LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Shepparton — 25 February 2014

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Ms L. Macdougall, Manager, Alcohol, Tobacco and Other Drugs, Primary Care Connect.

The CHAIR — I will reconvene the public hearing and call witnesses from Primary Care Connect. We have Mr Hamish Fletcher, who is the chief executive officer; Dr Paul MacCartney, who is a medical practitioner; and Ms Lynne Macdougall, manager of alcohol, tobacco and other drugs. Welcome, thank you for your time this morning. You are no doubt aware of the work we are doing in relation to this inquiry. It is an inquiry that was referenced to us by the Victorian Parliament, looking at the use and distribution of methamphetamines in Victoria, particularly ice. This is one of many regional meetings we have had in Victoria over the last six months, collecting a lot of evidence, and I think Sandy has probably provided you with some background in relation to some questions that we might want to ask of you. Please feel free, if there are any questions you want to ask of us in relation to this inquiry; we are happy for you to do so. But I would like to just read you the conditions under which you are providing evidence this morning, if that is all right.

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 have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees?

Mr FLETCHER — Yes.

The CHAIR — 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 proof versions of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. We have allocated time until 11.45 this morning for this session, and we invite introductory comments but do not encourage long introductory comments. Mr Fletcher, are you going to start off?

Mr FLETCHER — I can, yes. Thank you, Mr Chairman. Let me begin by saying thank you very much for the opportunity to present. On that advice around long introductory comments, I will keep it very brief just to say that today, as part of the team that we have at Primary Care Connect, we have brought along Dr Paul MacCartney. Obviously Paul is able to speak from a GP point of view with the work that he does here in Shepparton with our drug-treatment team, and Paul also has a long history of working with these communities in Melbourne. Also present is Ms Lynne Macdougall, who is our manager of the Alcohol Tobacco and Other Drugs team.

Primary Care Connect has been a drug treatment agency for 27 years here in Shepparton, under the community health primary health funding. I am going to let either of my colleagues talk about their response and how we attempt to allow those teams to work together to be able to support Paul as a GP, funded under the Medicare program, and Lynne and her team, working from a state-funded community drug treatment approach. It is really important for us to also point out in response to methamphetamine and its effects on our community how we as an organisation attempt to build much greater links and partnerships with organisations like the community legal service and that we have an ability to provide services to the Magistrates Court in particular, understanding that people affected in this area are far more likely to come in front of a magistrate. We provide support in that environment for how a magistrate can provide, or end up with, a reasonable outcome from that court involvement. So I can hand to Paul just to have a chat about his involvement.

Dr MacCARTNEY — Sure. Thank you for the opportunity also. I have been working for 14 years in Fitzroy at the community health centre there and for the past three years in Shepparton. The previous experience I have had is mainly treating opiate-dependent patients and alcohol-dependent patients, and methamphetamine is a more recent development.

The most important thing I would like to say, I think, is that the work that I have been able to do in Shepparton has been the more effective of the work I have done, and I believe that this is because of being able to work as part of a team. As opposed to a normal general practice, where I might,

you know, set up a shingle somewhere and have people turn up to see me, the way that it works here is that patients or clients are seen by members of Lynne's team — so they have a drug and alcohol counsellor or worker involved with them in the first place — and then through that process they are referred to see me. I see them on the first occasion with their drug and alcohol worker and a nurse who works with me, so immediately there is a team involvement. There is a sense from the client that time is given and interest is taken. We have good evidence from long-term methadone treatment that the success of the treatment is directly proportional to the time allocated, independent of the medication. I have found that this process has been fantastically useful in dealing with opiate-dependent patients and alcohol-dependent patients, but also interestingly, despite the difficulty of treating methamphetamine patients, I have found it has been a very useful way of managing these clients as well.

Often patients who are relatively organised by the time I see them will have been seeing Lynne or her colleagues for a couple of months and have been abstinent for that time. So there is no doubt that the intervention provided by the drug and alcohol counselling team and not just the talking, if you like, but the relationship has made a significant difference. Then I am able to do the things I am able to do — sometimes to prescribe medication to facilitate the ongoing recovery, sometimes to provide referrals to psychiatrists to facilitate recovery from the mental health implications of amphetamine use. In conclusion of my introduction I think there are significant benefits in a team approach where a GP with some willingness to work with this population can work with a team of people who are able to dedicate time to these patients and then be able to facilitate ongoing referrals both within the organisation and closely related to the organisation, as Hamish was mentioning.

