this draft will probably be the final document. I am not going to go through it all because we will give it to you. It is in three sections. The first section is focused on preventative and protective measures, which looks at building capacities and individuals and families, community education, supply reduction, safer drinking venues and environments, better policing and diversion programs, addressing underlying issues and more appropriate taxation. That is in that section. There are obviously strategies dealing with all those things. I should say at the outset that the plan largely focuses on alcohol and inhaled solvent misuse, because they are the two primary problems in the indigenous communities that this plan is attempting to address.

The second section is focused on treatment and rehabilitation measures and looks at better interventions, including early interventions, ways to get accessible detoxification and effective treatments, youth diversionary related programs, general diversionary mechanisms and disability services. The third section is focused on how to monitor and evaluate progress in some sort of manner against this plan. Because for years, to a large extent, a lot of the interventions have happened in a way that we cannot actually evaluate and see whether they have worked. There are a few major exceptions to that and I wanted to focus a bit on a couple of issues. One is the Tennant Creek alcohol restriction trials. Were you given a copy of the latest evaluation of that trial and was that discussed at Menzies or not?

Ms ELLIS—It was referred to, yes.

Dr Boffa—In a nutshell, I think what that shows four years on is that there has been a sustained 25 per cent reduction in per capita alcohol consumption. So it has gone from 19 litres of pure alcohol to 13.5. The biggest single finding is that there has been a threefold reduction in violence against men and women, Aboriginal and non-Aboriginal, in that community as measured by presentations at Tennant Creek Hospital. So we are talking about the serious end of the spectrum and it is over a threefold decline. There is virtually no other strategy that we are aware of that has had that impact on interpersonal violence, other than these restrictions on alcohol supply. At the present, this is an issue where it would appear that the Alice Springs town is moving in the direction of a similar 12-month trial. That is apparently going to be gazetted this week by the Liquor Commission, which would be looking at banning four- and five-litre casks and restricting trading hours of takeaway.

So we certainly think that supply, reduction and certainly not prohibition but getting the balance right—getting a greater balance between undersupply and oversupply—is part of what needs to happen. In fact, in the Northern Territory's 1991 Living with Alcohol Program—which was a good attempt by Marshall Perron and his government at addressing this situation in a comprehensive manner—the one part of that program which was never implemented was the aspect about buying back licences, restricting supply. It is only in recent years in some communities, after a big struggle, that that has actually been able to happen.

CHAIR—You might care to encompass in your comments this Living with Alcohol Program. Where is it at? You have touched on the part that was not implemented but you might just go a bit broader.

Dr Boffa—I think since the Commonwealth legislation basically made the tax illegal—originally there was the tax on the wine cask levy which was producing about $10 million of current funding a year. That was funding the program and since that is now—

CHAIR—That was based on the High Court decision in terms of excise.

Dr Boffa—Yes, the High Court declared that as an illegal tax, so that revenue has gone. Even when the revenue was there, the program did achieve some shift from full strength beer to light beer, which is a good thing.

CHAIR—The High Court made a decision, but what were the efforts made to say, 'Okay, that is a different funding stream that is required now?' Where did that end up, because it was not there? Was that the reason it was not funded? Wasn't there a discussion about how it could be funded alternatively?

Dr Boffa—Not that we have been made aware of. I think we hope that with the tabling of such a comprehensive plan there is a clear need for resources, and we would be expecting and hoping that the Northern Territory government would be able to come up with some resources against that plan. Since the loss of that wine cask levy, it seems to me there has been a significant net loss in recurrent funding of alcohol programs across the Northern Territory.

CHAIR—As fundamental as that?

Dr Boffa—Yes, it is that simple.

Ms ELLIS—When we were in Katherine yesterday we heard some reference to some outer communities being—for want of a better term—encouraged to build clubs.

Dr Boffa—Wet canteens, yes.

Ms ELLIS—We collectively were a little astounded by this. When I asked the question, 'Encouraged by whom?' there was a suggestion that it was not an accusation, and that was in the language. Do you have a view on this?

Dr Boffa—We hope we are coming out of the Dark Ages, but the reality was that there has been a very strong push, and it has been led by elements of government, in response to the problem of fringe dwelling Aboriginal people coming from outlying communities into urban centres. One simplistic understanding of that problem is that they are coming in to drink. The simplistic solution to that is if you put wet canteens in communities, of course, they will not come in there. They will drink on their community.

A break occurred in the transcript at this point due to technical problems.

CHAIR—How do you feel, from a young person's point of view? What do you reckon?

Ms Kantilla—My point of view is that today, we are all sitting here together to help each other, to work out ways to help each other—Aboriginal people and non-Aboriginal people. To me, when I work on a field trip, when I am away working with a bush camp, I see non-Aboriginal people with Aboriginal partners. I can talk to them about ways we can help each other, that there is somewhere they can go and have rehab, and tackle their drinking and drug problems. So for me it is really great to be here and listen to some things as to how we can help each other in all the organisations.

CHAIR—Craig, what would you like to see for the future?

