Submission to the NT Government 'Ice' Select Committee

Terms of reference item

a. **The reliability of government data on Ice use and measures to enhance the collection of data to ensure that the scale of the problem and its impacts on the health, justice, drug and alcohol, and law enforcement efforts of the Northern Territory Government are understood and measured as accurately as possible;**

The Criminal Justice Research and Statistics Unit provide services to the Departments of the Attorney-General and Justice, Corrections and NT Police. The information relevant to this item will be provided by the Criminal Justice Research and Statistics Unit and included in the submission from the Department of the Attorney-General and Justice.

Terms of reference item

b. **A comprehensive survey of the various government responses to the abuse of Ice in the Northern Territory and assess their effectiveness or otherwise;**

Abuse of ice in the NT observed by divisions within Northern Territory Department of Corrections

Unlike law enforcement agencies, which can test and confirm substances, the Department of Correctional Services must rely on self-reports that ice has been the drug of choice rather than some other form of amphetamine. This is particularly the case for young people self-reporting who may have little experience or drug history and are reporting on what another has told them they have taken.

Anecdotally there appears to be an increase in ice use from young people around 15 years and older reported by various government and non-government services. Youth and Community services have been reporting an increase (particularly in Palmerston and Katherine) in ice use.

Correctional Operations reports since January 2015 there has been approximately ten clients come into the care of Health at Alice Springs Correctional Centre (ASCC) who reported they had recently taken ice. In most cases there have been no issues however occasionally the prisoner can be argumentative, agitated and display unusual behaviour. The health staff at ASCC have not witnessed prisoners on ice behave violently towards staff members.

A medical staff member has undertaken receptions on six people who reported they were using ice before being admitted to ASCC, two of those were juveniles. It is noted that all information regarding youth and methamphetamine use within Youth Justice is anecdotal, due to a lack of urine drug screening occurring in detention. Anecdotal information from the young people during group therapy is that a majority of them that live in the Palmerston area commenced using ice around six months to one year ago. They are allegedly using fairly small amounts ($50-$100 over several days); however, as with most substance use reports, this is probably a minimisation of what they are really using. The youths have been open in stating that they enjoy using methamphetamines and are not at a stage of change where they are willing to reduce or stop this behaviour.

To date there has only been one prisoner from Darwin Correctional Centre removed from the Sentenced to a Job program for methamphetamine use. He was working for a local Darwin employer and escaped lawful custody in response to his knowledge that he would fail his recent urine test (the prisoner may have accessed drugs whilst on his work site or it may have been brought into the prison as contraband). The prisoner was a known drug user and his escape has highlighted the need to tighten up the management and security practices with regards to the paid employment program. One other prisoner who was on the paid employment program prior to release on parole has been returned to prison from Parole, following a positive urine test for methamphetamine.

In regards to prisoners attending Volunteer Employment Program (VEP) and Paid Employment Program (PEP) locations in Tennant Creek, no information has been received pertaining to prisoners that have used the drug ice while at the Barkly Work Camp (BWC). Occurrences of violent behaviour and threats can indicate potential ice abuse by prisoners attending the BWC. There are not many occurrences of this type of behaviour at the BWC.

Whilst not specific to Community Corrections experience; the most problematic, concerning and erratic behaviour of ice users is violence and psychosis. There is no safe level of ice use. The addictive nature of methylamphetamine (particularly ice), combined with increasing user numbers will likely create an increased burden on law enforcement and the health sector.

Community Corrections work with the police once criminal activity becomes known, particularly where the welfare of a child/adolescent is at risk. A traditional harm reduction approach (reduce supply, demand and harm) cannot be implemented in the historical fashion when relating to ice usage. "Harm" reduction is unlikely to have any effect with ice users given the levels of violence and psychosis that can be experienced. As such, a targeted approach to reduction in supply and demand may need to be adopted.

