EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 25 AUGUST 2010

SESSION FIVE

Members

Dr J.M. Woollard (Chairman)
Mr P. Abetz (Deputy Chairman)
Ms L.L. Baker
Mr P.B. Watson
Mr I.C. Blayney

Hearing commenced at 2.58 pm

BEGENT, MS JENNY IRENE
Minister of Religion, The Salvation Army, examined:

SMITH, MR KENNETH PETER
Minister of Religion, The Salvation Army, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I would like to thank you for your interest and for your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems. You have been provided with a copy of the committee's specific terms of reference. At this stage I would like to introduce myself, Janet Woollard; Mr Peter Abetz; Mr Peter Watson; Dr David Worth; Ms Lucy Roberts; and from Hansard we have Helen and Jacqui with us today. This committee is a committee of the Legislative Assembly. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to the proceedings in the house. Even though the committee is not asking witnesses to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. Hansard will make a transcript of the proceedings for the public record. If you refer to any documents during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to some questions we have for you, I need to ask if you have completed the "Details of Witness" form?

The Witnesses: Yes, we have.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes, we do.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Jenny, as you are an old hand at these hearings, I might ask you to go first. Would you please state your full name and the capacity in which you appear before the committee today?

Ms Begent: I am Major Jenny Begent. I am an officer of the Salvation Army. My current position is state director of the Salvation Army, social and community services.

Mr Smith: I am Captain Ken Smith. I am also a Salvation Army officer. I am currently the manager of the Harry Hunter Rehabilitation Centre.

The CHAIRMAN: Before we start, I will first off accept the document that you have handed to me as a submission to this inquiry. I thank you for that submission. You have both had an opportunity to look at the terms of reference for this inquiry. It is obviously a very major issue—we have a problem in the community. Initially we started looking at what was in the school curriculum, but it was brought to our attention when we were up north that we should have started probably at the prenatal area with education and then the preschool area. From your experiences you will be aware, particularly in the Kimberley, of the problems we have with children walking the streets because of

alcohol; children who have tried to get away from physical or sexual abuse. We have been looking at what is or is not in the school curriculum, and what is or is not in the curriculum for health professionals. We are looking at what programs there are in the community, or lack thereof. I will ask Jenny to start because I think she will be a bit more comfortable. We will bring Ken in later.

Having looked at the terms of reference for this inquiry, we are interested to hear your comments so that we can make recommendations in our report from this inquiry. We will not solve the problems but it may go towards reducing the problems that we have. Jenny, if you would like to make a presentation and then we will move on to Ken. We may interject. If not, I may stop for a while so Peter Watson can ask a few questions before he leaves.

Ms Begent: I am happy for committee members to interject and ask questions as I go.

I was interested and really pleased to see the inquiry and to see the three-pronged focus. We do forget that kids learn behaviour. It is in front of us every day. We have our own children and we often say, "He got that from you!" They learn how to solve their problems by watching adult behaviour and parent behaviour and they learn how not to solve them. Often using alcohol and substances is one of the ways they learn how to deal with issues. Focussing on a preventative approach I think is where, if the Salvation Army was asked, it would like most of its money would like to go—the preventative intervention end.

Mr P.B. WATSON: To what age?

Ms Begent: Two years ago, in Alcohol Awareness Week, we did a survey around foetal alcohol syndrome. The results were startling and really quite frightening. They were very frightening—particularly in the rural and remote areas there is a high incidence of Indigenous women who drink whilst they are pregnant. But it is not just Indigenous women—it was significantly high across the board. I would say we start immediately

The CHAIRMAN: This was more in the remote areas that you noticed this problem?

Ms Begent: No, it was across the board. There is a fair amount of acceptance. I am trying to remember that study that was completed two years ago. One of the indicators was around girls between the ages of 25 and 35, which I guess is the party age. When I was that age, that was the marrying age, but these days it is the party–career stage. I would certainly think in primary schools there needs to be different ways of approaching it. It should be part of the curriculum. Because kids grow in different ways and get to different stages at different times, and because children also learn to be relational early on, you need different things outside of the curriculum that can help them. That should filter through not just in things like advertising campaigns but should be really firmly rooted in the beginnings of sporting clubs and the whole way in which clubs and the community focuses —

The CHAIRMAN: So do you think sporting clubs should be advertising alcohol?

