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 BROOME
SUNDAY, 1 AUGUST 2010

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 10.12 am

LOVISON, MS MARIA
Chief Executive Officer, Milliya Rumurra Aboriginal Corporation, examined:

COOLE, MS JILLIAN SUSAN
Clinical Team Leader, Milliya Rumurra Aboriginal Corporation, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee I thank you for your interest and your appearance before us today. I acknowledge and pay respect to the traditional owners, past, present and future, of the land on which we are meeting 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 in Western Australia. At this stage I would like to introduce myself, Janet Woollard, and also Mr Peter Abetz, who is the deputy chair. We have with us our research assistant Grant Akkeson and, from Hansard, Judith Baverstock and Keith Jackman. The Education and Health Standing Committee is a committee of the Assembly. This hearing is a formal procedure of Parliament and therefore commands the same respect given to proceedings in the house. This is a public hearing and Hansard is making a transcript of the proceedings for the public record. If you refer to any document during your evidence, it would assist Hansard if you could provide the full title for the record. Before we proceed to the questions we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

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

The Witnesses: Yes.

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: We have had some hearings down south to look into alcohol issues and problems with alcohol, cannabis and other drugs. This week we have been focussing on the problems in the community. We are hoping to find some recommendations that we can make that may help address the problems. We are very interested in hearing about the work that you do. Could you describe the work that you do, and in that description try to bring in whether people who come into contact with your service have problems with alcohol and other drugs. You will have seen that we are looking at the area of education and whether the professionals have the training to help people, what programs are available, what programs need to be made available, and what are the social costs of those things. Who would like to go first, Jill or Maria? Alice Murphy has just joined us. She is also one of our research officers.

Ms Lovison: Milliya Rumurra was first set up in 1978 because local Indigenous people and non-Indigenous people were concerned about alcohol and other drugs within our communities, not only in Broome but also in the whole Kimberley region. Those concerns are still being heard today. As

you know I have just had a conversation with Grant about the local implementation plans. The alcohol and other drugs problem has been voiced by communities in the COAG sites. Beagle Bay in particular has requested Milliya Rumurra to work with them on this issue. We have just attended the Billard summit this week. Alcohol and other drug issues were also voiced at that summit. It is an issue with most of the communities in the areas that were represented at the summit, so basically Australia-wide. The programs we deliver range from those on anger management to those on cultural identity; parenting; and the affects of alcohol and other drugs on people's bodies, their families and their communities. In regard to education, I have had discussions with Beagle Bay already. They would like me to start looking at bringing alcohol and other drugs education within the school system. That conversation was held with the health committee out at Beagle Bay and also with the principal at Beagle Bay. We have had that discussion. We also have education within our corporation. We continuously provide training for all staff. We have just had first-aid training for all staff with the Red Cross. We are now looking at having mental health first-aid training. Jill, did you want to add anything more?

Ms Coole: Some of the programs also involve relapse prevention for people leaving rehab or even in a community setting—strategies that they can use to minimise their use of alcohol and, mainly, cannabis. We also have education programs in the community for other organisations and things like that if they are looking for guest speakers and that sort of thing.

The CHAIRMAN: How many staff do you have, and how many people would be in your programs here in Broome? Do you have any statistics on how many people, maybe over the past couple of years, you have helped here, what communities they were from, and how many people you are helping in other communities?

Ms Coole: We have a six-member clinical team. Milliya Rumurra is actually quite a big organisation, so there are other staff members ranging from cooks to cleaners, gardeners, admin and that sort of thing. There are actually six staff on the clinical team. Four of those are residential staff and two of those are outreach workers as well, who go out to communities to deliver programs and do follow-up care for people who have left. I could not tell you the number of people we have had through the service in the past couple of years because I do not have the statistics on that, being new to the organisation myself. I can say that this year alone, 87 people have been through the service since January.

[10.20 am]

Mr P. ABETZ: How long do you keep them? Is it three months?

Ms Coole: Three months, with an option for longer if need be. That is something we are looking at—actually wanting it to be a bit longer. Three months seems to be a good period of time to get people healthy again, to keep them safe and to implement some strategies, but for actual relapse prevention once people are back in the community, it seems that they need intense support for longer than that.

Mr P. ABETZ: How many do you cater for at one time in your facility here in Broome?

Ms Coole: We have 18 rooms, but six of those rooms are for families, so you may get mum, dad, two children and aunty, depending on who has been the main caregiver in the family situation. There will usually be a particular caregiver from the extended family if there has been long-term substance misuse by the parents.

The CHAIRMAN: Is Mulliya Rumurra unique to the Kimberley?

Ms Coole: Yes.

The CHAIRMAN: It is unique to the Kimberley.

Ms Lovison: But Ngnowar Aerwah Aboriginal Corporation has started as well in Wyndham, so it is looking after the East Kimberley region.

The CHAIRMAN: Who is doing that one?

Ms Lovison: Ngnowar Aerwah. That is another rehab centre up in Wyndham.

Mr P. ABETZ: So there are just the two.

