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 ALBANY
FRIDAY, 20 AUGUST 2010

SESSION TWO

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 10.03 am

BOURNE, MR ANTHONY
Manager, Palmerston, examined:

BATEMAN, MRS KARINA ANN
Team Leader, Yarning and Parenting Program, Palmerston, examined:

The ACTING CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and 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 in Western Australia. You have been provided with a copy of the committee's specific terms of reference. I would like to introduce myself, Peter Watson, the member for Albany; my fellow member Ms Lisa Baker, the member for Maylands; and our research staff, David Worth and John Pollard.

This committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal procedure of the Parliament and therefore commands the same respect given to 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. This is a public hearing and Hansard will be making 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 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 ACTING CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

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

The Witnesses: Yes.

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

The Witnesses: No.

The ACTING CHAIRMAN: Thank you for coming today. Anthony, it is probably in the submission, but is there anything you would like to give us a brief outline on?

Mr Bourne: I have a small document here, which is the same as the presentation I made to the Palmerston board a couple of months ago. It is on the history of the drug service team in this area and our programs and funding. Do you want a copy of that now?

The ACTING CHAIRMAN: Yes, please.

Mr Bourne: It might be useful. I found this as well—a brief summary of the yarning and parenting program. It is a little out of date.

The ACTING CHAIRMAN: Is that the one in Mt Barker?

Mr Bourne: Mt Barker, Katanning and Tambellup. Would you like me to make an opening statement?

The ACTING CHAIRMAN: Let us know what you do, what gaps you think are in the system and what programs are working.

Ms L.L. BAKER: And perhaps what is unique about this type of service in this region.

Mr Bourne: I will give an overview. Over the past 12 or so years since we started in this area, Palmerston has endeavoured to deliver services that relate directly to the needs of the community. Because we are an NGO, we are not encumbered by too much red tape. This is particularly in the Indigenous community, the Aboriginal community, which Karina will talk about. There are two main types of drug use, the first being recreational, which we are not particularly interested in. The people who come through our service who are recreational drug users generally come when they run into trouble with the law and they get referred to us. For them, drug use is something they do for enjoyment. For the clients that we mostly work with, drug use is a form of self-medication. It is a very complex matter because drug use is not the only issue. That has been our experience. Their lives are complicated because drugs are illegal and the difficulties that they have are many. We see the drug use as a symptom of the circumstances rather than a cause. Taking that as our philosophy, that is how we deliver our services. We also focus very much on harm reduction. Are you familiar with that term? We have a non-judgmental approach to drug use and we seek to reduce the harms rather than complicate matters further.

[10.10 am]

Ms L.L. BAKER: I have a quick question before Karina may like to add something. You mentioned that the recreational drug user is not a particular focus of the work that you are doing. We have spoken to people who have suggested that recreational drug use is indeed important because they see it as a precursor, as a doorway, into a more difficult regime of more complex, out of control drug use. Do you have any comments to make about that?

Mr Bourne: Personally or on behalf of the agency?

Ms L.L. BAKER: As someone who has been involved for how long in this area.

Mr Bourne: I have been working for Palmerston for 20-odd years.

Ms L.L. BAKER: I think you are in a good place to comment then.

Mr Bourne: Palmerston does not subscribe to the gateway philosophy; it is way more complicated than that, except, I suppose, cigarettes are usually the first drug that people use. What are you going to do about that—ban cigarettes?

The ACTING CHAIRMAN: What is the second one?

Mr Bourne: The second drug is alcohol.

The ACTING CHAIRMAN: We just had a magistrate in saying she sees six and seven-year-old Indigenous kids in Katanning who are on ganja. Is that a starting point?

Mr Bourne: There are not a lot of six and seven-year-olds who would smoke marijuana.

Mrs Bateman: If you are doing anything to alter your state of reality at seven, some things are not going to work anyway and there will be a gateway to a downhill spiral, I would imagine. If it is not drugs, it could be family violence or criminal behaviour.

The ACTING CHAIRMAN: That is availability, is it not, especially if you are in a house with 10 people and there is ganja, alcohol and violence there?

Mrs Bateman: It is exposure to what are the norms. Behaviours are picked up.