Ms Begent: No, I do not; because they are our heroes. In our society they are the people that the kids look up to. They are the kids that they think are cool. When someone like Ben Cousins, for instance, gets caught, a 10-year-old is not terribly fazed that he is a drug addict or he is a drinker; he is a great footballer. All his other behaviours that come along are part and parcel of who he is. That makes him a cool person. In some way we have to change the culture around that. Getting those sporting clubs on board is really important. How we do that is difficult because the Salvation Army knows all too well how many dollars you need to run things. They need those big advertising dollars that they get —

The CHAIRMAN: Do they need it from alcohol? Twenty years ago they said they needed it from tobacco.

Ms Begent: That is true.

Mr P.B. WATSON: When you are in a regional town and you do not have the support of getting funding through, there is a local hotel, which is a community place, and they sponsor football. They do not give people beer or anything like that, but they sponsor football. Do you think they should be looked at differently? If they do not have that, they do not have support. What are your thoughts on that?

Ms Begent: I would have to think about that because I know how important having the local pub involved in the community is; just being part of the community and the place of support that that provides to the local team. It would have to be around how it is managed; how you manage that kind of educative process and how it runs through your training programs.

Learning to play football is not just about playing football; it is about living a healthy lifestyle so that you can play football. So building into the training system those things that are about one drink being okay and quite nice and that we can have a great time, but that more than one can be dangerous, allows kids to come face-to-face with the realities of some of the dangers around excessive alcohol consumption.

Mr P.B. WATSON: That is a good answer; I really appreciate that answer. However, it still gets back to the parents, does it not?

Ms Begent: Yes.

[3.10 pm]

Mr P.B. WATSON: To me, the biggest cancer with alcohol is the parents. Parents tell their kids not to take drugs because it is bad for them, and they do not take them. It was not the same for smoking—they would say do not smoke and would smoke, and with alcohol that behaviour is also accepted. We have to get away from it being accepted that if you want to be a good guy you have to drink. I just do not know how we —

Ms Begent: Yes. I am with you; I agree with you. I do not know how, because our culture is locked into it. There is something about the Australian culture. I think Ireland is probably the only other place where it may actually be as endemic in the culture as it is here.

Mr P.B. WATSON: I think it is in England, too. People used to go down to the pub for a Sunday meal or for a pint and to play darts and things like that. That is embedded. I do not know how we are going to get out of it.

Ms Begent: I do not either. I wish I had a magic wand.

The CHAIRMAN: But we appreciate you being here today, because we are looking at how we can influence that cultural change.

Ms Begent: I think that starting early is the best way to go in prevention. I am not necessarily saying that we need to scare kids into it, because we do not want to do that, but I think we need to be starting with some of those early groups so that kids learn early on what is a good behaviour and what is not a good behaviour. Working with parents has to be part of that. You cannot look at the family in isolation. I agree with you that there is no point running a really good healthy lifestyle program in a sporting club or a crèche or a primary school or a high school, when kids go home to see dad come in from a stressful day and deal with it by having a drink and having another one and steadily getting drunker as the night goes on, and mum taking three or four pills in order to sleep, because they are getting two messages and they are mixed. It has to be a whole-of-family approach. We need to be picking up those other family members as well as working with the kids—and trying to engage parents in the process.

The CHAIRMAN: Do you mean engaging families more in the school?

Ms Begent: Yes—in their children's environment more. It is about getting parents engaged. A lot of parents work seven days a week these days. We do not live —

Mr P.B. WATSON: That is both parents.

Ms Begent: Yes. When I grew up I never went home without my mother being home, but that is not the case for families today. It is an even bigger ask to get families involved in their kids' environment and to engage in their kids' activities, but somehow or other we have to find ways to do that.

Mr P. ABETZ: Prevention is a big area. The Salvation Army has a very proud and long record of working in the rehabilitation area. What are the special challenges that you face in, say, funding and the whole rehabilitation area? What are the challenges? What could government perhaps be doing differently in terms of helping the NGO sector that does so much rehab work?