Ms Lovison: Yes. That one is quite new. We are not only unique to the Kimberley region, but we also take in people from right throughout Western Australia. We take from Narrogin —

Ms Coole: Albany, Wagin—all sorts of places.

Ms Lovison: The Pilbara region and the Geraldton area.

Mr P. ABETZ: What is the waiting list to get in? We have heard from a few people that there is a need for more centres like yours because there is a waiting list. Have you got a waiting list, or does it not quite work that way?

Ms Coole: Waiting periods are not actually the main issue. Our waiting times are not actually that high. Probably a bigger issue is actually contacting people to come in to rehab once they have been assessed and we have approved their assessment. We then have to make contact with these people in the communities. The logistics of getting them from a community into Broome in a week —

The CHAIRMAN: How long does it take from someone agreeing that he or she would like to have treatment for that person's application to be processed and for you to be ready to take that person in?

Ms Coole: From the first referral, you would try to make contact within a 24-hour period, if not sooner. The problem we have once again is that very few of our clients have landlines or mobile phones.

Ms Lovison: Remembering that the people who are going to come into the service have drug and alcohol issues —

Ms Coole: Their lives are quite chaotic.

Ms Lovison: Yes.

Mr P. ABETZ: I have worked in drug rehabilitation. I certainly understand what you are talking about.

Ms Coole: We are actually looking at even greater distances as well to try to provide this service as a phone service. You usually try to do the majority of your work at that first referral because that is when someone has actually gone to a service provider or is visiting a community and has accessed a phone. You try to do the majority of your work then, which you will do, but then there will be a period of not being able to contact these people for various reasons. That is a huge issue.

Mr P. ABETZ: And often they move on again, I guess.

Ms Lovison: That is where we utilise our outreach workers for those periods. We might say, "When you go to Bidyadanga, we have had a phone call from or a referral for so and so. Can you go and check up on them, sit with them, and maybe do your assessment face to face while you are there?" Where there is no contact, and if we are travelling in that region, the outreach worker will be used to chase up those clients.

The CHAIRMAN: So would you like to roll out your program to other places; and, if so, where?

Ms Lovison: We would like to do it in all communities, if we got the funding to do it. We would like to see alcohol and other drug workers located in all these communities.

The CHAIRMAN: When you say all these communities—I do not have my map on the table at the moment —

Ms Lovison: Mainly the big communities like Halls Creek, Bidyadanga, Fitzroy Crossing, Warmun, Kalumburu, Umbulgari, Beagle Bay, One Arm Point, Lombadina Djarindjin, and maybe up the Gibb River.

The CHAIRMAN: Balgo?

Ms Lovison: Balgo, yes. Mulan, Bililuna—all those communities.

Mr P. ABETZ: None of those communities at the moment have a full-time drug and alcohol worker?

Ms Lovison: No, none of them.

Ms Coole: Very few of those communities have full-time anything. It is fly in, fly out.

Ms Lovison: We are finding that the people coming to our sobering-up shelter are coming from those regions as well.

Mr P. ABETZ: What about housing? One thing we have heard from a lot of service providers in the past week is that even if they get funding for a position, there is nowhere to house that person. Is that a problem for you as well?

Ms Lovison: Well, it would not be a problem if we are going to use community people to work with us.

The CHAIRMAN: Do you use local people then? Could you explain how you use community people?

Ms Lovison: That is what we would like to do. We would like to have local alcohol and other drug workers in these big communities—people who live there, so they will already have their housing there. Our issue would be to support and train them to work in those areas. Our outreach workers give that support when they go out.

The CHAIRMAN: So training local Aboriginal people, or both Aboriginal and non-Aboriginal people? How would you see it working in those areas?

Ms Lovison: Well, whomever the local communities wanted to appoint. They would appoint somebody and we would work with them. That is our ideal and what we want to do in the future.

Ms Coole: That came out of the summit we have just been to. People were saying that they want to make their own choices and have their own people in the community to do this. It has not worked that well in the past where service providers have flown in. They are calling us seagulls—we are flying in, working on the problem and then flying out again. It needs more consistency.

Mr P. ABETZ: What is the challenge in actually training up people? The impression I have gained—it may not be an accurate impression—is that in a lot of the communities, a lot of the people are not that literate or are not that well educated. To take somebody who is perhaps just able to read and write and to train that person up to be a drug and alcohol counsellor, you have got quite a way to go there. How do you envisage doing that? I would imagine that would be quite a process. What do you think?

Ms Lovison: It is hard, but we have to start looking at ways to work with the community and have the community control these things. One way of doing that is by having the communities appoint these people and maybe having the training go out to them. If we had four or five people in one area, maybe we could get trainers to go out there and do the training instead of those people leaving their communities for two or three weeks. I think it is about the system changing to suit community people rather than us imposing our way of working on them. Of course funding is a big issue. If we could have funding and if we could take the training out to the communities, who had appointed their own people, I think we would be halfway there.

Mr P. ABETZ: What is the issue in some of the communities? We heard that some communities have problems with family feuds, so if the person who has been trained up is from one family group, that family group will make use of that person, but there is no way that the other family group will visit the person because of the long friction that has been there. How do you envisage overcoming that, or is that only limited?

