LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

11.45 am – 12.15 pm, Monday 7 September 2015

Litchfield Room, 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:

Australian Medical Association NT

Associate Professor Robert Parker: President

Mr CHAIR: On behalf of the committee, I welcome everybody 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 give evidence to the committee AMA president, Associate Professor Robert Parker.

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. 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 you to state your name for the record and the capacity in which you appear. I will then ask you to make a brief opening statement before proceeding to the committee's questions.

Could you please state your name and the capacity in which you are appearing, sir?

Professor PARKER: I am Associate Professor Robert Parker. I am President of the Australian Medical Association Northern Territory Branch.

Mr CHAIR: Do you have an opening statement?

Professor PARKER: Just a very brief one. We have submitted a document to the committee. A couple of key things from that statement. Alcohol is 10 times more problematic than ice in disability, that is, life years lost. Ice is a comparatively small issue in the substance abuse area compared to the major damages of alcohol.

The history of ice is quite interesting. History may point to solutions. The fact that ice appears to have been developed for the recreational market in the US, particularly the recreational sex market, in the late 1990s. Our belief is that a significant portion of people who are addicted to ice still come into it via that area.

I have listened to the evidence from INPEX and from the builders and there are ways of working with occupational groups. There are probably a couple of distinct groups who use ice for various reasons. Maybe, as you pointed out, it is a community issue and there is probably a range of solutions that may need to be developed. Empowering GPs and education are probably ways forward for that.

Mr CHAIR: I am aware that one of the issues we have in the harm minimisation space of this is around the appropriateness of detox facilities, how many there are and how they are operating in the extent of time they are detoxing people for different types of substances. I see a role here - and clearly the federal government is looking at this too – for GPs to have a much bigger role in this space of working on first, detox, and then that rehab space to take the pressure off designated rehab centres which might cater to a different audience, if I could say that. It is becoming apparent that in some areas the prevalence of this drug, not necessarily in the Northern Territory but Australia-wide, is quite drastic.

What do you see the role of GPs being in this process as part of this community response? How can GPs be a part of the solution at the harm minimisation end to take the pressure off rehab centres?

Professor PARKER: I agree with the potential of educating and empowering interested GPs – not every GP is going to be interested - with information about safe harm minimisation techniques for dealing with people who are affected by ice and giving them good information about pathways.

For example, one of my other roles is as Chair of Board of the Foster Foundation in the Territory, so I am aware there is a very good rehab service available in the NT. I am not quite sure many GPs recognise that service is available and know about referral pathways for substance abuse.

I am not quite sure about GPs organising detox themselves which can be dangerous and potentially problematic. Some may be able to do it, but it is probably more awareness of referral pathways and having a link in to that person for their general health as much as their substance abuse so they have confidence in the GP and will take their advice on board.

Mr CHAIR: So what would GPs doing detox involve?

Professor PARKER: I do not know, to be frank. Most of my experience with detox is that it is done by people who are experienced in detox. For example, the issue with ice is there are related physical and psychological issues. The physical issue - ice has a very short half-life. It is in and out of the blood within 48 hours. That is one the reasons - a lot of people are uneducated on that, which is why – that gets back to the history of it. They use it on a Friday night for a good night out and know by the time they turn up for work on Monday it is usually out of their urine so it will not be picked up in urine tests.

Mr CHAIR: Hence my question to INPEX about greater …

Professor PARKER: I have a particular view on that which I am happy to share with you. Some of the people using it for a good night out on a Friday will have adverse events or effects from it. Some will develop psychotic episodes, some will become incredibly aggressive, and it is unfortunate that the high levels of aggression have been confused with psychosis. The ad where the guy head butts the nurse and is held by three cops - he is not psychotic, he just has a high level of aggression. He may be psychotic, but there is this public persona that everyone who is aggressive on ice is psychotic. That is not necessarily correct.

You have the physical addiction stuff, but then you have the psychological addiction. I think the detox is primarily getting over the physical addiction, and that is usually high levels of arousal relating to the substance not being present. It is more common with things like alcohol or opiates. The psychological addiction is much more difficult to deal with. That is where you have a need for the substance to self-medicate for a range of emotional issues you may have - anxiety issues, low self-esteem or loss of empowerment - and that is much more difficult to deal with.

That is where the rehab process is really important because you - I presume you have had more informed issues from the Forster Foundation about the rehab process, but it needs a level of wisdom where you really need to come to terms with that desire to self-medicate, the wisdom to overcome it, and look at the reasons you do not want to be using ice and the consequences.