Ms Begent: Funding is always an issue. There are never enough dollars. I often say, "Give me five minutes with Treasury; I'd like to talk to them!" But the Salvation Army also commits enormous amounts of its own dollars and in our residential rehab we can match the government dollar for dollar, and sometimes more in terms of what we give. I think drug and alcohol services in this state need to be a bit more devolved from residential rehab. A certain group of people require residential rehab, but not everybody does. I think community-based services with access to really good counselling services for periods of time help people to deal with their addictions while remaining in the community. One of the big issues for residential rehab is that people have to come out of their community, often out of their house and their job, to do the program. There are people who require that and who have to do it. But at the end of that residential rehab, they are often without a job and without a house. They may be sober, but they are homeless and unemployed. There is not enough money in those resi-rehab programs to put into employment and training opportunities while they are in rehab, so you cannot provide a really diverse service. Ken manages a rehab centre so he may answer this differently from me.

Mr Smith: I think the early intervention stuff is really important. But some of that intervention, as Jenny was talking about, is the generational intervention stuff—if you are picking up the children early. We are fortunate that we have a family counsellor, a family therapist, on our program. A lot of the interventions are around the family understanding the things that are happening. For a lot of the people we work with, it is not uncommon for some to have picked up their first substance at six, seven or eight years of age. It is often in a party context; that is, they have been at parties where they have picked up the cans of beer at the end of the party, because that is the normality of what happens for them where they are. Sadly, even just a couple of weeks ago, I went to a party with my own young boys—I have a three and a four-year-old boy—for some little boys in foster care; it is the first time they have been in foster care. At the end of the party, one of the little boys said, "But it wasn't really a party." Talking about it with him afterwards, the only reason he identified that it was not a party was that he was used to alcohol being everywhere and everyone being legless. With his new foster family, that was not an option. Yet for this little guy, it was only his fourth birthday, it was not really a party. The connection for him and the perception is that partying is alcohol-fuelled and the parents or adults are off doing other things while the children play on their own in the corner. That flows in for a lot of our clients; they have not known anything different, because they are the behaviours that came through for them as they were growing up—that is their normality; their points of reference.

The CHAIRMAN: Because you are involved in the program, Ken, I was going to ask you how many residential places you have. You were talking about the other community programs that focus on the family networks. Could you tell us, firstly, how many places you have and how many people you can take into your residential program, and, secondly, what programs you run outside of those areas to help people who have alcohol and drug problems? We might then come back to Jenny, because we would like to know about the major problems that you are dealing with, whether it is alcohol or drugs, and the consequences of them. Could you, Ken, tell us about the different programs that you have?

Mr Smith: I will talk about the bridge program rather than the Harry Hunter Centre, because that centre is just one part of it. In the bridge program in Western Australia, we have a continuum of services. Our first service for someone coming in off the street is the sobering-up unit located in Highgate. When you are talking about community impact, we have some challenges around our sobering-up unit. Up until about two years ago, it was a 24-hour unit; it is now a 16 hour a day unit, but it really has an operational capacity of eight hours. When I say that, I mean people start to enter the service at four o'clock in the afternoon, but they have to be in by midnight. We accept people from the police until two o'clock in the morning, but because we have to make sure they are sober before we release them at eight o'clock in the morning, we have now gone from providing that service 24 hours a day to effectively producing that service for eight hours a day. That service, particularly being in the Northbridge precinct, was widely used by the police and the council and those sorts of groups. In the resourcing aspects —

The CHAIRMAN: Is it from four o'clock, because you have many people coming in at four o'clock?

Mr Smith: It is about our staffing model, I guess. I mean, four o'clock has been identified as the peak time for pickup when we can get some flow over into the evening. There has been some discussion about whether we should start that at six o'clock, so that we can accept people until two o'clock in the morning—that is, take them in later. But it really is a resourcing issue and is about the funding available to run the program. We were fairly fortunate that the AERF—Alcohol Education and Research Foundation—also funded it for a couple of years. One of the initial stages for us would be to have that service available all the time. The capacity building in that area could be done with the police, the transit police, the local council, the rangers and the Nyoongah Patrol. Our program works quite widely with those people, but the availability of our service to them now is quite restricted—as I said, it has gone from a 24-hour service to a service with a functional capacity of eight hours, in the real sense. For the following eight hours we are working with the people to sober them up, but we are not taking anyone else through the door. Down on that same —

The CHAIRMAN: How many beds are there in that sobering-up unit?

