LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

3.30 pm – 4.00 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:

Pennington Institute

Chris Boag: Acting Operations Manger

Mr CHAIR: On behalf of the committee I welcome everyone to this public hearing into the prevalence, impacts and government response to the illicit use of ice in the Northern Territory.

I welcome to the table to give evidence to the committee from the Pennington Institute, Chris Boag, Acting Operations Manager. 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 a 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?

Mr BOAG: Christopher Boag, representing Pennington Institute in the position of Acting Operations Manager.

Mr CHAIR: Thank you, Mr Boag. Do you have an opening statement for us?

Mr BOAG: No.

Mr CHAIR: Okay, then we will kick off with some questions. Can you provide an overview for the committee on what Pennington Institute's programs are, and whether they are available in the Northern Territory?

Mr BOAG: They are available in the NT, although we have not done much work in the Territory. Pennington Institute is an agency which operates across a few different fronts in the area of drugs policy and drugs education. We have a number of different government contracts to provide education in Victoria, principally into the needle and syringe program sector. We are also funded to be a peak body for that sector.

In addition to that we operate independently through other funding sources to develop drugs policy and make submissions to inquiries such as this. We also do some training outside the funded sector.

Mr CHAIR: Right. I see that you have made a list of recommendations for the committee in your submission. We are very aware of many of them such as having culturally-appropriate targeted strategies, early intervention and these things we hear a lot about. Is there anything in your recommendations that would be particularly useful for the Northern Territory's context?

Mr BOAG: Perhaps I could respond to that by picking out some of the key points that flow through the recommendations, most of which are related specifically to terms of reference for the inquiry.

On a slightly more general commentary than the specific recommendations, a point we were making in the submission on the subject of data was that whilst Australia has very sound sources of data about drug use, the data tends to be somewhat dated by the time it becomes available. We have experienced, with the emergence of ice use in Australia, that it is a relatively rapid growing problem and the historic data sources reference for following drug trends in Australia have not necessarily served us all that well when it comes to ice use. The point we make about the data is that there would be some value in governments looking to develop more leading indicator systems rather than rely on the population level data, which tends to be two or three years old before it can be accessed.

Developing more data systems that give us early trend analysis would help those involved in policy development understand and respond to emerging drug trends a little earlier than we have been able to in the past. That has been particularly highlighted by the emergence of ice use in Australia, where the change has occurred more rapidly than we have seen with other emerging drug trends.

A second feature of ice use in Australia which differs a little from earlier experiences is the fact that access to the drug outside metropolitan areas is easier than it was with other drugs in the past. Becoming a problem in regional and remote areas is a feature of ice use.

Mr CHAIR: Your recommendation 7, that the Northern Territory government notes the high rate of methamphetamine use in regional and remote communities - what data do you have to show us the rate is high in remote communities?

Mr BOAG: I think the specific reference was to the household survey data, which is one of those population level surveys. The most recent edition identifies ice use in remote and regional Northern Territory as being a little higher than some other parts of Australia. That is referenced in the submission.

Mr CHAIR: That has not been our experience. Police are saying ice, particularly in remote communities, is either not there at all or there in minimal quantities. That is coming from people in the communities, the health services and police in the communities. People are starting to talk about it and are worried about it in communities but, given you said it was there, is that a separate set of data you have been looking at?

Mr BOAG: No, it comes from that household survey, which is sample-based data and may not have sampled extensively in remote communities in the Northern Territory.

Mr CHAIR: Okay.

Ms MOSS: In relation to your submission and support for families, would you mind expanding on what sort of assistance and support you think is needed for families? That has come up multiple times around families looking for help and being the referral point at times as well.

Mr BOAG: We are breaking up just a little, but I think the thrust of the question was around the basis on which we recommend family level and community level interventions.

Ms MOSS: Yes. Could you expand on what you think is needed?

Mr BOAG: The Pennington Institute, over the last two or three years, has done quite a lot of community forum work outside metropolitan centres. Firstly, there is a very high level of community concern about what is perceived to be a growing problem with ice use and that comes out consistently in the forums we conduct. Typically, responses to drug problems have been built around providing support to the individual drug user. Our recommendation is based on the fact that families and communities affected by ice use by individuals, but aggregating at a community level, require a level of evidence-based information going out to the friends, families and communities. This is particularly relevant given that there is a high level of experimental use of the drug by individuals who are not yet touching the drug treatment system. There is a good deal of evidence that can be provided to families and communities to help those around the drug users recognise when a problem is starting to emerge. That information can help them understand the nature of the drug itself, how the shift from the lower purity powdered forms of methamphetamine across to the higher purity crystalline meth forms can be recognised, and the increased level of harm that has come about with that.