Ms Lovison: I think the communities themselves need to overcome these issues rather than service providers coming in and trying to overcome these issues. I think the communities need to appoint the people they think are going to be the best people for their communities, and then we would work with the community and with that person. Remember too that a lot of people who come through us are back in their communities. They already know the service and what is required. Some of them could be ideal AOD workers. They would just need formal training to get them working.

Ms Coole: There does not seem to be as much emphasis on family feuding up here. I am originally from down south where I dealt with a lot of Nyoongah communities. The situation is very different up here. Down south there would be two agencies for one town and one family group would use one agency. That is not as prevalent up here in the Kimberley. The feuding seems to involve more individual situations instead of the whole family taking on that feud forever and a day. It is actually a little easier for me to deliver those services.

The CHAIRMAN: Are most of the people who come to you coming to you because of alcohol problems, or do you also get people coming into your program because of cannabis and other drugs?

Ms Coole: Mainly alcohol.

[10.30 am]

The CHAIRMAN: When you say mainly alcohol, is it 70 per cent or 80 per cent?

Ms Coole: Probably 80 per cent alcohol, with poly-drug use being cannabis.

The CHAIRMAN: So cannabis and —

Mr P. ABETZ: Amphetamines and heroin?

The CHAIRMAN: The highs. Not seeing those yet?

Ms Coole: We do not see anyone coming in for heroin use. That is not to say that it does not exist up here because it obviously does, but for our service, it is not a service that people are choosing to use. There are very, very few with amphetamine use.

The CHAIRMAN: So probably 70 per cent alcohol and then 20 to 30 per cent cannabis.

Ms Coole: Yes.

Mr P. ABETZ: But the cannabis people also have an alcohol issue.

Ms Coole: Absolutely.

Mr P. ABETZ: In a sense, 100 per cent of the people have an alcohol issue, but some also use marijuana.

Ms Coole: Yes, poly-drug use. On top of that, there are the mental health issues that come along with those.

Mr P. ABETZ: I am not sure how long the service has been running, but have you got any indicators of how successful the rehab is in terms of, say, two years after people have left rehab? Are 60 per cent of participants still living a drug-free, alcohol-free lifestyle, or are 20 per cent? What sort of success or otherwise do you have?

Ms Lovison: It is funny; I had this conversation at the Billard summit. Somebody asked, "Well, what's your success rate?" I said that it is hard to really state what our success rate is. For me, our success is people coming to us in the first place and saying, "I have this problem. I want to do something about it. I want to come into your service." Or it could be that they have gone through the whole three-month program. Is that a success? I do not know. Or is it that they have stayed off it for a year. Is that a success? We have not seen them for that whole year; they have not come back to us, is that a success? I do not know. We have not seen any research about our service. That might be really good research that we should undertake. I have been saying that we should have a book about all the people who have come through our service and that we should find out where they are now. Maybe that will give us our success stories.

Mr P. ABETZ: My experience of people in residential rehab has been that they really need post-rehab support where somebody meets with them one-on-one, or at least if there is a number of them in an area that they get together once a week as a support group to continue on the journey. Even after they have done rehab and learnt some new life skills and all that, it is still a pretty tough journey for them. Especially if they go back out into a community where alcohol is all around them, the temptation to succumb to the old ways is just so great.

Ms Lovison: That is right, and that is why we rely so much on our outreach workers. Now we are even looking at community mentors, where we identify strong leaders within the communities and then get them maybe to work with our clients when they do go back to their communities. That is one thing we are kind of looking at. We have not done it yet formally. Informally we have contacted people and said, "So and so is coming back to your community, can you just watch over them for a little while when they get back."

Ms Coole: The relapse prevention is much more difficult to provide up here because we do not have access to training facilities like TAFE. Part of your discharge plan for people leaving rehab is to help them develop life skills and to further their education and training so that they are employable and things like that. Up here you are actually sending people back to the exact same situation that they came from.

The CHAIRMAN: The same social situation that caused the problem.

Ms Coole: Nothing has changed out there and nothing has changed even in their family group. It is very difficult.

Ms Lovison: One thing we do is discharge plans. We get them ready for when they leave our service by putting support referrals in place for them to give them extra support. But like Jill was saying, they just go back to their communities and to the same situation basically.

The CHAIRMAN: Have the liquor bans made a difference to your work?

Ms Coole: No.

Ms Lovison: Not really.

The CHAIRMAN: Have they made a difference to the people you send back to their communities? Would people come to you and then maybe refer back to you, or do they get only one shot?

Ms Lovison: No, they can come back any time they want. If they go back to their communities after doing the three-month program and, within three or four months, they feel like they are getting back into it again and they want to come back, they are welcome to come back.

The CHAIRMAN: Have they discussed the liquor bans with you and the influence it has had on communities?

Ms Coole: No, but we discussed it a bit at the summit that we have just been to. That was one of the questions I was asking other people and service provides—whether they felt that it had made any difference. The majority of people were shaking their heads and saying that it had made no difference at all because people were going elsewhere to source the alcohol, which then sets up a

whole different set of problems of people being away from their community and their family members for longer. They are staying longer in other communities waiting for their next Centrelink payment to come through. So there is a whole set of other problems that have arisen from that.