Mr FLETCHER — If I might invite Lynne to give a snapshot of the teams that she manages and some of our response.

Ms MACDOUGALL — Primary Care Connect have been fortunate to have quite a few drug and alcohol treatment programs over the years and continue to have them. We have a Four Cs program that looks at the mainstream community. We have KADDW, the Koori Alcohol and Drug Worker — which is my position as well — that works with Aboriginal members of the community. We have two youth programs and an ABI — an acquired brain impairment — worker as well. We have got about 10 members to our team, and that makes up the programs we have. In addition to that we also have the added value of the ATOD clinic, and ATOD is alcohol, tobacco and other drugs — since nearly four years ago. That grew out of the fact that a lot of our clients were banned or not encouraged to seek medical treatment at a lot of GPs because of their behaviour. We worked out a program where they were supported and stabilised with counselling and then moved to the GP with that support. From that our knowledge has grown, and it could not have come at a better time because in that four years we have seen the incredible increase in methamphetamine in our community and coming through our doors.

When Paul first started in 2010 we had about 9 per cent of our clients presenting who nominated ice as their drug of choice. It now sits and is stabilised at around 34 per cent of our intravenous drug users. It is very difficult to get an idea of all our substance users, but our IV drug users using ice is about a third of all people that use our needle and syringe program. As I said, Paul's arrival at Primary Care Connect coincided — suspiciously so — with a massive increase in methamphetamine within the Goulburn Valley.

Mr FLETCHER — She did not mean that.

Ms MACDOUGALL — Is that one of those things I cannot say outside of here?

Mr FLETCHER — Yes, it is. We talked about that.

Ms MACDOUGALL — Sorry. But what it has done is give us a medical intervention added to talk intervention, which we have never had before. It has been fantastic.

Mr FLETCHER — Just in conclusion, Lynne did touch on what we call our needle-syringe program. We have an unstaffed needle exchange or needle-syringe program as they are now called.

We have often identified that resource as a really important point of contact with this chaotic and often frantic community. It is an opportunity for Lynne's staff members to engage with someone at a point when they are willing to make a change and move them into a medical response. Otherwise we might not have contact with some people within this community at that point of willingness to address the issue.

Mr SCHEFFER — Paul, I will come to you first. In your presentation you said that as a general principle — a rule, almost — the larger the amount of time invested in a person who has drug issues, the better the outcome. That was your proposition. One of the things you instanced as a reason for that is the relationships that are able to be built with the user. At different times throughout the series of hearings that we have conducted we have been told that the time needed for a person to detox from methamphetamines is longer than, for example, the time needed by a person using heroin and that there is a stress point around that with resources that are available. Coming from that space, could you talk a bit about why, beyond the relationship, which is important, the long investment has the better outcome and what kind of pressure that puts on you in gathering the resources to do that.

Dr MacCARTNEY — I think there are two aspects to that.

Mr SCHEFFER — Yes, there are.

Dr MacCARTNEY — There is a physical withdrawal process to achieve detox. I am rather cynical about the idea of detox. Physically, with heroin for example, it is very clear; people can be physically detoxed from heroin within seven days. It makes absolutely no difference. If you speak to people who deal with patients suffering this illness, 99 per cent of people will go back to using that drug very soon after that detox process. The physical detox itself is not the issue. As I say to patients, this is all psychological in the same way that requiring a breath is psychological. We can all hold our breath for 3 minutes, but we do not; our brain tells us we need to — this is what people are going through.

For people with methamphetamine use the detox process is probably around 14 days of feeling pretty miserable. If we can get people to 14 days, there is perhaps the potential for them to continue on in a form of abstinence. The issue with that, though, is that after 14 days there is still the psychological issue that remains. It is very strong.

Now I will go to the other issue, which is the time allocated to patients. This comes to a more general understanding of the cause of addiction. There is a very interesting doctor in Canada, and if you do not mind me quoting — I have written it down. I think it is very interesting. In referring to addiction he says, 'The primary cause always involves the separation of an individual from the sources of meaning and identity that are normally found in human society'. In my opinion the reason that the success of treatment is dependent on the time is that it helps to reconnect people with sources of meaning and identity in society. If you have a doctor, for example, or professional case manager — somebody who connects and spends time with people — that is the point of connection between the patient and society again. You start to develop that identity and sense of purpose and meaning. In my opinion that is the importance of the spending of time.

