LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Wodonga — 24 February 2014

Members

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Ms D. Griffin, Aboriginal Drugs and Alcohol Counsellor, Albury-Wodonga Aboriginal Health Service.

Mr T. Church, Aboriginal Drugs and Alcohol Worker, Albury-Wodonga Aboriginal Health Service.

The CHAIR—Good afternoon. Are you all here.

Mr BURKE—There is one member who could not be here, Mr Ramsay. She had a death in the family. Four of the five are here.

The CHAIR—Thank you. Welcome, and thank you for your time this afternoon. Can I, on behalf of the committee, from the outset acknowledge the traditional custodians of the land on which we are meeting today and pay our respects to the elders past and present. Now, here with us I have Mr Matt Burke, chief executive officer, of the Mungabareena Aboriginal Corporation. I understand Ms Joy Kelly is an apology due to a family death. Our condolences go to her and her family. I also appreciate we have Ms Sharyn Jenkins, an Aboriginal Family Violence Worker. From the Albury-Wodonga Aboriginal Health Service we have Ms Di Griffin, Aboriginal Drugs and Alcohol Counsellor, and Mr Tim Church, Aboriginal Drugs and Alcohol Worker.

This is a joint parliamentary committee of Law Reform, Drugs and Crime Prevention. We are conducting an inquiry into the supply and use of methamphetamines in Victoria, particularly ice, and we have spent a lot of time in regional areas trying to understand what the impact of the drug is having in regional areas particularly, but also in the indigenous population. We have collected quite a lot of evidence from regional cities and in fact we are going to Warrnambool next week, next Monday. It is part of our reference and I am pleased that you are able to be here this afternoon in helping us with some of the impacts that this drug is having to your specific communities. We have allotted time to 2.45. I am not sure if you all want to speak or if you have someone that is going to present on your behalf, but certainly the committee will ask questions of you all at certain times during the session. Mr Burke, do I assume you are going to take the lead?

Mr BURKE—I would like to start if I could.

The CHAIR—I would certainly invite the others to make a contribution. Thank you. I will read you the conditions under which you are presenting. Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees. Yes.

It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of parliament. We are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. That is the conditions under which you are presenting this afternoon.

Mr BURKE—I am sure we collectively accept that.

The CHAIR—Thank you.

Mr BURKE—Mr Ramsay, and the Parliament of Victoria, thank you for the opportunity, firstly, to give you a small presentation. I will take lead but these are the experts on my left and right. For the record, I am the CEO of Mungabareena Aboriginal Corporation, and there is another organisation across the river that is called the Albury-Wodonga Aboriginal Health Service. Just for a 30-second grab, we are the social model of health and they are the medical model of health, but we work in collaboration and partnership across the border. We do not let rivers and streams divide our community. If people come to us for help, no matter what shape or form it might take, we provide it; whether we connect you or give you

a doctor, whatever we might do.

Very briefly your paper is quite specific about the number of areas you want to talk about in the term used commonly in the marketplace, ice. I have Sharyn Jenkins who is our Mungab family violence worker, and has been with us for a number of years. She is also a team leader of the families unit and deals with this on a different basis, on a day-to-day basis. Di Griffin, who works at AWAHS—Albury-Wodonga Aboriginal Health Service—and Tim Church, are drug and alcohol counsellors and outreach support workers where they are also at a deeper level working across this issue. I am going to defer to them to start off with and let them tell you how they interact. It is certainly an issue, we all know that. It is how it affects the Aboriginal or Torres Strait Islander community across Albury-Wodonga. As a CEO I am supposed to know the whole lot, but these guys are the ones that are intimate, work it every day, and other than me getting a brief at the end of the period, they are the ones dealing with it. With full respect to them, I wish for them as my team today to present to you, and thank you again for the opportunity. We will start off with you, Sharyn, perhaps in your family violence role.