The CHAIRMAN: Some people have asked us for the bans to be implemented Kimberley-wide because they may have gone alcohol free, but people are still taking it back into the community. Were the bans and maybe an extension of the bans discussed at the summit? Will there be a report presented from that summit that we would be able to —

Ms Lovison: Yes, they said that an action plan would be developed and distributed in a couple of weeks to people who attended.

Mr P. ABETZ: I think for people working in rehabilitation, even if the alcohol problem were halved in the Kimberley, you would still be flat out—you would not see that much difference because you are still being hammered; people are knocking on your door wanting help. I think one of the difficulties of working intensely with people with such needs is that you cannot see the bigger picture—the aerial view, if I can put it that way. People who have travelled through Fitzroy Crossing and Halls Creek say that the towns are just so radically different. There has been a huge improvement in Halls Creek. School attendance has gone from 33 per cent to 79 per cent. That has to be a really positive thing in terms of getting kids to school and all that, but it is certainly not the be-all and end-all. I do not think anybody would suggest that it is, but it gives that opportunity to hopefully put extra services in to maximise the benefits that the restrictions have opened up. Is that how you would see it?

Ms Coole: Yes, it is. People have the image that a lot of our clients are alcoholics who drink every single day of the week. We do have clients who come in who have huge long-term alcohol issues, but the majority of our clients are coming in with legal issues. It is to do with the courts.

The CHAIRMAN: With the courts sending them to you?

Ms Coole: We are not a mandated service, so they come voluntarily, but they are given options of whether they would like pre-sentencing.

The CHAIRMAN: To attend a program, so it is a pre-sentencing option.

Ms Coole: Yes.

The CHAIRMAN: That is good.

Ms Coole: We have the Indigenous Diversion Program.

Mr P. ABETZ: We were told, I think it was in Fitzroy Crossing, that there are just not enough slots to access the drug and alcohol counsellor, so the only people who are seen are the ones referred by the courts.

Ms Coole: That is right.

Mr P. ABETZ: So a person who has not got in trouble with the courts yet, who says, "Hey, I've got a problem; I want to see a drug and alcohol counsellor," is told that he cannot see one. That is pretty hopeless.

Ms Coole: That is right; it is not promoting self help. Some of these people are binge drinkers, so they are not long-term alcoholics. They are binge drinkers and it just so happens that when the situation happened they were drinking and it has come to the attention of the courts, so then it becomes a drug and alcohol issue. But it is not actually a drug and alcohol issue it is a social issue—overcrowded housing, family violence, unemployment, boredom and all sorts of issues—but it is deemed to be a drug and alcohol issue.

The CHAIRMAN: Who funds your program? Therefore, who would fund an extension of your program? Have you prepared a business case to extend your program?

Ms Lovison: We get funding from two areas—the state and commonwealth governments. State funding is through the Drug and Alcohol Office and the commonwealth through OATSIH through the Department of Health and Ageing and through Aboriginal Hostels Ltd. We have not started a business plan in the way you are talking. I guess our business plan is going back to the local implementation plan in regard to taking our service out to the communities. I have already started consultations with one community about that. I set up another meeting with One Arm Point at the summit as well.

[10.40 am]

The CHAIRMAN: When would the right time be to ask for additional funding for those areas?

Ms Lovison: As soon as I complete all the consultations with the COAG communities. As soon as the community consultations are completed, we will develop a working document agreed between Milliya Rumurra and the community. We will trial the services that they have requested. I think I would contact COAG after that for funding for AOD workers to be located in these COAG sites, because I could use the document that comes straight from the community as well as service delivery for that time to show that, yes, this is working and this is what the communities want.

The CHAIRMAN: When you receive that paper from the summit, could you send us a copy of it? We will send you a copy of this transcript. It would be nice for us to look at the recommendations that came out of that summit and to compare them with the recommendations that we, as outsiders, think might be applicable across the Kimberley. That would be very useful. There is another thing I am going to ask you. You are involved with people who have problems with alcohol and drugs. We know that bans have been introduced in different areas, but we also know that there are loopholes to those bans. Have people told you that? Do you know what some of those loopholes are?

Ms Coole: This once again comes from the summit, because it gives you a good opportunity to discuss things with people. A lot of people are setting up home-brew kits. Quite a few problems come from that, such as health problems with people using pure alcohol. People are also setting up home-brew kits in the community, or members of the community are setting up home-brew kits, and then making good money from other people by actually selling the alcohol.

Mr P. ABETZ: It would take quite a few home-brew kits to brew enough to get drunk on. One of my boys was into home brewing for a little while.

Ms Coole: I would say that that is the problem; it is going on at quite a large scale.

The CHAIRMAN: With the heat here and the added sugar —

Mr P. ABETZ: It would be fairly tasty and go a bit quicker.