Mr CHAIR: One of the issues when I look at this - I am glad you are here because I like asking questions that get to the crux of it because we then know where the holes are. You almost say there is a physical detox then there needs to be an emotional or mental detox and then people are in a position to start rehab. How do we structure that?

Professor PARKER: The ideal would be referral pathways so people could be detoxing. Banyan has a number of detox beds at the moment, so allowing for people to detox in a safe environment with people who are trained to observe, see if they are having any problems, side effects or whatever. The key factor for people and rehab is that psychological issue, because you can go through a physical detox but if you have not dealt with the psychological issues of whatever the substance is medicating you will still be using it. That is the key factor of rehab. Often it can take three, six, nine months for people to come to terms with that because the psychological issues are probably much more damaging than the physical issues.

Mr CHAIR: In regard to physical detox, we have heard some people say the time frame - because usually the detox here goes for five, six or seven days. Is that long enough? I know what you are saying about half-life, but not just out of the system in a couple of days, but the need for that arousal.

Professor PARKER: What you are talking about is more psychological than physical.

Mr CHAIR: Other people have given evidence to say the detox period needs to run for a few weeks not five days.

Professor PARKER: I am not an expert on detox. I am aware of the short half-life. My impression is the addictive quality of methamphetamine - because of it is short half-life the addictive quality is fairly short, and I suspect they are talking about anxiety issues that are probably more psychologically based. What they are dealing with is an initial issue - when we are dealing with people who are psychotic the substance works its way through the system in a couple of days. The psychosis, which is the excess level of dopamine in their brain caused by the use of the methamphetamine, is usually out of their system in a couple of days. They turn up at the mental health unit where we give them medication and usually discharge them about four or five days after they come in.

I suspect what has been described by some people as a detox is actually high levels of arousal which people normally have and which have been used to self-medicate. The methamphetamine have been used to self-medicate. I am not convinced there is, necessarily, a physical detox requiring three weeks. It is much more a psychological issue where the person has a pre-existing vulnerability and as soon as they stop using the substance that comes up again.

Mr CHAIR: It peaks. So there would be your detox period proper - a physical detox period - then they might need some pretty close mental health supervision for a period of time, and then they are ready for rehab? Where are you seeing rehab starting and ending?

Professor PARKER: Mental health really does not have a role. We have a role in dealing with people who are dangerous and who are psychotic. Mental health at the moment is not funded to do rehab or long-term rehab.

Mr CHAIR: But clearly, from your facial expression and your body language when we are talking about this, you are looking at us and thinking, 'What is this guy talking about?' The issue we have is people in rehab are saying that we get all these people in who have an ice addiction but are not ready for rehab and we are having to take them.

Professor PARKER: Yes.

Mr CHAIR: What is the problem?

Professor PARKER: Well again …

Mr CHAIR: If it is not a physical detox, what is the problem?

Professor PARKER: Well, they are not; they often have high levels of arousal. Actually mental health is a misnomer. Mental health is people being healthy. We deal with mental illness. In our inpatient unit we deal with people who are usually either psychotic or have severe mood abnormalities. We keep them safe and give them medication to reverse that and discharge them. We do not have long-term therapeutic goals within the inpatient unit for people affected by anxiety, emotional disturbance or addiction. And we have to work within the confines of the *Mental Health Act*. People who require treatment under the *Mental Health Act* have certain levels of safety issues to require management.

I tend to agree; there can be physical issues where people require some form of treatment. That may be anxiety which comes up again. But the Mental Health Unit is usually not the place for that. The hospital has detox beds for alcohol. If you were putting all the ice users into the RDH detox beds that would totally block them up for other reasons.

To be frank, the rehab people are being a bit precious. Detox involves certain physical and mental issues that are pretty common; generally arousal, agitation and issues of blood pressure, racing pulse or whatever. Generally most detox people should be able to accommodate that.

I am not quite convinced we should be putting people into the Mental Health Unit or a hospital to do that. If the rehab facilities were better resourced so they had a couple of nurses on board to assist with detox - mental health/nurses - that would probably be adequate.

Ms MOSS: That in part answers the question I have. I also read the article you contributed to over the weekend and understand some of those challenges about Cowdy Ward and our residential mental health facilities and the number of people who are in there with ice or other addictions. I wanted from you a view of whether you believe the two sectors are working well together. What opportunities are there for us to maybe improve the way the AOD and the mental health sector work a bit better together on these issues?

