LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Traralgon — 28 January 2014

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Mr Christofer Beal, Coordinator, Tanderra AOD Services, Bairnsdale, Gippsland and East Gippsland Aboriginal Cooperative (GEGAC).

The CHAIR—Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Joint Parliamentary Committee. You understand we are conducting an inquiry into the supply and use of methamphetamine, particularly ice, in Victoria.

Mr BEAL—Yes.

The CHAIR—Thank you for your time. I understand we have Mr Jon Borkowski, who is the coordinator of Alcohol and Other Drug Services Morwell, and Mr Christofer Beal, coordinator of Tanderra AOD services Bairnsdale. The organisation you are representing is the Gippsland and East Gippsland Aboriginal Cooperative.

Mr BEAL—It certainly is.

The CHAIR—On that basis I would like to say that this committee would like to pay its respects to the custodians of the land on which we are meeting here today and pay our respects to the elders past and present.

Mr BEAL—Thank you very much. Representing an Aboriginal organisation, I would like to acknowledge the traditional owners of this land and its elders past and present also.

The CHAIR—If you bear with me for a minute, I will read you the witness conditions. Welcome to this 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 evidence to parliamentary committees?

Mr BEAL—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 a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. We have allowed time till 12.30 for this session. Are both of you making a verbal submission?

Mr BEAL—I will be making a verbal submission, but Jon will be chipping in as required.

The CHAIR—Thanks very much.

Mr BEAL—No problem at all, and I would like to say thanks to Sandy for supplying such a thorough presentation outline, which really helped greatly.

We had 14 questions to respond to. The first one was whether, in my experience, crystal meth use was becoming more serious amongst Aboriginal people in the region and, if so, why. 'Why is it occurring now and how does it compare to the use of other drugs?' There is certainly an increase in reported and treated and anecdotal cases of methamphetamine usage. There has been an apparent increase in availability around market supplies, I believe. This is around supply and demand but also demand and supply. The low financial cost, the administration of the drug in a number of ways, including smoking and drinking, its use recreationally in social settings and the extreme stimulant effect all contribute to experience and, worryingly, the potential to self, family and the wider community.

However, I do believe that we must put this into context. Currently 79 per cent of representing clients of GEGAC are identifying alcohol as their principal drug of choice—a legal drug, a socially acceptable drug and as damaging, some may say, as any other drug. Cannabis comes in at 12½ per

cent. Ice, including amphetamine, comes in at 8.5 per cent. It is interesting to say that, because current reporting systems do not allow for a breakdown of ice and methamphetamine. This is something we are working on with the regional department to rectify, and hopefully that will enable us to collect some proper data and actually be able to use it for something constructive.

This is not to say we are complacent about the issue of methamphetamine. The uptake in usage is increasing. It is being taken throughout all communities and by people of all ages. The effects are obvious to those using and those coming into contact with those using ice. As with all class A drugs, usage rates are difficult to predict accurately. Due to their illicit nature, people are less likely to divulge and less are coming into a therapeutic alcohol and drugs setting.

When you speak of consequences, it is more a question of potential damage. Increases in violent assaults in community and family have been reported in the media and raised in the community. Our work with the VicPol family violence correction units has shown the links between family violence and methamphetamine use. We already have extremely high referrals to Child Protection in this region.

So it is more a question about what the damage could be, how it could look in a year or five years; socially the damage caused when there are increased incidents of violence against families; the destruction of social fabric. We are already, as I said, over-represented in referrals to Child Protection. With increased issues created by addiction and dependency, this situation is unlikely to improve. The impact on children, both through use and through association or coming into contact with people using meth, is obviously of great concern to us as well.

Financially, although comparatively inexpensive, any expenditure on ice or amphetamine of any sort will be placing more stress on a group of people in a low socio-economic group anyway, impacting on their purchasing of essentials, including food, education, health and housing.

To the individual impacts, you have the physical impacts; increase in violence; erratic behaviour, resulting in impacts on ability to work and engage socially; forced involvement with the Department of Human Services, Child Protection included, police and the Justice Department; the ravaging of physical health, the health of muscles, teeth, mouth, unknown long-term physical impacts, but again Aboriginal people are over-represented in poor-health statistics. The use of ice will again not help this situation.