GPs in general do not have time to spend. They are not that interested in spending time with this population of people. In this town we have been doing some work in the four years that I have been coming, trying to encourage the treatment of people who are dependent on drugs that we have excellent treatments for. But even that has been a bit like banging our heads against a wall. It has really been hard work. If we have got individuals who are interested in doing the treatment, their practice principals have prevented them from doing so. The people who own their practices have said, 'We don't want these people in our treatment' — I heard Dave on the radio, who spoke to you yesterday from Wodonga, saying the same thing about hospitals — 'We don't want to treat your sort of people'. It is all too common. We even have senior leaders in our community here — —

Mr SCHEFFER — Can you either just indicate to us or point us to a source where we could identify the steps that you or people working in your field use towards reconstruction or

construction of societal meaning? You do not have to answer it now, because it is complex. But if we could have something, it would be good to talk about that in the report.

Dr MacCARTNEY — Yes, I can prepare something on that.

Mr McCURDY — In that same vein, would it be true to say that post-treatment programs could be more valuable in regional Victoria than a rehab facility, for example? We can get the rehab done wherever, but the post treatment, particularly in regional Victoria, is the ongoing support that we need more than anything else.

Dr MacCARTNEY — I think so. One of the weaknesses of rehab — and I do not mean to dis the whole system so far — is that people are pulled out of their community and sent to a foreign land. They go into a place for 3 months, or even 12 months or two years in some cases, and they learn some connection. The reason it works is that they develop therapeutic communities. They develop a source of identity and meaning with the people they are with, but then it finishes and they are plonked back into their community. Again they are struggling for those sources of identity and meaning. I agree with you, Tim, that post-rehab is absolutely vital. Building connections within the community is essential.

At Primary Care Connect we have been fortunate enough to be able to have psychologists on site. There is learning to develop a sense of meaning, if you like, and building that capacity. We have physical health services; people can see a dietician and start to become physically healthy so they can contribute. We have a relationship with work trainers — a job rehabilitation service. This is what becoming a whole person is about. It is about connecting on the bio-psycho-social level. That is the framework we always use.

Mr SCHEFFER — You did not answer the bit about the resources.

Dr MacCARTNEY — The resources, I think, are difficult, and I do not think that the medical system is particularly good at building these connections again. I can only speak from my perspective, but the way I would work with people is by allocating time. The mentor who trained me in dealing with people who are struggling with substance abuse used that process. He spent a lot of time with people, and through that connection over time — it is not a miracle; there is no magic wands in this situation, but by giving that time over a prolonged period we see significant improvements in people's lives.

The CHAIR — Allocating time is nice, but the fact is that if we went to Odyssey House, we would see 50 or 60 there all going through some rehab and a waiting list of three years. I am just trying to take your scenario of time, and I am not sure what resources are required for that time. It is almost like a one-on-one case management of connection again. Is that really possible when you have got 300, 400 or 500 who are looking for time and resources?

Dr MacCARTNEY — It is absolutely not, of course. There is time and there is time. There is that significant intensity that is offered through organisations like Odyssey House, which is, as you say, nice but not practical. I am speaking from the perspective of seeing people get better through interaction with Lynne and her team and through that ongoing relationship. I saw a young man on Friday who had been a methamphetamine dealer in Frankston. He had an interaction with the courts and as a result had stopped. He had been abstinent with the support of Cara, one of the workers from Primary Care Connect. He said to me quite clearly, 'She gave me the time. She was interested enough. She is the first person I have ever been honest to. I have pulled the wool over the eyes of psychiatrists, counsellors and psychologists for years and years, but she is one person who is making a difference to me'. That support is what makes the difference in the end. I really believe there does not have to be a time when you are in a camp together, but a time, as Tim sort of hinted, when you have a relationship with a person who can help to guide you back into connection, and that counsellor may have a number of clients.

The problem in Victoria at the moment is that services for community drug treatment have been tendered out and that role has been whittled down significantly and pushed across as a cost-shifting exercise onto psychologists, because that becomes a federal government funding issue. There is a

high risk at the moment that Lynne and her team will be not around in the next few months. I think that would be a disaster.

The CHAIR — Does Lynne know that?

Dr MacCARTNEY — Yes, she does. It is nothing to do with me. It is this sense that it is not just a practical thing, it is the connections, the relationship with the people who have time to offer that relationship that makes the difference.

The CHAIR — We hear what you are saying.