Mr Smith: The sobering-up unit has, I think, 28 beds, but I would need to double-check that figure.

Ms Begent: Yes.

Mr Smith: Yes—28, but I would need to double-check. I do not work directly in that area. Yes, it is 28 beds in the sober-up unit. Then we have a detox unit as well. The detox is a five to seven-day residential detox service we run also from Highgate at the same service.

The CHAIRMAN: Do they go from the sober-up unit straight into the detox?

[3. 20 pm]

Mr Smith: They can on occasions. A number of people who go into our sober-up program are frequent fliers, if you like. They are people who come in and out on different occasions, such as a dry-out night to get over, but are not really people who are ready to take that step to want to do something about it. Certainly, if there is a bed available and people want to go into detox, as best as we can, we try to incorporate them straight from sober-up to detox. That is not the normal pathway for a lot of people because a lot of them bounce around in and out of sober-up for quite a time before they say, "Hey, I need to do something about this." There are the sober-up and detox programs. Within the program at Highgate, we have an assessment program.

The CHAIRMAN: The detox was for how many people?

Mr Smith: It has eight beds.

The CHAIRMAN: On average, how many days do they spend on the detox program?

Mr Smith: Usually detox is five to seven days. Because of the nature of what they require, if people require medical detox, they come into us after having been for a week or 10 days on Next Step.

They may come to us from Next Step to address the medical detox issues and then transfer into our detox program and then to our assessment. In a case like that, they may be in detox effectively for 20 to 25 days, depending on how severely affected they have been.

They can then move into our assessment program, which is also based at Highgate. This is continuing the residential model. We have 21 beds in the assessment program. The context of that is that they stay in the assessment program for three to four weeks, working through all the issues to prepare them to go into residential rehab. Working through the issues involves: "Are you serious about this? Do you understand what this involves? Can you do this?" "Do you need to do this?" is the other part of it because some people do not have a really good concept of what rehabilitation is about. Sometimes it is about working out who it will work for and who it will not work for and where they go from there. From assessment they come out to us at the Harry Hunter Centre.

The CHAIRMAN: How many days are spent in the assessment program?

Mr Smith: On average, three to four weeks. That varies a little bit. Occasionally, if people have been through our program before—some people repeat the program down the track—they may not necessarily be in assessment for quite so long if they have a sense of what is happening. At other times we hold people for a longer period in our assessment program, particularly if there are issues around mental health and things like that and we need to do some validation of where they are at in terms of their capacity to deal with the residential program and that sort of thing. The assessment process is fairly full-on. It is living together for 24 hours a day in that setting. It is not coming in and out, as a lot of people might do with some services for a one-hour or two-hour assessment interview. It is very much a live-in program and assessing how people will interact and cope in that setting. From there, they come out to the Harry Hunter Centre, which is our residential rehab program. It is a basic program of 13 weeks, so it runs for three months. It focuses very much on the addiction. But a lot of the things we do are around life skills. We do a lot of stuff around boundaries, assertiveness—those sorts of things. A lot of things very much address the underlying issues such as anger, abuse, forgiveness and those sorts of things. It is a diverse program. We have teaching–education aspects of the program, counselling, group sessions, work therapy—a raft of things happen within that three-month period. At the end of that 13-week period, some of our people apply to stay on an extended program, so we have an extended program. That can roll on very much on a tailor-made basis at that point of time. People who have come through the three-month program may stay with us for another three months or another month; it really depends on the issues they are working through, their counselling, and some of the education things they want to do. The extended part of it is about that involvement back out into the community from where they are at the centre. When they are on the extended program, our clients participate in our program, but they might go out and do one or two days a week part time or volunteer work to get used to being back in the community. That provides reintegration whereby they can come back to the centre if they are stressing, and talk to the counsellor and say, "Hey, this is what's happening for me", and work through some of those issues and come up with strategies. Sorry, Peter.

Mr P.B. WATSON: That is okay; I do not have anything else.

The CHAIRMAN: Can you tell me the youngest, eldest and an average age of people who go on each of the four programs you just described? Do you have statistics? I have not had an opportunity to read this yet.

Mr Smith: They are not in this report. We could provide you with statistics, but we have not brought them in. We can certainly send statistics in.

The CHAIRMAN: That would be useful. What about the ages?

