LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

2.30 pm – 3.15 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:

NT Council of Social Service Inc.

Wendy Morton: Executive Director

Ann Buxton: Deputy Chief Executive Officer, Anglicare NT

Karyn Cook: Executive Manager Primary and Early Psychosis Services, Anglicare NT

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 give evidence to the committee from the Northern Territory Council of Social Service, Wendy Morton, Executive Director; Betti Knott, CEO St Vincent de Paul Society; Ann Buxton, Deputy CEO of Anglicare NT; Karyn Cook, Executive Manager, Primary and Early Psychosis Service with Anglicare NT. Did I get all that right?

Ms MORTON: I apologise that Betti is not …

Mr CHAIR: No Betti.

Ms MORTON: She sends an apology.

Mr CHAIR: 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 each 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?

Ms MORTON: Wendy Morton, Executive Director of the NT Council of Social Service.

Ms BUXTON: Ann Buxton, Deputy CEO of Anglicare NT. I am also on the Board of NTCOSS.

Ms COOK: Karyn Cook. I am Executive Manager at Anglicare and one of the programs I look after is headspace and the Youth Early Psychosis program.

Ms MORTON: Do you want me to start?

Mr CHAIR: Wonderful. If you would like to make an opening statement.

Ms MORTON: Thank you very much for the opportunity to present today. We put in a submission and I am not going to go everything that was in the submission. I just wanted to highlight or emphasise a few points.

Alcohol is still the number one issue in the Northern Territory and we cannot afford to let resources be taken away from the alcohol area to deal with the ice or methamphetamine issue. We feel very passionate and strong about that. Many of the members we have talked to have said the same things.

Some of the members we have talked to recently have emphasised the fact that those presenting at their service who have a methamphetamine problem also have an alcohol issue and that is still the number one issue and the methamphetamine issue has come secondary to that. So we cannot let out focus be taken away from alcohol; we still have an awful lot more to do in that area.

I also emphasise that the use of methamphetamines goes across all sectors, and that this is not just confined just to young people or a particular group of people. It goes more broadly. And the broader sector, of which NTCOSS members range from organisations working with young people, working in the mental health area, families and children, drug and alcohol and disability across the services. The broader sector is often the first to see the problem of people using ice before they go on to access alcohol and other drug services. Whatever we put in place, whatever recommendations are made and whether it be around training it needs to be going across the broader sector and not just targeted to drug and alcohol services. There is a lack of understanding coming from some of those broader sector services around whether people are using methamphetamine - presenting with that or other drug issues. Training, which we highlighted in our submission, is an important element in any recommendations that are made, and working with people in an early intervention and preventative approach.

Whatever recommendations are made by this inquiry we encourage you to develop a bipartisan long-term sustainable approach. This issue needs to be beyond politics and whoever wins the election next year, or

the four years after that - the approach continues beyond that and there is certainty within the NGO sector and for the community about the approach the government is taking no matter who is leading government.

One thing that has happened since putting in our submission is, at a recent meeting the Chief Minister held with representatives of the NGO sector - he holds those meetings every six months - NTCOSS agreed at that meeting to bring NGOs together to look at the issue of ice and how, as a sector, we might be able to share information and work together better. Government is doing it internally between departments, but it became clear the NGO sector was seeking something similar. At that meeting we agreed with the Chief Minister to take the lead and we expect to do that in the next of month or two.

Ms COOK: I am happy to answer questions. You made be interested to know that I was director of the SMART Court so you might have some questions about that. I was one of two directors in the court diversion program during the time it ran. It started off with the Alcohol Court and the credit bail program and the legislative piece that was written became the SMART Court. I was there until that was repealed. That is something I am happy to talk about, and certainly the drug court has been mentioned in the NTCOSS submission. I would like to get the message across that we would like to see a bipartisan approach to addressing all diversion programs, including a drug court in the Northern Territory.

In relation to what we see across the sector and also with the early psychosis program which commenced in April this year in an initial service model, which has currently been put on hold by the federal government - we cannot expand it but we have an initial service operating - about 50% of the young people would have been assessed with a first episode of psychosis and accepted into treatment also have or are still using crystal methamphetamines, which is interesting.

