LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

11.15 am – 11.45 am, Friday, 19 June 2015

Litchfield Room, Level 3, Parliament House

Members:

Mr Nathan Barrett, MLA, Chair, Member for Blain

Ms Lauren Moss, MLA, Deputy Chair, Member for Casuarina

Mr Francis Kurrupuwu, MLA, Member for Arafura

Mr Gerry Wood, MLA, Member for Nelson

Witnesses:

Department of Children and Families

Anne Bradford: Chief Executive Officer

Lee-Anne Jarrett Sims: Senior Policy Officer

Mr CHAIR: On behalf of the committee I welcome everyone to this public hearing into the prevalence, impacts and government responses to the illicit use of ice in the Northern Territory. I welcome to the table to you evidence to the committee from the Department of Children and Families, Anne Bradford, Chief Executive Officer and Lee-Anne Jarrett Sims, Senior Policy Officer.

Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. This is public hearing and is being webcast through the assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public you may ask that the committee go into a closed session and take your evidence in private.

I will ask each witness to state their name for the record and the capacity in which they appear. I will then ask you to make a brief opening statement before proceeding to the committee's questions. Could you please each state your name and the capacity in which you are appearing.

Ms BRADFORD: Thank you. Anne Bradford, Chief Executive Officer, Department of Children and Families.

Ms JARRETT SIMS: Lee-Anne Jarrett Sims, Senior Policy Officer, Department of Children and Families.

Mr CHAIR: Ms Bradford would you like to make an opening statement?

Ms BRADFORD: Yes, thank you. Chair and committee members, thank you for the opportunity to make some opening comments to the committee on behalf the Department of Children and Families. I would like to introduce Ms Lee-Anne Jarrett Sims from the department from the Policy and Research division. Ms Jarrett Sims has undertaken research and reviewed the work of other government agencies and jurisdictions on the issues relating to ice. This has been a sobering task. It is evident that there are real risks for children and challenges for the child protection field that we and others will need to meet both now and in the future.

First and foremost understanding the prevalence of ice use in the Northern Territory and its impact on the child protection system is quite difficult to quantify. Those using ice or any illicit drug for that matter do not freely admit their use of drugs and under reporting is common. It is certainly not a disclosure that is readily made by parents to child protection workers undertaking investigations or family support work.

There are limitations in the department's client information and reporting system. The Department of Children and Families uses the Community Care Information System, known colloquially as CCIS which does not allow for the reporting or recording of specific information about drug misuse in relation to child neglect and harm. Workers are able to nominate drug and alcohol misuse as a factor when substantiating a harm type, but this relies on an assessment by the worker and the nomination of drug or alcohol use as a contributing factor in the child protection case. As you can appreciate, this is imprecise and at times likely to be inconsistent.

Anecdotally, there is an increase in notifications and therefore child protection investigations relating to ice. Increases have been noted by my central intake team from December 2013, and are currently reported as predominately evident in Darwin and Alice Springs, but are currently featuring in notifications relating to children in Katherine.

It should be noted that in all instances where ice was reported to central intake, other drug and alcohol use was also reported. Notifications relate to young people using ice with the central intake team estimating around two to three notifications per month. There are approximately four to five notifications about parents using ice each month. The central intake team receives approximately 1200 reports each month, and while the figures for ice-related reports are comparably low, they indicate an emerging trend which is of concern to us.

Ice use, like other illegal or illicit drug use has implications for child protection practice in understanding risks for children, engaging with families and making decisions about a child's safety.

Children growing up in families where ice is used are more likely to come into contact with the child protection system because ice-affected parents may not be aware of, or ignore their child's basic needs, either as a result of being affected by ice or as a result of the prolonged coming down period reported by ice

users. Ice users report being sexually stimulated when high, thereby increasing risks of sexual exploitation and sexual abuse. Children may witness, or be subject to, violence or punitive or reactionary behaviours if a parent is affected by ice or its after-effects.