Mr Smith: We are an adult service. We do not take anyone under 18 years; 18 is the minimum age. I have been out at the Harry Hunter service for six years and in that time a 79-year-old has been

through our program. That is exceptional, but we have had people of that age. Our average age is about 33, 34.

The CHAIRMAN: Success rates?

Mr Smith: I guess success is always a bit of a dodgy one when you talk about success. In terms of completion rate and who graduates our program, we are probably sitting at about 45 per cent at the moment who start at the Harry Hunter Centre. I guess when I say that, we need to qualify that, because we have a fallout rate at each of the other services prior. When I say 45 per cent complete when they come to us, within the assessment program, I think the fallout rate is around 50 per cent. That is 45 per cent of the 50 per cent who have come through. Not everyone chooses to come from detox into assessment and through that pathway. That is the residential aspect of it.

One of the big opportunities for us is some of the non-residential work we do at the moment as well. We have a program called the continuing care program, which is a community counselling program. That is working with the clients of our services who have been through our programs and are leaving so that they can have ongoing counselling. We are also working into the community, so it is open to the community through the continuing care program. We currently have funding from DOA at the Harry Hunter Centre for an out-reach support worker as well. Out-reach is one of the areas I think, strategically, we should be looking at investing in. We have a worker at the moment who works with a client group of 25 people who live in the program. Currently, because we have the one worker, they generally work with people who are leaving the Harry Hunter Centre—sometimes on completion and sometimes because they have left early because they have relapsed or whatever. We are, working with people who are in a relapsed position with everything. The opportunity for that outreach support is incredibly powerful, if we can put the resources back into it. Even for some of the gaps between detox and sobering up in some of those early stages, to be able to work with people at those crisis points and try to bring them through would be a really powerfully important thing that we could do. There are numerous instances, for example, I can think of a girl who came through fairly recently, who had a major psychotic incident and was hospitalised, who in the past would have been pushed out from where she was. But her out-reach worker was able to work with her all the way through, keep her in the accommodation she was in, keep her sobriety going and keep things moving from there. She has gone very well. The outreach side and the non-residential support are really important. Then we have chaplaincy and other services that go with that as well. It is about trying to work to get the whole person back into the community.

The CHAIRMAN: Before we come back to Jenny on the main drugs or alcohol, how many places do you have at rehab? Are you able to say that, for the percentage of people you have for those four programs, what is the percentage of non-Indigenous and Indigenous people?

Mr Smith: At the moment we have 40 places for rehab. Some building work is starting this week, in fact, so there are another 12 beds going into the service. The present 40 will bump it up to 52 in the next six months or so. In terms of the breakdown of Indigenous people, that varies at different points through our program. We have a high Indigenous intake at our sober-up unit particularly and, to a lesser extent, at our detox unit. As we go further through the program that up-take rate drops off. Percentage wise, in terms of Indigenous people coming through at Harry's at the moment, about five per cent start the program, and, of those people, not a lot of people complete for a range of reasons.

[3.30 pm.]

The CHAIRMAN: So five of the 45 per cent?

Mr Smith: Five of the total group that come up there. In terms of who completes, we often find, depending on a lot of the external factors that are buying into it—family requirements that they are going back and things like that—we have transferred a number of our Indigenous guys to a couple of the other northern services up in Broome and things like that, because they want to be back

closer to their family units. So we have worked with them through the program, up into the beginning of the program and got them started and then transferred them part of the way through and got them up into different services. At other times it is just the external pressures that happen. On occasions we have had carloads of people coming to collect their brothers that need to come out and not be there any more. That has really been quite forceful at times. We have had to physically take a stand and say, "This is not really right." But they end up going because that is what they need to do in terms of saving face in their cultural sort of setting of where they are and things like that. So certainly to some of our Indigenous clients when they come through it is a hard ride—a really hard ride.

The CHAIRMAN: Jenny, if we move back to you: is the problem alcohol; is it cannabis; is it other drugs? Ken just mentioned that the Salvation Army do not just have support services in Perth but you have support services elsewhere. So is it alcohol; is it cannabis, is it other drugs; and does it vary? In what other parts of WA do you provide these support services and does it differ in those places in terms of what is the major problem?