Mr CARROLL — Congratulations, Primary Care Connect, on all you do and for your written submission. It is excellent. I think we could pick your brains all day, to be honest. We have heard a lot of the evidence on what you are talking about, Paul, about the holistic approach and time and looking at what led the person to the drug, their background DNA and the psychological issues with it. We appreciate you putting all that on the record.

Following on from what you said about the outsourcing of the community drug treatment program, I want to get to the heart of that. I also take up your point that it is a psychological issue. I remember when the commonwealth government used to provide the mental health plan, I think it was called.

Ms MACDOUGALL — They still do.

Mr CARROLL — They still do that? I think it is 20 sessions at a wholly subsidised — —

Dr MacCARTNEY — Six initial sessions and then another four per calendar year. Up to 10 calendar visits per calendar year.

Mr CARROLL — Okay. It is not a lot when you are talking about time. On that post-rehab area, I am just trying to work out what the committee can do to try and assist in that way in terms of recommendations. It does seem, from some of the evidence we have heard, that we need to look at inter-agency agreements and how that all works, like from Goulburn Valley Primary Care to Odyssey House, and priority access to things like that — just how the whole relationship would work. Do you, Lynne, want to just talk about that? I know it is a complex question I have asked.

Ms MACDOUGALL — Yes it is. The first thing that comes to my mind, Ben, is that through a better understanding of the sentencing options coming from the Magistrates Court I think we can develop better streams of treatment. That is a cohort of a lot of methamphetamine-using clients who end up in front of the court. It would be a way of almost trapping that group — trapping is probably a bad word — but utilising the courts as a referral agency. That is already in place. The courts still sit there. They have diversion, they have access to different sentencing, but it is underutilised to a certain extent. Not all areas of Victoria are set up to take all the work coming out of the Magistrates Court.

Mr CARROLL — Very good point. Just on that, we have heard a lot of strong evidence on the CISP program that operates at the Latrobe Valley Magistrates Court.

Ms MACDOUGALL — Yes; not here.

Mr CARROLL — Exactly, the court integrated services program.

Ms MACDOUGALL — We have developed that ourselves. We saw that that was a real need at our courts, so we developed a roster of workers so that we always have someone down at the court to do those cell assessments, to respond to the magistrate if they require a screening or assessment to see if drugs are a contributing factor to their offending. Then the magistrate will stand that matter down. They will do an assessment, then the recommendations will go back up to the magistrate. It works really well. We would have loved to have the funded model, but we do what we do. It has been incredibly successful.

I did hear, as I came in, some comment made about mandated clients probably not being the best place to capture clients for treatment. Yes, that is true, but if you have got them, you have got the opportunity. No matter how they walk through the door, whether it is pushed or whether they step in themselves, that gives us an opportunity, and all drug treatment service is an opportunity to start doing that connection. They might come in belligerent and angry, but it is certainly our job to make them feel that we are there to work for them, and that is what we do. I think we do it quite well, and I think most of the drug treatment communities over Victoria use that opportunity; they do not let that chance go by just because they are mandated.

Mr SOUTHWICK — Two questions. Firstly, it seems from the evidence we have heard so far that a whole lot of great work has been done, and we have heard about some of it today, but for the users, if they are not referred via a court or via a hospital, there is the difficulty of them finding where to go or what to do. There is that sort of missing link of information. Is that something that you are seeing as well? Is there a solution that we could have, particularly with this drug that seems to be taking over areas in many respects — almost like a signal of an ice hotline or something that very much refers people over to service provision like yours?

Mr FLETCHER — I can respond to that if you like. I think it is really important, and I am speaking from the CEO's point of view, to acknowledge that Lynne and her team run in excess of the current funding requirements when it comes to the key performance indicators. We go above and beyond; the court assessment and the cell access are things that we fund out of our own pocket. I make that point because, when you attract the attention of the desperate community, and often desperate families, struggling in this environment, the resources to meet that demand are expensive. In our own community I think, in round figures, last year, in the last recorded year for our organisation, we saw up to 1000 people come through the drug treatment program.

Now we are about to go into a re-tendered environment in the state of Victoria where this catchment of Goulburn that we are in will move to activity-based funding, and there is a capped catchment of involvement from Yarrawonga to Wallan. We are part of a consortia obviously re-tendering for this business. We believe that as an agency we can pretty much meet the catchment requirements for the tender just with Shepparton, and that has to spread from Yarrawonga to Wallan. That is probably as crude as you can put it, if you like. You could not argue around your point of creating a much greater access point for struggling community members to know how to support their child or their workmate, but in the chicken and egg scenario we would have to have that system in place of what we would do with that extra traffic.