Community Corrections is unable to provide data about adult and youth on community-based orders who may have used ice, and subsequently been referred to Alcohol and Other Drug (AOD) residential rehabilitation and other treatment programs. Outside of individual case studies, the success of such programs for ice users is also unknown. At the individual case management level, information is recorded in the Integrated Offender Management System (IOMS). Community Corrections manage AOD use through Motivational Interviewing, referral to AOD treatment programs, and (where there are specified court or parole conditions) urinalysis and breath testing with an overarching offender management framework that includes policies and procedures for 'breach' action. Often this is a process for achieving a 'baseline' for newly received offenders and monitoring the reduction in their levels of substance abuse. Urinalysis testing will alert Community Corrections to poly-drug use which (obviously) has its own complications in terms of referral to treatment programs.

It is likely that a number of ice users are people who may be not yet be released to parole, and so it could be sometime before Community Corrections feels the impact of the current rise in ice use. Service delivery should be conducted in collaboration with multidisciplinary teams to manage any impact on supervision or court and parole orders. As AOD treatment programs report they are ill equipped to manage the current rise in ice use and have growing waiting lists, there may be an impact on what can reasonably be managed in a community-based setting.

Community Corrections is working to improve the data collection as a systems level to have an understanding about what programs and services are available, and their efficacy. Regardless, it is likely that self-reported data will continue to be the primary mechanism and therefore will continue to have a level of unreliability.

In the Northern Territory, a significant increase in the number of young people entering the youth detention centres affected by ice has been anecdotally observed over the past three years. Although Youth Justice has no formal statistics or drug testing data available regarding specific drug use, youth detention centre management and staff believe that the extreme and unusual behaviours, and withdrawal symptoms[1] they are witnessing and experiencing with detainees are ice-related.

The Director/Superintendent of Youth Detention explained that over the past three years the instances of ice use self-reported by young people upon admission into the youth detention centres, has gone from rarely being self-reported or diagnosed, to a significant proportion of new admissions self-reporting. In his experience, the apparent use of ice amongst the young people has been more prolific than any other drug, making an observation that "revolving door" detainees who had previously self-reported using other drugs are now self-reporting using ice.

There have been around ten young people in the last three months who have been received into detention with methamphetamine withdrawal symptoms. They have reported using large amounts of methamphetamines prior to their incarceration. This has not been confirmed through testing. Several of the young people have not been regular substance users prior to using ice. They have all reported that it reduces their boredom and improves their mood and is

[1] National Drug and Alcohol Research Centre (NDARC). Booklet. (2012). *On Ice* [PDF:701KB]

a social behaviour that they enjoy. They have admitted to committing crime to fund their methamphetamine use.

Since 2014, nearly every young person (between 90-100 per cent) received at the youth detention centres and assessed upon admission self-reported that they had used ice, and/or exhibited behaviours associated with ice addiction.

While it is young people between the ages of 16-18 that typically self-report using ice, more and more young people from the 13-14 age group are self-reporting ice use also.

Youth detention staff have noted an observable increase in the uptake of ice by the younger cohort from the influence of the older cohort (who use and deal ice), with whom they are often associated with both in and outside of detention. Youth detention centre staff believe there is a recruitment/prospect/grooming system happening between the older and younger age groups.

There also appears to be an unfortunate intergenerational impact amongst family members (siblings and cousins) being detained who self-report using and obtaining ice together.

Offence types that young people are coming into detention for are different from ten years ago, and are progressively increasing in severity and/or frequency particularly over the past three years. Youth detention management and staff noted that there has been an apparent increase in young people committing and/or being involved in property crime, and believe this is attributed to funding their ice use, or being paid in ice.

The current legislative parameters of the Youth Justice Act and Regulations do not provide for appropriate intervention. Working within the current legal parameters makes establishing a comprehensive response for managing the overall complexities associated with any drug use (including ice) challenging.

Youth Justice suggest an imperative need for the following:

- Legislative review
- Centre-based AOD staff or access to a facility where detainees can be placed on a supported withdrawal regime prior to transferring to a youth detention centre
- Training for staff
- Ice education and awareness training for detainees, their families and staff
- Access to appropriate intervention and programs

Youth Justice is very concerned with the long-term offending trajectory in addition to the long-term health outcomes for this cohort of young people given the high levels of risk involved in managing them, and the lack of access to appropriate services available to adequately address the issues and the escalating numbers self-reporting using ice.