Ms Begent: In WA our support services regionally and rurally are generic services, so they are not specific drug upon drug but they pick them up in their service responses, whatever that may mean. It is generally accommodation responses and emergency relief responses. Alcohol is certainly the high incidence in Indigenous communities. There is some cannabis use but not very much. Alcohol is the real issue there. In metropolitan areas and large rural towns it is a mix. Young people today are poly-users; they do not use just one thing; they use pretty much everything. The rise of the party drug and the party drinks is a lethal combination in residential services.

The CHAIRMAN: How do you mean "residential services"?

Ms Begent: I have been in social services for over 20 years and I have been where Ken is. When I was first working in drug and alcohol services we dealt mainly with alcohol users and some cannabis, not a lot. It was a reasonably safe client group to work with. Then we had in the 70s and 80s the advent of heroin and cocaine, not so much cocaine in this country but heroin certainly. That changed the nature of the client, but it was still a relatively safe working environment. In the late 90s and now in the 2000s, with the use of party drugs, speed and benzodiazepine being on the rise, those clients can be dangerous, and they can be dangerous in a split second. So the working environment in residential services, working with that client group, is volatile and can be, unless managed well, quite dangerous. It is different. Certainly in rural and remote and definitely in Indigenous communities it is alcohol, so it is still a reasonably safe environment, if you can call that a safe environment, but the risk to workers and other clients with a poly-drug user can be quite difficult. So residential rehab I think needs a rethink right across the board in the way that it is managed and how it is funded and costed, and a fixed funding formula around residential rehab placement would be great. And I think there needs to be significant work done around that so that we are able to provide the service both to the client, to the full extent, and also provide an environment whereby you can work with the client. Right now I think we are at a stage where we are struggling to do that and to do it well within existing funding guidelines. What was the other question?

The CHAIRMAN: It was the drug and what services, because the committee had just come back from a visit to the east and west Kimberley, where alcohol was a big problem for both Aboriginal and non-Aboriginal people. In some of the places we heard of hotels with a turnover for some of the tills of $25 000 in an hour.

Ms Begent: I can understand that. We have services in Karratha, which is not quite as high up, but significantly, too. We would not get a client through our accommodation service in Karratha who did not have an alcohol addiction of some varying degree.

The CHAIRMAN: Peter has been doing some research in relation to models being used in other countries to tackle this issue. I might let Peter explain the Swedish model to you, because once he

has explained that, I would like to ask you some further questions. Could you maybe just explain that model?

Mr P. ABETZ: Basically, the Swedish model particularly applies to the illicit drugs. They went from being fairly much down the harm minimisation kind of road, and it blew out their mental health budget, so they had a change of heart and they basically developed a zero-tolerance approach. But instead of putting people into prison when they come before a court for being in possession of even small amounts of drugs, they are given the choice, "You go to jail or you go into rehabilitation." It is, shall we say, forced rehabilitation, but once you opt for that, if you abscond or anything like that, it is straight into jail. You have regular urine, blood tests, or whatever it is, and the minute you show positive it is back to prison. So it is pretty regimented. The result has been that they now have the lowest illicit drug use in Europe, with only 2.4 per cent of the population in the past 12 months or whatever it is saying that they have touched anything illicit. So it seems to be working extremely well. It is something that focuses on trying to get people into a drug-free lifestyle. I think the Salvation Army has been one of the few rehab services that, despite the trendiness of the harm minimisation Road, has always maintained that your objective is to get people living a drug-free or an alcohol-free lifestyle. Do you have any comments on that?

Ms Begent: I am familiar with the Swedish model. Yes, I do have some comments. I think it is a really good way to go with those people who are small-time users, or maybe a third or fourth-time user. I say that because prison is expensive, and we all know what it costs to keep a prisoner. It is half that to keep someone in resi-rehab. So for governments to look at models like that I think is an excellent idea because it is about the useful use of public moneys. But, secondly, I think the other thing about it is that young people in particular need to learn to live different ways, and they have not learnt that. Living in those drug-free environments helps them to do that. It has to have a skill base to it, though, because kids have to learn. They need the skills to live drug-free. It is not just about removing the drug. It is about skilling them to live without the drug.

The other thing I think we need to be careful around that, though, is the cultural imperatives. I mean it is an Australian culture as opposed to a Swedish culture. One of the things that the Salvation Army does sometimes is that we look to the United States for some of our practice in terms of our social work or our social context, and it rarely translates well from the United States back into an Australian culture. Whilst I agree that we need diversion for those kinds of things rather than prison, how we play it out in our environment will be crucial as to its success.