Mr Spencer—Basically, having listened to what was said here today, and also from being in the field, I think one of the biggest things is education. I am an ex-police officer, and it seems to me ironic at times that, on the one hand, you have so much money being spent by one government agency chasing druggies, and on the other hand you have got people supporting them and helping them out. It seems to me that we send out double messages in society to people, which is confusing. Then we have phrases such as 'tough on drugs' and that sort of thing. We really end up playing both sides of the stick at times.

Mr Sigston—I would follow Claudia's line in really pushing for a cooperative approach to things. One of the things that the CAAPS council has tried to get us to do is to work in partnership with other organisations, and that is starting to pay off. There is a long way to go but I think that is an important part of it. I think this barrier between abstinence and controlled drinking models is something that can be overcome. We were asked to do that by our council. We were able to bring in workers from Living with Alcohol to teach our staff some of the alcohol and other drugs subjects. Some of them did not like it for a little while, but we have to build bridges in order to realise, when working in an abstinence model, that 60 to 80 per cent of clients are going to drink when they come out of the service. You have to deal with that. You cannot close your eyes to that. You must demystify your approach and say, 'If you put alcohol and drugs in, this is what it will do.' Knowing that, we can work with it. I suppose one of my experiences that helped with that was doing a client outcome study. I recall vividly in Katherine sitting with a man who had been through the program and he had to get his carton of beer first, before we could sit and talk. Coming from an abstinence based organisation initially, to think that the rapport could be there to do that was a real eye opener to me. I would like to push for resourcing and evaluation of family based programs, and also a coming together of organisations.

CHAIR—Leonie, would you like to sum up for us?

Ms Young—Many of us have talked about partnership and collaboration. You have heard many of the local solutions to the problems here, with respect to working in a partnership with communities, with organisations, across governments and so on. Clearly, you are also aware that we need to be doing a lot of work in strengthening that partnership—enabling it to be a robust and strong partnership but bringing governments to the table to progress the discussion. Nationally, we need very strong policies and strategies that enable people, wherever we live in Australia, to access services, to participate and to come up to national levels or go under, depending on our local issues. I would look to the committee very strongly to take back the

issues here and to give those issues that we have talked about some consistency, and come back and share those with us, because regardless of the government of the day, locally and nationally, we need those strong policies and programs.

Mr Walker—We have heard lots of points of view about the lack of funding; we could all do with more funding. I think it is important to point out that our organisation, Banyan House, is specifically funded by the one and only residential rehab in the whole of the Northern Territory for drugs other than alcohol. But it is only to the extent that we are forced to run therapeutic groups in an area where, when it rains, the rain falls through the roof. The neon light fittings fill up with water and go green because of the microscopic plant life growing in it. We are based in a series of pre-Tracy dongas that actually survived Cyclone Tracy. We wonder why we have a client retention problem—because they come in here and we feel embarrassed to show them where they are going to live. You have probably seen it?

CHAIR—Yes.

Mr Walker—It would be great for us to have just enough funding to not try to do anything else, not to do any outreach, not to meet any of the other needs, but just to put a roof over our clients' heads so that it is basically safe, livable and waterproof. That would be great for us.

Ms HALL—The accommodation at Berrimah seemed to be of a little bit higher standard.

Mrs Gilchrist—I would like to emphasise the importance of a collaborative approach. What happens is that whoever can speak better or loudest tends to get the outcomes. I think it is important for everyone to be heard, for everyone's needs to be met, in whatever fashion that can be done.

Mr Wurramarrba—I want to throw a few things in the middle of this area. We are talking about two roads: one is the dollar road; one is the poor, undollar road. One is the painful road; one is the rich man's road. We can see all of that. One road is for Aboriginal people and one is for the Balanda people. Why can't we build a road to reach the rich man's road later on, from behind? Let us talk about the dying road and the painful road—forget about the dollar road—that leaves people, white and black, dying on the road today. So we just talk about the money and the dying. Let us leave the money behind. The government hears about giving us a bucket. 'There is your bucket, this is your bucket and that is your bucket.' Let us hear about the dying road, the painful road.

This is what I see for people in the community, black and white. The black man is fighting outside the door, in the public eye. Balanda are fighting: shut the door, shut the window and put the curtain up, so we can't see. I am not criticising, but I can throw the good news to you people and good news for me, too, so I can understand what I am saying to you people. So we shut the door on the fighting wife and husband, on the big violence between wife and husband, with the kids crying in the middle of the corridor. Aboriginal people fight outside the community, with the knives and the machete and the gun. These are things that I am saying about the sadness road and the dollar road. Let us forget about the dollar road and just concentrate on the poor, unrich man road. Just concentrate on that. Talk about it and how we are going to fix it. How are we going to mend it?

A break occurred in the transcript at this point due to technical problems.