Wendy mentioned it, but one of the things we are noticing across the social services sector - I have recently done some work in Katherine – the trend is young people are getting younger and younger with their exposure to crystal methamphetamine. They are particularly - not necessarily using it - seeing it in families in their community, being approached in the school or whatever they are doing outside of school hours and that is a worrying trend. The age group seems to be getting younger and younger - right into the lower grades in primary school young people are being asked about it, hearing about it or seeing their friends or other family members using it. In looking at broader community solutions, we definitely think there needs to be a Territory-wide approach to looking at the harm minimisation framework and how you can integrate early intervention and education and training for the social services sector. They would not necessarily specifically or obviously be identified as frontline workers who need that education and training to be able to deal with alcohol and other drug issues, but around the complexity of identifying when people are exposed to crystal methamphetamine.

Mr CHAIR: Wonderful, thank you. Would you like to kick off with some of those court questions since it is something that you …

Mr WOOD: It was something I was very sad to see go. I do not think it ever had chance for a long-term analysis. I noticed in your report there is a lot of emphasis on the SMART Court. Do you think we should have a SMART Court again, and if so would it need changing from what was originally put forward by the previous government?

Ms COOK: What was the first question? Do we need one?

Mr WOOD: Do we need one, and if so would it be the same model or a different model?

Ms COOK: If you look around Australia and overseas - and Victoria is one of the only ones that has succeeded with legislation - certainly the model holds up. The model itself does not necessarily need significant changes. It is important to have it seeded in a legislative framework so you have that ability to evaluate, control and structure it.

Does it need a lot of changes? I do not think so. There was widespread consultation that was two to three years of consultation before that legislation passed. If it had been able to continue running we would have been able to see significant benefits coming out of it and statistics around it.

Anecdotally - and I was there from the start - we had some really positive outcomes for in the order of about 60% alcohol-related offenders. The rest were either illicit use of licit drugs or illicit drug use in the cohort. We were looking at compliance with the quite rigorous requirements of the court in and around 80%-plus. It definitely had an impact and many of those people ceased offending, ceased using and started to get on

with productive lives, whether that was re-engaging with their families and taking care of their children again or reintegrating back into training or employment.

It was all very positive in the three jurisdictions the SMART Court was operating - Alice Springs, Nhulunbuy and Darwin, of course. We did not manage to crack into Katherine. We were looking like we were going to, but then the legislation was repealed.

From my point of view, one of the reasons the current government repealed that was because it was a twin piece of legislation with the Banned Drinker Register, the mandatory …

Mr WOOD: The BDR.

Ms COOK: The BDR. But I have forgotten the name of the legislation. They were linked so the whole piece, the two pieces of legislation were ...

Mr WOOD: If the people had not gone to the SMART Court they would have gone to prison. Is there a relationship there that not only we are trying to rehabilitate people but we are trying to reduce the number of people going to prison?

Ms COOK: **Y**es, absolutely.

Mr WOOD: And that would have done it. If we had one, do you think we would still be keeping those numbers down? I am not saying there would not be anyone going there.

Ms COOK: Yes, absolutely. Upon sentencing - all the participants in the SMART Court were allowed to complete - there were transitional arrangements – and they all completed between 1 July 2013, if they had not already completed, and the end of December that year. Apart from sanctions where they had not done the right thing on the program and had a little holiday in prison for a week or two, at sentencing most of them were not sentenced to a custodial sentence because of their participation in the SMART Court.

If they had not participated they would have incurred a custodial sentence. Over time that would have had a significant impact on the prison population. Also, there was an opportunity for us to look at recidivism rates. Even though it was only operating – I have forgotten the dates – for about 18 months …

Mr WOOD: Nine months for the BDR, but I think you started earlier.

Ms COOK: It did start earlier. It was about 18 months we had it operating. It was very small numbers - probably less than 10% of people were reoffending and coming up on the radar, and that was easy to track because all of them had some supervision order beyond the SMART Court. They might have had a good behaviour bond or an arrangement with Community Corrections. If they were reoffending we would have been able to pick that up.

Ms MORTON: I suspect that was also economically beneficial. It is much cheaper to have somebody access treatment in the community than to be in the prison system.

Mr WOOD: Yes, it is an expensive hotel.

Ms MORTON: Very.

Ms MOSS: I am interested in the number of young people you have seen through the early psychosis program so far before the brakes are put on, and also to get a sense of how many of those had associated drug use.

Ms BUXTON: We started the service in April so we have just a handful of clinicians, a consultant psychiatrist and a registrar. At the moment our total FTE, including the operations director and the admin, is 9.5. We are fairly small, and we were to be scaling up to double that in FTE and having extended hours - seven days a week and probably after-hours. We are still negotiating how long that would have been, but it would have been between 8 pm and 10 pm. We still hope to scale up, but we are waiting for the outcome of the health commission expert reference group implementation.