Ms JENKINS—As a family violence worker we are seeing a lot more family violence due to ice, not only in the indigenous community but also in the wider community. There has been a huge impact—the women and the men—from ice. There have been a lot of problems there. Also one of our workers works with child protection and there are a lot of reports going through there that are connected with the ice problem. I am three days a week as a family violence worker and sometimes it is bigger than us. But I think that Di and Tim are probably the experts that you need to speak to because they are dealing with the people that are using the ice, and what goes on more often. I wanted to say that in family violence and child protection it is a big issue.

Ms GRIFFIN—I have been working at the Aboriginal Health Service for six years as a drug and alcohol counsellor. When I first started there were a small number of people using ice, or methamphetamine, or even amphetamines. The main drugs of choice were, first of all, alcohol and, secondly, cannabis. I have noticed more and more people—when I do a drug and alcohol assessment—are now saying they are using ice. People who would not normally go on to those kinds of drugs until they had gone through using cannabis and then maybe then going on to ice, I am now finding young people going straight on to ice. That is what is really concerning. I do not have any stats to give you exact numbers, but anecdotally it is very worrying, the number of people I see.

I see on average 40 clients a month, different clients, and it is now the norm for them to admit they are using ice as a drug, usually in poly drug use. They are not usually using ice on its own but it is becoming the drug of choice.

Mr SOUTHWICK—You mentioned that people are now going straight on to ice.

Ms GRIFFIN—Yes.

Mr SOUTHWICK—They are skipping smoking marijuana, and ice is the first drug they try?

Ms GRIFFIN—Yes, they are smoking ice instead of smoking cannabis. What we know about ice is it seems to be more addictive and people develop dependency much quicker than they would with cannabis. A number of people can smoke cannabis and not become dependent on it, but the ice use seems to really grab these kids, particularly young people. It is grabbing them and not letting them go, that is what is really concerning.

Mr SOUTHWICK—Why do you think that is the case that people are going straight to that step?

Ms GRIFFIN—I suppose, firstly, availability. It is easy to get a hold of, possibly

even more easy than cannabis is now. I do not know for sure but I ask my clients, 'Do you have any trouble getting it?' They do not have any trouble getting it at all. It seems to be everywhere. I think because there is more money to be made in dealing ice that people are tempted to go that way rather than be selling pot. They sell ice because there is more money in it for them as well. A number of my clients buy a deal of ice and then they are able to sell on and support their own habit that way. That is an attraction for them as well.

Mr SOUTHWICK—Because of the addictive nature of ice, do you think that dealers are knowledgeable of that in trying to get people onto ice quicker than they maybe with marijuana? Is there a deliberate attempt, do you know?

Ms GRIFFIN—I cannot honestly comment on that because I do not know but that would make sense. If you are in it to make money or you are in it to support your own habit, then it does not take a rocket scientist to work out that that is going to be a better option.

The CHAIR—Mr Church, would you like to say something?

Mr CHURCH—My dealings with the clients is after Di has seen them through counselling. I try to help them out with regaining access to housing, that outreach and things like that. I think the conversations I have during the transportation of these clients, I get a lot more information out of that than any other sessions I have. Simple things, like, when they know the drug ice is in town, they left off firecrackers and stuff. These are the things that my clients tell me, and they tell me they are better off smoking ice than getting on the marijuana.

Mr CARROLL—A firecracker to let others know the location of it?

Mr CHURCH—To let them know that it is in town.

Mr CARROLL—That it is in town. Okay.

Mr CHURCH—Like, it is asking them in transportation, and some say it is attractive as well, but these are my clients, I want to know how far from the truth it is anyway. It is our conversations we have within the transportation.

Mr CARROLL—Is that transporting them to their housing?

Mr CHURCH—It is me trying to work closely with them to break their cycle. Being on the drug and even going to pick them up and bringing to AWAHS and helping them out, we try and get them in with other programs to get them out of their home environment where they are stuck in that cycle of taking the drug.