Ice using families are often highly chaotic, and over time can affect a child's development and psychological health and wellbeing. Older children may be 'parentified' when they are expected to take on the parenting role for younger children due to parent neglect, and household income is spent on ice rather than on essential household items. There are also immediate and long-term safety risks if children are exposed to the chemicals or manufacturing process involved in ice production in the home.

Child protection workers working with complex families are adept at judging the dynamics and risks within families day on day. However, there are some particular features of ice use which make the role of the child protection worker challenging, especially engaging with families and assessing risk. In summary, these are: ice is highly addictive and a child protection worker should be sceptical of any claim of regular safe or recreational use; safety risks to child protection workers visiting or entering homes where ice may be manufactured or regularly used; paranoia, or potentially violent or highly reactive behaviours, that may be exhibited by parents; and an inability or lack of willingness to be honest about the extent of drug use which therefore impacts on parenting.

In these instances, the personal safety of the worker and the child or children is our imperative. Child protection workers therefore operate in pairs and will always seek additional information from the Northern Territory police if they have concerns about visiting a residence. In some instances, where there are concerns about a situation escalating a police officer may attend. Child protection workers will also seek family or other service involvement to verify and help mediate some of the potential paranoia and reactionary behaviours. Workers should be focused on the child's safety and be decisive about protecting children where ice use is a feature in the family. This is one of the lessons we need to learn from the recent coronial inquest in South Australia.

The relationship between child protection services and drug and alcohol agencies is not yet well developed in the Northern Territory, and there are limited illicit drug treatment options available. Better coordination of support for parents and for young people affected by ice and improving the Department of Children and Families referral protocols is warranted. This will become increasingly important if services for ice users develop in the Northern Territory in response to increasing prevalence.

There are a number of internal recommendations that the Department of Children and Families identified in its submission to you. These recommendations included: developing our internal capacity and skills to understand the impact of ice and to more effectively work with ice-affected families, children and young people; reviewing the child protection practice manual to ensure that child protection workers have the necessary information to understand the risk of ice to children; and to effectively engage with families and make decisions about the child's safety.

The Department of Children and Families will also be increasing its training schedule on alcohol and other drugs and will be sourcing dedicated training on methamphetamine use or misuse for child protection workers. The department has also commenced an assessment of its current work, health and safety protocols for when child protection workers visit homes to ensure that workers recognise some of the unique risks associated with drug manufacture and drug use.

As mentioned earlier, having better relationships and formalising case management protocols with other services whether that be drug and alcohol services, police or mental health services, will both equip staff with options and improve our understanding of and responses to families and children.

You will hear statements from us about the impact of ice on individuals and on our community safety, crime and social disorder. These are significant and of real concern. As I have highlighted, there are genuine concerns and risks for child protection services and for vulnerable children as a result of the increase in the prevalence of ice. This proactive approach to tackling a problem that reaches so far across our community is encouraging and I look forward to reading your final report.

Mr CHAIR: We have a very limited amount of time, so just going to - I see you are training people so they are able to identify this being a problem, ice being involved, and then being able to bring the services in and do what you need to. No one on this committee will have a problem with that. Would it help you to be able to enforce a drug test if someone was concerned?

Ms BRADFORD: On behalf of the department, we are not in the business of validating illicit substance abuse. We would always bring someone with us. If there was a requirement or a suspicion we would do it with our police colleagues or mental health.

Mr CHAIR: Something that has been raised with me several times leading up to this committee is where one parent has a kid and that parent is likely to be using illicit substances and the other parent is screaming out for them to be tested. If they are tested at least there is some data to use as evidence to make a decision about the welfare of that child. Do you have the ability right now to enforce that?

Ms BRADFORD: The ability the agency has is to work collaboratively with Police, Fire and Emergency Services and the ambulance services to ask for their support. We do not have the ability, at this stage, to enforce an individual to take a test to demonstrate whether they have or have not taken illegal substances.