In the meantime we have had about 70 young people referred to us. There are two streams of treatment. One is the first episode of psychosis, which is the one most people would be familiar with, which is the epic

model, the Patrick McGorry model. There is another stream called the ultra-high risk stream, and that is ultra-high risk of becoming psychotic. It is not necessarily around suicidality but might include risk factors.

In those groups we have had about 10 people in the ultra-high risk and currently have 12 young people registered with another 10 being assessed, because sometimes the assessment can take several weeks. That is quite significant. It might not sound like many young people, but for our population and our catchment area, which is greater Darwin - we are not able to travel remotely at this stage, although we would see people if they were transiting in and out of Darwin for significant periods of time.

Based on the population model we should only be seeing about 20 young people a year and we have seen 70. If they do not fit the criteria for the early psychosis program it does not mean we are not seeing them, we just might be seeing them in the primary headspace platform and/or doing referrals to other more suitable services. We are not trying to have a 'wrong door' approach, but it might be that for this program they have not met the threshold for an early psychosis, which is positive but it still means we can do some early intervention work. So 19 in that short space in time with limited services is quite a significant number in the Northern Territory. About 56% of those young people are Aboriginal or Torres Strait Islander. There is a significant percentage - and I cannot tell you what it is and I will not make it up -that have identified as either gay, lesbian, intersex or bisexual as well.

Mr CHAIR: And the frequency of those looking at ice?

Ms COOK: About 50%.

Mr CHAIR: Half of them?

Ms COOK: Yes.

Mr CHAIR: Can I ask you the dumbest question of the day? Define psychosis. What is a psychosis?

Ms COOK: Psychosis is a mental health disorder. It is a cluster of symptoms. Schizophrenia, for example, is a psychotic disorder. Whereas we talk about psychosis in relation to a cluster of symptoms, what that means is they might have some form of distorted thinking. It could be some form of hallucination where they might be seeing things that are not there or hearing things, which is a fairly common one. They might have delusions where they might believe Ann is going to kill me because of the way she is looking at me. They might have some less obvious symptoms that might …

Mr CHAIR: What do you mean distorted thinking? Their perceptions of what is happening is weird?

Ms COOK: Yes. It can be quite dramatic for people. They might not have the ability to comprehend what someone is saying to them. They might be fearful all the time because of the delusions or the hallucinations, so then their behaviour becomes quite erratic and they make poor decisions. Sometimes, after people use crystal methamphetamine or other amphetamine-type substances, they can also have those symptoms but usually they are short-lived. To have a diagnosis of an ongoing psychotic illness, those symptoms need to be sustained over a certain period of time and be interfering with your ability to actually manage your life every day.

Mr CHAIR: Are there any studies or solid things we can point at that link ice use with psychosis?

Ms COOK: Not necessarily. There are some studies that say it creates vulnerability to it. There is a direct link to having a psychotic episode. Obviously, we have all seen the TV ads and so forth. But to have that sustained longer-term psychotic illness, not directly there is more evidence around the use of marijuana use in psychotic episodes.

Mr CHAIR: I am going here for a reason, but it is not much to do with you guys; it has to do with testing industries. This psychosis you are talking about that is short-term onset from ice use - how many days is that?

Ms COOK: Oh, it can vary …

Mr CHAIR: Minutes? Days? Hours?

Ms COOK: Yes, but it is normally around days.

Mr CHAIR: How many days?

Ms COOK: It could be 12 hours to 72 hours, something like that.

Mr CHAIR: All right. So we are not talking about four days later?

Ms COOK: Yes. It could be in the context of the use or in coming down or withdrawing. It can be variable. But for someone to have an ongoing psychotic illness it would have to be sustained over a much longer period. That is not to say it could not make them more vulnerable to …

Mr CHAIR: If we can create a link between psychosis that exists over a longer time frame than a P6 test can pick it up, a firm that has a zero tolerance to drug use in its workforce should therefore have to consider drug testing their workforce over a longer period than a P6 can pick it up. We are looking more at hair follicle testing which would then pick up a whole lot of other things and puts a big dent in the type of people who would take it functionally or recreationally. They would know, 'I cannot do this', and we might be able to interrupt the demand.