Ms Coole: That is what we are looking at; the process is not being done properly and then there are the health aspects of people being poisoned. Then there is the continual problem of people bringing it into the communities as well—by people in positions of power and respect as well.

The CHAIRMAN: Are taking it into the communities?

Ms Coole: Yes.

The CHAIRMAN: What about purchasing alcohol? Have you heard of any loopholes in relation to purchasing? Are there some areas where you have to have a car to be able to pick up alcohol? Is it Fitzroy where you have to have a car to drive through and pick up alcohol? Which community is it?

The Advisory Officer: Broome is one. Derby is one as well.

The CHAIRMAN: I think it is in Broome where the taxi service is round the corner from the liquor outlet. I was told that people can pay a minimal amount to go in the taxi to drive through and pick up their alcohol. One of the cards that people are given and that they are not allowed to buy alcohol with —

Ms Coole: The BasicsCard, yes.

The CHAIRMAN: We have heard that some taxi drivers in some areas will charge them more for the fare and then buy the alcohol for them and put it in the boot. Have you heard stories like that?

Ms Coole: You do hear a lot of stories like that, even to the point of stories of actual proprietors in areas holding people's key cards as well. It is more about —

The CHAIRMAN: What do you mean, "holding their key cards"?

Mr P. ABETZ: The ATM cards.

Ms Coole: The people give their key card—their ATM card—to the shop owner, the bottle shop or whatever and then they constantly run up credit during the week. When their Centrelink payment comes in, the shop owner has access to their money and recoups his money—it is a continual process.

The CHAIRMAN: Right. Where have you heard of that type of thing happening before?

Ms Coole: In remote communities where people are not in control of their own finances and the options are very limited—there is only one shop.

Mr P. ABETZ: Laverton had an issue that was quite public a little while ago where the local store owner had 50 or 60 ATM cards. There was quite an issue there.

Ms Coole: Yes.

The CHAIRMAN: I think that the way in which you are doing outreach will obviously get the community involved. What other options are there? It is such a big problem. As Peter mentioned, we are being told that in some areas, even in Broome, the wait for Homeswest housing is eight years for some families. Housing has come across to us as being a big problem. Jill mentioned the problems with crowded living conditions and all those factors that contribute to alcohol use. If the government made money available, what would your three priorities be to try to fix the problems with alcohol and drug abuse that you have up here in the Kimberley?

Ms Lovison: The first priority would be housing, and it would be about transition housing. We are finding that Milliya Rumurra clients go straight back to the communities or straight back into Broome here. A lot of them do not have homes and, as we said, they are going back to the same situation that they were in before they came to us. So transition housing would be really good. It would help them go from Milliya Rumurra to a transition home here in town where we could give them continuous support and help them into employment, education or training, if that is what they need. It would be good for them to stay there for maybe six months just to get them going again, but to also be back in society. Another issue is housing back in the communities. We have a grandmother, a daughter and a granddaughter with us at the moment from Halls Creek. They do not have any housing in Halls Creek, so when they go back to Halls Creek there is nothing for them. They will go back into that same situation of trying to stay with family, so they will face overcrowding and alcohol and drugs being there on a daily basis. Having funds to purchase them a place, even a rented place, would be good. I think it needs more than funding; I think it needs a partnership with the Department of Housing so that we can say to it, "These people have come through us, they have identified that they have these alcohol and drug issues and they have done something about it. Let's support them now by giving them housing when they get back or putting them on the priority list when they first come to our service so that when they are about to leave our service we contact you and there will be a flat or a home available for them to go back to." I think it will need more than having funds available. It would be nice to buy them all a house. I do not think that is ever going to happen but I think we need to have good strong partnerships with the Department of Housing and with the communities themselves to support these people when they go back by putting them in a nice home environment.

Mr P. ABETZ: Are you aware of the housing issues? We have been told that even when money is available to build a house, the land is not available because there are some native title issues and all that sort of thing. Are you aware of what is going on? I still have not been able to get anybody to explain that to me. Are you aware of what goes on exactly?

Ms Lovison: That might be a situation in the township areas, but it would not be an issue out on the communities. The issue would be having money to actually build the homes.

[10.50 am]

Ms Coole: And getting tradespeople out there to build them.

Ms Lovison: Land title might be an issue in a town like this. Milliya Rumurra is on Aboriginal Lands Trust land. Something that we have not touched on is that people with mental illnesses are coming through Milliya Rumurra.

The CHAIRMAN: In other hearings we have heard that where it used to be that alcohol was treated here and mental illness there, they are trying to merge the two services because most people who are taking alcohol also have a mental illness. Are you finding the same thing?

Ms Lovison: Yes. In the three and a half months that I have worked at Milliya Rumurra we have had seven medically diagnosed mental illness clients who have had alcohol and drug problems as well. We have found that quite hard on our resources, especially the ones who need that one-on-one intense attention. And finding other services to help us to come in with mental health expertise is quite hard.

The CHAIRMAN: That is two. We shall move to Jill and you can think about whether there is another priority. If the money were there, what would you see as the priorities?