Mr CHAIR: If one of your frontline workers at the coalface felt it was important to know the outcome of that, what mechanisms are in place for them to go ahead with that?

Ms BRADFORD: I may have misunderstood, Mr Chair, but we always work collaboratively with police.

Mr CHAIR: You can ask police then police do a drug test?

Ms BRADFORD: No, we can encourage police to come to the site with us to get their support in addressing if there is illegal drug use.

Mr CHAIR: Thank you.

Ms MOSS: In your submission you talk about the Families Crying out for Help group. I have met with that group and family support services continue to be an issue, which you have identified. What do you see as the gaps in family support where families identified methamphetamine use as an issue?

Ms BRADFORD: Thank you. I might refer that one to Lee-Anne.

Ms JARRET SIMS: The type of family support services needed would depend on the drivers and factors affecting families that have led to the use of ice or any other illicit substance. Across the Northern Territory, we are well aware of the levels of disadvantage, poverty and overcrowding of houses and those factors. Family support services would be required to work with other services to address some of those structural factors, but also then to work with families around their parenting capacities to notice and respond to the needs of children so they are in a position to meet the children's needs.

The level of support required across families varies depending on the level of risk and the level of concern needed, plus the issues affecting families. It is not easy to say a particular type of service is needed. We need to tailor it to the specific issues affecting families, and that may differ from different families in different locations. It is having a breadth of services that are well coordinated to respond to the multifaceted needs of families.

Ms MOSS: With regard to the issues your department is consistently coming up against, what would you say are the most pressing needs in family support? Is it addressing structural needs, helping them with coping mechanisms and family strengthening?

Ms JARRET SIMS: Yes, relationships and understanding children's development.

Mr WOOD: The first question was in relation to your opening statement about the community care information system and you said you cannot get the detail you need into that system. What does the government need to do to allow us to get the correct information?

Ms BRADFORD: We are currently reviewing our CCIS - the information system we have. It is a system we have inherited and one we need to make contemporary. We have some work that will require money to make changes to the information system.

It is our intent, once we have done our review of what information needs to be input, that we can then advise on the extent of work required for that system for the future.

Mr WOOD: Ms Bradford, you have worked with some information systems that have not worked. Do we have a guarantee this system will do the job you hope it will?

Ms BRADFORD: It is a really good question. The system currently does not cover off on everything we need to; it is an old system. I am not saying throw out the old to introduce the new. What I want to do is work with our other NTG colleagues to not build something from the ground up, but use a commercial off the shelf product that will address what we need to.

Mr WOOD: From a practical point of view, I know the Chair was talking about testing someone for drug use, and a priority for your department is to protect a child. How does it work in the practical sense? Someone goes to a house and sees someone who might have all the symptoms you talk about - paranoia, stomach cramps, blurred vision etcetera - then we see you have given the risks to children in relation to someone in the family using ice. If you immediately identified someone in that family as using ice would you immediately take the child away because of all the risks that could occur?

Ms BRADFORD: It is a really good question. The role of a child protection worker is to focus first and foremost on the best interests of the child. In the first instance, if there is an immediate risk to the welfare of the child we will take action.

The second part would be to engage - if we believe there has been illegal substance misuse we would then inform the police. In our protocols, the first thing is in the best interests of the child - what action should be undertaken? If we are concerned about their welfare or it is life threatening, we have a responsibility to act immediately.

Mr WOOD: I am just seeing how it works. Obviously people are also affected by alcohol. That is not saying the child is not at risk either from violence and domestic violence, but we are dealing with ice. We know ice is a serious drug and it causes a lot more aggression and paranoia than other drugs. I am worried that a member of your department visits a house - can they make a judgment to say, 'We believe, to the best of our ability, that this person is affected by ice'. Is there a protocol which says, 'We think we should work on due diligence and remove that child or children from that premises based on what we know about the risks of using ice'?