Injecting users are at risk of hep C and other hepatitis and AIDS. Smoking users: damaging lungs and mouth; increased STD, what with the breakdown of inhibitions, again an issue in Aboriginal society but across the board as well, I believe; physical accidents and injuries; the risk of driving—drug-driving is a huge, increasing area we are coming across at the moment—and if that person is able to detox, the rigours of going through detox are extreme with ice—I have not heard a great deal about that, we can allude to that a bit more later—and the likely relapse as well. So you are in that cycle of detox, back on it, detox, back on it.

Mental health: obvious links and a growing body of evidence between ice use and psychotic behaviour and long-term damage. There have been a number of cases I am aware of myself to the local Flynn Ward just over the road there, which I believe personally were isolated. The impact of people with existing mental health issues must also be considered.

Next question, 'Is it as addictive and is it used as a social recreational drug?' Ice is generally stronger and more addictive than any other types of amphetamine. Amphetamine type stimulants are often used as a social recreational drug to begin with and the addictive nature of ice as reported could see a potential increase in non-recreational use, moving toward habituality and then dependency. We must consider the pharmacological addictive nature but also the propensity for groups in lower socio-economic cohorts who will consider to try, use and experience further or more extreme dependency.

Ease of access: anecdotally easy to access and readily available. Relative simplicity and mobility of set-up: recently in Bairnsdale we had two clandestine labs broken down. I believe if there are

two, there will be another two the following week. The demand is so high that supply does not necessarily need to come from out-of-area. It can be dealt with in-house really, region by region.

Another issue particular to the Aboriginal community is reciprocity or sharing. When you are in a community experiencing poverty, there is often a need to share essentials such as food. This is also the case with those in addictive cycles. If you do not have enough food for yourself, you can borrow off somebody else. However, you are now obliged to help that other person out. You create a cycle of dependency, now involving a number of people.

Sources of supply: the neutrality of our therapeutic service at GEGAC enables clients to access us with confidentiality and with confidence. We do not seek out sources of supply, and it is known by our clients that this is the case. That is the role of the Victorian Police.

'Are Aboriginal people more vulnerable and why?' The Aboriginal community generally, as we know, experience lower socio-economic opportunities and higher rates of unemployment, homelessness, referrals to protective and correctional services, alcohol and drug issues, poor health and over-representation in the criminal justice system. This already puts Aboriginal people in a more vulnerable position. However, the increase in anything that could potentially put further strain on the community could be disastrous.

Polydrugs: what are the drugs and consequences? Again, reported usage would often be associated with alcohol and cannabis. Ice reports by principal alcohol and drug users are classed by us as recreational and social. Usually this is the early stages. The group who use prescription medication are reporting higher ice and amphetamine usage, and this may be around the use of a stimulant and your benzo type drugs, where you have your up and your down cycles, so using benzos to come off the ice, then back on the ice, back on the benzos, again creating a cycle of dependency. Consequences would be the dangers to a user's mental health and their physical health and the potential danger to community and family, dealing with someone who may not know what they have taken and how it will affect them. This is especially the case when prescription medications are abused.

'Treatment options, challenges providing these options and what other options are available, specialist or general?' The Morwell office of GEGAC runs an intake and referral service and works in partnership with the existing mainstream services in the area. In Bairnsdale we offer counselling but also an AOD community nursing service, so that basically means that the nurses will go out and do promotional work but also do some general health care for the clients that come to our service. They are reporting physical issues with clients on ice.

Our holistic approach enables us to refer and work collaboratively with other GEGAC services internally, and this is important for the community, that they can come to us for AOD issues. We will undertake a full assessment of their problems and we can then internally refer to the most appropriate services, maybe family services, family violence counselling—medical services as well. There is a whole raft of services and I will supply you with documentation regarding GEGAC and what we can offer.

There is a recognition that mental health and an AOD service need to be carried out in a complementary manner. We do this by engaging with our own GP to develop mental health plans and we also work with psych services in an ongoing case management setting. We also have specific services for ABI clients that we access, and of course you can have an ABI from drug abuse. We also provide forensic counselling for Department of Justice clients and work collaboratively with the Department of Justice to ensure that the best treatment is received by our community, working towards better outcomes. We do arrange detox and we do arrange rehabilitation.