Professor PARKER: In my other job as Director of Psychiatry, I am aware that the AOD now has been combined with mental health in the government. AOD and Mental Health Services in the Top End now have one manager who manages both government areas. I am also aware that before that mental health in the government services did have a reasonably good interaction with Alcohol and Other Drugs. We regularly discuss clients of common concern. We used to have a monthly education session. We would get together to educate each other about issues that could be improved and developed.

I have also had quite a lot to do with Amity and the Forster Foundation over the years, and there are real opportunities for understanding from both areas. The key is the support of the community and the NGOs

who work in the area. The government has a role, but the NGOs, Amity and Forster, which are the two main resources, and CAAPS and the Aboriginal day program in Stuart Park …

Mr WOOD: FORWAARD.

Professor PARKER: Yes, FORWAARD, CAAPS, Forster Foundation, Amity probably ought to be the leaders in most of the rehabilitation because they have the levels of expertise and training and more of a role than government services. Government services tend to pick up people in crisis or where there are issues of safety or regulations, such as people on methadone who require treatment under a regulated program. I think you get more bang for your buck by enhancing the resources of the NGOs in this area.

Mr CHAIR: A push to get GPs to take a heavier load, do you think that would work?

Professor PARKER: I think GPs could be resourced to identify people who have an ice addiction and assist them with general health issues and referral pathways to rehabilitation services.

Mr CHAIR: I do not think that is where they are going. I think they are going to GPs taking a role in doing this not referring them away, but GPs working like the rehabilitation centres or the detox centres are and taking the load away from them to space it out. Do you see problems with that? Do you agree with that?

Professor PARKER: It requires a certain level of expertise by the GP and also requires availability. Someone in detox requires a GP who is pretty available. They just cannot see someone in two weeks' time, they have to probably be monitoring people on pretty much a daily, two-day basis to check how they are travelling, because someone who is going through detox will probably have high levels of arousal or agitation and need a fair amount of physical/psychological support.

It is great if GPs can take on the role, but GPs would have to be trained and available to do that.

Mr CHAIR: Do you think the system, as it is now with GPs, would lend itself to them doing that? Are they busy and it seems like hard work and they would rather deal with more load hanging fruit and work in spaces where it is better for them? Would you see lots of GPs taking this up as something they want to do, or is this something that GPs might want to avoid?

Professor PARKER: To be frank …

Mr CHAIR: I would rather frank. Frank is really good.

Professor PARKER: I think a lot of GPs will try to avoid it because of the level of involvement. You would have to have a particular interest in it, and it is a lot of work looking after someone through detox. You have to be available and have the expertise.

Mr CHAIR: Which is probably why they have avoided it to date?

Professor PARKER: Yes, and also …

Mr CHAIR: An initiative which says stop avoiding it might not be effective?

Professor PARKER: You have also the waiting room effect, where you have someone with a high level of arousal in your waiting room which tends to drive all your patients …

Mr CHAIR: Scaring everyone else.

Professor PARKER: Yes. GPs are a business and you do not want to be driving away your customers. I suspect it will not – it is really good for GPs to be better educated so they respond well to patients with ice issues, but I suspect detox will not be taken up by many GPs.

Mr CHAIR: Maybe that should be part of the community responsibility.

Professor PARKER: I suppose GPs look after people for health. They have a certain level of medical intervention. The current funding system may or may not allow GPs to be more involved. It is complex and you would hope that someone who had a good relationship with their GP would come to the GP for help if they had a problem, and the GP would respond to that because they know the person. With drop-ins or people with high levels of arousal or agitation who expect an immediate take up from a GP – that may be

more difficult. Again, it is very difficult for a GP to respond and there are often safety issues, which is why rehab – places are much better set up for dealing with – rehab knows how to deal with people with addictions and, at worst, ED is probably a better environment.

GP surgeries, because they are a business and because of the other patients involved, are often quite difficult to start this process.

Ms MOSS: I have a couple of questions on different angles. In your submission you talked about improved education about these things, particularly in school setting. It is something the committee has talked about and is very interested in. My first question is whether you have a view on what that would look like and who you think would be best placed to deliver that.

Professor PARKER: The whole current federal government advertising is totally wasted money. Someone has identified two groups of people who take ice. There are the ones who are out for a good night on a Friday - for the same reasons it was developed in the 1990s for exactly that group - then there are those who have issues with low self-esteem, anxiety or whatever and are self-medicating so it gives them a bit of a hit. None of those people take it to have a psychotic episode or to go out and whack some copper or nurse in ED. There is no intent to do that.