Ms Jessen—We all need to work together. Your visit here just demonstrates that yet again, particularly in the illicit drug area, there is a high level of denial and sweeping under the carpet and I think that is very detrimental at this stage because it is a hugely growing problem. I guess the other area I am particularly interested in and concerned about is having a broad range of treatment options. If we are to be a just, humane territory moving to a state, I think we need to have a broad range of services that meet all people's needs, not only a narrow focus of things that are seen to be palatable or whatever. I think there is a lot of evidence that a number of programs we do not have are effective. I think we really need to be able to offer people a broad range of treatment options if they choose to address their substance misuse problems.

Dr O'Reilly—I agree with much of what many people have said and I think Kitty's idea was very good and I support what Janice has said. I would just like to step along a little bit from what she said. I would like to push that we really need good research and evaluation frameworks because we cannot be dynamic and progressive in this issue unless we constantly self-assess it and self-evaluate what is going on. I would say that that is a real priority, both locally, nationally and globally, but it all has to blend together.

Ms Mills—My view is that alcohol and drugs do not discriminate. Our services certainly do not. What concerns me is that there tends to be a lot of young people that are having a go at harder drugs. Once upon a time it seemed to be the marijuana. There is a really big concern of mine that people are taking whatever they can get hold of. Out in a lot of remote communities petrol sniffing is the only thing that is around so that is what they go for. There is a lot of the speed and stuff like that that young people are getting into. The trips we are hearing about are really scary. With our programs we have court diversion participants coming through our system which makes it a little bit hard because our organisation was formed in the seventies and it was on a voluntary basis where you came along for assistance. Now the governments are saying that they want us also to deal with mental health and the court systems and it can be pretty disruptive. Some people are saying that people are not going to stop using. It makes it really hard for us to try to focus on total abstinence because our program is based on the AA 12 steps, total abstinence, but it is very hard sometimes to get it across. At the same time we are really cooperative with the people and we are not forcing anybody to go for total abstinence—that is fine, that is your choice when and if you do it, but it needs a lot of education I think. One of my concerns too—I get really frustrated with the adults sometimes—is the younger generations. We really have to start educating them, preventing the young people that are going through domestic violence and turning straight to drugs because there are leaders that are not trained in that way. So never forget the young generations. It is a vicious circle, as we know, and we need to prevent the young ones.

Mr Gill—I am really glad that young people and education was mentioned there. It has not been mentioned previously. Alcohol and other drug education is a core component of the curriculum in Northern Territory schools and it is not being delivered; that is the reality. It is not happening in schools. That needs to change.

The second thing—this is vitally important—is that nobody has talked about the fact that there are no detox and treatment services for young people in the Northern Territory. There has been resolution after resolution, request after request, particularly in Alice Springs, for some

detox and treatment facility to be made available for young people. It does not exist. I see no signs that there is any willingness to actually have it happen. It must happen, otherwise there will be more deaths.

The third thing is that I know you have got 15 beds in Darwin for other drug problems. In Alice Springs we have no beds for our other drug problems whatsoever. There is no other drug treatment rehabilitation available in Central Australia. I have to send my clients up to Banyan and God knows Darwin has got enough clients potentially for Banyan of its own. So those are three priority areas.

CHAIR—We just need to chat afterwards if we could. Can I thank you very much. It has been valuable for all of us to visit you—and the usual criticism of federal politicians, but that is the nature of it. My only defence is that I live on your southern border. And that is no disrespect to my colleagues. Thank you very much and you know, as we know, that we do not have the answers. We have some various snapshots of what we think we might do better, but the only way to find a better future is to keep doing the sorts of things that we have tried to do this morning right around the country. We are 12 or 15 months away from where we will end this part of the journey.

Ms Jessen—What is your timeline? When are you reporting?

CHAIR—Politics will intervene with an election. But we will do Queensland and Tasmania and we will then have been right around Australia. Therefore we will have an intermediate summary of what we have done before the election, and then the reference will need to be referred from the minister of the day to the committee, and then concluded we would hope, mid next year. That is where we are at with it. Thank you very much.

Ms Kittel—I would just like to make a public statement. Mr Wakelin, I have noticed that since Territory health services are not allowed to participate in this, the very important issue of co-morbidity has been totally ignored. My son had a mental illness and an addiction. There is nowhere in the Northern Territory for these people to get treatment and I think that should be an important part of the whole study.

Ms ELLIS—It is an issue that we are looking at.

Ms Kittel—It is an issue I will raise later.

CHAIR—Thanks very much for that.

Proceedings suspended from 11.00 a.m. to 11.18 a.m.

A break occurred in the transcript at this point due to technical problems.

Mr Dunham— ... Turning to tobacco, this has also been newsworthy lately and I put on the committee's *Hansard* record that the Northern Territory will be taking a look at options that are happening in other places. That is a paper that I will take to cabinet and ultimately the decision will be that of cabinet. The Northern Territory does not have prohibitions on smoking in public places, as do other jurisdictions. Our Tobacco Act largely relates to the age at which one can purchase tobacco and certainly, in terms of its prohibitions in public places the act is totally

silent in that area. I am unhappy to admit that it is a major health problem for us and that people in our hospital system with problems relating to tobacco use are over represented. It is one of the most illnesses that can be prevented with a diminution in tobacco consumption.