I am interested because of the psychosis of it. I am trying to see if there is a link or not. We can show there are still real and present risks days later when people take ice. Someone can have a psychotic episode on a piece of machinery even though there is no ice in their system.

Ms COOK: It is more they would commence the episode and then it would then subside over days. It would be very unusual for someone to suddenly have an episode if it was not in the direct context of having drug use in their …

Mr CHAIR: Immediate past.

Ms COOK: Yes. If that was happening you would probably be looking at some other disorders, maybe an affective disorder or psychotic disorder, something like that. Certainly drug use impairs people's ability to make good decisions, think clearly and it makes them more vulnerable to other cognitive distortions. There is a lot of evidence around that. The risk of them having a longer term psychotic illness - there is not a lot of evidence to support that. Any drug use, particularly for young people, makes them more vulnerable to developing mental health issues and psychotic disorders. Does the help?

Mr CHAIR: Not really. I wanted you to say, 'Yes, absolutely Nathan', so we could say, 'Right'.

A WITNESS: Someone would have already said that if it was the case.

Mr CHAIR: Only one other person - the AMA guy today - trying to get a read on it. Most other people are more Certificate IV AOD level workers as opposed to somebody who might be quite versed in psychiatry.

Ms MOSS: I am particularly interested in your recommendation for education programs and early intervention prevention. What would you see an education program looking like? I know you represent diverse services so I am interested in what an education program should entail. Who do you think would be best placed to deliver that?

Ms BUXTON: That is an interesting question. We are often reliant on interstate providers to provide specialisms in training in the Northern Territory. If we are looking at long-term strategies in regard to cost reduction and economies of scale, we would encourage embedding training capacity within relevant key providers in the Northern Territory so we are not up for limited service provision, limited training opportunities, and not carrying the cost of external consultancies and training providers, airfares, accommodation and everything that goes with it. There is something very useful in building up the training education sector or specific NGOs with training capacity to deliver onsite across the different regions. That embeds training within the community services sector.

In regard to training, who are we talking about and why? Something that has come across really strongly for us all is that ice - methamphetamine usage - whether it is young people or working with families - there is a sense that it is here and is impacting on services in different ways ranging from accommodation services for homeless people, young people and adults. Some of our intensive family support services - the primary client might start off being the young person, but once you unpack what is going on you are dealing with parents using ice. That changes the landscape of what a youth worker might have to deal with in home visits, how they manage safely for themselves and their colleagues and the type of interventions that will be viable within a family setting. If you are running a homeless shelter, what does it mean in dealing with the

day-to-day challenges that are behavioural? They may be there anyway, in alcohol and other matters, but there is a new layer there that some services are being exposed to. We think it is more obvious when you get to the pointy end in ambulance, police, emergency service personnel, because they are dealing with the peak episode. If we pull it back from there, who is it impacting on in the community sector is broader.

It is the youth workers working with young people, unpacking their stories about what is happening at home. We have youth support workers working with young apprentices who are in their first job on a building site who have access to ice because it is part of the landscape of some contracting firms. We have staff in Alice Springs and Katherine working at out-of-home care services that are seeing a little interface with ice, either direct use with young people within the out-of-home care system or their peers.

There is something very important about us being able to skill up the broader workforce, because they are the bulk of the numbers. That is who is going to be interfacing with support services on the ground. Of course, as things escalate in usage, you then move into the realm of interventions by police and health services staff.

The type of training we are talking about at this stage is general awareness raising, capacity to identify, knowledge about the referral points for additional information and assistance, whether a generic support service needs extra information or help in the needs assessment they will be undertaking with clients. We are also looking at building up the awareness of services in what the treatment options are. If you have youth workers working with young people, it is really critical that they know what the treatment options are and the referral points.

Ms MORTON: Adding to that, the more remote location that your organisation is working in, the more those staff have to be across so many different things because they do not have the specialists to call upon. I am sure that for staff of Anglicare in Darwin, for example, there are many more people around them to assist in matters when they happen. But once you are in Katherine or in a more remote location the staff need to be that much more skilled in being able to deal with any issues that arise. We need to think about that when we are developing what training we are providing to workers in whatever locations they are.

Ms BUXTON: For me, it is about developing a shared language about what things mean. We know there has been significant benefits in the suicide prevention area. Providing common training to frontline staff means you have common language within sectors; people talk about being able to make referrals more effectively because they have trained with colleagues within health services. There is a language that emerges that people can understand.