Ms Coole: Early intervention, so education and intervention programs around drug and alcohol use for very small children—we are talking kindy and pre-primary—covering health issues and even protective behaviours around sexual abuse and things like that. We are dealing with people after years of long-term trauma and difficult social situations. People are literally self-medicating with alcohol and substance misuse to dull the pain. As Maria said, people are going back into the same situation of overcrowded houses, so even if you are hell-bent on making a change when you leave Milliya Rumurra, it is very, very difficult when you are going back into these situations. As I said, we are dealing with the end of the scale of people. For me, it needs to go back into the communities and to deal with young children by providing that support and with the confidence to speak as well. That is a huge issue for people in these communities because there are repercussions for speaking out when trying to make changes. They become isolated from other community members sometimes. The other thing that happens is when the person who is helping to make all the changes gets burnt out—they do not have adequate support from service providers or the training to deal with these situations, but they are just doing the best that they can for their own family group as well as the rest of the community.

The CHAIRMAN: There is no halfway house for children in Broome. When people drive around the town they see mothers with young babies lying on the street and young children on the street. Maybe in towns like this—the bigger towns—there should be a halfway house for children. What do you think about that? What do you think should be done for those children who are maybe out on the streets to try to get away from physical and sexual abuse?

Ms Lovison: There is a lack of housing in general here, not just necessarily of a halfway house. It is the lack of housing in general that we need to fix. Sorry, can I go to a fourth priority?

The CHAIRMAN: Yes.

Ms Lovison: The fourth priority I think is about building community capacity around alcohol and other drugs. It goes back to that outreach work, to local AOD workers, and to working with communities and building partnerships with them.

Mr P. ABETZ: I have a question on housing. Somebody at one of the hearings said something along the lines that some houses are being built for Indigenous people but they are four-bedroom, two-bathroom houses, and the person said that that is not the sort of houses they are wanting. Is it still a problem that the Department of Housing is not actually providing the sort of housing that is appropriate for Indigenous people in the communities?

Ms Lovison: I do not really know about that. We have been working with Indigenous people for a long time and for us not to consult with them about their needs would be halfway to all our problems. I think we should be consulting with Indigenous people and asking them, "Well, what type of house do you want for your family here?" and building the houses that they want and not the houses that we think they need.

The CHAIRMAN: What do you think about the punishments here? People are repeatedly going back to prison for drink-driving or cannabis offences—because of the drugs. We have been told that in some instances prison is a nice break away from home. It seems that there is a higher incidence of not just alcohol problems but also cannabis problems in the Kimberley. We have legislation before us in Parliament that is going to probably mean that a lot more people will be sent to prison because they possess cannabis. If prison is seen as a break, what is the way to deal with that? Should it be more work—what do they call them?

Mr P. ABETZ: Diversion programs, I guess.

The CHAIRMAN: Work camps and community work orders. What have people said to you? Have people who have been to prison discussed with you what they have been to prison for and what it is like?

Ms Lovison: We have just come from the Billard summit where the theme was "hard yarns". It is about having really hard talks about the issues that affect us as a community, as a family and as individuals. One of the issues was the affect on families and communities of people taking alcohol and drugs, and that it is time to really start having hard yarns with them and saying enough is enough. I think it would go halfway to solving that issue if people said, "Enough is enough. This is how we are going to deal with it and you either like it or you don't like it and if you don't like it, you leave the community or the house or whatever." I do not think that the way we have been punishing them has really made much of a difference, so we have to be creative not so much in how we punish them but in how we deal with the issue as a whole community. So far, sending them to jail has not really worked. As you say, they keep going back and back for the same offences.

The CHAIRMAN: Does your program need to be a live-in program? There is no program at the prison. I think 99 per cent of the people who are in Broome Regional Prison are there because of alcohol-related offences. The prison service is not running that program at the moment, so who can supply that program?

Ms Lovison: We have just had a conversation with the Department of Corrective Services to run those programs in the prison.

The CHAIRMAN: You have?

Ms Lovison: Yes.

The CHAIRMAN: When you say that you have had a conversation, have you asked whether you can run those services?

Ms Lovison: They have actually asked us.

The CHAIRMAN: They have asked you? Wonderful.

Ms Lovison: We have given them a full program of what we would like to take into the prison system for men and women. We are still waiting for Corrective Services to get back to us.

The CHAIRMAN: Could we have a copy of what you put into them on what you would like to run?

Ms Lovison: Yes, we can give you a copy of that.

[11.00 am]

The CHAIRMAN: I am sure we would both like to support that 100 per cent, because it is so sad that the people in there are not getting assistance.

Ms Lovison: Exactly. We do have a day program with people from the prisons.

Ms Coole: They come out to us.

Ms Lovison: The day program comes to our service.

Mr P. ABETZ: Broome Regional Prison is a minimum-security prison.

Ms Lovison: Yes, but we would like to take our program into the prison. We have said that we could do it two days a week for both men and women. We could hold programs there no worries. We are just waiting for the Department of Corrective Services to get back to us.

