# LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

## 12th Assembly

## 'Ice' Select Committee

### Public Hearing Transcript

2.15 pm – 2.45 pm, Friday, 19 June 2015

Litchfield Room, Level 3, Parliament House

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| **Members:** | Mr Nathan Barrett, MLA, Chair, Member for Blain<br>Ms Lauren Moss, MLA, Deputy Chair, Member for Casuarina<br>Mr Francis Kurrupuwu, MLA, Member for Arafura<br>Mr Gerry Wood, MLA, Member for Nelson |
| **Apologies:** | Mr Francis Kurrupuwu, MLA, Member for Arafura |
| **Witnesses:** | **St John Ambulance Australia (NT) Inc**<br>Ross Coburn: Chief Executive Officer<br>Michael McKay: Director of Operations – Ambulance<br>Dr Malcolm Johnston-Leek: Clinical Director |

**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 NT. I welcome to the table to give evidence to the committee from St John Ambulance Australia (NT) Inc, Ross Coburn, Chief Executive Officer, Michael McKay, Director of Operations for Ambulance, and Dr Malcolm Johnston-Leek, Clinical Director. 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. This is a public hearing and is being webcast through the Assembly's website. 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 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 each witness to state their name for the record and the capacity in which they appear. I will then ask you to make a brief opening statement before proceeding to the committee's questions.

Could you please each state your name and the capacity in which you are appearing.

**Mr COBURN:** Ross Coburn, CEO of St John Ambulance (NT).

**Mr McKAY:** Michael McKay, Director of Ambulance Operations for St John in the Northern Territory.

**Dr JOHNSTON-LEEK:** Malcolm Johnston-Leek, I am Medical Director of St John Ambulance in the Northern Territory.

**Mr CHAIR:** Would you like to make an opening statement.

**Mr COBURN:** Mr Chair, we have put our proposal forward and I am sure everybody has had a read of it. We would be more interested to get some direction on what we can do to help in this forum. We can give you experiences etcetera, but basically it is a growing issue for us and it is not just ice issue, it is all forms of methamphetamines. It has created a new approach for us as far as our officers attending to patients suffering from an overdose or from the drug.

We find that one of the big changes for us is the different nature of people presenting. Alcohol-affected patients can often be quite friendly and are able to be talked to, but when we get into ice our paramedics will tell you it is a lot more difficult dealing with a patient firsthand. We have probably had a significant increase in the amount of cases where we have had to seek police assistance to attend with us on the job.

We are eating up a lot more resources on it, but I will deflect to Michael from an ambulance perspective. Michael, if you would like to say a few words.

**Mr McKAY:** For the committee, since 1 January this year we have attended 230 patients who have had a toxidrome consistent with potentially methamphetamine use, so substance abuse. We cannot quantify that on previous years because of a change in reporting systems. In the future hopefully we can do so. However, of those 230 people we attended, 85 needed sedation because of their paranoia, hallucinatory state and their aggressiveness. Of those 85, 22 required police assistance to restrain as well as drugs to calm them down. That is significant.

Recently a paramedic had a serious head injury attending a case where it is believed ice was involved.

It is a big problem to our workforce and my peers. These people are very difficult people to restrain and protect from themselves. One thing we are doing is working closer with the police and having a better approach to how we deal with these people.

**Ms MOSS:** Are you required to report where there is aggression and how is that recorded?

**Mr McKAY:** We report every incident of aggression to our paramedics. We have an electronic patient care report, we had a manual case card before that or patient report, and basically we tick on a box the type of aggression or the cause of risk to our staff. The risk to our staff can vary from being on the side of the road with traffic going past to an intoxicated patient, to a really aggressive patient. Again, it is how we mitigate that risk, which may be someone directing traffic, or in a situation like this police being present when we arrive or before we arrive.

This leads to delayed responses. We will not send our crews into volatile situations. We do not want to take more patients to the scene so we will hold off, wait for police to arrive then we will enter the scene. We report in a couple of ways.

**Mr WOOD:** Is there a location in Darwin or Palmerston you have to attend more than other places in relation to picking people up who have been affected?

**Mr McKAY:** At the moment I could not give you a clear answer on that. We do not record that – well, we record that data but we do not run those types of reports. What happens is if we attend a location and it becomes - and we have had some in the Territory where there is a greater risk to our crew. It may not be substance abuse or a toxidrome, but if our crews are at risk we will put it down as a location of interest and we will not enter that residence without police being there.

**Mr WOOD:** Some licensed premises may be a place where some of these drugs are exchanged, and I was wondering if there was a relationship between that and where you pick up some of your 235 people?