Mr SOUTHWICK — Following on from that, a lot of the people that you and other agencies are seeing tend to be people who finally recognise a fair way down the path that they need help. What can we do in the earlier years in terms of supporting those who are relatively new to experiencing the drug? I take up Paul's point before about the problem and the solution of very much filling a gap in their lives of a need for something that they are not able to experience, and the drug ice fills that gap. Is there something that we could be looking at in terms of mentoring or supporting one another and young people in a broader program, to give that broader community responsibility around providing support for those who are looking for something else and needing someone to talk to and needing advice?

Mr FLETCHER — If I may, just before Paul, I think it is really important to draw attention to the nature of this substance and to the fact that we see with young people, say, cannabis as a gateway substance, spending months or years. I will let my colleagues talk about that experience, but before they get to that, with something like methamphetamine your pathway between using the substance and ending up involved with the legal system, in many environments, is incredibly short. I have a long youth worker case management background, and it is a very difficult environment to create a peer-led mentor program with such a horribly invasive and voracious substance as methamphetamine. Lynne's team runs Cautious with Cannabis. There are a number of similar types of programs we would use that I think relate to your question, but I will let Paul talk a little bit about the nature of this substance and how quickly we find those susceptible to addiction in that trouble.

Dr MacCARTNEY — Just in response to your question, Mr Southwick, I am glad Hamish spoke because it gave me a chance to have a think about it. The question is, and it is an age-old question: what can we do to prevent these kids using drugs? The first thing, in my opinion, is that you have to identify the children who are most at risk. While I am sure you have heard evidence that there are all sorts of people in the community who are at risk of using this drug, the significant proportion of people in those who end up fronting the courts and those sorts of things are from a particular demographic, where there might be intergenerational unemployment and intergenerational drug use. I do not believe that we do enough to identify those children who are in that environment. I mean, you have to be a child out of the box to not get dragged down this path, if you are in that scenario.

The evidence around the world is that drug education does not make that much difference in schools, but what does make a difference, the one thing that has been shown, is that if you support at-risk children in their first two years of life — that is, you are supporting their family — by identifying at-risk mothers and supporting those children, then 15 years later those children will be much less likely to be using drugs than anybody else, of people who did not receive that support. In the UK — I am not sure whether it is still going — but until the recession they instituted this program of providing support in the first two years, which is a midwife attending the home, providing monthly support to the mother or the primary caregiver to learn how to parent a child. That makes a difference 15 years later. But it is a challenge for any government to be planning that far out. But that is what makes a difference.

Mr CARROLL — So a woman comes in — she could be single — and gives birth to a child. Are you suggesting that almost right at that moment the health-care professionals who are assisting her identify the newborn as potentially a child at risk, and then there is a referral of some sort so she, in her first couple of years, can have assistance with that child?

Dr MacCARTNEY — I think something like that would be good.

Mr CARROLL — In an ideal world?

Dr MacCARTNEY — Yes.

Mr CARROLL — Would the referral be to a Primary Care Connect or someone?

Dr MacCARTNEY — It could quite possibly be, but there is some advantage in it being directly related with the hospital or increased support for the infant welfare — child maternal health care kind of support. It does not have to be particularly intensive or it does not require doctors. It is providing some parenting guidelines for the people. In the end, the hospitals tend to know the women — obviously, they are the ones having the babies — who are at risk in this situation. One of the challenges is for those women who may be at risk to be able to identify and be honest about what has been going on in their lives for fear of the children being taken off them. A more significant DHS involvement is one of the fears, but I think there certainly would be an easier middle road.

The CHAIR — Can I pull something out of the submission. In your submission you said:

> Shepparton has one of the largest Aboriginal populations in Victoria and the emergence of ice as a drug of choice to a population that is already dealing with health and social consequences of long-term substance misuse is devastating.

You say in your submission the Koori Court with the elders and respected persons assisting the magistrate also are having problems understanding and knowing how to deal with particularly the impact of methamphetamines within their own community. I ask this question because the next witnesses will be coming from an Indigenous cooperative. In respect to training and helping those elders come to grips with how to deal with this drug, do you have some guidance perhaps or experience?