Mr Bourne: We have to be very careful because saying that a six-year-old, seven-year-old or an eight-year-old uses marijuana, there is an immediate emotional response whereas the issue is way deeper than a six or seven-year-old smoking marijuana. A lot of other things are going on as well. What has happened, particularly in the media, which makes our job harder, is that the focus always seems to be on the drug rather than the conditions that allowed that to happen.

Mrs Bateman: All the things you were talking about.

Mr Bourne: It perpetuates. We focus on the substance rather than the conditions. I have been in this field since 1987 but I do not know how many years we have now had of trying to eliminate the supply. And, look where we are, realistically.

The ACTING CHAIRMAN: Do you think that if it was made legal there would not be so many problems?

Mr Bourne: I do not want to sidestep that but in some ways that is not the issue. There will probably come a time when different drugs are not illegal because it simply has not worked and it has caused too much distress. Even if marijuana was legal, it would not change the conditions that give rise to people wanting to alter their state of consciousness. If a person is in a reasonable state of consciousness or feeling good about themselves, they will only use drugs recreationally. They will not want to be obliterated.

The ACTING CHAIRMAN: Some people might not want to use them at all.

Mr Bourne: A lot will not want to use them at all. Even though we are called an alcohol and drug service and we do address the drug and alcohol use a lot, we also have to take into account the cause.

The ACTING CHAIRMAN: The magistrate was talking about the STIR program that has been very successful.

Mr Bourne: The diversion program?

The ACTING CHAIRMAN: Yes. Talking about diversion, this YAP program is tremendous. Karina, maybe you could explain it to Lisa because it has been explained to me by Anthony before. Do you know what the program is?

Ms L.L. BAKER: I sure do but I am happy to have it put on the record.

Mrs Bateman: YAP is a program within the drug service team that focuses on women and children. The objective of the program is to reduce drug and alcohol harm like family functioning, child development and community belonging. There are three components to the YAP program. One is a group component where we come together and form a play group. The play group has educational programs with guest speakers and lots of art and craft activities where learning happens together. The play group also has a childhood development focus. We have a childcare worker who role models activities with women and children. During the group component we focus on the attachment between the mums and the children. YAP has a counselling component as well. That is where a lot of the risky drug and alcohol behaviour, the harm reduction, happens, but also the other determinants such as domestic violence and mental health. The big three with all of our families are, firstly, substance misuse—their own or someone else's. They may have come out of their substance-taking career but their partner still uses it a lot and their family and those who sit around them do. The second is domestic violence. If there is not domestic violence, there is family violence or inter-partner violence. Our girls have conflict-style relationships with their families, partners and communities. The third is mental health. Postnatal depression is big with our girls, and there are cases of anxiety, personality disorders and trauma. They come to us when they have children and they are really struggling with that. We work on those three through the counselling.

We have an outreach component. A lot of the outreach work is about advocacy. We use the outreach component as a way to link in other allied health professions. During the outreach it might

be that the childcare worker and the outreach worker go together to the appointment to get the grommets done and they hold hands. If I am a mum and I have no car in a town such as Katanning and I need to be in Narrogin or Wagin to get my teeth done or something like that, I have to take my four children. Even if I get there with my four children and I can have conversations, I cannot think, so the childcare worker looks after the children and supports them. The outreach worker can build those bridges to allied health. We are big on trying to grow our women to feel comfortable with mainstream services. We invite lots of other services not only through the outreach component but also through the group. This year we have had a big focus on child development because recently we got some Communities for Children funding. It is really hard to screen our objectives through the children. All of our objectives are about risky drug and alcohol behaviour for adults. Although we know that child development and growing children is the greatest cause of joy and stress for our girls, we have not been able to focus on the children so the Communities for Children money has allowed us to do that. The child development team handles all the disciplines such as speech and hearing and a child health nurse now comes. We are collaborating with Aboriginal health to get COAG funding. We invite those agencies to the group. They are the three components of what we do.