The current advertising misses the point. To my mind, I would have a 'do the math'-type advertising where some guy is offering you speed with all these images of you becoming superman or doing this or that, followed by you sitting in ED with a couple of broken limbs or sitting in a prison cell. You have to look at why people are using it, and the advertising totally misses that point.

With education in schools, probably kids are so educated about life in general these days. Those sort of things should be developed by young people, rather than a bunch of advertising executives sitting around having lunch in north Sydney, looking at why kids are using it, and trying to look at the consequences: yes, it might give you this but then you end up killing your mates in a car crash. Giving them the potential consequences of using it is a much better strategy.

There is a concern. There ought to be much more mental health education in schools generally which would involve information about substance use. There was a curriculum called MindMatters which was available a number of years ago. My feeling is every kid in Australia ought to be doing MindMatters. I do not think schools have to do it now, but ...

Mr WOOD: Taminmin, I think, still does MindMatters.

Professor PARKER: Yes, but every kid in Australia ought to be doing MindMatters as a compulsory curriculum. It is not just for substance abuse.

There has been an important study called the SEYLE Study in Europe. It has looked at 11 000 teenagers in Europe and has found that there were three groups of suicidality and potential suicide risk. There was a very safe group, a really risky group who were the kids we normally know about, but there was this middle group who tended to use the Internet a lot with lots of Facebook time, very significant issues with sleep disturbance and often problems with weight too. These kids had either not enough or too much weight because they were not eating properly because they were spending a lot of time on Facebook.

The study found that the middle group are at the same risk of suicide and suicidal ideation as the high-risk group, but were not recognised. No one recognised they were at risk before they turned up dead in their bedroom. They did not have the personal confidence to do things, which is why they were spending a lot of time on Facebook. They were very vulnerable to bullying and harassment on Facebook, and all those issues.

The same Swedish group did a study of interventions and found that a MindMatters-type program, conducted over eight hours, had a major influence on this middle group and significantly reduced their suicidal thinking and suicidal actions.

It reinforces that kids are quite savvy; that if you can address a curriculum to kids of what mental health issues are - not just 'you are psychotic or depressed' but grief, emotional issues and emotional regulation, and how substances affect that. Potentially, that can have a lot more effect.

Mr CHAIR: You will be happy to know that we have taken a similar approach and divvied up our users into addicted, out for a party and functional - people who need to stay awake for some particular reason and use

it to stay awake. We are looking for recommendations across all of those spaces. We do not want to be ignoring a group or weighing everything too heavily on one side, so we are trying to take a comprehensive view. It is interesting to hear your views on how it can be better marketed, for a lack of a better word.

Professor PARKER: An education campaign using kids as advisers rather than the North Sydney advertising set, and an informed advertising campaign that looks at risk issues is probably one way.

The issue of hair samples is quite interesting. The occupational group know if they take ice on Friday it will be out of their urine by Monday. It will not be out of their hair.

Mr CHAIR: I would love to do hair. I would do it tomorrow if they would let me. It is really expensive.

Professor PARKER: It is expensive but maybe there are ways to make it cheaper. Maybe one of the issues is looking at technology to make it cheaper. The other thing is I gave a similar talk to the magistrates the other day and the commander mentioned a police person turned up at work one morning totally shaved everywhere. I think you need to develop some legal issues to say when people start a job you will be taking hair samples. If they have any major objections sign what they are before they start otherwise, if they turn up at work with a totally shaved body, they will be sent home or sacked.

You need to set those standards at the beginning of employment to make it very clear to people that …

Mr CHAIR: We have zero tolerance to drugs.

Professor PARKER: … you will be taking hair samples. If there are any objections make them now otherwise they will be sacked if they turn up totally shaved and it will automatically be assumed they have been using substances and they will be sacked. That would be quite useful for the recreational group who are using it for a good time out on a Friday because quite often …

Mr CHAIR: I would love to see that as the industry standard test.

Mr WOOD: It does not apply to swimmers.

Professor PARKER: No, everybody.

Mr CHAIR: Unfortunately …

Mr WOOD: Swimmers need to do it to keep their speed.

Professor PARKER: No, everyone needs to do it. You need to set the standard right at the beginning so that people realise if they are shaving to avoid it there will be consequences.