Kava is not such a problem in many other jurisdictions but it was introduced into the Northern Territory, I believe, by well-meaning people who saw it as a harm minimisation effort and saw it as the lesser of two people between alcohol and kava. Being a soporofic, they saw it as not having the same travelling companions as go with alcohol which is violence and disruptive and unruly behaviour. It presents a significant problem for us here in the Northern Territory with some communities where vast amounts of kava are consumed. There is a Kava Act that leaves communities with the capacity to make decisions in this area, and it is a controlled substance that will be legal. We have not been able to go to other scientific journals to any great extent because places where kava is consumed is not consumed at the same level as here—where it is used recreationally. Unfortunately, here it is also cocktailed with other substances, particularly alcohol, which has a terrible effect on health.

Inhalant substance abuse, anecdotally, came to the Territory during World War II with US servicemen. It has certainly been present in the Northern Territory for many decades. We have had a variety of approaches to it with mixed success. Our biggest impediment, as was pointed out in our submission, was a lack of collaboration and coordination across agencies. This is an area, as I am sure your committee has found, where there are many agencies with responsibilities and many of them are trying to grapple with the issues. Sometimes they feel like they are doing it by themselves but really the onus is on all of us to have a concerted approach to the problem. The problem achieved some notoriety, and that came through the front page of the *Weekend Australian* more than anything else. It is a significant problem for the Northern Territory. There are some solutions that have been trialled successfully, particularly in the Top End of the Northern Territory. The problem is definitely greater in the Centre, which I think everybody would admit to. We were pleased that the Prime Minister committed $1 million on a recent visit to Darwin to firstly, trial and analyse some solutions and, secondly, to put some programs into place. I also put on the record that the Commonwealth is a major contributor already to inhalant substance abuse problems and that those contributions, when they were wrapped up with moneys that can come from other areas like, for instance, sport and recreation, local government and territory health services can be leveraged up to provide good impact, I would hope.

On illicit drugs, at the top of the list I would put illicit used illicitly, particularly schedule 8 drugs that have found their way on to the black market. We know that to be the case by evidence that has been before the courts, by police actions and by other means. We have noted that there has been a significant problem with people illegally or by deception obtaining schedule 8 drugs and using them recreationally. Our statistics over two years peaked to about 1999 and they were certainly far in advance—particularly for one drug, MS Contin—of any other jurisdiction on a per capita basis. Two of the strategies that we put in place are in our submission. One is the contracts between doctors, pharmacists and the patient, the client; and the other is the auditing by the Health Insurance Commission. Both of these interventions have seen a drop over the last couple of years. I am not sure that data is in your documents, but I can get it for you. Essentially what you are seeing here is fewer of those schedule 8 pharmaceuticals hopefully entering the illicit stream.

When you talk about other drugs—for instance, marijuana, amphetamines and other substances that are used recreationally—I suppose the Northern Territory would be overrepresented, depending on how you find your data. Data is notoriously inaccurate in this area, as you would know. In the Northern Territory, again we would find that we probably have higher levels of consumption than other areas would. Another area of difference here in the Territory compared to other places is that we do not have a methadone maintenance program, and that has been commented on widely. It is the government's position that our programs should be aimed at abstention, not maintenance.

There is significant debate about this from many practitioners and many impartial researchers from around the place, but that continues to be the government policy. There is a limited capacity to access methadone, and those criteria were provided to you. There are some drugs like naltrexone that are proving some efficacy in treatment of opiate addiction, and the Northern Territory is actively investigating how that might be introduced here in the Northern Territory—likewise for buprenorphine. The chief health officer has provided some preliminary advice to me and will be providing more advice to me on how, and under what circumstances, those particular interventions should be introduced into the Northern Territory.

CHAIR—Thank you very much, Minister, that is greatly appreciated. I invite Dr Bauert to lead off with a paediatrician's point of view.

Dr Bauert—I am President of the Australian Medical Association but in my real life I am a paediatrician. I came up here in 1977 with my wife, who is also a medical practitioner. From those earlier years I have been visiting remote communities doing paediatric clinics. I wanted to spend my five minutes of glory just telling a little story, if I could, about one of the communities that I visit. I present this story on behalf of my patients there. If I make a mistake and mention the name of the community, I hope it is not used. I have undertaken not to use the name of the community because occasionally things are misrepresented.

The story starts with the beginning of the wet season in the year 2000. The community consists of about a thousand people, and during the wet another 200 come in from outstations, and the odd one or two who have made it to high school come back from boarding school. The community then gets flooded in for about three months. At that stage, there were 10 hardcore petrol sniffers there, regularly sniffing. During the wet season, as had happened previously, they were concerned that the numbers of casual sniffers would increase. The sports and recreation officer down there put in a submission for around $1,500 to run a sport and recreation activities over the wet season. That money was found and the program was a success.