We have been really lucky. We have fantastic buildings. The sense of belonging to the place as much as to the group is really important. Predominantly, we have Indigenous women just because that is how that started. We talk about reaching our clients. Vulnerable families are really difficult to reach. If substance misuse is the starting point, you never get anywhere. We are a harm reduction agency. We accept the fact that people use drugs and we look at reducing the harm. We particularly look at reducing the harm on family functioning. In lots of ways it comes down to simple things. If mothers are going to put children in day care, before they started coming down they were getting by with one or two loaves of bread in the freezer so some meals can be eaten. They may be managing their substance misuse but it still happens, and sometimes when you look at these families, you think, "I would be getting sloshed on a Saturday night too." It is really hard trekking in their lives. Many of our mums are under 25 and they can be having their third or fourth baby.

[10.20 am]

The ACTING CHAIRMAN: Do they come to you or do you go to them?

Mrs Bateman: We go to them. There is an aspect of group readiness with our girls. Even though we are a group that is made up of their own people and it is casual and easy, it is still really difficult to walk in there so the outreach grows the relationship, and it grows the relationship with the childcare worker.

The ACTING CHAIRMAN: How do you find them?

Mrs Bateman: Most of them come to us. In Katanning we have a really close working relationship with CJS. Community justice recognises the fact that parenting is an important thing to do and it pays the girls for their community hours, or pays their fines. We need to recognise that these girls live in a small town and may have lots of fines and no way to pay them back and no child care but they have to paint the swimming pool in Katanning in the morning in the middle of January because that is their job. That was the scenario that got me thinking about the fact that we have to be able to offer these girls something better to do. If they do not turn up, they breach, and the fines infringement thing comes on, it keeps ticking up and they will never get a licence or get their licence back. That is a great thing in Katanning. It has not really taken off in Mt Barker because we are full with the referred girls. It is a really valuable component of what we can offer. Otherwise they just come or people tell us or doctors refer them.

Mr Bourne: It is a commonsense approach. I do not think that should be underestimated. It is so obvious that the people we work with are dislocated from the community, so in these towns we have set up a community centre or a place in these towns that is welcoming, friendly and belonging. That is not that hard to do if you do not get tied up with red tape. Once you do that, you can create,

in effect, a small community around that place and then that grows. Very soon the clients feel part of the community that is around the place in Katanning, which we call "our place" or in Mt Barker it is called Mt Barker community house or something like that. It is the idea of having a place where people can go and start. That is so basic, really. People ask us what YAP is. It is just very much commonsense. We use whatever agency we can to help because they are there.

Mrs Bateman: YAP is right in the middle of a National Drug Research Institute evaluation that is looking at lots of things. It is difficult for our sector to include children because of all the red tape. It is hard. What is coming out early in the research is that the most unique thing we do is include child development. That is really valuable to our girls and to all the things that they are measuring our success against, such as school readiness. We really care about school readiness. If we can grow our children and parents to belong to a school community, once we get the concept of community happening, no matter how small, it can always expand into the community that they sit within. Second only to family protection around drug use as a protective factor is community belonging. That is what our families really lack. They can belong to that community and there is pride in those communities.

Ms L.L. BAKER: Do you get a lot of foetal alcohol syndrome?

Mrs Bateman: Absolutely. Also, we think we are at third generation foetal alcohol syndrome. When we look at our mums there is all the FASD stuff like the inability to forward plan, emotional regulation and the bits of the memory that do not work. We reckon we are at the third generation. Parenting from that perspective creates a whole different thing. The more we learn about it, the more we can design our service delivery around the norms of that sort of behaviour.

Ms L.L. BAKER: How long have you been working in the area?

Mrs Bateman: I have been with Palmerston for 10 years. I started YAP six years ago.

Ms L.L. BAKER: From both of your perspectives, has anything changed in either the number of people presenting with problems or with the style of drug use and the preference of substance? Have there been any big sweeping trends? Are there suddenly a big bunch of people who just want to drink alcohol? Has comorbidity gone through the roof?

Mr Bourne: There are little things, and some are not so little. Amphetamine use took over from heroin, but heroin is a big city drug. In the country, people take what they can get. Most people's drug use is really messy. A lot of it comes from prescribed medications.

Mrs Bateman: If we have noticed an increase in anything, it is access to prescribed medication and people knowing what they are using the prescribed medication for.