Mr CHAIR: Where is technology at? If you have been looking at this - it is something I have been looking at, but these guys see their legal responsibility as somebody not under the influence, which is why I asked the question, 'Do you want somebody working for you who takes ice?' Even if they are not under the influence that week or during their swing - and I see hair follicle testing is a good way of doing that, but the companies run into legal issues firing somebody for using something when they were not at work.

Professor PARKER: If you say that at the beginning and they are signing a document before they start work that would take it away. They would accept that they do that as part of their condition of working. I do not know, and that is probably why they do not do it at the moment.

Mr CHAIR: From a technology perspective, how far are we from that being cost effective?

Professor PARKER: I do not know, but I think your federal counterpart ice committee, would probably have more power in regard to pathology rebates. If they are doing ice tests it is a pathology rebate issue. If the federal government wanted to put more money into pathology rebates for hair follicle testing that would make it cheaper.

Ms MOSS: I am going through some of the things you have suggested and hope to get some more information from you. Your recommendation around strategies for improved resources for ED departments in Darwin, Alice Springs and our mental health services - what do you think is needed? What resources are you referring to?

Professor PARKER: I would be stressing possibly mental health nurses and more safety officers. Every person is not a one-size-fits-all. I am in regular discussion, in my day job as Director of Psychiatry, with the clinicians in the ED about best management and there is no one solution. Every person comes in with different levels of risk and other clinical manifestations and you have to manage each person according to their risk. Having an ice room, for example, which I think the minister is quite keen on, is probably not a solution and there are significant clinical risk issues relating to that.

I think enhancement of ED resources with more safety officers and probably more mental health professionals in ED to assist. Having said that, I want to make the committee aware that mental health nurses are an increasingly rare breed and it is often very difficult to recruit mental health nurses.

Mr CHAIR: Why is that?

Professor PARKER: It is an historical thing. Basically, it started in the 1980s when there was a significant revision of nursing education generally. Before that, nurses used to train in hospitals and mental health nurses used to train in mental health hospitals. There was suddenly a revision of it so that nurses went to university, which is not a bad thing, but the problem was they took people away from those work-based training areas. It meant that when nurses did their degree they did a bit of mental health nursing, but then they had to do a further postgraduate diploma when they came out. But of course most nurses wanted to be out working; they did not want to be doing any further education.

The other thing that happened was the registration people did not recognise mental health nursing as a separate organisation. So no one really knows how many mental health nurses are around in Australia at the moment.

The midwives did something totally different; they set up a separate craft group. They have a different training organisation now. You turn up as a midwife rather than as a nurse. Midwifery has a significant amount of nursing in it. The midwives (a) have a separate craft organisation and (b) know how many midwives there are in Australia.

To give you an example, a couple of years ago I went to a mental health nurses' function in Darwin and there were probably about 60 nurses in the room and only one was under 30 years old. Most of those nurses now would be retiring in the next five to 10 years and there is no one replacing them. We have very few young people going into mental health nursing.

We are having real problems now recruiting. We are finding a lot of nurses in New Zealand and Africa, possibly Ireland, but it is a real problem for the local mental health service. And that is just the start of it. It is going to be …

Mr CHAIR: It is going to get worse?

Professor PARKER: Yes. Finding these so-called professionals to work in ED is going to be more problematic.

Mr WOOD: Can I just ask a couple of questions but make a comment first. Your comments about GPs not necessarily being involved in detox sounds fairly sensible. They do not also get involved in other things. If I go to a GP and I say I have sore eyes, he may say, 'You have sore eyes but you need to see a specialist.' I presume it is something similar; they are the people you first contact and if you need to go to a specialist, the specialist is someone who deals in detox.

The issue I am struggling with a little – and this probably also relates to the hair follicle part of it. A person working in an industry who takes this drug, ice - in a couple of days it is out of his system. Once it is out of his system, is he a danger on the job? Does this drug actually cause cognitive damage that is permanent, and therefore the person does have or will have some sort of mental disability?

Professor PARKER: It is a bell curve. The majority of people who take ice on a Friday, as long as they do not have any more on a Sunday, will probably be okay to work on a Monday.

Mr WOOD: What would a hair follicle test do then?

Professor PARKER: Well, it shows they are taking ice and ...

Mr WOOD: That is right, but is the ice a problem after three days? You know you should not be taking it, but from a work point of view is it a problem just because you recognise they did take it three days ago?

Professor PARKER: It is if they become psychotic. Psychosis does not go away after two days. You cannot tell who is going to take ice and become psychotic. Someone may take ice on a Friday and they will become psychotic on a Saturday and they will still be psychotic when they turn up for work on a Monday. They are a significant risk at work, I would have thought.