I think it is worth mentioning Wulgunggo Ngalu at this stage. The esteemed magistrate mentioned the service earlier. I would have to agree that it is a good service. However, it is only available to people post sentence. There is no opportunity for early intervention. It is for men only, so the women once again, and the children, miss out. We find voluntary services are accessed more freely and the results are possibly better.

Challenges for us with the client would be the initial engagement. The erratic thought process makes it very difficult for them to know really what they need and what they want. However, we consider it a success if they come across our door. The willingness and capacity to access the detox and rehabilitation services is also a major issue.

Available services for us: we access a number of traditional detox services in various locations for those in the chronic and the problematic cycle. Recent development of ice specific detox—and this is an Indigenous specific ice detox—is on the table. They are looking at an extended detox process up to six months long. If you consider that a traditional detox is rarely more than two weeks, I think there is some recognition—and this is coming from North America with their indigenous Indians—that it is not a short-term, short sharp shock. This is an ongoing issue, and even after that length of time there is a need for ongoing therapeutic support.

Whether the services we access, the mainstream services, are effective for Aboriginal people is difficult to say. However, I will say that results from culturally specific programs show increased levels of engagement and are preferred options for our community.

Regarding the access to these programs, we have to say that GEGAC's two sites in the Gippsland area provide counselling and AOD nursing, as I mentioned. There is no culturally specific detox or rehab in the area, and I think it is also worth saying there is no detox or rehab service for anybody. We have minimal access to hospital detox. The detoxification of methamphetamine clients in a hospital setting as they are set up now I would have to say would be inappropriate. It is not that you can throw them onto a general ward. It simply would not work. It is just catastrophic for everybody involved.

With limited detox opportunities—I will give you an example—say we have to get a client into detox in Melbourne. That is a 300-kilometre-plus one-way trip, so for myself that is a drive into Melbourne and a drive back in one day, 700 kilometres. After they have been to detox they may choose or be guided into going into rehab. Three months ago I delivered a client to Echuca from Bairnsdale, a 700-kay one-way trip. That gives you some idea of the difficulties we have in accessing culturally appropriate rehabilitation for clients.

Issues with the nonavailability of local services, barriers to people wanting to access, is being away from family, as also mentioned earlier; no contact while in rehab with their family; feeling unsupported and vulnerable; and the impact on services, dollars and time, and that goes for the clients' families as well.

I would like to also talk about the reduced sentencing options, particularly in Bairnsdale. I would agree that the CISP program is a fantastic program and has shown great results. We unfortunately are unable to access that service in Bairnsdale and I would strongly support any move to increasing any assistance in that regard. There is also the CREDIT/Bail system, which has proven to be very effective.

'Can interventions be tailored to meet the needs of Indigenous people, particularly in rural areas?' Yes, they can. Speaking with the communities is vital. How are things affecting them? What do they think is the best approach? Every community is different and it is unlikely that a one-size-fits-all approach will be effective. There needs to be recognition of those hard-to-reach rural and remote areas through targeted funding and resourcing; consideration of culture, again through effective and meaningful consultation. We need education, not scare tactics. People need strategies and tools to help with their families and their community, and this is about quality information.

One thing I would like to raise is the need to train up the community. Our workforce contains very few Aboriginal people. I sit here as an Englishman, Jon here is an Australian non-Aboriginal person, and this is pretty much how the system works. I think we really need to drive getting the community working for their own communities. We need a new employment strategy in that regard.

There is also the issue of 'Is the increase in meth use a symptom of the underlying issue or is it the cause of the issue?' As I mentioned before, we have extreme poverty, we have housing issues, we

have poor education outcomes, we have poor health outcomes. Is ice just another contributing factor to this or is this something that people are using to get away from the terrible options that these people have?

'How effective have past policies been on ice?' Ice is a relatively new drug. However, there is a body of evidence of effective and less effective strategies from elsewhere in the world. North America, as I mentioned, has experience of indigenous people and ice and it does not look good. Current policies are not adequate. Due to increased availability and usage, the previous amphetamine policies were not ice focused. This needs to change. Emphasis on diversion and early intervention has proved effective and partnerships between statutory and non-statutory organisations are essential. Nobody can do this alone, and I might say that we do a lot of work with the police, Child Protection, Department of Human Services, working in a collaborative and partnered way as opposed to statutory versus non-statutory. We get really good results. The community are becoming aware of these relationships and are looking at it as a positive as opposed to a negative. We are there to advocate for our clients to make sure that the outcomes that they receive are good.