Ms L.L. BAKER: Is it prescribed for them?

Mrs Bateman: From anyone. As part of an Improved Services Measures project, we did some data snapshots. We extended ours in this region to look at prescription medication use—one's own or another person's. From memory, 40 per cent regularly used other medication that was not prescribed for them. That was interesting to us. We suspected that that was the case. We are growing the drug interventions now to include that. They are much more complex drugs than the one central nervous system effect that the other drugs have.

Mr Bourne: One thing we have noticed—this is a federal thing—is that when that money comes in; what do they call it?

Mrs Bateman: Our girls call it the big money but it is the family tax money.

Mr Bourne: It is mayhem. That is when you really get the big spikes in drug use. That has not happened before because they did not have that sudden input of money.

Ms L.L. BAKER: That big amount of cash.

Mr Bourne: Yes. When that comes, that is when it goes crazy. We plan for that now. We have to.

Mrs Bateman: We do. For example, a financial counsellor comes in and as many bills as possible go on Centrepay, and we make sure that happens, obviously with their permission.

Ms L.L. BAKER: Do you support Centrelink payment plans and income management?

Mr Bourne: Yes.

Mrs Bateman: Hang on! In that sense, yes, but on a personal level, probably not. I think it victimises people who are already quite victimised and adds to the sense of powerlessness. At the same time, some management strategies are important. I have never asked recipients of Centrelink benefits how they would like it to be managed if it was going to be managed. That might be something I start asking people.

Ms L.L. BAKER: Is it you guys who have some federal Strong Families funding?

Mrs Bateman: Yes.

Mr Bourne: Community for children.

Ms L.L. BAKER: I heard you say that earlier.

Mrs Bateman: We love Strong Families. It is collaborative case management. We are the highest referrers to Strong Families in our region as an NGO.

Ms L.L. BAKER: Can you define Strong Families because we have already spoken to other witnesses about Stronger Families. There is probably "strongest" somewhere as well. We need to have the difference on the record.

[10.30 am]

Mrs Bateman: The Strong Families program is a Department for Child Protection-funded collaborative case management program that all the government agencies are mandated to sign up to. It is a voluntary program. For us as an NGO, it means that we can get those government agencies such as Homeswest, Mental Health and DCP to the table and we can be really clear about the goals or expectations of this person.

The ACTING CHAIRMAN: How many Indigenous staff do you have?

Mr Bourne: One. Our agency is changing in the way it works, particularly around Indigenous people. Because we are an NGO and a certain size, we think that if we can do stuff with other agencies, in some ways it is better than us employing them ourselves because that it is a lot of work just managing a big team. We work with quite a lot of Aboriginal workers but generally—this is my observation—it is very difficult at the pointy end to be a Nyoongah person working in your town with the people. You can imagine what it would be like if we were in that situation and how we would feel. I do that sometimes. Amongst friends and people I know, if I were a drug and alcohol worker, they could shut you out because there is that shame and confidentiality.

The ACTING CHAIRMAN: And different families.

Mr Bourne: The Nyoongah family system is so much more complex. It is very difficult.

Mrs Bateman: From my experience—it happened last week—when you are referred to a government agency or program, you can usually give your client two choices: such and such is a wadjala lady or such and such is a Nyoongah lady from wherever and they will say, "Give me the wadjala lady."

Mr Bourne: We did a research project quite a number of years ago and found that generally Nyoongah people either did not mind or they would rather see a white person. I understand that. It is not racist at all; it is just commonsense. If you have a very tight family network and grapevine, you just want to keep it quiet.

Ms L.L. BAKER: Is the youth assistance program that you run out of Mt Barker and Katanning separate?

Mrs Bateman: Are you talking about Lesley's stuff?

Ms L.L. BAKER: I am not sure. We have in our notes that you are running a youth assistance program out of Mt Barker and Katanning. Is that not just YAP?

Mrs Bateman: We have some funding for a youth worker who works with us. She fits our demographic because so many of our mums are younger. We also find that a lot of them come with their nieces or nephews. Those young people are quite transient and head around to different households. That is a good way for us to catch them for engagement or they will bring them and say, "She's been here for two weeks" and we sort it out.