Ms MACDOUGALL — I sit with the Koori Court, and it is through my experience that comment has been made with the number of people attending Koori Court now who are stating in

court their offending has been under the influence of ice. With the increasing clients in my own workload — and I only see Aboriginal clients — the numbers now are excessive. Nearly all the clients I see have ice either as their primary drug of choice or it is one of the multiple drugs they use. That has been an amazing change in the way Aboriginal communities within the Goulburn Valley use this substance. When we sit in Koori Court one of the things that the elders and respected people do is give some cultural advice and support to the magistrate prior to sentencing and fill in the magistrate a little bit with the connections with community and cultural implications of the person that sits in front of them.

In my opinion this is causing a great deal of concern amongst the elders, because they do not understand this drug. They can reflect back on their own experiences which may have been that they have seen alcohol as being a very dangerous substance within their community and through their history, or they may even be able to reflect back that they have used — or not that they have used, but they have seen — how cannabis has also impacted on their community. But with this drug they have nothing to go back to, so they are sitting there with lots of questions about how they as elders of the community, as respected people within the community, can support the community when they are using a drug with which they have no experience.

How can they be supported? They could be supported through information sessions being targeted to the court, to the elders and to the respected people so that they would get some information and some understanding of how this drug works. It would not be that difficult to do.

Mr SCHEFFER — I will follow the chair's question because I want to ask something about that. Being mindful that we are talking about colonised people and the kinds of social disruptions that Paul was referring to at the outset, I think we are all profoundly aware of that type of context, but in meeting with people speaking for Aboriginal communities what has been put to us is that the services are not targeted. I think they have mentioned a few ways they are not appropriate — they are not accessible, they are not affordable — to Aboriginal communities. In your work with them, how do you try to get over some of those problems, with a widespread perception from the Indigenous community about 'white services'?

Ms MACDOUGALL — I can talk to the point at which they go to Paul. Our service is free. Obviously all the services provided at Primary Care Connect are without charge, and access is built up through knowledge and being part of the community over a period of time. You build up. People know you are there. An aunt or an uncle or a cousin or a friend or somebody has been to the service. Word of mouth is huge, and that is how we work through that process. They come to us. They start to make connections with workers within our agency if that is what is required. Paul's service is also no charge; he bulk bills all the treatment through the clinic. If they get a mental health care plan, that is also without charge, so they can go through and have a whole lot of professionals working with them with there being no charge, and that joined up care is very culturally appropriate. We have quite a large Aboriginal community within our ATOD clinic and within our services themselves, and that is just a relationship that has built up over a long time.

Mr FLETCHER — If I may, I was speaking to our dear friends at Rumbalara just before we presented. Primary Care Connect is a mainstream agency, and we see ourselves as an agency of choice for members of the Aboriginal community. Rumbalara runs a huge amount of programs that cover many of the needs within a person's life experience, and we believe that if a community member does not want to access Rumbalara for support around substance abuse, we can be an agency of choice. But it is really incumbent on us as a mainstream agency to ensure that a community member gets access back to family services, dental services or a range of other provisions that Rumbalara does and does very well. In that mix we create a culturally appropriate and safe service response given that we work alongside the largest Aboriginal population in Victoria and a service like Rumbalara with its history and its commitment to the community here in Shepparton. That is a very important point for us as to where we sit with service to the Aboriginal community.

Dr MacCARTNEY — Very briefly, I have not had a lot of experience in looking after specific Aboriginal populations, but I will emphasise again that as a result of working in a team clearly

there is a need to be sensitive to particular needs, but because the clients have a relationship with Lynne and her team that facilitates the process. That has been very useful.

Mr McCURDY — Hamish, very quickly, in your written submission one of your recommendations highlighted that particularly in regional Victorian local court users networks there are no representatives from the medical community and that GPs were needed on the boards. Can you expand on that?

Mr FLETCHER — In those networks that we would include, it is often very difficult to bring members of the GP community into what is our normal interaction from a community services point of view and often to create an environment for a GP such as Paul who has a clear connection in this environment. But I would think as part of our core network we would open up that environment and try to create the access as appropriate, given that GPs are often running a private business in the community. Community services like us need to be very cognisant of what it means to work in private business and then be involved in the types of meetings and committees that become somewhat bread and butter in what we do.

Dr MacCARTNEY — The challenge is having enough local GPs interested in the topic; that is the challenge.

The CHAIR — All right, we might have to draw to a close there. Firstly, thank you very much for your submission. We have pulled bits and pieces out of it as required this morning, but obviously it will form a large part of the report that will be tabled to the Parliament at the end of August. I thank you on behalf of the committee very much for your time this morning in presenting to this inquiry.

Mr FLETCHER — Thank you very much.

Witnesses withdrew.