Ms BRADFORD: I will answer that question slightly differently. We will get a notification. We cannot front up to someone's house unless we received a notification. Once the notification is received by central intake, an assessment is made as to whether it meets a threshold that a child is at risk. They will make a determination as to whether it falls into, 'Do we need to take action with 24 hours?' within a designated period of time and there are four priorities that we give.

If someone receives a request for a Priority 1, which means that when the first notification came to us there was a general concern about the welfare of the child because of likely injury or something happening, then it is appropriate, once the child protection worker has sighted the child and the circumstances, to immediately take action to make that child safe. It is not just about ice, we will determine if it is safe? Is the child at risk? Is there likely to be death, injury or something that will escalate, and it will also have an overlay, 'Is the child able to get away if they need to?' Are they of an age where they can take action themselves or are they the most vulnerable, under two years of age, or are they between two and seven, or at an age where they can protect themselves?

Mr WOOD: Are there gaps in that you think need to be looked at, or do you think the system is fine as it is?

Ms BRADFORD: It is my belief that the system that does the prioritisation is only as good as the training undertaken by the people using the tool. It is not infallible. Someone may look at a situation, follow the decision-making tool - the standardised tool we use - and make a call. It could be an accumulation of things, but in the majority of instances, the system works with its prioritisation. We need to continue supporting the staff in making wise judgments and good decisions and backing them to err when something does not sit right.

Mr WOOD: Do you think training is adequate at the moment or are there gaps? Do we need to improve it because of ice coming into the issues we have to deal with?

Ms BRADFORD: I would say to you, as was said in the submission, that we need to do more training specifically targeting staff safety when it comes to ice and ice manufacture. I do not think we do enough training regarding what you do, the protocols associated and how you protect yourself, not just the child. If

a staff member is injured, the child will not get help because the problem then becomes staff are injured and wary about taking action.

Mr WOOD: Thank you.

Mr CHAIR: In your statement you gave an example of Katherine, where grandparents are assuming protective roles of their grandchildren. These extended family members report frustration at having taken this role of parental care because there is a lack of service delivery to support the parents and address methamphetamine use. What services do you think are needed in light of these complaints, and how would you address methamphetamine use from your department?

Ms BRADFORD: From my department, it would be working with colleagues in the Department of Health and supporting them to provide the accurate information needed, working across departments to make sure information that comes to light through Police, Fire and Emergency Services then forms part of a whole-of-government view as to how we each, regardless of our department, can contribute to that knowledge base.

Ms MOSS: I am interested in the minors who come into the care of the department. Are you seeing an increase of minors who come into contact with the department who are themselves users of methamphetamines? If that is the case, are you identifying gaps in treatment service options for those particularly young people? It has been raised with us a number of times.

Ms BRADFORD: In my opening comments I referred to the prevalence of anecdotal numbers. They are all very small but are we seeing trends? At this stage, no. We have a minor number of notifications that our central intake team are saying - it is a small number. Are we seeing a prevalence or a determiner that there is far more out there? I could not say that at this stage.

Ms MOSS: Thank you very much. I am very aware of time and appreciate the time you have given so far. In your central intake process, are referrals made out from the central intake service to other services where, perhaps, there is an assessment that a child or a family does not require further investigation but perhaps requires the support of other services? Is there a process? Is there scope to improve that process?

Ms BRADFORD: I am not sure of the answer to that. I will ask Lee-Anne if she knows.

Ms JARRETT SIMS: There has been some work looking at the role of central intake in referring families to alternative services. Part of the difficulty is that the notifications, on the majority of occasions, are from a third party. The family itself is not making a notification so it is difficult for us to say to the notifier, 'Can you talk to that family and ask them to go to that service'. There are some problems. We have been looking at it and it is part of the work we are continuing.

Ms MOSS: Thank you.

Mr CHAIR: Thank you for your time.