The ACTING CHAIRMAN: Can we get a copy of the report that you did on people wanting to go to particular counsellors?

Mr Bourne: I think we still have it.

Mrs Bateman: We have still got it. It was a while ago. It was one of the community investigations that we did to set up YAP. We had to fight quite hard to get money at the start.

Mr Bourne: I do not know where it is. Do you know where it is?

Mrs Bateman: I have seen one in the past six months.

The ACTING CHAIRMAN: That is a good start.

Ms L.L. BAKER: If you had a wish list for filling some gaps, what are the gaps that you have identified? What are the gaps in services in the Great Southern basically?

Mrs Bateman: There are gaps in allied health profession services, paediatric services and speech therapy services. Physio is not so bad because our kids have so much to play on. Definitely there are gaps in occupational therapy, Charterhouse hours are down, visiting stuff, perinatal and postnatal depression. Aside from the mental health stuff, there are the services that go out and do something practical. We have SAAP, the supported accommodation assistance program, but they cannot take a trailer to put the rubbish in or take it away. They do not have a lawnmower. Interestingly, Homeswest has changed its policy about breaches. This is how things affect our families so much. Not having your lawn mowed can be a breach. If you do not have a car, it is really difficult. Lawnmowers get broken. If you get three breaches, you end up in court. It is becoming a really complex issue. We say to the supported housing worker, "Could you not just put a lawnmower in the back and she will do it while you stand there?" They say they cannot do that. Those sorts of services are really valuable. When you talk to our girls and ask them what they need, they need help doing what is practical at home. They have no idea how to get their kids organised before 8.30 to get to school. We organise for someone to come in and do lunches and set up a routine. That real-life help is useful.

Mr Bourne: It is not so much that there is a gap; it is that what we do can be expanded upon. There are things that we could get more of but it is not like —

Ms L.L. BAKER: It is not like there is a big gap. What would you like more of?

Mr Bourne: Cooperation. It is crazy. There is a conference in Perth next month.

Ms L.L. BAKER: That is DAO's?

Mr Bourne: I do not know what they are going on about. It is suit after suit and theory after theory and it is so commonsense. What needs to be supported is on the ground. If you looked at the percentage of on–the–ground workers compared with experts who will endlessly debate the causes of this and that —

The ACTING CHAIRMAN: We have been to some of those conferences.

Mr Bourne: Anyone can tell you that it is about community. You feel happy when you are part of something. It does not sound very sexy. I cannot even make it sound interesting. When Karina says

that we have a play group, people think, "A play group!" but it is so fundamental and it is such a brilliant idea to have a play group where kids, mums and health workers can come, but we say we have a play group and we have nothing else to say.

The ACTING CHAIRMAN: We were at conference in Melbourne and a street kid gave a talk. All these people were giving their government-funded ideas. She said, "When you apply for your next substance money for the next 12 months, why don't you just get something that will help us and not just help you get your next six month's funding?"

Mrs Bateman: Absolutely. She was clever.

The ACTING CHAIRMAN: This was from someone at the coalface saying, "I have come to this conference. I have heard everyone talk. I am talking as a street person. Why aren't people doing things instead of putting up ideas?" I know it would put a lot of academics out of work but we could put that funding here and here.

Mr Bourne: At the YAP play group all these people would come along who do not have anything better to do. It is a little frustrating.

Mrs Bateman: Peter, you are right. We eat together. We do self-surveys for all of our reporting. We are really interested in our clients' feedback. One girl who had been coming for a little while was asked how her risky drug and alcohol use has changed. She said, "On a Tuesday my kids will always get lunch and I will not start drinking before two or 2.30 because that is when we finish." That is significant. That day the kids get lunch. Of course they want to come. We have a garden and we share that. It is great.

Ms L.L. BAKER: Do you have a community garden on site?

Mrs Bateman: Yes, in Katanning we do.