What strategies do I think will work? A strategy I do not think will work is the continuing move towards centralised intakes. The beauty of the current system, especially in the Aboriginal AOD setting, is the ability of clients to walk up to a service and begin treatment. We recognise that if somebody wants to make a change, they want to do it now. That initial phase of treatment can often be the most important and the placing of any barriers may affect that person's recovery. There should be diversion as opposed to incarceration. Education and alternative treatments need to be considered. The over-reliance on jail terms and punishment has little impact on reducing drug usage and its impacts. We need education; a properly funded and recognised AOD sector; easily available detox and rehab. It is time to start treating dependency as an illness as opposed to a criminal activity.

Early intervention, as I mentioned before, and we will continue to do so. Education within schools and colleges needs to be increased, avoiding hysteria. I have just been talking with my colleague sitting over there, and he is saying that this needs to be at year 7 level. These kids are not staying in school past year 9, so getting them at year 10 is not going to do any good. We need to get them when they are there, when they are in school, when they are young and you can actually get some information into them.

The continued and promoted partnering of services: linkages between police, as I mentioned, DOJ and community service organisations. This is occurring and those involved should be commended for realising that this is not a problem that can be dealt with solely by the police or Aboriginal services. The whole of society is impacted by drug dependency and we must take responsibility. I will leave it there, thank you very much.

The CHAIR—Thanks very much, Christofer. Jon, did you want to make some supplementary comments?

Mr BORKOWSKI—Yes. In relation to whether ice is addictive, I have only been here for a short period of time. I spent 10 years up in the Pilbara working for the Department of Health and also working with the mining industry. There was a question asked earlier about testing by industry in relation to drug use. I have had a lot of experience with that, and unfortunately it does not work, mainly because the testing is not comprehensive enough. The industry itself does not like the idea, because it puts an onus on them to report, which they do not like doing. It can be tested for, yes, but it does take a period of time. So workers are usually suspended if they are suspected of it until confirmation is required.

A lot of the workers up there were actually using ice—it became a real issue about five or six years ago—as basically a social usage. They were not necessarily addicted to it. It would be once a week, sometimes twice a week, usually on their days off, because by the time they got back to work, if they were tested, they were usually clean. I cannot really say that it would be as addictive as some of the other harder drugs—heroin, for example—because it certainly can be used just on a social level.

The other thing that Chris raised was training up Indigenous people to work in our field, to help them out. One of my roles there for 5½ years was managing the Aboriginal drug and alcohol program, so all of my staff were Aboriginal people, all university-trained. Our success rate working with Indigenous clients was far higher than the mainstream. So I really think that one thing that the Victorian government could look at is improving training for Indigenous people that want to get into this particular field, because it does help, especially if they are from that particular region, because there is a lot of association, a lot of family contacts, and quite often they are very well respected. I think that is a good area to look at.

The other one is the area of dual diagnosis. I think that a few years ago training in dual diagnosis was quite big. There was a lot going on. Unfortunately, over a period of time that has declined. Within our field we have a very high turnover of staff. If we are getting new staff coming in that have not been trained in dual diagnosis—because we know that there is a link between drug use and mental health issues—we struggle. So training is extremely important to be maintained within our sector, especially looking at new drugs coming in, because ice is relatively new. We know how to deal with amphetamines. Ice has a different aspect to it. I think that is about it for me.

The CHAIR—All right, thank you. You talked about extending the detox unit, which is on the table. What authorities are dealing with that?

Mr BEAL—There is a group called Telkaya, which is an Indigenous network, and it was brought up within that group. They actually brought some indigenous peoples from the United States over, and that really got the conversation going about what is required and their experience. This is the whole thing: there is a huge body of evidence. Although it is a fairly new story in Australia, although Jon believes five years ago there were problems up in the mines, there are things that we can look at. One of those things that they spoke about very clearly was that we need to extend that detox period.

I am unable to tell you who exactly is doing it at the moment, because it is not actually running as yet. The last meeting we went to, they were kind of another step closer to it. But it is for Indigenous peoples. It is an extended detox and a supported program afterwards, and this is the real crux of it. You finish detox, you go back to your home, you go back to your community. You may have changed but very little has changed from where you have come from. It is about wrapping that service around them. It is about that holistic approach as well. If they want to get into education or they want to work, that there are people there to facilitate that happening as opposed to them coming back and going, 'Dave and Steve are back on it. You know, it's easier for me to rejoin my social circle, as opposed to sitting in my house on my own thinking about what I can do.'