Terms of reference item

c. The social and community impacts of Ice in urban, community and remote settings;

There is no doubt that ice is a significant issue in the community and the prison is a reflection of that community, the evaluation of prisoners for the Paid Employment Program (PEP) is now more rigorous and is better informed by closer scrutiny, using all the resources that are available to the correctional facilities.

However, Illicit Drug Data Reports[2] produced by the Australian Drug Foundation, National Drug Strategy Surveys[3] produced by the Australian Institute of Health and Welfare ("AIHW"), and various statistics collected by Youth Support Services, Alcohol and Other Drug ("AOD") providers, emergency hospital admissions, and through police apprehension, indicates that ice is becoming an overwhelming issue on a national scale.

[2] www.crimecommission.gov.au
[3] www.aihw.gov.au

The ice situation we are seeing in youth detention centres appears to be a reflection of what is happening in the community.

Terms of reference item

d. Government and community responses to Ice use in other states and some assessment of the effectiveness of these responses in terms of prevention, education, family and individual support and withdrawal and treatment modalities;

On 8 April 2015, a National Ice Taskforce was launched (www.dpmc.gov.au/taskforces/national-ice-taskforce) to improve the efforts of the federal, state and territory governments to combat the growing use of ice in our community, and develop a National Ice Action Strategy to tackle the growing use of crystal methamphetamine. The Taskforce, led by former Chief Commissioner of Victoria Police Ken Lay APM, will work closely with government agencies, expert groups and the community to examine existing efforts to address ice, and to identify opportunities to improve education, health, law enforcement and other policies to combat the impact of ice in the community. Additional Taskforce members are Professor Richard Murray and Dr Sally McCarthy. An interim report will be provided to the Council of Australian Governments in mid-2015 and the final Strategy will be released before the end of 2015. The reported use of ice (by methylamphetamine users) has more than doubled, from 22% in 2010 to 50% in 2013.

On 21 April 2015, the Victorian Government launched an "Ice Action Plan" supported by a budget (for the taskforce, programs and interventions) and a 24-hour hotline 1800 423 238 to assist AOD workers and others to access the most current and accurate information in relation to ice and its use. The Action Plan focuses on six key areas: Helping Families, Supporting Frontline Workers, More Support Where It's Needed, Prevention Is Better Than Cure, Reducing Supply On Our Streets and Safer Stronger Communities. A similar centralised plan of action may prove beneficial to coordinate a targeted (crime reduction and therapeutic) response.

Terms of reference item

e. The sources of Ice including cross border trafficking, local manufacture and derivation from legal pharmaceuticals and other legal precursors; and

The Department of Corrections has no information of the purity of the ice (or frequency of ice dependency) specifically in the Northern Territory.

Terms of reference item

f. Best practice work place health and safety measures for those in the health system who come into contact with users of Ice.

Workplace health and safety within Northern Territory Department of Corrections and health issues as observed by Department of Corrections

The Principal Health Advisor is currently working with Primary Health Care Provider (PHCP) to ask if they can test youth and adult offenders as part of their reception health screen to test for Methamphetamine

There has been discussion around establishing a Meth Clinic in the Complex Behaviour Unit at the Darwin Correctional Centre however this is in its infancy stage and there needs to be robust calculations around the cost and implementation of such a clinic.

Due to the short-term effects of ice, the user may experience hours of immediate 'high' but then take several days to 'come down' from using ice. During this period, Community Corrections (and other programs and services) will have limited effective engagement with these individuals as they may be experiencing difficulty sleeping and exhaustion, headaches, dizziness and blurred vision, paranoia, hallucinations and confusion, irritability and feeling 'down' through to full blown psychosis. Using a depressant drug such as alcohol, benzodiazepines or cannabis to help with the 'come down'

effects may result in a cycle of dependence on both types of drugs (Australian Drug Foundation). Recent media reports from Darwin based services purport the withdrawal from ice may take up to 70 days, however this is not supported by other research that indicates the physical withdrawal (from ice) may take up to two weeks and is not life threatening such as it is with alcohol, or extremely painful as can be the case with heroin. After the initial couple of weeks, there is a period of months following this where the changes in the brain chemicals will stabilise, but it is not thought that this would interfere with the effectiveness of counselling. Regardless, it is recommended that withdrawal is medically managed due to the risk of psychosis and to allow for an appropriate assessment and assisted detox from (possible) poly-drug use.

