LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

4.00 pm – 4.30 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:

Drug and Alcohol Services Association Inc.

Carole Taylor: Chief Executive Officer

Mr CHAIR: On behalf of the committee, I welcome everyone to this public hearing into the prevalence, impacts and government responses to the illicit use of ice in the Northern Territory. I welcome to the table to give evidence to the committee from the Drug and Alcohol Services Association, Carole Taylor, CEO. 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?

Ms TAYLOR: My name is Carole Taylor, CEO of DASA.

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

Ms TAYLOR: DASA has been around for 30 years this year. It is our 30th anniversary this year, and it is the only service of its kind in Central Australia with the full range of treatment for people who misuse drugs or alcohol. We have a sobering-up shelter. We have the rehab services with associated low-level detox. We have transitional care units following rehab so people can go for a lot longer than the traditional 12 weeks, and we have independent living. We also have an outreach service that follows people as they come through that journey and beyond.

There has been a lot of talk about supply, and that is fantastic but it is not our area of expertise. Our area of expertise is the healing process.

Methamphetamine use is, by comparison, relatively new in the central desert. It is not something that has been around for – it has been around, but it has not been around in large quantities in the past. In fact, it used to be described by a lot of people as a white man's drug. That is no longer the case. It is certainly going through the Aboriginal population, particularly the young boys or young men, and that is a great concern to us.

The other thing of great concern to us is the focus at the end of this process is equally divided. Yes, you have to look at supply, and yes, you have to look at education. The educational stuff needs to be addressed a little differently than other things, but we need to look at rehabilitation and getting people back into society otherwise we will lose an awful lot of young people to this drug - a lot of people, not necessarily young.

I would like to raise something said by the people who were a few before me around education and the way education should be presented. I have a personal view, not necessarily the one of my board because I have never raised it, regarding educating young people in schools when it comes to this type of thing. I would like to see a little money, a little energy and a little effort placed on utilising fairly young role models in training people with regard to drugs and alcohol. There is a fairly big group of Aboriginal and non-Aboriginal people in their early 20s, particularly in Alice Springs, who would be very good at this who are not being utilised and would have a huge impact. They are football coaches, football players, people of note in the community, and people in Aboriginal communities who have gone through law, and therefore have some respect. They would be a very good group of people to use to teach the younger kids about the use of alcohol and drugs. Bringing in people and systems from interstate is an absolute waste of time. Thank you.

Mr CHAIR: No worries. Thank you for being so frank with us. In your submission you noted that a hole in the service model we have is in the detox space. That has been spoken about by a few different organisations. Do you see that as the bottleneck?

Ms TAYLOR: I see that as the bottleneck of fear. There are many people who are very afraid to even go in the detox space with people who are on meth or on ice, depending on what level of addiction they have. I suggest - and it was not a submission, it was simply a letter to the committee out of various levels of frustration - that we need to look at how we detox people from this drug or set of drugs in general, because they are different. They are a lot more aggressive, a lot more paranoid, a lot more difficult to deal with. So there is a bottleneck.

In Alice Springs - and I cannot talk for Darwin; I do not know much about Darwin except how to get here - we are the only people who do detox. Our detox is fairly low level anyway because we do not have clinician support.

If a person is detoxing from alcohol, it is probably a little more dangerous to them than if they are detoxing from ice because there are many more health issues that can come up as a result. Hospitals traditionally only take someone who is detoxing for two to three days. That is all they have the space and the time to do. After that, they would normally come to us.

Mr CHAIR: So in Alice Springs most of the detox is done in the hospital? Yes, we heard that when we were there.

Ms TAYLOR: Sorry?

Mr CHAIR: We heard when we were there that most of the detox in Alice Springs, if not all of the detox, is done at the hospital.

Ms TAYLOR: For three days; it depends on how you classify detox. The first two or three days, while people are getting out of the health concerns associated with detox, but the actual detox mental health concerns are often done outside hospital. As I said, we are the only detox except for the mandatory treatment people. They do mandatory treatment detox out at the gaol.

One of the issues we have raised - and it does not really worry us one way or the other – is there is a building associated with our building which is like a duplex. I am unsure what the modern term for a duplex is ...

Mr CHAIR: A duplex.

Ms TAYLOR: It is a duplex? Okay, that is fine. … which used to be juvenile justice. Associated with our building is a building that is already purpose built, if you like, to incarcerate – we do not want to incarcerate them, but to separate people. It would be an ideal place to turn into somewhere we could detox these people for a little longer.