Regarding the question about 'where is it?' I will find out where it is likely to be and I can inform you of that, but certainly for me it is more of a responsive way of dealing with the issue at hand. We did not know that we would have to be doing five months of detox, but we gathered information, we spoke with people who have been through that experience themselves, and hopefully we can put that into place, but again it is about resourcing—available resources, future resources—so we are just having to wait and see really whether this is a goer and whether it gets built.

The CHAIR—Thanks for that. Mr Scheffer.

Mr SCHEFFER—Thanks very much for the presentation. It was very informative. I think you said, 'What we need is education and reliable information and not scare tactics.'

Mr BEAL—Yes.

Mr SCHEFFER—What are the scare tactics you are referring to?

Mr BEAL—For me, I do think that the media are prone to—maybe 'exaggerating' is the wrong word; 'hyperbole' is probably a more appropriate word—picking up on individual stories. It is an issue affecting us all. We need to hear what we can do about it, not just how terrible it is. This is about the tools and the strategies. You can say, 'It's awful, it's awful, people are dying, people are dying.' What can we do about it? What can we do to change that? It is about sort of understanding

that it is here with us now and as a country we need to address that. It is not to put it on one social group or it is not to talk about the importers. It is about how we can deal with that problem. It is about education. It is about people knowing that maybe it is not so addictive that you look at a bag of it and you are never going to be able to let it go.

We need quality information and whether that quality information is there is another thing. How it is delivered is a different story, but it has to be targeted, it has to appropriate, it has to be done at an early stage. It is pointless educating people at 35 about the impacts of alcohol and drugs. We need to get in there early. We need to be teaching our children about it in such a way—sex education is often spoken about, teaching young children about sex. There are two schools of thought. Do you tell them about it when they are nine years old before they are active or do you tell them when they are 13 years old when they are that much closer to being involved with it?

So the scare tactics are explaining to those people that there are ways of dealing with that, there are services that you can access. If your family members are involved, you can talk to people about it. So it is not about making it something fearful. When Mr Alsop was 16, 17 and 18 he said he was bulletproof. If someone tells you not to do something, you will go and try it. That is what I mean about the education and the early intervention.

Mr SCHEFFER—Did you go to any of the community meetings that have been—

Mr BEAL—No, I have not, but we are in the process of having our meeting in East Gippsland. That will be in March sometime. I am staggered by the numbers who have been—but again, I think the feedback from that was it was not giving people strategies; it was not giving them tools. It was just about how bad it is, 'We are knee-deep in ice.'

Mr SCHEFFER—So the forums were—

Mr BEAL—Well, the feedback I received—

Mr SCHEFFER—But you weren't there?

Mr BEAL—No, but the feedback seemed that it was very much, 'This is terrible. It's all going to end badly.' To hear things like we are knee-deep in ice in the valley is not right. We are not knee-deep in ice in the valley. It is a problem and we can deal with it but we need to have the tools and resourcing to deal with it. That is just my take on it.

Mr SCHEFFER—Right, thank you.

Mr SOUTHWICK—Just extending on from your presentation, Chris, and from questioning in regards to education, you suggested year 7 is probably an ideal place to start.

Mr BEAL—Yes.

Mr SOUTHWICK—There are issues about young people now being able to go online and see all of the upside of taking a drug like ice. Do you have any concerns that you start to bring them into the classroom and then the kids are out there googling and it is creating more awareness to a problem that we have?

Mr BEAL—As I was saying about the sex education thing, is it better to be taught by someone who knows what they are talking about, as opposed to going on some random search in Google, which is what we do? We do that as adults with medical stuff, getting bad information. It needs to be conveyed by a professional person in such a way that it is not going to be parents going, 'I don't want my children learning about drugs at this age.' It is maybe educating the parents as well, but now is the time to do it; before they are setting their goals about trying things and experimenting. There is a very small window of opportunity and maybe that is too young, who knows, but you do need to get in there before they leave school because once they have left school they are gone.