Mr P. ABETZ: Governments are always trying to stretch the dollar as far as they can. We are told that to keep a prisoner in prison costs $100 000 to $120 000 a year. Some people, because of their violence, need to be in prison—there is no question about that—but somebody who is in prison because of a fifth drink-driving offence or whatever is in a sense not a danger, unless that person gets behind the wheel. That kind of person could be given the choice of going to prison or going into a residential facility. They might be sentenced for 12 months but instead of doing 12 months in prison, they would have to go to, say, your rehab service for 12 months. If you were given $100 000 for every person who had to be at your service for a year, I suspect you could run that for a lot less than $100 000 —

Ms Coole: Absolutely.

Mr P. ABETZ: So it would actually be a cost saving. If the government gave you that amount of money, you could then run the program for other people as well. You could probably run three people through the program.

Ms Coole: That is it. You would be getting more bang for your buck, basically, as it would be delivered to a group of people instead of individuals. There is a saving. The majority of our clients come in for things like disorderly conduct and breaking restraining orders. It is related to the overcrowding in the houses as well. Someone might be given a move-on order in town because he is street drinking, so of course he has to go back to the family home where his missus and kids have a restraining order against him. Family violence breaks out and the police are called; it is a continual cycle. These people do not have huge, really violent offences against them. We have to read the criteria before they can come—the actual charges and convictions—and it is very much one after another of disorderly conduct, resisting arrest and things like that. They are in the prison system but they are not high-risk prisoners.

Ms Lovison: But going back to your suggestion, remember that our service is a voluntary service. Yes, we could get $100000 for one person to come to us, but at the end of the day they have to make a decision to come to us and they can stay for however long they want to stay during that three-month period. We cannot force them to stay for the 12 months that you are suggesting. They can stay for two weeks and then leave if they want to.

Mr P. ABETZ: A system has been developed in Sweden. I am not sure whether it is connected with alcohol but it is certainly for illicit drug users. They have developed a system where if a person is sentenced, for example, for stealing a handbag from an old lady to get money for drugs, the judge will say, "I sentence you to 12 months jail for your offence. However, you have the option of going to jail or into one of these residential rehab facilities." The real issue is not that the person is a thief;

the real issue is that he has a drug problem. They have to do weekly urine tests and what have you and the minute they test positive again it is off to jail; they have no say in it. But as long as they do the right thing in that rehab facility, they do not need to go to jail. If they complete the rehab with a clean slate, they end up not even having a criminal record—that gets swiped—so it gives them a fresh start. Apparently the success rate is about 70 per cent, in that five years after the program, 70 per cent have not gone back to using drugs at all. To me that seems a much more productive way to go. But you still have the big stick over them in the sense that if they step out of line, they have to go to jail. There is some pressure on them to do the right thing. Could a system like that be made to work in Indigenous culture?

Ms Lovison: In a sense it is kind of working the same now with the pre-sentence condition that we have.

Mr P. ABETZ: That is true.

Ms Lovison: In a sense it is kind of happening now.

Ms Coole: If they leave the indigenous diversion program early, we actually have to then make contact with their corrective service officer and say that they have left. Then it is up to corrective services to track them down and do what needs to be done through the courts, so that does not actually fracture our relationship with the client either. It leaves us that little step out of there. When they want to come voluntarily to rehab—they are ready or whatever—we still have that really good relationship with them. We do not want to break that relationship by being seen as a mandated service, and having clients being fearful of our service.

The CHAIRMAN: Jill, you also mentioned starting education at a young age. I believe that education on alcohol and drugs is not in all the schools. Can you tell us a bit about what you know is happening in education, what is not happening and perhaps what should be happening?

Ms Coole: There are very few programs in schools that are continual. You will get a lot of one-off situations, with guest speakers coming in and telling kids about certain health aspects of taking drugs and alcohol and things like that. It is quite difficult to implement those programs in schools. They have to be passed by so many people before they can start to be delivered in schools—through the Department of Education, the school itself, even the P&C committees and things like that. There is also the issue of taking time out of the school curriculum to deliver those sorts of programs. What tends to happen is a very hit and miss sort of delivery in schools. There is no continuum from the very small children to then tracking how those kids are actually going and the issues they are facing, and what needs to be the focus for this year.

The CHAIRMAN: Do you think there should be a K–12 curriculum? I know that many years back there was a K–12 curriculum for sport. I do not know whether it is still K–12. Maybe we should have within the K to 12 curriculum some programs on alcohol and drugs—the problems with them and what they do to the body.

Ms Coole: It is also around emotional wellbeing and recovery and seeking help early, but for those sorts of things the services need to be in place for children and young people to access. It is all very good to say that people should seek help early. We did that at headspace; it was all about promoting help-seeking behaviour. But what if there is no service in town? We are putting so much more money into services like Lifeline. That is great, but once again we are saying that these people do not actually have access to telephones. What if someone from up here is suicidal and is on the end of the line to a Lifeline worker in Canberra or Sydney or something? Where are they going to send them? There is no accident and emergency department, which is where they would normally be sent. There are lots of those issues. You can look at that issue but then you have to go tenfold under and see all those other issues that are failing. That is why a lot of these programs just are not suitable. I think the community people up here were saying that one size does not fit all. Every individual community is different and their needs are different. We put this blanket across of

alcohol and drugs but there are a lot of other issues that they are saying are actually very individual to their communities. Education and early intervention need to be looked at. That is where the communities need to tell us what their individual community needs are instead of us going, "Okay, they need drug and alcohol education. Let's do a program and run that across every community in the Kimberley." It just does not work.