The community saw that this was a success and they had identified that substance misuse, particularly petrol sniffing but also marijuana, was a major problem. They applied to Territory Health Services for funding from moneys that became available through the S100 scheme. The amount of money that they asked for was $8,800, and that money was to be spent, once again, in beginning counselling programs. They had identified the counsellors for these hardcore sniffers. The money was not forthcoming. There has been a cut put on all funding. This is what I have been told from the community.

The council then put in a formal submission to the Northern Territory Safe Public Behaviour Program. I would just like to spend a couple of minutes talking about what the council have

asked to do, and what they would like to do with money that they had been asked to put in a submission for. They sent off to the Alcohol and Other Drugs Program, particularly the Northern Territory Safe Public Behaviour Program, their expression of interest. Their initiative seeks to address the need to prevent and reduce the incidence of anti-social behaviour amongst the petrol sniffers resident in the community. I am sure you have come across the CRC document from Peter D'Abbs and Sarah McLean. If you had not, I was going to give it to you. The complexities of all of this are vast, but the behaviour in the communities was really terrible by this group of 10, and during the wet season by their colleagues that have joined in.

At one stage during this recent wet season, it was estimated that 60 per cent of the kids between the age of 8 and 18 in this community were sniffing. So the project's aim was threefold: intervention, diversion and prevention through education components. Each component must be addressed otherwise the project's aims will not be achieved. That is, to stop the petrol sniffing—intervention; provide an alternative activity—diversion; develop high esteem through helping disadvantaged groups in the community, that is the old people. They were linking all of this together.

So they had a plan of action. The first step was to conduct community consultation. A meeting has already been held to determine a plan of action to address the above issues. The plan of action was to (a) identify the petrol sniffers and other drug users, (b) obtain a list and information from the police, (c) identify the plans they belong to, (d) identify those people from other communities and send them back, (e) liaise with their traditional elders on action and assistance that may be required, (f) provide work opportunities; that is, work project with the CDEP fish farm and small machinery repairs, work with the sports and recreation officer—and it is necessary to note the sports and recreation officer's important role in this—work with other members of the community assisting with the aged care program, and liaise with the police and wardens.

The second step was to identify a coordinator. Council has identified a coordinator to work with this program who has had experience in other communities prior to moving to this particular community. The coordinator identified has had many years of experience working with juveniles at Wildman River, Malak House, the Don Dale Centre and other community young people development schemes. He worked, most recently, on tourism in another two communities nearby. He worked for Correctional Services in one of the communities, et cetera.

The third one is identify and locate resources available to the program for interim use. Council has already identified the resources to assist in this program to give it every possible support. So far we have had the police involved and we have had the sports and recreation person involved. We did not get Education involved because they have provided the library at the school, and it is one of the areas that this program can go on. The coordinator will build up a rapport with the client group, then identify a group to help as part of the program—that is, the clan leaders, those responsible for their welfare under traditional law.

If you will allow me just to spend time with this because it is a well thought out program which encapsulates a lot of what is said in here about what should be happening. The idea was to re-establish the fish farm to provide fish for the old people, keep the old people fishing or hunting at least once a fortnight, arrange a fishing trip to catch fish for old people, prepare at least one meal a week for the old people, et cetera. Then they would provide positive feedback

for the client group to raise self-esteem of the individuals and the group as a whole. For example, they would acknowledge the work they have done in the local newspaper and various other newspapers.

Finally, funds would be used to support the above initiative in terms of part salary for the coordinator, fuel, food, barbecue, fishing, hunting gear, et cetera. The coordinator has agreed. They then put together an extensive budget of how this was going to run, and funds were coming from the Anti-Social Behaviour Program, for which they wanted $32,500. The CDEP program was providing $76,000; the council was providing $49,000. They saw this as a program that would be ongoing, that has involved all these various aspects of their community, which would stop the rise of hardcore sniffers in the community. A letter came back to the town clerk. It states:

> I write in relation to your organisation's recent expression of interest to the Northern Territory Safe Public Behaviour Program. The Public Behaviour Program Advisory Group assessed 35 submissions. In this instance your submission was not successful. There were limited funds available for this funding round and it was felt that your expression could be better addressed through the National Drug Strategy Scheme ...

For which they have given a contact and a telephone number, who is a person in the 'Living with alcohol' program in Katherine.

The reason I wanted to spend the time on that was to say that what this community has done is what has been talked about—I caught the tail end of this morning's session—for ages and what is official government policy, in other words, empowering the people. Two out of three submissions for funds have been knocked back. The total amount of money involved was about $40,000. This is a community which is on the edge, it is really under resourced. It is a community that has so much learned helplessness in it that it has been a mammoth undertaking to have the actual council get up, work hard, put this together in such a detailed way and provide a format for the handling of what they see is a very difficult problem.