[3.40 pm]

I think we need to be really careful about how we do that. I would suggest that those services need to be flexible so that we do not take a one-size-fits-all approach to a client. They need to be innovative so that we can work outside of the box with a client. I am just trying to think of an example. You get a first time user who needs to change their drug habits. They get the chance to go into resi rehab, and they abscond. Is it a good idea to send that person straight back to jail, or can we be innovative there—do you know what I am trying to say there?—so that that it is tailored to the client's need and we look at the client as opposed to looking at the system. Sometimes what happens for clients, and one of the reasons they do not live drug-free lifestyles, is because they get system response rather than client response. That is difficult, because when you run big resi programs it is hard to be flexible; you have got to have rules and guidelines and all of those kinds of things. But the more flexible we can be with systems, I think the better the outcomes will be.

The CHAIRMAN: It has been suggested to us as a committee that for some Aboriginal people, a fine or prison is the easy option rather than going into a treatment program.

Ms Begent: I would suggest that too.

The CHAIRMAN: So it has been suggested to us that we should have those treatment programs rather than putting these people in prison. In fact, on our Kimberley trip we were told that prison is

often seen by some Aboriginal people as a bit of a holiday, because it is three meals a day, there is a gym there, and it is a break from the family and the problems that may have caused them to go to prison. As you have said previously, the cost several years ago was over $100 000 a year for each person who is in prison, and I am sure the costs will not have gone down over the past few years. If things are as you say, how can we get, not a model that has just been taken from elsewhere and put in here, but a model that really fits? The model might possibly be different in the Kimberley. If we think about Broome prison, that has 99 per cent, if not higher, Aboriginal prisoners, and the majority of them are in there because of alcohol-related problems. If a program could be introduced that was tailored to the surroundings and the environment and the problems —

Ms Begent: Yes. That is the key to it. I agree with you. Fines do not get paid. Let us just shrug our shoulders and get over it! People do not pay their fines! A prison term because people have not paid a fine does not solve the situation, because they go to prison for a $500 fine and it costs us $20 000 a week to keep them there. So that it is just ludicrous when we think about it in those terms. But it does need to have the environmental and cultural aspects that will make it work for them.

The CHAIRMAN: I missed that word "cultural". Thank you!

Ms Begent: I would not send them to prison. If I was being blunt, I do not understand why governments do send them to prison, because it is a political hot potato to lock the Indigenous up for really small crimes, and it gets the entire community offside, not just one or two. There has got to be a better way to do it. It has to be done in relationship and in conjunction with the Indigenous community so that we do tailor it towards them. I think it is a much better option than prison— absolutely. I would like to explore some of that with you later on.

Mr Smith: Potentially, another move away from that in terms of the flexibility is that it is not just about the residential intervention but also having very strong intensive case management options that can be provided within the community too, and regionalising it so that is not about dragging people back to a central point all the time and saying, "Come here and we will fix it for you", but having the availability of those services to work in those environments. That should also not be just a slack, "Yes, I am seeing a counsellor once a week and everything is good now", but really quite intensive case management with an agreed contract where people know that this is what they are committing to and there is a consequence. People need to understand that there are consequences for their behaviour. Certainly the option of just putting people immediately into a residential program can actually be counterproductive on a lot of occasions, too. We see that on occasions with our current drug diversion programs and some of the other therapeutic jurisprudences around the place, where people get moved out because they are keeping themselves out of jail and that is really what they want to be doing, but then the negative impact that can have at times on the other 30 or 40 people involved in that community is intense. For some people, that shift happens. We work with people, and we can see that shift happen, and people get it and they move on and it is really great. But at other times, it is just a nightmare all the way through and they do not get through that anyway. So it does really need to be that intensive case-by-case situation that you have been talking about.

The CHAIRMAN: Unfortunately, time is limited. The committee had hoped to ask you some questions in relation to the cost of alcohol and also the strength of alcohol. One suggestion that has been put to the committee is that after midnight in some pubs in some areas the beer should be only low-strength beer.

Ms Begent: Why are they open after midnight?

Mr P. ABETZ: Good point!