[10.40 am]

Ms L.L. BAKER: My brother and his wife are both police officers. They were in Narrogin for quite a while. Stacey and James were frantic about the fact that when they were called out to intervene in family and domestic violence issues—generally the man was causing the problems, not so much the women, although I know there are issues with that—the only option they had was to put them in the police cell. They would let them out again and they would go straight home and it all started again within hours. Is there anything on that issue that you want to comment on as far as the services required and facilities needed?

Mr Bourne: That is important, but if you are not addressing the root causes, which we are trying to do, it does not matter what bandaid you put on it. That is a difficult problem and no-one can get their head around the problem of what to do with this male. If you start working with the families at the base level, every kid who goes to school from coming to YAP is a win because they are going to school and their ears are not blocked and they know what is left and right. The building blocks are important. I do not know what you do with those guys. Is that not what Closing the Gap is meant to be?

Ms L.L. BAKER: Oxfam or federal?

Mr Bourne: The COAG funding.

The ACTING CHAIRMAN: Is there a waiting list for Palmerston in Albany?

Mr Bourne: We do not have a waiting list.

The ACTING CHAIRMAN: Do people just come in and you deal with them?

Mr Bourne: Yes. We do not follow the so-called medical model. We do not see ourselves as a clinic. It is much better to see people in group settings. We do one-on-one work but we do not focus

on that exclusively because I do not think it is cost effective, especially when they do not show up, which happens a lot. If you have a group and people do not show up, you still have a group.

The ACTING CHAIRMAN: What about you, Karina; are you full or can you take more people?

Mrs Bateman: We can. Because of the unique nature of what we do, some days are huge and we would not have any more than 30 kids and we say, "This is ridiculous; what are we thinking?" Then we always seem to find a balance.

Mr Bourne: We could always do with more staff. The building we have in Mt Barker is now up for sale so we will have to go to Lotteries and find the money. It does surprise me that people do not come along and say, "I have seen what you are doing; how can we help?" That is the philosophy we need, not to come up with something innovative.

The ACTING CHAIRMAN: Do you feel that in the past 10 years more young people are coming to Palmerston with alcohol problems?

Mrs Bateman: I do not think so but I do think young people are more likely to seek help now. We have done a good sell, or we are starting to reap the rewards of selling the fact that they can come and do something. In saying that, I also think that the court systems and drug and alcohol services still do a lot of victimising of the mother. We do not balance the test bias enough. We make situation placement-based appointments for women. If DCP take children, it is women who end up in court. They are the people who are struggling to parent. We still have a culture of victimising the mother. You were talking about FASD, Lisa. There is blame around women who did not know or did not know any better or it was the only way they were going to get through their pregnancy. Having created these babies, they have all this stuff. I hope that we can look at changing that because there is enough guilt and shame around regular parenting let alone parenting with a raging substance addiction. Parents want to be good parents. That is why what we do works; they want to do well and they love their babies.

The ACTING CHAIRMAN: Do you have a night service?

Mr Bourne: For emergencies and things?

The ACTING CHAIRMAN: Yes.

Mr Bourne: We see some people a little later but it would be expensive.

The ACTING CHAIRMAN: So you do not go out on the streets or anything like that? Do people come to you during the week?

Mr Bourne: We do a lot of outreach but you have to in a regional area because people often do not have cars.

Ms L.L. BAKER: I want to pursue that. That is a really good question, Peter. We have heard so many times that DCP is not available or someone is not available after 5.00 pm or during crisis times of the weekends or at night. I know that that is not your speciality but what narrative do you give yourselves about the good work you are doing to get a Tuesday between such–and–such a time and two o'clock drug free and food in the baby's tummy and whatever?

Mrs Bateman: We build community rapport and connectiveness. Our girls ring each other. They become a support network for themselves and each other's children. We hear the stories of someone who was off on the weekend so they had the kids. That is what we teach. If someone is having a bad day, we say, "Lisa's having a really bad day; Peter, can you do her pick-ups with her child today?"

Mr Bourne: That actually works.

Mrs Bateman: It works for us. If they do not know people when they come, they grow friendships and connections and support for each other back into their community. I can manage that one.

Ms L.L. BAKER: I knew you would be able to.