Not only were the funds not provided, but they have just found out that their sports and recreation position is now no longer going to be funded and that all funding in this area has been stopped. These people have just been kicked squarely in the guts. They are struggling and trying to do it themselves and they get kicked in the guts. I do not think it is good enough. What this story illustrates is exactly what is in Peter D'Abbs's and Sarah McLean's book. It also illustrates exactly what is in Richard Trudgeon's book, *Why warriors lie down and die*. It is just not good enough. What is the answer? My pet hobby horse at the moment, as Mr Dunham will tell you, is that there has to be some coordination of all of this. They can do it in the community all right. They can get Education, Health, the police and the sports and recreation working together with council, but coordination has to be done at the top. Surely, if there were some system of meeting of CEOs of all these different departments and this sort of thing came to their attention, the cutting of the sports and recreation officer, for instance, would not have happened. I have lots of other things to say, but I will leave it at that for the moment.

CHAIR—Thank you very much for that. We will have a conversation later following the statements. Barbara, would you like to put an ATSIC perspective?

Ms Cummings—Yes ... We have provided the committee with an overall general report on the various drugs that are used and the effects that it has caused. I just want to say that I come

from this town, and last week I spoke at the formal land council meeting regarding the itinerants and the migration of people into this town and the public drunkenness that is occurring as a result of that. I said that it was at its worst in the 25 years that I have been involved in Aboriginal affairs, where we are seeing aged people drunk in public places and extremely young people drunk in a public place. We have a major problem with the night patrol services. As you know, night patrol was promoted nationally through the Royal Commission into Deaths in Custody whereby lots of communities have initiated a night patrol in protection of their people. That is a cause of great concern to me, personally, as the chairperson for ATSIC in this town, because the existing resources for night patrol are insufficient. What is happening is that it is policing rather than looking after the public drunkenness. We only have two vehicles—

A break occurred in the transcript at this point due to technical problems.

Mr Tippett—... On behalf of the Law Society and the legal community of the Northern Territory, I am grateful to have an opportunity to participate and to say a few words, but I am not going to tell you anything that you do not already know. I am not going to refer to figures that you do not already have, or ideas that you have not already canvassed. That, in one sense, is the tragedy of it, because we know how we need to go about it; it is just that we have not done it for 20 years. The problems that have developed in Darwin now were developing in Alice Springs in the 1980s with movement of people, greater access to transport, greater access to drugs, alcohol and so on and, of course, the failure of the Northern Territory community to truly embrace the fact that its citizens live in outer lying areas and that they have the entitlement to all the services, education and life opportunities that the rest of us do living in Nightcliff and Fannie Bay. It is just that we have not got around to accepting the fact that we have to take the steps to accord those people those rights.

There is a second problem, and you will be aware of it. It happens all over the country, but particularly here, and that is the use of the justice system as a dumping ground for social problems. So if you have got a social problem, you introduce a law and you make it unlawful. Then you attach a penalty to it, so that that person who has suffered the penalty somehow is not going to do it again, or is going to persuaded not to do it again. The alcoholic who is picked up for stealing and goes to prison for a year is to be persuaded not to be an alcoholic and the justice system somehow is supposed to make a difference.

What we know is that the emphasis upon the operation of the criminal justice system is one that has not worked. I would hope that this committee acknowledges the point about moves made by governments—with due respect, of course, to all politicians present—with regard to their constituents. They say, ‘We’ll get tough on crime. We’ll fix these problems. What we’ll do is we’ll go out and we will get particularly tough on crime.’ One of the other political parties says, ‘Well, not only that, we’ll meet you and we’ll get tougher.’ Then everybody is getting tough. What is then produced, as has been produced in the Northern Territory just recently, is a draft anti-social behaviour act. I will provide a copy of that to the committee. It comes up with things like designated areas and all sorts of other rather bizarre approaches to dealing with behaviour which is essentially substance abuse behaviour, and which is more to be associated with our social experience of perhaps an earlier time last century.

The committee, from the legal profession’s point of view, should be able to conclude one thing: the emphasis upon the justice system making a difference has dramatically and tragically

failed. The justice system is not designed to have the flexibility to deal with the fundamental problems. The justice system is not set up to do it. The justice system receives the problem—the end result. It cannot drive at the source. We have been very grateful to have $20 million given to us for the purpose of setting up diversionary programs as a result of the disastrous experiment in mandatory sentencing. But the problem is this: can you imagine what that $20 million would have done if it had been spent over the last 10 years? How would the communities that Dr Bauert talked about have benefited? The fact is that we might not even be sitting here making the sorts of complaints we are making.

So that is one aspect of the approach that I would like to emphasise. The justice system is not the answer, and punishment of people because of their position in the community, their lack of opportunity, their economic and social disadvantage, does not work. It did not work in the gin mills of London. It did not work with the people who were brought here, to places like Port Arthur, and it is not going to work in the Northern Territory in the 21st century. If we appreciate that simple practical parameter, then we go back to what Paul Bauert really was talking about. He was talking about giving people the tools to carry on the struggle. The legal community is well aware of the difficulties of these communities.