Mr CARROLL—We are also, Tim, trying to work out to what extent and what role outlaw motorcycle gangs have had with the trafficking of ice. Has that ever come up?

Mr CHURCH—I am not sure, no. They have talked about bikie gangs but not specifically; not to me anyway.

Mr BURKE—You heard Di talk about—she made a comment that is very valid. It was Joy Kelly, who sadly cannot be here today—I asked her, 'Give me three things I should talk to the inquiry.' The first point, she said, was that it was easier to get ice than it is to get marijuana, and we had that conversation and I locked that away, thinking, that is actually incredible. One of the other points she made was that sadly, we have people, such as grandmothers, who are selling this in the community, in our Aboriginal and Torres Strait Islander community. It is quite a sad indictment itself. They are some of the issues that we, as an Aboriginal community, are dealing with on a day-to-day basis. When it is coming from within that is another issue we have to deal with.

The CHAIR—Are they doing that to protect their children though, because they are

getting into debt by—

Mr BURKE—To follow up on Di's comment about the availability of cash, when you come from a low socioeconomic background and how difficult it is in life and day-to-day living then, of course, this is an easy option. I am making this as an assumption, an assumption based on what different staff are telling people at CEO groups, how easy it is to access. We were warned about this three years ago that it was coming into Mildura, and be careful, it is on its way. Before I returned from a meeting in Melbourne, it was already here. I wanted to make that comment.

The CHAIR—Thank you.

Ms GRIFFIN—I think the comment I would like to make, if you look at why people are using ice, apart from the easy availability, if you look at the past history of Aboriginal and Torres Strait Islander peoples and what we refer to as intergenerational trauma that they have experienced and the adverse disadvantage that Aboriginal people have, ice is a drug that, to begin with, helps them to feel better about their lives because of the high that it gives, the quick high that it gives. It makes them feel good, it helps them to forget about how bad they really feel underneath. I personally believe that is why it is devastating Aboriginal communities in particular because Aboriginal people that are struggling with a lot of those issues—poverty, cannot get employment, poor education, poor health outcomes—a lot of underlying grief, loss and trauma which makes them feel terrible about their lives, ice comes along, 'Whammo, nice hit, feel great. It gives me the motivation that I'm lacking because I'm depressed.' I think that is why it is so attractive to the Aboriginal community and why the young ones in particular are really diving into it.

Mr McCURDY—Alcohol does the same thing in many circumstances.

Ms GRIFFIN—No, it is a different drug and it reacts differently in the body. Alcohol is a depressant drug. Whilst those of us who drink know you get a bit of a relaxed feeling and it makes you feel okay for a bit, but it suppresses the central nervous system. Ice is a drug that reacts in the brain receptors that releases all of those feel good chemicals, those hormones in the brain that make us have motivation, feel alive, feel alert, feel awake, feel great. That is what is missing for a lot of Aboriginal people. They never feel great about life. Ice does that for them to begin with. By the time it has wreaked havoc, it is too late, often. I mean, it is never too late but it is already causing a lot of problems and they are possibly dependent, and the way out of that is we need a lot more resources to help people get out of it because we are totally unresourced here. I am the only Aboriginal drug and alcohol worker in this area. If you take Albury-Wodonga and the wider surrounding area, I am it, and Tim is the only outreach worker. We have no resources for clients to withdraw. We have no detox beds available in this area. We have no rehab facilities available in this area. Our nearest rehab is in Benalla which has a waiting list of three months at any given time. We are being approached for help by both the users themselves and their families and we are truly struggling to cope—truly struggling to cope.

Mr McCURDY—More so than a non-Aboriginal, do you think?