It also means that, even in liaison with police, if you have staff trained, they can talk the language of the day about the issue. It means they can have more useful conversations and contribute more to the discussion about what has to happen for a client or family. It levels the playing field in ensuring staff have a base level of information.

There was some training held a few months ago that was targeted at the child protection area and services working in child protection where ice was present within families that had been referred. That was the first specific training that we had seen our staff being able to access over the last year or so. It was in demand and it was well received.

Mr CHAIR: Who delivered it?

Ms BUXTON: DCF contracted an external provider from Queensland. I do not have the details, but I can take that on notice and get that for you. It was tailored to the child protection interface. Staff in some of the agencies who attended found it very useful.

Mr CHAIR: Do you think we need to rewrite parts of the AOD certificates?

Ms BUXTON: Interesting one.

Mr CHAIR: A national approach?

Ms BUXTON: That may well be warranted. I also think you have a high number of people doing general studies in community services - the Certificate IV in Community Services - and there is social work. There is general training - VET level and higher education level - where the bulk of your staff are being trained. The AOD-specific training would need that, but it is also about ensuring components of more general

courses pick up on AOD issues because AOD is not solely the preserve of AOD agencies. They have a specialist, important, critical role but many of these …

Mr CHAIR: Not necessarily the frontline person dealing with it at the time.

Ms BUXTON: They may be once someone gets to the AOD agency, but a raft of other organisations and services deal with people who have AOD problems every day, particularly the homelessness services and youth and family support services.

In relation to Anglicare's profile, the majority of clients who have long-term working relationships with our different services - significant numbers have AOD issues and we may work closely with some of the specialist AOD services. At the end of the day, clients are presenting all the time at AOD services that will not just be serviced by the AOD sector.

It is the same with mental health services. There is a small cohort of specialist mental health services in the Northern Territory. Homelessness services and general child, youth family support services also deal with vast numbers of people who present with mental health issues. It is not just preserved for the specialist services to deal with these issues and we need to build up that broader capacity.

Mr CHAIR: When was that training?

Ms BUXTON: It may have been earlier this year. I will find out, but it is my understanding it was rolled out in Darwin, Katherine and Alice Springs.

Mr CHAIR: I would love to know what date that was and the date of the hearing.

Ms BUXTON: Okay.

Ms COOK: One focus needs to be on early intervention training so you get across the cohort of people Ann has been talking to before they think about using, or they might have just dabbled in it. I cannot quote the stats, but not a lot of people using crystal methamphetamine, even amphetamines, become dependent so they do not fit into the group ...

Mr CHAIR: They do not get picked up.

Ms COOK: They do not get picked up, or they do not necessarily need or go well in residential AOD traditional services. It is the community services sector that really deals with them and the fallout across the families and homeless sector. That focus on early intervention - what are the staff on the ground - the homeless staff, the youth staff, the community services staff - looking for? What do they know about illicit drug use, harm minimisation, demand and supply and all those things.

With regard to minimum qualifications in AOD, the Northern Territory – I see my colleagues up the back listening – has done a pretty good job around supporting the AOD sector in that minimum qualification which sits is the national framework. However, when you think about that to be the minimum standard, a lot of organisations are still working towards that. When working in the AOD sector until about 18 months ago, I would visit agencies and see a lot of people working towards the Cert IV. That needs to be looked at, but I had a period of time working in Victoria writing modules for some of the universities for training doctors. They are lucky to get four to eight hours of alcohol and drug-specific training in a medical degree that might take six years. When you think about it, these are our frontline GPs. Unless we can rope them in and train them to be prescribers for things like methadone and buprenorphine …

Mr CHAIR: We had a very interesting chat with the AMA about that this morning.

Ms COOK: Right. It would be interesting to hear what Rob Parker had to say on it.

There is minimal training, so think about four to eight hours, if you are lucky, for a doctor. In the community services sector you might not get any exposure but you are at the front line dealing with families that are impacted, or you are seeing a rise of it coming in or people are pushing it in the community. If you are working in remote communities in East Arnhem, West Arnhem, outside of Katherine, Tennant Creek or wherever, what do they have in their tool kit to identify, manage and cope with that? For us, that is one of the big messages we would like to pass on.

Mr CHAIR: Understood. We very much appreciate the time you have taken to speak with us today. We hope, as you said, to not make this a political football but work towards something together as a team here so what we will put up will be pretty solid and work towards trying to solve some of these issues.

Ms COOK: Thank you.

Ms BUXTON: Thank you.

Ms MORTON: Thanks so much.