I will descend into anecdote for one moment, because it demonstrates the relationship between the legal system and the problem. In 1982, I was sitting in the Papunya courthouse. It is a lovely little courthouse. It overlooks the ranges and the mulga. The desert sweeps over to ranges that are bright red and the sky is bright blue. It is 10 o'clock on a winter morning, so it is about 8 degrees—cold as buggery. In the courthouse sat Dinny Barrett, now deceased, as the magistrate, and a superintendent of police, a particularly capable man who was a superintendent in our police force. We sat for the day's hearing. Then out of the window, as we looked at this wonderful panorama, we saw in the distance, about 150 metres to 200 metres away, little coloured dots walking through the mulga, a group with the biggest person at the front. It was almost as if they had been arranged in a line like ducks. They went through the mulga and we all looked across at this group that was moving and Dinny Barrett said, 'I think'—and I will not mention the police officer's name—'the petrol sniffers have been at it again.' 'Yes', said the police officer, a particularly capable man.

While we had been sitting, the petrol sniffers had hit the local store for their winter clothing. They had dressed themselves in coloured parkas that came down to their knees. The youngest of them was nine; the eldest 13. They lived in a house by themselves. They were ostracised by the community because the community simply could not cope with the problem. These kids were the future offenders—the future fodder for schemes like mandatory sentencing and other such schemes that have been raised within justice systems. Of course, their futures were limited to the point that they were unlikely, because of their environment, to survive very long anyway—into their 20s, perhaps.

That scene in 1982 is the scene that we see now, 20 years later. It is not different. If it happened in New South Wales, Victoria or somewhere else, there would be outrage in the community that our children could be engaging in sniffing petrol. When I first heard of it when I arrived in the Northern Territory, I was horrified. I had never heard of it before—sniffing petrol. We watched communities go through self-help exercises, like 'No-one can own a petrol vehicle, only diesel vehicles.' Avgas was introduced. All sorts of other mechanisms were introduced—everything except opportunities for the people; everything except a future;

everything except educational programs and, more particularly, everything except sporting facilities.

So we now sit around the table 20 years later and speak of the same problem. Dr Bauert put it eloquently: things have really not changed. Seventy-one per cent of sentenced prisoners committed an offence under the influence of alcohol. The figure, we believe, is close to 100 per cent with Aboriginal people. Eighty per cent of offences committed by prisoners in the Northern Territory are alcohol related. The circumstances in which most of those people are sentenced are such that they do between six months and a couple of years, for the vast majority of moderately serious offences. They go back to these communities; they go back to the drinking camps and back to the environment that produced the behaviour in the first place that we, in our wisdom, describe as anti-social behaviour. Those people call it surviving or living or getting by.

We have courts that are constantly having submitted to them circumstances of violence that are just awash, that have been drowning in alcohol at the time the offence was committed; women who are suffering grievously as a result of drunken violence.

CHAIR—Jon, I do not want to interrupt but we need to bring this to a conclusion.

Mr Tippett—I want to conclude on this point: there is a police officer who was awarded Policeman of the Year. He works at Groote Eylandt and he introduced a scheme promoting football. The ramifications of his work have been significant. This committee should focus on things of that nature that can really make a difference. The people that Dr Bauert was talking about just want the schemes that make the difference.

A break occurred in the transcript at this point due to technical problems.

CHAIR—Do you have a comment on that? That is a pretty serious comment, isn't it, that we can throw money at something but we need to know what it is doing? I am not disputing it, but could you respond in that sense?

Dr Bauert—Yes, I did know of that. In this particular submission that went in—and I will go back to my story—they specifically addressed the question of monitoring and—

CHAIR—Not to worry. It is just a general point that critical analysis—

Dr Bauert—My point was that in their actual submission they addressed the point of monitoring the success of their program by the number of severe behavioural disturbances, the number of offences reported and the number of times that intoxicated children attended at the community health centre. I think it is very important that every project that does apply for funding does have something built into it. Am I allowed to mention something else?

CHAIR—Just quickly. I need to allow my colleagues an opportunity to put questions.

Dr Bauert—Following on what Jon Tippett said, I hope you do get a chance, if you have not already, to speak to Richard Larkin, the President of the College of Physicians. Their Health Policy Unit has just produced a document. The summary of that is that really the way of

addressing this problem is through drug rehabilitation programs—end of story. Education and law enforcement are not going to help as much as drug rehabilitation.

CHAIR—Thank you very much, Paul.

Ms ELLIS—I would like to ask a question of Minister Dunham. In your introductory remarks to us, Minister, you made a lot of comments in relation to the overuse of alcohol creating problems. I would like to refer to the Territory Health Services submission to our inquiry. In the area that deals with the Living with Alcohol Program—it is on page 4 and 5 of the submission—there are five or six dot points outlining the administration or the application of the program. Immediately after that there is this paragraph, which states:

> In delivering the program, a range of sensitivities have to be taken into account. These include: the balance between individual and community rights, acknowledging the positive contributions made by hospitality and alcohol industries to the economy and culture of the Territory, and balancing competitive policy and harm minimisation.