Ms GRIFFIN—Yes, because the difference is for Aboriginal people, they need—not everybody, you cannot generalise, but they really do need to have an Aboriginal specific facility, one where they feel comfortable. Aboriginal people do not feel comfortable generally in mainstream services. If you can build the trust and that engagement to get them into treatment, I have found in the past the treatment always falls over when they have to go away. As soon as they have to go away for help it falls over because they become uncomfortable, they feel out of their comfort zone. If they are in a facility that does not understand Aboriginal ways, then they get very homesick and pull out.

Mr BURKE—I think the point Di is making, Mr Chair, is it needs to be culturally appropriate—in this instance, me talking about Aboriginal people. If you look at the program

called Closing the Health Gap, why did that start, because a lot of Aboriginal people presented to hospitals across our country and would walk out from the ED earlier than they should have without treatment. Hence COAG decided to do that about four or five years ago, to everybody's pleasure, they actually recognised that single fact alone. To take Di's point about two Aboriginal workers working in the community of Albury-Wodonga, I have to home in on the Aboriginal population that we work with that the Department of Human Services and Department of Health give us, it is just under 4,000 people. If you go one step further, in the Aboriginal community, people travel. They are very nomadic. They visit from all over the country. They do not park for the night, they could park for months before they move on. That figure of 4,000, it could be 5,000, it could be 6,000.

That is being reasonable, use a reasonable hypothesis and say it is 5,000. That two people could be expected to carry that load, given the magnitude of this particular issue in terms of ice, is quite significant. That is why I started by saying it is very pleasing to know that our parliament in Victoria is taking some notice to set up this inquiry because no matter how much we see as department chiefs, I do not know whether the message is getting through, but we need more than two people to service 4,000.

Ms GRIFFIN—Also the treatment facilities we need. As Matt said, the first point of call is the hospital. When somebody has an overdose of ice and becomes psychotic, the place they present to is ED. The ambulance gets called in, they end up in ED, and for Aboriginal people, as soon as they start to come good, they are out of there, they will not stay. They are not engaging in the treatments. I have been banging on about it for years since I have been in this job. We need to have facilities here where we can treat people because all we are doing is putting a bandaid on it, then going back out and going back around into the same cycles. The drain on the local resources—the hospitals, Nolan House, the mental health resources—is huge because people are not receiving the treatment that can help them to get well and stay well. It is a bandaid approach and it is a revolving door that is going around and around.

Mr CHURCH—What I was thinking is that this is not my community and you will find that in Albury and Wodonga there are a lot of different communities coming in to the one area. It is not all Wiradjuri people here. It is a whole diverse community of Aboriginal people and that in itself is hard to understand and look at the situation like that. I think the ice problem is so out of control here. Most of the lads that I am seeing that is their preference drug on top of every other drug they are abusing. It is not the only drug, there are prescribed drugs out there they are abusing as well, and there is also marijuana and alcohol.

Mr SCHEFFER—Tim, can you unpack that a little bit more for us. I understand there are all different Aboriginal communities and groups, but what I would like you to talk about a little bit more is what are the problems that poses for your support of those communities?

Mr CHURCH—There is a divide in the community because of the different groups, because of the family dynamics and because of the misunderstanding that goes on between a lot of the groups, like, where you live—Lavington and over at Glenroy. Sorry, I am only new to there.

Mr SCHEFFER—That is okay.

Mr CHURCH—There are different groups where you live. You have West Albury and you have other places around for people who work and live, I suppose, a normal life, who have a licence and all that, that is a not a normal thing for these people. They have to catch public transport from all different places. It is hard for them to get out of that situation where they are stuck in a group of people who all smoke ice. It is not as simple as saying, 'Stop smoking and we'll get you into rehab,' because they come back to it. They are the issues tackling where that is coming from, the dealers. I have a client saying that he has told police where it is being dealt but nothing has been done about it. That is being honest about it.

Ms JENKINS—I know that for a fact too is that with police—you tell them what you have learnt from other people and they do not seem to do anything about it. It is still happening 12 months later, the same people are still dealing the ice.