Mr Bourne: Another example of that is a different program where we run groups for older women using arts; we have a studio. These are people who have been through everything and it has not worked. Often they have quite severe mental illnesses, bipolar, schizophrenia and severe depression. We have found over the past two years, which I have been documenting, that they enjoy being part of a group, and that has started to work and they have gone on and done things; for instance, all these women joined a choir together and they go camping. Humans are smart. If they get a chance, they will form their own support networks. That is why parent groups are good too—anything that is not reliant on the service because that is another dependency. If you keep saying, "We'll be here when you really need us" instead of teaching people how to build that support, that is what is important. Emergencies do not happen a lot but when they do, it is always dramatic.

Ms L.L. BAKER: Thank you very much for that. Time and again we hear about community capacity building and all that sort of stuff, which sounds good. What you have been able to do, judging from your response, is make that real; that is, you can put as many services in place as you want but if you do not have the community doing exactly what you have said, you are throwing money down the drain.

Mrs Bateman: Yes, and it is not sustainable. Sustainable growth is to link it back to themselves.

The ACTING CHAIRMAN: How well do you get on with the police? Do they work in well with you or are they a bit funny?

Mr Bourne: Brian, being an ex-copper, has a pretty good rapport. That is really good for us. We keep in touch.

Mrs Bateman: We have an interesting relationship with the police in Mt Barker because my husband is a police officer in Mt Barker. Community policing is a model that we really like. We have encouraged Constable Care and Blue Light. I had an incident maybe four months ago that brought home to me the importance of the police. One of the families was at the building. The police came to get fingerprints for a crime that was unrelated to us and the child started to shake because the police had been there on the weekend and had taken dad and it was traumatic. Because I know what police cars are like, I said, "Let's go and look at the car", noticing he was just shaking but did not quite understand what was happening. We got to the car and he started screaming. This child had been traumatised not by the police but by what had happened. If he never has any dealing with the police again, that will be his preverbal memory. His body will kick in to that preverbal trauma. He will not grasp it but he will go into flight or fight response when he is 20, 25 or whatever if he sees the police.

It is so important that we familiarise these children with the police. We spoke a lot with our girls. They said that we would love their kids not to go dog when the police walk to the door and they would love their kids to know that the police could help them but it is not like that. Fortunately in Mt Barker we have recently had a change of sergeant—someone who is a bit younger and has a family of his own. He appears to be saying, "Let's create a community policing model and see how it goes." It works for us to know from the police what is happening, not to keep clients honest but to know that we are all really clear about what is happening and know where they are on the weekend. It also works for the girls that we can talk to the police. We are trying. We have a big focus on growing that in Mt Barker and hopefully we will come up with a model where it works.

The ACTING CHAIRMAN: What one new initiative should the WA government consider to limit the impact of alcohol consumption?

Ms L.L. BAKER: You only get one choice. I will not talk too much because it is your hearing, not mine. We are talking about things like the price and availability of alcohol. It is not really about drugs; it is about alcohol specifically as a drug.

Mr Bourne: I could give a flippant answer.

Mrs Bateman: Please don't because that would mean I have to give a serious answer.

Ms L.L. BAKER: It would be in *Hansard* and *Hansard* has no sense of humour. The written word does not do it. Trust me, I have tried. It is not funny when you see it in print!

The ACTING CHAIRMAN: Is there one thing that would help you guys, looking at the big picture? I suppose you can include what you were saying before about more support services.

Mrs Bateman: Maybe just recognising the fact that alcohol is a chronic toxic drug to our families and our communities. We should not always make illicit drugs the worst possible thing but try to get an evening up of the scaremongering if that is the tactic we are going to use.

Ms L.L. BAKER: What would happen if the price of alcohol was tripled?

Mrs Bateman: People would get black market alcohol. They would make their own. That would create another justice system around prohibition and that sort of thing. While there is a shutting down, our families would be devastated, as they are with the cigarettes. Costing more does not make people smoke less; it is a management strategy. It is part of what they do to manage day–to–day functioning. One thing I would not do is put up the price. I probably cannot come up with anything.

The ACTING CHAIRMAN: Thank you very much for your evidence before the committee today. A transcript of this hearing will be forwarded to you for the 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. 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. Thank you very much for your time this morning.

Hearing concluded at 10.54 am