With that in mind, do you have a view about the success, as I understand it has been, to the trials that have been held in Tennant Creek in relation to alcohol?

Mr Dunham—The trials in Tennant Creek basically are based on the notion that there should be a grog-free day, and to do that everybody should go grog-free. It is probably worthy of analysis. Certainly the police and the health systems reported much lower levels of attendance during that time. It coincided with the social security benefit being paid, which is a system that has now changed because it can be paid on different days. It was based on the notion that, if you were not allowed to buy grog when the cheque hit the hand, possibly people would buy other things and then buy grog; whereas if the cheque hits the hand and you can immediately procure alcohol, that is what would be procured. So it was seen as a stall of the inevitability—that a lot of the cheque would go on grog but perhaps there could be an earlier call on it.

We have had some mixed successes with the business of taking alcohol away from communities. I talked about dry areas. Certainly Kalkaringi and Dagaragu are dry areas with some limited exception, and take away was prohibited from the Top Springs Hotel, which was just down the road. Grog was being purchased at Woolworths in Katherine and taken in by cars.

Ms ELLIS—So what is your view on how to handle it?

Mr Dunham—I think people will go to great lengths to obtain alcohol if they are addicted to it. It is like many substances that people are addicted to. Barbara talked about why people come to town and made the comment that the Tourist Commission was partly responsible because if you never never go, you'll never never know. There is some truth in that, though I would not blame the Tourist Commission. But many of the people who come in are looking for the bright lights. People from Aboriginal communities are coming in. Some are being ostracised, as was pointed out by a previous member. The community is saying, 'We're sick of you. We don't want to have anything to do with you any more. Out of here.' That is really not a prerogative that is available for urban centres. But there are people from remote communities in town who have been told they are not welcome in their home communities because of their behaviours. I think that if you take alcohol away you have the potential to bring problem drinkers into town.

Ms ELLIS—Would that be some of the thinking behind having wet canteens in more remote areas?

Mr Dunham—The Living with Alcohol Program was called that because the intention was to say to people that it is possible to have a canteen here, where the only capacity to purchase alcohol is within the setting. Instead of people drinking to excess, there is some recreation. There are some good clubs in communities out bush, where I would quite happily take you to sit down and have a drink. You would find that the surroundings are quite pleasant.

Ms ELLIS—And there is no misuse of alcohol there?

Mr Dunham—I think there is a potential for alcohol to be misused anywhere. What we are trying to point out is that the community really should have the option of saying, 'Should there be limited access to alcohol here, where we say there are no fortified wines and there are no spirits, we are only selling light beer between these hours. You can only sell X amount of beers.' That might be a better option for that community than to go totally dry and find that problem drinkers leave the place and are all living in Darwin, doing it tough.

Ms ELLIS—Can I just draw this out by saying that the evidence that is coming to us is that, in fact, a wet canteen does not guarantee that people do or do not go anywhere, and that there has been some enormous concern put to us that communities that were dry, because there was no canteen there, are now not dry. There is an encouragement to some degree to actually establish wet canteens in some of the remote communities. From my logical perspective it seems a bit bizarre to be trying to tell people that there are useful ways of living with alcohol—and I do not for one moment criticise a program like that—and at the same time acknowledge that one of the greatest problems that you have in the Territory, and you have said this yourself, is the problem of misuse and living with alcohol. At the same time as all of that is being acknowledged, it is encouraging communities, where they did not have access, to actually have access on their community ground.

Mr Dunham—The word 'encourage' is the wrong word.

Ms ELLIS—I am little bit puzzled by the logic in all of this.

Mr Dunham—Essentially what we are trying to do is educate communities that there are options. It is not our business to encourage them to go dry, be restricted, have a club or anything. But it is our business to say you might want to look at what they are doing at Peppimentarti, because that might be a model you might like. You might want to look at some of these other communities and see whether those models might suit your conditions better than somewhere else. There is a problem with people commuting large distances to obtain alcohol. They are commuting back to their community with some of that alcohol in their bellies, and they are having prangs on the way. So there is no simple answer to this.

Ms ELLIS—I understand that only too well.

Mr Dunham—If the simple answer is prohibition, it means you take alcohol further and further away from the reach of Aboriginal people. Not only is that a tad paternalistic, but you

also have a problem that you can never ever fully take it away from people. As I said, in the case of Port Keats, people were flying alcohol in from Kununurra and at vast cost.

Ms ELLIS—Who pays for that to happen?

Mr Dunham—The consumer.

Ms ELLIS—The consumer puts it on an aeroplane?

Mr Dunham—The consumer puts it on an aeroplane at a cost of probably $100 a carton.

Ms ELLIS—I have one further question, if I may, on a slightly different tack. You said before—and we know this for a fact—that there is no methadone program here per se in a maintenance fashion. There have been a lot of trials around the country in relation to buprenorphine, and some of the advice from the experts in the medical field on this is that it is proving to come up as a pretty good alternative to methadone.

A break occurred in the transcript at this point due to technical problems.

Committee adjourned at 12.31 p.m.