The CHAIR—I know we have had discussions around alcohol being a problematic drug, a legal drug, but I see you cannot really compare that with crystal meth in that crystal meth is very profitable as a distribution sale drug, whereas alcohol is not because it is legal, it does not have a price. That is where you are very caught in this cycle of both having a drug that is very profitable in the dealership of it, but also the fact that people want to be on it. They can go to detox and rehab, but the actual high they are getting off the drug, because of all the socioeconomic factors that Di has outlined, is that they will come back to it. They are missing it in their life, it is creating such a buzz. The problem for us is how do we deal with a drug like that that has so many perceived benefits, but from a health and a mental health point of view some dire consequences, and because it is highly profitable too. We get back to this question about who is doing the dealing, because there is a lot of money in it, and our advice is somehow you have to dry up the money chain to stop the supply of the drug. In your communities, is that an organised group of dealers that are pushing the drug through or individuals that are trying to make money off the drugs so they can continue their habit?

Ms JENKINS—From this side of the border I think it is individual people, but then where is it coming from that they are getting it?

The CHAIR—We have heard it is coming through Melbourne and Sydney and places in between.

Ms JENKINS—That is where you have to go back to the bigger people that are bringing it in. There would be hundreds of people in Wodonga that are dealing ice, hundreds of them. Every now and then we hear about one or two of them, and you would go to the police and tell them you have this information, and you give them names and what you know, but I do not know what goes on behind their scenes but it never seems to happen where we can go, 'Wow, someone has been stopped.' It never seems to happen.

Mr McCURDY—Tim, the credit cycle that we hear about from other community groups, people getting caught in that credit cycle—freebies, and all of a sudden the time comes that you have to pay up somewhere down the track. The indigenous communities, do they have those same issues, they fall into those same traps?

Mr CHURCH—They definitely have the same—hook them up credit—until it is suddenly put on them again and then—I mean, that is how the clients that I have seen have got into trouble and that is why they need to go to rehab because they are so deep into it they cannot backtrack and get out of it. They have no employment, they have no job. It is definitely a big thing.

Ms JENKINS—I think too, from where I sit in this, you see families, you see kids missing out on things, missing out on food in their mouth because their parents are using ice. The money is going towards the ice instead of feeding the children or doing what needs to be done there, and then from that comes the family violence because there is no money to spend and arguments start. It is a vicious cycle, the whole thing, and there are so many paths it can take.

Mr SCHEFFER—I do not mean this question in any way to disrespect what you have told us because I do certainly respect the authenticity of what you are saying, but we have had questions raised with us about how do we know what we are dealing with. You talk about a lot of people using ice and the disruptions it is causing the community. Ambulance Victoria, for example, is saying that they have no way of measuring whether the people they are picking up off the streets—who have been disruptive or whatever, and delivering them to emergency awards—are really using ice, because illegal and people will not tell you. You are in a different space. If I ask you, do you know because people tell you or because you see it?

Ms GRIFFIN—I do a drug and alcohol assessment on every client that comes to see me, and part of the questioning is, I am finding out what drugs they are using. People do not tend to lie, funnily enough, because we build up that trust and they know it is confidential what they are telling me and they know it is going no further. That is where I am getting my information from. I see 40 clients a month, and if I went and pulled out every one of those assessments I would be able to tally up how many of those were using ice, and how many of those are using ice as their drug of choice.

Mr SCHEFFER—I know what you said with you two serving such a huge area, you do not have time to twiddle your thumbs and do stats at night-time, but you obviously do not have the staff or resources to be able to tabulate this.

Ms GRIFFIN—Sadly we do not have a program but I have been fighting for that for some time. Our current computer program is not able to pull that information out. We are about to change and I am desperately hoping that every time I do one of those assessments I can press a button and say, 'How many are using ice? How many are injecting drug users.

Mr SCHEFFER—Yes. You do not have the resources to do that at the moment.

Ms GRIFFIN—Yes, it would all be done manually.