Currently, young people are not drug tested upon admission. Consequently, there is no concrete evidence that conclusively links ice with the high level of paranoia, impulsivity, violence, severe mental health issues, physical deterioration and the recent incidents at the youth detention centres.

Introducing drug testing at the youth detention centres falls within the remit of the Department of Health, and discussions with Primary Health Care have been undertaken in recent times. Several issues with testing young people upon admission at youth detention centres have been raised and require further consideration. These are primarily:

- Testing Validity: there is no metric available that can distinguish ice from other forms of amphetamine/methamphetamine concoctions.
- Saliva: there is only a 12 hour window before methamphetamine-based drugs become undetectable. Prior to young people being delivered to a youth detention centre they may be held in police cells for a period of 12 hours. Saliva testing is not very reliable as it produces frequent false positive results.
- Urinalysis: there is a 48-72 hour window to detect methamphetamine. While urinalysis is a more credible form of testing it is resource intensive and comes at a higher cost per test.
- Resourcing: there are financial and resource implications associated with drug testing. The Department of Health has advised that self-reporting is an acceptable means of collecting data and it is considered (at this point in time) the most accessible form of collection and confirmation.

Youth detention centre staff are not trained to manage the range of drug-induced behaviours and withdrawal symptoms, including those related to ice. There is an argument that people affected by drugs, regardless of age, should be managed within an appropriate treatment facility prior to entering a prison or youth detention centre in order to effectively address their treatment and criminogenic needs.

Youth detention staff noted the negative impacts that ice has on detainees with devastating effects on their social and emotional development, physical and mental health, and personal safety. Youth detention staff currently deal with the resulting psychosis, disruptive and violent behaviour, and suicidal/self-harm behaviour through standard policy and procedures in place to manage difficult and high-risk detainees.

Many of the detainees already present with complex mental, physical and behavioural difficulties and concerns. The additional issues relating to residual paranoia/psychosis, aggression, and impulsivity from ice use, creates another layer of complexity for youth detention staff to deal with.

When a young person first comes to a youth detention centre and is assumed to be on ice or coming down from ice, they are taken to an isolation cell to be observed at 15 minute intervals for several hours. There is no provision available to isolate these youth for a longer period of time and this would also have a significant impact on staffing.

Once removed from isolation detainees are accommodated in a shared room with relatives and/or appropriately matched detainees to ensure the young person is looked after through peer support measures.

Youth detention management and staff are concerned that there will be a change in the mortality rate for detainees through ice-related suicide successes. Many young people are presenting with a strong sense of hopelessness and often

talk to staff about wanting to kill themselves.

There is an observable decline in their behaviour and attitude, and an increase in aggression, violence and unpredictability. The detainees "I don't care" attitude can make them particularly dangerous and difficult to manage because no messaging gets through to them. They also show very little remorse or any sense of consequence/accountability for their behaviour/actions.

Youth detention staff expressed their concerns for their own personal safety when dealing with young people affected by ice. Some Youth Justice Officers refuse to work with certain detainees out of fear. When detainees are physically aggressive, there may be a requirement to implement a critical response to protect both detainees and staff.

The physical deterioration of young people affected by ice is also very concerning. Youth detention staff noted an observable decline in appearance with young people leaving the detention centres at 70kgs and returning weighing 50kgs.

One of the most noted issues with the significant behavioural and mental decline is that these young people do not appear to "go back to normal" over an expected period of recovery time. The damage can be destructive and often long-term.

Currently, there is no legislative or policy provision for withdrawal, sedation or treatment measures.

Furthermore, treatment options for young people are scarce, and not available within the youth detention centres.