Mr CHAIR: If there is research that can make that linkage you have a shot at building that in as an argument to make testing regimes more thorough and more historical-based, as opposed to 'Here, suck this saliva stick' and 'Oh, yes, you are good to go'. That is what I would like to see happen.

Professor PARKER: Yes. If someone becomes aggressive, as per that guy on the ad, as a result of ice - they take ice on a Friday and they develop aggression, they are still likely to be aggressive on a Monday and that could interfere with their work ...

Mr WOOD: But that aggression can continue for a longer period than it is in the body?

Professor PARKER: Yes.

Mr WOOD: That is what I was trying to get at. I could not quite get the relationship.

Professor PARKER: Yes. The aggression and the psychosis are likely to be much more long lived than the ice in the bloodstream.

Mr WOOD: Is cognitive damage permanent?

Professor PARKER: It can be. I think I incorporated an article by Fatovich in our submission. He did a study in Perth where he did sequential MRI scans on people who came in with ice intoxication and found a number of them developed holes in their brain. If you are getting that level of brain damage you are almost certainly getting cognitive damage.

Mr WOOD: For a lighter user, someone who uses infrequently, is there less risk or is it the same?

Professor PARKER: The cognitive damage is much more likely to be from more frequent use.

Mr WOOD: That would be a cost to society?

Professor PARKER: Yes, they end up in rehab or nursing homes. The issue is also motor vehicle accidents. Think about the young lady on the weekend, the one who crashed a couple of cop cars and into other people. Think about the other motor vehicle accident and the number of people dying or severely injured in motor vehicle accidents in moments where, potentially, ice is a causative factor.

The other issue is the addiction factor. It can lead to major addiction, which can profoundly impact on people's financial social circumstances. As I put in the reference article, it also leads to criminality and people's relationships falling apart. The problem is you can never quite work out who will develop an addiction. Someone could use it for a good time on a Friday night and is suddenly addicted to it. You hear a number of stories where that has happened, which is where the occupational thing is probably useful. If they know they will get hair follicle tested on Monday, they probably will not be using it on a Friday night so a proportion of those people will not become addicted. That would be the idea. Hair follicle testing on a Monday probably is not really to do with people's work ability but it will stop, potentially, people who will be using it.

Mr CHAIR: The argument business will use is it is not affecting their work ability and what they do in their time is not a problem. If we can make a clear link to say because it is not in their system does not mean they are not affected by it - how many standard deviations from the mean are we talking on this bell curve?

Professor PARKER: I do not know.

Mr CHAIR: If we can display a significant risk of psychotic behaviour happening three days later, four days later, a week later, then companies that take zero tolerance to any risk happening would be obliged, under their zero tolerance, to do hair follicle testing and pay for it themselves.

Professor PARKER: That is what they do. That is why they use cannabis. They have urine testing for cannabis for exactly that reason. You have to look at their rationale for testing for cannabis. If someone is turning up cannabis in their urine - why are they testing for it if someone may have used it in the last week or two?

Mr CHAIR: Two weeks ago - they are not affected by it anymore but if they get a positive result they still have to get …

Professor PARKER: Why are they testing for cannabis if they are not testing for methamphetamine?

Mr KURRUPUWU: I am interested in remote communities. I do not know whether there is any research on remote communities. Do you see the effect of drugs in the community?

Professor PARKER: It is very significant, Francis. There is an ongoing study in New Zealand called the Dunedin Cohort Study which shows there is a genetic vulnerability of about 15% to psychosis in any population. My argument is because of trauma and other factors there is probably 25% vulnerability in most Indigenous populations. That means if people are taking substances such as cannabis or ice, they are much more prone to develop severe mental health issues, particularly psychosis or severe mood disturbance. There is significant vulnerability for Aboriginal people evidenced in the national statistics where Aboriginal people are three times more likely to be hospitalised for psychosis as a result of substance abuse compared to the rest of the population. Given this basic vulnerability factor of possibly 25% of any Aboriginal population they have a vulnerability to psychosis, and if they are also using ice and cannabis we have a major health problem, I agree. If ice gets to the communities.

Mr CHAIR: We are well and truly out of time, but thank you very much. It has been great having you and would love to hear from you further if we had time to look at some things we could do in that space.

Dr PARKER: Again, education is probably the best thing. If we can get a greater PBS benefit on hair follicle testing and get it more widely used, I suspect that may affect the occupational group and have some benefit.