Mr McCURDY—When people come to see you they are probably in a more rational frame of mind than when Ambulance Victoria obviously—

Ms GRIFFIN—Yes, I am sure. They would be seeing them at their worst.

Mr McCURDY—Very defensive.

Ms GRIFFIN—Yes. When the ambulance come or the police come they are usually fairly guarded.

Mr CHURCH—All of our clients come off their own bats too because they are ready for change, and they are really honest and open when we talk to them.

Mr McCURDY—They are at a low.

Ms GRIFFIN—Yes.

Mr SCHEFFER—When do you meet them?

Mr CHURCH—When they have gone too far, I think; when they are too deep into it; when their families are breaking up and they are starting to get into more trouble with the police—all that kind of stuff.

Mr SOUTHWICK—Are they referred to you when there is a court order?

Ms GRIFFIN—Yes, we get those as well. They are the most difficult to work with. If they are mandated then they are not ready. They are there because they have to be there. That is okay because we still work with them and build up the trust and the relationships, and when they are ready to change they know where to come.

Mr CARROLL—You have success stories, Tim?

Mr CHURCH—Yes, I do. What I do is transport them down to Melbourne to Galiamble because that is run by Aboriginal people. It is not a high success story but one out of five or six go through the program. It is also helping them when they come home too. They are doing a good job by completing the program but they have to come back to the same

environment as well.

Mr CARROLL—That must be incredibly difficult when they get home.

Mr CHURCH—Yes, sure. That is how close we have to work with them nearly every day to see where they are at, what they are doing, if they need help with housing—try to get them out of that situation.

Mr CARROLL—You painted a picture today of almost an epidemic in the indigenous community with the drug ice locally. We have to hand our report in at the end of August and I understand you said, Di, about tailor-made treatment facilities that are sensitive to the indigenous culture and how much that is needed locally. It almost seems what you have said today is above and beyond treatment, like some of the stories Sharyn is saying, you almost have to get right into the intervention now because there is family violence, grandparents are selling it, which is the first we have probably been told of that. We understand young kids being involved but to hear about grandparents selling, it is disturbing. In terms of intervention, do you have any ideas, like, education, prevention, that could be tailor-made for the indigenous community? I know it is a very broad question.

Ms GRIFFIN—We have mentioned it already, you really do need to work on those psychosocial needs. We have to be addressing the inequality, the disadvantage. A few of us have talked about this for a long time. 'How do we do this?' We figure that if we could come up with a model, like a therapeutic community, where families can come and get away from the drugs and learn how to live without the drugs, and gradually improve their own personal circumstances through training, through education, and develop those role models within their own group, we believe that would have a knock-on effect, a ripple effect out into the community. We are doing good work cross-border already with looking at the social disadvantage. We have some younger people going into more specific training that fits with them. We have to meet Aboriginal people at their level, what they want, how they want to do it, not keep imposing our way of doing things and expecting them to fit in because we know that does not work. It basically comes down to more people that can work with individuals on a one-on-one and support them through those hard roads to help with that behaviour change that can then spin out into the wider community.

Having our own therapeutic community here, for a start. At AWAHS we have the Men's Shed happening. People are coming there and they are touching base with their cultural roots. They are doing artefacts and learning about their culture, and they are going away on camps. I have noticed through men coming to do that has created a connection. What has happened with a lot of Aboriginal people they have become very disconnected. They have not only become disconnected from the wider society but they have become disconnected from their own families and their own communities. If you throw drugs into the mix it ostracises them even more. Having those places where they can come back a sense of belonging, that is what we need to be promoting as well—in a gentle way, not a big razzamatazz. Aboriginal people do not like razzamatazz, I have learnt. They very quietly become involved. We need to find those kind of programs and build on those programs. Find things that are working well already and build on them; not come along with yet another new idea that we impose onto Aboriginal people. Let's ask them what they need, what they want.