[11.10 am]

The CHAIRMAN: What about at a high school level? Do you think there should be classes on child care, cooking, hygiene and sewerage rather than maybe having trigonometry or some of the high-powered things that go on at school? I said "trigonometry" because I was never very good in those areas! Is that something that would be useful? What do you think might help at the high schools here but also the high schools down south where a lot of Aboriginal boys and girls might be going down to school? Is there something that could be in the curriculum at that higher level? So, yes, we could start from the ground, but what could we put in at the high school level that might help to address some of the problems?

Ms Lovison: Going back to what Jill was saying, even for primary school, we should be putting programs in place for schools in general. Health education could incorporate alcohol and drug issues within it. As I said before, the consultation I have had with Beagle Bay was that that was one of the things they wanted in their community. The spokesperson for the health committee did say that they would like education on alcohol and other drug issues in the high school and the primary school. In the primary school it could be incorporated with sport and recreation by showing that to be fit and to play the sport you love, you cannot be drinking alcohol or taking drugs. The principal of the school was supportive of those ideas as well. Even that particular community has found that alcohol and drug education within the school system is important. It would probably also be important to other communities and schools in the city and big towns.

Ms Coole: I think some of the people at the summit were also talking about cultural identity being implemented in the schools. There is a lot of talk at the moment about bridging the gap. They were saying that when it is still directed only at Aboriginal children, you are not bridging the gap. It needs to be directed at the whole school as a part of history and learning about Aboriginal culture and the issues that go on for Aboriginal people. That would help with a general understanding—then you are starting to bridge the gap. If you are still directing it only at the Aboriginal kids, it is still setting the whole thing apart, even for the parents as well. It is about people's perceptions.

Ms Lovison: Milliya Rumurra has found it to be important that we not only be an alcohol and drug service, but also that we incorporate culture into our service and into how we deliver our programs on alcohol and other drugs.

The CHAIRMAN: Is your program kind of like the Alcoholics Anonymous program? Is it about abstaining?

Ms Coole: Abstinence and harm reduction.

The CHAIRMAN: I am okay with the abstinence. The harm reduction part is—I am sorry, we have to speed you up a bit because we do not want to miss out.

Ms Coole: Yes. Controlled drinking, drinking safely and minimising risk-taking behaviours—it is around harm reduction.

The CHAIRMAN: Can you think of any areas that we may not have discussed today that you think are important for us to be alerted to, or would you like to make a one-minute summary?

Ms Lovison: I think our priorities are important here today and how the committee brings them out. Housing is an issue for us. Having halfway houses is an issue for us—that is our need. What were the other two?

Ms Coole: Mental health.

Mr P. ABETZ: Drug and alcohol workers.

Ms Lovison: Mental health is an issue with us, and accessing experts in that area.

Mr P. ABETZ: Training up drug and alcohol workers in the communities?

Ms Lovison: Yes, and taking our service out to communities—setting it up on the communities and incorporating the communities within our service by working in partnership, so that the communities actually deal with alcohol and other drugs in their way.

The CHAIRMAN: A local action plan for each community.

Ms Lovison: Exactly.

Ms Coole: It is about empowering community members. It was very apparent from the summit that we have just been to that it is not working by us going into these communities once a fortnight or once a month. It needs to be a constant thing in the communities, and these people need to be trained. The community feels that they need to be trained, too. Once again, it is not a matter of us going, "Okay, so you need to have a certificate III in alcohol and drugs training, which means you have done this and this." It is about how we are going to provide that training and support to workers and how they are going to be compiling stats and things like that to give back to us. Agencies will need to undertake a very supportive role to provide that sort of assistance to people.

Ms Lovison: And funding for our service to continue the good work!

The CHAIRMAN: How long are you funded for? Do you have continual funding?

Ms Lovison: We have to do it every year.

The CHAIRMAN: You have to re-apply each year?

Ms Lovison: Yes.

Ms Coole: Every year, which sets up a bit of a rollercoaster for workers as well.

The CHAIRMAN: So three or four months would be wasted in preparing for it.

Mr P. ABETZ: You need long-term funding. You really need to be able to have funding in place for three, four or five years so that you can put your head down and focus on your work rather than always looking over your shoulder and trying to work out where you are going to get money from.

Ms Coole: That is it. It gives your staff some stability as well.

The CHAIRMAN: I would like to thank you both 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 28 days from the date of the letter attached to it. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added by these corrections and the sense of your evidence cannot be altered. 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. That is when you could send back the evaluation from the summit as well.

Ms Lovison: And the corrective services proposal you said you wanted a copy of?

The CHAIRMAN: Yes, please. We ask that you send us a copy of your corrective services proposal. Again, thank you very much for giving up your Sunday and coming along.

Hearing concluded at 11.16 am