A good deal of the work we have been doing, not only the community forums but follow-up work around community capacity building to enable communities and families to respond to what they see developing around them, has proven to be beneficial.

To summarise that, recognising that the response to this drug goes beyond simply responding to the needs of the user themselves, but to deal with information going out to the people whose their use affects.

Ms MOSS: Thank you very much for that. I am interested as well. You are talking about community forums that have been run. Obviously we have been up and down the track with the committee and we held public hearings in Katherine and had a significant number of community members talking about this issue. I am interested in your experience about how government might work to support communities to develop community-level local solutions to this issue.

Mr BOAG: Yes, that has been the purpose of us running those. The first was to simply provide good information to those who have an interest about the drug, in some ways dispelling some of the myths about the drug. At the same time, we provided good evidence-based information about what can be quite severe harms caused by this drug, building the level of understanding of the problem with the participants in the forums we have run. Then, separate to that was to follow up with more specific training with frontline workers and other people in the community who are more likely to be exposed and affected.

Much of the embedded drug treatment and drug response services we have developed over many years have been focused, or are focused, on alcohol and cannabis principally, but also the drugs that have been

around for a lot longer. Unfortunately, the presentations, particularly the more acute presentations from those using ice, are significantly different to those which the drug and alcohol services and the frontline workers have typically been exposed to. Even for people who have worked in the system for quite some time, these new presentations can be quite confronting. There are responses that can be introduced, taught and learnt that provide greater capacity for the people working at the front line to be able to respond.

Ms MOSS: What sorts of things would be involved in that kind of training for frontline workers?

Mr BOAG: That is a whole subject in itself. But briefly, there are certain behaviours on the part of ice users which differ from other users. The tendency at the more severe end of harms is violent reactions, psychotic behaviours and more evident mental health problems that develop in problematic users. There are also signs before that which are recognisable when people are trained to look for them and can produce much earlier responses and earlier interventions. That leads into the second issue, which is there are early intervention strategies and techniques that can be used and are designed to head off development of the problems into more problematic use.

One of the features of methamphetamine use, ice use in particular, is that typically people think of other drugs and about them being problematic. Alcohol, for example, if somebody is drinking a lot every day - opioid use tends to be a daily behaviour when it becomes problematic. What is not recognised so much with ice is what seems to be intermittent recreational use - maybe two or three times a month - might not be considered by the individual or by those around them to be a problem. However, even at that level behaviours can start to develop, and quite quickly, that make it quite difficult to respond to and recognise when the problem is heading in that direction. Early interventions can be introduced much more quickly, and sometimes people who are not in the traditional drug and alcohol treatment field - because a lot of these behaviours are witnessed and experienced by people in surrounding support services like housing support, community health and so on.

A lot of our training has been going into the frontline worker sector to give them the skills to recognise problematic ice use early, and to teach them techniques around early interventions designed to direct them into treatment, if necessary, and also to get them thinking about the need to question their drug use.

Ms MOSS: Thank you.

Mr WOOD: Chris, in the section of your report on methamphetamine use in the workplace you say, 'Punitive approaches such as drug testing for methamphetamine use and dismissal upon positive results are not beneficial'. I am not sure if that sentence is meant to be joined, but are you saying punitive approaches such as drug testing are not beneficial?

Mr BOAG: No, it is much more complex than that. I suppose in some ways the limitation space in a submission does not really deal with the complexity of the situation. Essentially, what it boils down to is the question of whether or not the objective of any workplace-oriented intervention program is to get the worker back being functional, or whether, in fact, that only outcome is drug-testing and then using that as a grounds for punitive action, dismissal or whatever.

There are programs around where drug testing is a component of a program that then streams the workers into interventions and treatment, if necessary, so they become a functional member of that same workforce again. That was what that comment was intended to do. If the purpose is solely punitive it tends to generate behaviours on the part of the workers that avoid the testing regimes where possible, and it is not really working in conjunction with the joint objective of everybody being functional and safe at work. The use of drug testing as part of an overall response is not a punitive environment. It is not a comment on drug testing per se, it is a comment on the way in which the program that is in place is being structured and what its objectives are.

Mr WOOD: Thanks, Chris. It is just the way the sentence is written. It might be technical, but it gave the impression that you were opposed to drug testing.

Mr BOAG: No, that is not intended in that part of the submission.

Mr WOOD: Okay, thank you.

Mr CHAIR: Is there anything else you would like to raise with the committee in relation to your report?

Mr BOAG: No, not specifically. I thought there was an opportunity, which has been the case, for you to ask any specific questions about it. Regarding the need to provide an overarching statement, no we are happy with the opportunity we had to make the submission.

Mr CHAIR: Wonderful. Thank you for your time, Mr Boag. We will be looking to make recommendations that will hopefully solve some issues in this space.

Mr BOAG: Thank you.