Ms JENKINS—I think that is one of the most important things is not us deciding what is wanted by the Aboriginal people, it is getting with them and finding out what they want. That really plays a big role in how we work with Aboriginal people. We can think something is a great idea but they do not. It is about encouraging and engaging the people to make their own decisions.

Mr SOUTHWICK—We had some evidence earlier today from Junction Support Services who said that some people have up to 40 different caseworkers and support them in a whole range of different things and different issues. Would that be the same type of thing within the indigenous community, in that your clients would have a range of people that

would be supporting them in other areas—health, employment, housing?

Ms GRIFFIN—Yes and no. What I have noticed is that a lot of Aboriginal people do not engage with the other services. They may be referred to a lot of other services, they may be on their books but they have not actually engaged with those workers. While it looks like they have lots of workers, nobody is really doing anything.

Mr SOUTHWICK—Right.

Ms GRIFFIN—They kind of fall through the cracks.

Ms JENKINS—I think sometimes in my role you do more than what your role actually is because you have made that connection with someone, and they are happy for you to travel whatever path they need to take to get to the outcome that is wanted. You might have put in place five other workers but they do not want to work with them. You have to keep working with them so they get the outcomes you want or they want.

Mr SOUTHWICK—Following on from that, is there such a program that exists around Big Brother, Big Sister type mentoring for Aboriginal communities?

Ms GRIFFIN—No.

Mr BURKE—Not really, no.

Ms GRIFFIN—We have nothing like that here.

Mr BURKE—This was a resettlement area many years ago. I will not take you through that history but several tribes were relocated here, if you go back in the history of what happened around here. As Tim rightly says if you are in your area, you are from Shepparton, you have the Yorta Yorta, you are dealing with one nation of Aboriginal people; over here you are dealing with about 11 different groups. Each one is different. Some things might be similar but generally speaking it is different. That is exactly what Tim said is an issue that he deals with, and Di deals with, that is relating to those groups. We work with a mob in Shepparton called Rumbalara, which you are familiar with, Tim. Getting back to Di's point—and I think Sharyn mentioned earlier—that having something that is intrinsic to Aboriginal people, such as detox or a rehabilitation centre in this region, as opposed to having Tim having to travel down to Melbourne all the time, when they come back there is a disconnection, because they have gone to Melbourne. That is a different area again in terms of Aboriginal space.

If there was something that could be regionalised in the Hume region, where Rumbalara and AWAHS and Mungab could all work together in some cohort, to perhaps help with those intervention strategies and preventative strategies that are needed, and get some of that cultural connection happening, that could be a useful point to start. Certainly there needs to be more discussion at community level in those areas, and before we go racing off and saying, 'Let's put that here,' well, that might not be the answer either.

Ms GRIFFIN—Working with Aboriginal people you do need a lot of resources. When I talk about resources I am talking about the people on the ground who can make that engagement because what I have noticed, some of the successes we have had, has been, for example, a young couple with a baby had all the services involved but going around and around and nothing is really happening. Tim gets involved with the young man, I get involved with the young woman, and we work very closely together, and because they do not have transport we pick them up, we make sure they get to their Tuning Into Kids parenting program, we make sure the young fellow goes to his TAFE training or whatever he is involved in. Most organisations cannot work like that but we make that extra effort to do it, and it probably steps over every single professional boundary I have ever learned but it works. It is one of the lessons that we as white fellas need to learn if we want to engage Aboriginal

people. It will truly make a difference. We have to step over our own comfort zones and our own professional boundaries and meet them where it works for them, but it does require a lot of extra resources to do that.