They are not going to get down off any drug in three days. They just are not going to; it is not going to happen. We do not put a time on our detox either, by the way. It is when we - not me, I am not qualified - our staff and the people involved in the therapeutic model, believe they are ready to start the process. They start the process at level one. Level one starts after they have detoxed. It goes for however long it needs to go. But we could keep people in there if we needed to in a quieter and calmer environment.

At the moment, our detox beds are associated with our rehab beds. It is a separate room, but we will spill that over into the rehab beds if we have to. If you asked how many rehab beds or detox beds we have we, I do not know; it depends how many people are detoxing.

They are in the same system, whereas if you could keep them separate if you like - it is only separated by a wall and the laundry - you might be able to cross-use staff which would make it a little cheaper, although it would be fairly expensive to do up, it is a bit tacky. It might be of value, that is all. If the government does not want to use that for that space and is not prepared to pay for it, I am happy to turn it into women's and children's services.

It is available if people want it, but we need to look at - if that is not to be utilised - how we do this. As I said, there is a lot of fear in organisations, a lot of fear in people about, 'We don't want to do this. We don't want to handle these people, they are too hard.' We have these people in our services now and have had for a long time.

We also believe that after people are detoxed there is not a lot of difference. There has been a lot of talk about a difference and they are different when they are healing. We have not found that. We have found that once each group is detoxed they are much the same. They can mix with the others in a rehab environment quite comfortably, and we have not found people going berserk a long time afterwards.

Mr WOOD: Banyan mix people after they have detoxed.

Ms TAYLOR: Yes, as we do.

Mr CHAIR: Lots of people say that, but the rehab process from any addiction is relatively the same process no matter what. Even if it is non-substance related - people rehabilitating from a gambling addiction - it is a very similar process. It is just the detox part of it is …

Ms TAYLOR: It is the detox, and it depends on how long you consider a detox should take and how long it actually takes. Staff can tell. They know when someone is ready to move into rehab.

Mr WOOD: So I can get some idea of the geography in Alice, you have CAAAPU and Big Mob, is that right?

Ms TAYLOR: No, you went to BushMob.

Mr WOOD: BushMob. Are you a third provider?

Ms TAYLOR: BushMob is a youth provider. We would say we are the first provider.

Mr WOOD: I am looking at the Alice area overall. How many people are working in this …

Ms TAYLOR: BushMob is different. BushMob handles young people predominantly from out bush, kids who come into – town kids too, but kids who come in from the communities to be dealt with and they take them at a much younger age than we do. Basically in the general population there is CAAAPU and there is DASA.

Mr WOOD: All right.

Ms TAYLOR: CAAAPU is predominantly alcohol based …

Mr WOOD: Mainly Aboriginal.

Ms TAYLOR: … and totally Aboriginal. They have to be, yes, except in their mandated program.

Mr WOOD: You are an association. Are there groups involved to make you an association, or is that just the name you have?

Ms TAYLOR: That is just the name we were registered under originally.

Mr WOOD: It is not an association of other bodies?

Ms TAYLOR: No.

Mr WOOD: I just thought I would clarify that.

Mr CHAIR: In rehab, what programs do you run for people? Is it mostly a counselling-based service? I have written psychological interventions. What are they and how are you finding their effectiveness?

Ms TAYLOR: We use a lot of different programs. Psychological intervention is based on work we do in conjunction with Hollyoak which is a place where psychologists hang out and bring services in for us - they bring in drumming services. We have services around getting back into the mainstream. We have literacy and numeracy programs, music programs, we have a plethora of programs we utilise in different - depending on who we have in there and their needs. That also alters as we go through the process.

If a person leaves the rehab process, which is the 12-week process, and goes into transitional care that is done in association with employment, study or whatever. They still remain part of the program, but are also involved in working, education or whatever. That is a joint program.

Mr CHAIR: Are your staff having issues with their skill levels? Do your staff need up-skilling in this area?

Ms TAYLOR: No, I do not think they need up-skilling. What a couple of my staff, not all of them, would benefit from is something that makes them realise they have the capacity. The people with AOD Certificate IV have the capacity to deal with this, and our people have been in the system for quite some time. A lot of our people have dual mental health and AOD diplomas. As I said, there is a lot of fear around this drug and you say to them, 'What is your problem? You have a quarter of the population in there now.' It is a matter

of confidence. If we are going to up skill people we should maybe upskill them a little about the effects of the drug. But the major issue is to look at dealing with one's own capacity. People need to understand that they can do this, and the world will not end and they will be fine. I was saying before that one of the things we are doing now is putting people who are confident in dealing with such people with people who are not so confident, so they get the capacity off each other.