The CHAIRMAN: You are right. There is a bill on the table at the moment that says that nightclubs are to close at five o'clock —

Mr P. ABETZ: Instead of six o'clock in the morning!

The CHAIRMAN: But it does not say that pubs should close an hour earlier. A lot of the drinking we know is done in pubs. You might like to think about things like opening hours, the number of liquor outlets, and the cost of beer. In New Zealand they have just amended their legislation so that a person under the age of 20 is not able to buy alcohol —

Mr P. ABETZ: Takeaway alcohol.

Ms Begent: So they can purchase a glass of beer but they cannot go to BWS and purchase beer?

The CHAIRMAN: Yes. We need to think as a community about what measures can be introduced, because particularly for younger people there is this culture at the moment that it is okay to binge drink.

Ms Begent: Absolutely.

The CHAIRMAN: We can take only a quick summary from you now. But when I do the final formal part, I will say that you are able to supply us with additional information. So if there is anything that you would like to say on this issue now, please do so; and, if not, you could take it under consideration and get back to us on some of those issues. We are looking at what measures can be introduced. Another thing is the use of plastic glasses to stop the very serious, nasty injuries. Do you want to maybe sum up with some of those things now?

Ms Begent: Okay.

The CHAIRMAN: Just sort out all the problems for us! Two minutes!

Ms Begent: Sure! Cool! I do not understand why pubs have to open beyond midnight. I do not get it. It does not make any logical sense to me at all, particularly when, if you want to keep drinking, you can go home, where you are actually much safer if you go home than if you stay in a pub on the street between midnight and whatever. I understand the nightclub issue. But I still think why on earth would you want to be partying at four in the morning, and at what point have you lost any consciousness that you are partying? Maybe I am the wrong generation or something, but it just is not logical to me. I am not sure about the alcohol content. We are an abstinence organisation, so I cannot speak from any experience on the matter, but I am not sure how you can reduce alcohol content when you are making a beer or making a whiskey or whatever. So I am not certain. I do not think I could answer that with any clarity. I think we ought to be much more mindful around advertising. I think we need to look at the way we make it trendy and cool for young people, because right now it is. I did like what the commonwealth government tried to do around those "girly drinks", I think they called them

[3.50 pm]

The CHAIRMAN: Alcopops.

Ms Begent: Alcopops. But I do not think it went far enough. I do not think that drinks should be targeted to a youth market at all, and why would they?

The CHAIRMAN: That comes in with the advertising again. In some countries, like France, it is banned; France banned alcohol advertising in 1992.

Ms Begent: I do not know why we do not because, for example, smoking has survived. I do not think that the manufacturers' idea that they will lose billions of dollars is valid. The question I would want to ask them is: how rich can you be? Remove it altogether, we do not need it, it is not helpful. It just makes it way too acceptable, and that, I think, will go a long way towards changing the culture around the attractiveness of it for young people.

The CHAIRMAN: Ken, is there something you wanted to add?

Mr Smith: Just on the back end of what you are saying about the costing, I think that one of the challenges around the costing issue, about trying to price things out of the range of people is that if we are not careful, it could have a double impact. It could go back into creating problems in terms

of criminality, particularly where there are really severe addiction issues. People who are really caught up with their addiction are going to get their drink or whatever, no matter what. If that is going to flow into criminality issues, that is a really major issue.

The CHAIRMAN: I think that people are saying a minimum cost for a standard drink, so that bottle shops cannot sell clean skins, for example, at two dollars a bottle, or enormous casks of wine very cheaply.

Ms Begent: They are a step up from methylated spirits!

Mr Smith: The other costing issue is the social impact. For people with severe addiction, it just means that they are going to feed their addiction no matter what, and their children or wives will go without and they will lose their house and everything else. There are much broader social issues that come out of a purely cost-driven response, they can make a broader impact, community-wise. That is just to comment on what you are saying about the cost-driven response.

Mr P. ABETZ: If you could change one thing, what would you change in terms of legislation and rules?

Ms Begent: The advertising. The hold it has on the culture is the thing that most keeps us where we are at. I think changing the way people view alcohol is something important, and that can be done with really good advertising and community investment.

The CHAIRMAN: I would like to thank you both very much for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. However, should you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript of evidence. Once again, thank you very much for coming today.

Hearing concluded at 3.53 pm