The CHAIR—I was going to ask a question on a similar theme. I was going to ask you about what are the trends in relation to a typical Aboriginal drug user, whereas truancy or something else is the issue, them not going to school, there is a problem with the parents. When you mentioned transport I was suddenly reminded of some other evidence collected in relation to an Aboriginal community that did not want outside rehab. In fact the public transport issue and the whole parental community thing was of more concern into keeping them where they were and having the community at large trying to help them through the rehab rather than shunting down somewhere else. This is not unusual. In one inquiry we did in Dandenong there were, I think, 136 different nationalities that were trying to provide a community safety program for. We had Pacific Islanders, Serbs and Croats, Iraquis, and you could go on and on. We were trying to find some recommendations that would suit.

We have noted the Aboriginal communities do require specific support. It is the early intervention that is probably the most cost-effective for governments. If they are not at school we cannot intervene. Is truancy a big issue? Once you become educated you become more aware of roles, responsibilities and better prospects of employment. Another issue that came up was in fact certain communities discriminated against Aboriginal people in the workforce. Even if we get them through the education system there seems to be a reluctance to take them on in the workforce. Is that the first port of call, getting them into the school system and keeping them there?

Ms GRIFFIN—I think keeping them there is the answer. My observation is that for Aboriginal people it is safety in numbers. If they do not feel comfortable wherever they are, whether that be at school, whether that be in their workplace, whether that be in the hospitals, if they do not feel safe there because they do not have their own mob around them to support them, then it will fail. The engagement will fail. It is not about just getting them into school, how do you keep them in school, and how do you make sure all those other supports are around those kids to keep them getting to school, because if things are not working at home, sooner or later that is going to fall over and they are not going to get to school.

The CHAIR—It is keeping them interested in school.

Ms GRIFFIN—All the interest in the world is not going to work if things are not working at home because family comes first. Is that right, Tim? I am speaking out of turn here because I am a white fella, but what I have observed is family is so important and the children will follow what the family is doing. If what is happening at home is drug use or unemployment or whatever else, sooner or later—no amount of getting to school and there being great programs for the kids or whatever—they are going to follow what is happening at home.

Mr SOUTHWICK—Is the drug use likely done in isolation or is it done in a group?

Ms GRIFFIN—It is a very social activity. That is usually how people get into it, through family, mostly family.

Mr SOUTHWICK—Matt, you mentioned earlier about the nomadic characteristic of many of the indigenous communities. Those that are involved in ice, would they then move around or once they have a problem would they stick around with a group of people?

Mr BURKE—They can move from group to group. Nothing says they have to stay.

Mr SOUTHWICK—From what Tim and Di have seen, are they—

Ms GRIFFIN—They tend to run away, they tend to try and escape often. They think

they are going to go to another area and their problems are going to be over, and then they discover that it does not matter where they go, the problem follows them and often they do come back. They do come back to their roots. I have worked with a number of clients that have moved away and I have thought, hopefully, that is going to be the making of them or the saving of them, and they come back and they are often worse, in a worse situation.

Mr CHURCH—None of my clients at all have said that they have sat there by themselves and taken the drug. They are all in a group environment, wherever it is. It can be anywhere. It does not have to be indoors either with them. If they are hooked, they are hooked, and it takes a lot to get them off. We cannot do anything about if they are not coming to us. They think they are not doing anything to harm themselves and they go with it. We can only focus on the people who come in to see us and that is probably not even half of our indigenous population here.

Ms GRIFFIN—Yes.

Mr SOUTHWICK—I know this is only hearsay, Tim, but in terms of some of the clients talking about their issues, are the dealers that they are coming into contact with, dealing in other things as well or are they ice dealers? Are they dealing in marijuana and a suite of other things?

Mr CHURCH—I am not sure.

The CHAIR—Any other questions? If not, any closing statements?

Mr BURKE—Thank you again for listening to us and giving us the opportunity to give you a small snapshot in a small period of time of what is happening in our community in Albury-Wodonga. We do say Albury-Wodonga, even though it is two different governments, but as I said earlier, if there is anything you guys can do in your recommendations going forward to get that support from both—the New South Wales government in this area as well—for our people, it would be fantastic.

The CHAIR—Thank you very much.

Witnesses withdrew.