Mr BORKOWSKI—I think a good comparison between do you speak about it to your children or not can be made in relation to the old beliefs about suicide. The old beliefs were that you do not mention it because it may put the thought in the head. That, over the years, has changed and now we are encouraged, if there is any suspicion or any thought, to raise the issue and make the person feel comfortable with speaking about it. I think the same goes for drug use as well. The thought may be, 'Goodness, if we start talking to our seven-year-old kids about it, is that going to encourage them to try it?' Then you look at the other side of it. If we start talking about it now it does raise that awareness. If you educate them in the correct way then the chances are that they are not going to try it.

Mr BEAL—It may be that the education of the younger generation will find its way into the older generations as well. So Johnny comes home from school talking about ice and you are an occasional ice user and your 10-year-old kid is talking about it; it is going to make you have a think about it.

Mr SOUTHWICK—So what is the message that, in terms of the education, we need to be delivering to people when you have got the flip side, the marketers that have done so well in selling up a story that this drug is great and has all of these great positives? What do we sell on the other side to try and negate that positive message?

Mr BEAL—It may be about facts. It is actually about real information because if you start spinning a line to these younger people, they will work it out. They will go on Google and do that research. I have not got the answer to how you would specifically do it. It is more a case, with me, that the earlier the better. As you say, it needs to be very tailored to that age group. There is a fine line, as you are alluding to, to becoming 'Go out and try it. It's really good.'

Mr BORKOWSKI—If you teach them the facts, smoking offers a great example of that. We taught the facts to the children and a lot of the kids would go home and if mum or dad lit up a cigarette, they would be on them straightaway. That was a very, very good campaign and it worked.

Mr McCURDY—I think seatbelts was another example.

Mr BORKOWSKI—Yes, seatbelts was another one where the children had a big influence on what the adults were doing.

Mr CARROLL—Thanks for your presentation, Chris and Jon. Did I hear correctly that you said there were no Aboriginal people working—

Mr BORKOWSKI—Very small numbers.

Mr CARROLL—So how do we improve that? GippsTAFE operate a—

Mr BEAL—Koori unit?

Mr CARROLL—Yes. To get Aboriginal people interested in becoming drug and alcohol counsellors to then assist their own people, have you got any suggestions or recommendations for the committee on how to address that? There is obviously a demand there.

Mr BORKOWSKI—Yes.

Mr CARROLL—Like inspiring them in some ways? You are talking at secondary schools. Is it financial assistance to undertake the courses?

Mr BEAL—It is worth noting that it is not necessarily—although the AOD sector is an issue, I think generally it is an issue. The organisation works for GEGAC. It is maybe 60-40 non-Aboriginal to Aboriginal, so 40 per cent of the work force are Aboriginal. Really and truly that figure should be significantly higher. There are traineeships, so using traineeships, using work experience. Getting people in pre leaving school is another thing that we have done, simply for our community problems. We will take on someone on the holidays and give them a bit of work

experience. It also gives them that kind of motivation to maintain education, which is a big issue. Dropout rates are very high in Indigenous society. That needs to be changed.

There are some cultural things as well. The tall poppy syndrome is an issue. It is difficult for me to say it, but it is the case—you know, name the elephant type thing—so it is about giving those kids the opportunity but also that sort of—it is like a movement, isn't it, that it is good to be educated, it is good to be in the work force, it is good to be working and helping your own people. It is about access to quality education and I think the Koori units are a really good example of how that can work. Encouragement and jobs available; jobs at the end of the line for the kids.

Mr BORKOWSKI—One of the other big issues is, and has always been, the salaries that are being paid for these workers. You are expecting people to finish school, or at least year 10, then go on and do another year or two at TAFE, learning the counselling area, or go to university. Yet they can walk out of school at 15, walk into a shop and earn as much money as a retail assistant. We are not giving them the encouragement, really the financial encouragement, to actually go on and do additional training. Quite a lot of the people that I know that are in the drug and alcohol sector only last a few years because it is a very, very trying occupation and it has a very high burnout rate. If they are not getting the financial encouragement to stay there, you are not going to get the people in.

Mr CARROLL—I understand.

Mr BORKOWSKI—It is far easier to go and do something else.

The CHAIR—As there are no more questions, can I thank you both very much for your presentation.

Mr BEAL—Thank you for the time. Much appreciated.

Witnesses withdrew.

Hearing suspended.