Mr CHAIR: I believe when we were in Alice Springs – I might be completely off the mark here – you had referrals or you were going out to the prison to do things? There was a funding issue. They were funding you and then they stopped funding, but you were going anyway?

Ms TAYLOR: Yes.

Mr CHAIR: Can you talk us through that?

Ms TAYLOR: We were funded originally under the Safe and Sober program ...

Mr CHAIR: Which was funded from where?

Ms TAYLOR: From the federal government.

Mr CHAIR: Okay.

Ms TAYLOR: That funding has ceased.

Mr CHAIR: Yes.

Ms TAYLOR: We were doing some work out there. We are still going out there to do DDE work – drink-driver education work. We are currently negotiating with the prison to do further drug education work there in a private capacity, as opposed to a funded capacity. Our other Safe and Sober program has just wound down.

We firmly believe that there is so little going on there in education for their clients. I cannot even make up the percentage but the Alice Springs prison has an enormous - I think it is around 80% of the inmates are in there with a drug or alcohol, predominantly alcohol-related - issue that something needs to be done before people come out.

We have, however, an agreement with the prison to take some pre-release prisoners into TACU, which is the lifestyle living skills-type unit. Whether it is to get them ready for transition to the outside world or not – I am not sure what their thinking is; that is what they are saying. These people are prior to being released. We are doing a bit of that with them, but that is only a couple. We are not talking large numbers of people; we are talking two or three at a time.

Mr CHAIR: Yes. I believe that one of the recommendations we will be looking at will be around that prison space and having detox and rehab happening within that space. Would you see a gaping hole in the services that are provided in prisons at the moment?

Ms TAYLOR: Yes. The gaping hole is that there are none. That is a big enough hole.

Mr WOOD: We have a letter from the minister saying that the Department of Corrections' prisoner treatment services provides an intensive group program called Safe Sober Strong for prisoners during the last six months of their sentence. Obviously, some people are not in for six months. The Safe Sober Strong program is compulsory for all prisoners wanting to secure a job. Do you know if that is in Alice Springs or have you heard of it before?

Ms TAYLOR: I have never heard of it. I would be very surprised if there was – I could well be wrong. I have been wrong before many times – not very often. If there was a program such as that I would be very surprised if we were not part of the development – not so much the development but the delivery of it.

Mr WOOD: What about the Prison In-reach Program? Have you heard of that?

Ms TAYLOR: I have heard of the Prison In-Reach Program but I am not sure how much it is delivered inside at the moment. I do not think there is much in there around this space at all, to be honest, if anything.

Ms KNIGHT: Is that in Alice Springs? Does it say Alice Springs or is it …

Mr WOOD: No, it does not, but I did not know whether it was left out because there is no mention of Alice at all in this.

Ms KNIGHT: I got the impression from the Alice Springs hearing that if they have an issue, they send the person to Darwin.

Ms TAYLOR: They do. Most of those training things are in Darwin. There is very little in the way of training capacity in Alice Springs now.

We are very happy to do those sorts of programs. We are very skilled in those areas. Our outreach team has been working at the gaol for quite some time and have a good rapport with both the clients, or inmates or whatever, and the people out there.

Ms MOSS: Through DASA, how many clients do you have requiring detox services at any one time? What is the average number of people you are managing through detox?

Ms TAYLOR: Ten. Maybe eight or 10. We are a 20-bed facility however that is structured, whatever that looks like. But then we have another eight which are federally funded and another three in independent units.

Mr CHAIR: Does Tobacco Alcohol and Other Drug Services, TADS, have an office in Alice?

Ms TAYLOR: No, I do not think so. We are south of the Mason-Dixon Line and do not get a lot.

Mr CHAIR: Do not be like that, we love you very much. I am south of the Berrimah Line. We get less than you guys.

The Safe, Sober, Strong program was the one you mentioned where the funding for it …

Ms TAYLOR: It has had a variety of names but, yes.

Mr CHAIR: This says the Safe, Sober, Strong program is compulsory for all prisoners wanting to secure a job.

Ms TAYLOR: As was the Safe and Sober federal program.

Mr CHAIR: We are trying to find disconnects between what some departments may imagine is the case and what NGOs imagine is the case. Sometimes the twain does not meet.

Ms TAYLOR: I am terribly surprised. What you have to be careful of going forward - putting programs in prison is terrific - is that the mandated space does not become the only paid space in the discussion. Most of the money for AOD in the centre has gone into mandated services. That is great if that is what you think is a really good process, but you cannot forget the people who are not committing crimes and going into rehab as well. It would be horrible to think you needed to commit three crimes in order to get into detox. We have to be careful that while building one we are not choking the other. When you look at recommendations about whether you do mandated drug treatment, or whatever you decide to do, it does not suck up the entire funding base for the sector.

Mr CHAIR: Okay.

Mr WOOD: A question we asked earlier was about the role of GPs. When we were talking to Robert Parker he said he sees their job more as being able to understand what issues the client has and then refer them to people who could do the detox or rehab. Is that how it happens in Alice? Not only but …

Ms TAYLOR: Yes, pretty much. We have a very good relationship with Congress and they work with us. We take new clients there and we draw up the primary healthcare plans and all the rest of it around that. It is our experience that normal GPs, non-Congress GPs, have very little to do with the AOD sector at all. I cannot recall - I have only been there 15 months so we are not talking a huge period of time - any referral from a GP. There has been the odd referral from Congress but your average GP, no. People do not

normally go there. Keep in mind too that our client base varies a lot, but it is normally around 90% Aboriginal.

Mr WOOD: They are not likely to go to the local GP?

Ms TAYLOR: No. Why would they when Congress is an excellent health service.

Mr WOOD: They probably would not know where to go if Congress is the normal place.

Ms TAYLOR: It is a one-stop shop and a particularly good service.

Ms MOSS: Can you give us an idea of how many clients you would have provided detox services to where ice has been a factor over the last 12 months?

Ms TAYLOR: We have had 375 people go through detox in the last 12 months. How many of those have been ice affected I honestly would not know. However, just before I started our average meth user, as a percentage of our organisation, was incredibly low and we had perhaps one a year. We are now looking at perhaps 20% at any one time. That sounds like quite a small number, but we are going from one a year to four every 12 weeks. In my view that is a large leap because nothing moved it up until then.

Ms MOSS: It has gone from one to four in a short period of time.

Ms TAYLOR: I would also like to, while I have the opportunity, refute what was said by the guy before me about this being a problem in remote communities. That is not true. We have no strong data, but anecdotally the further out you go the less likelihood it is to be there. A few communities on the bitumen may have had a dabble, but what we understand, and what young people are telling us, it is not there.

Mr WOOD: We got that impression when we had the meeting.

Mr CHAIR: Yes, we certainly got that impression across the Territory.

Ms MOSS: Are there any other issues you want to raise with us while you have the opportunity?

Ms TAYLOR: I would like to reiterate what was said before: don't throw the baby out with the bath water. Alcohol is still a massive problem in the Territory, and I would be very disappointed to see all the available funds diverted to ice. I know it is an emerging problem, there is no doubt about that whatsoever, but we still cannot forget the enormous damage alcohol does in this Territory.

Also, it is terribly sad that organisations such as mine - I was not planning to do this today because people do it all the time - have to struggle to get base funding to continue when you have this happening. We had our contract signed on Friday and it should have been signed on 1 July for 12 months. There was absolutely no indication that when it goes to tender we will keep going after that process has gone through. That is a really difficult way to have staff. It is difficult to ask staff to go into training. We had staff working with us, on my recommendation that it will be okay, with no funding coming in for the first three months of our year.

Ms MOSS: Is that federal or …

Ms TAYLOR: No, that is predominantly - it is both. The Northern Territory government has been a very difficult area for us this year.

Ms MOSS: Okay.

Mr WOOD: Perhaps we need 15% GST on alcohol and 5c goes back to programs.

Ms MOSS: What was the hold up on the agreement?

Ms TAYLOR: Discussions around the budget.

Mr WOOD: We understand funding is a real issue for people running proper programs.

Ms TAYLOR: My concern was we would at least get what we got last year, but if people asked us to reduce by significant amounts I was not prepared to go there.

Mr WOOD: It also sends out the wrong message: are people serious about it?

Ms TAYLOR: It puts you in deep trouble for the next three years put it that way, and I was not prepared to do that. Part of it not being finalised was my fault, but if you are only asking for what you got last year plus indexation, having already made several staff redundant, it makes life very difficult.

Ms MOSS: Thank you very much for that.

Mr CHAIR: We appreciate your time. It has been great having you here.