**Mr McKAY:** In the entertainment precinct of Darwin, being Mitchell Street, and the waterfront area we see an increased amount of antisocial behaviour in the general area, but that is no different to anywhere else in Australia where you have areas where people congregate.

**Mr WOOD:** You said 235 people were picked up for ice, but what does the comparison say with alcohol so we have got some comparison?

**Mr McKAY:** I have not pulled the alcohol figures?

**Mr WOOD:** Would you be able to give that to the committee?

**Mr McKAY:** Yes, we could.

**Mr WOOD:** We have heard that alcohol is still the number one problem, but it would be nice to make sure that when we are discussing ice we keep things in perspective.

**Mr McKAY:** I could not agree more. I have recently come from the States and their biggest problem moving forward is dehydrated alcohol - powdered form alcohol.

**Mr WOOD:** I thought you were going to say dehydrated water for a minute.

**Mr McKAY:** Dehydrated alcohol, so there are other emerging problems.

**Ms MOSS:** The submission talks about major events, specifically music events in the Territory, and probably nothing new ...

**Mr McKAY:** *BassintheGrass*.

**Ms MOSS:** What have you seen this year? I note it talks about 2014 and 2013, so what did you see this year and what are your thoughts on how we manage that at major events?

**Mr COBURN:** I think Malcolm would the best as he has experienced it firsthand this year.

**Dr JOHNSTON-LEEK:** This year at *BassintheGrass* there were about 7000 people and the biggest problem by far was alcohol, even despite the fact it was being sold at $10 to $12 a can inside the venue and you could take alcohol in. It was a fine art for a lot of people to somehow smuggle alcohol in. There were a number of drug-affected people and I saw all of them. I would definitely say probably only one was probable ice, the others were more fantasy and ecstasy, so NMDA-based drugs, but the main thing - this is similar to last year, although last year there was no ice that we saw. Last year it was predominately fantasy and snap chat, which are again NMDA amphetamine-based drugs. Last year they were very cheap. A point of drug was about $25. I wrote a report pointing out the economic argument that if you are paying $12 for a can of beer or Captain Morgan with coke, and it is $35 for a hit of fantasy which will last you all night, the economics are much more in line to take a drug.

Ice, at the moment, I believe is about $135 a point and about $250 for a little ball. The economics appears to be swinging away, but talking to people that does not seem to be stopping them at the moment. There is

some anecdotal evidence that ice is supplanting marijuana as the drug of choice even though marijuana is considerably cheaper here.

As far as things like *BassintheGrass* go, there is always a big drug problem and it always happens around sunset, which is interesting. What can we do about drugs at major events? We already have police going in the week before having daily checks around the site because people bury the stuff or put it in trees and all the usual things - throwing it over the fence during the event. We had one patient who broke their arm while doing that.

Can you get more stringent with the drug checks? It is very difficult because they are already searched as they come in. All bags are searched. It is a personal view, but it may be common sense to lower the price of alcohol. It is harm minimisation, but if you are looking at it from a purely economic point of view – this is a personal view not a view ...

**Mr COBURN:** We had a chat about that this morning. We think there is a lot more opportunity for education prior to events. We think groups should get together and put out what it is about and what we will be doing on those days. Let everybody know we are checking the venue prior to the event and we are following this up, but more importantly, talk about the drug and how it can harm you in those circumstances. Heat, sweat, dehydration - just run a few of those things past the guys. What was the program you talked about this morning?

**Dr JOHNSTON LEEK:** At an event like that it would be ideal to have brief intervention. It is called, from emergency services, an all-hazards approach. It is not just ice; it is all drugs, including alcohol. You would have a facility that gives advice on alcohol and drugs, and the idea of a brief intervention is if someone is thinking about it that is the time for you to step in and say, 'It's not a good idea you got drunk tonight and had a little fisticuff'. They are vulnerable and perceptive because there has been an adverse event and are receptive to the message, whether it be smoking, alcohol, drugs, even violence.

**Mr CHAIR:** You talk about a comprehensive public education program, and I know you guys do great education programs having done a couple. How are you situated in being able to provide drug education broadly in the community?

**Mr COBURN:** We run a first aid program in the school system and we touch on drug use. It is an area where you need to be very careful about how far you go outside. It is not a core topic for us, but it is something that could be easily linked into what we do in those programs.

It might be someone else with the expertise has a segment in our program when we get the kids to the school. We would love some form of that to be - no one likes using the word - mandated within the school curriculum - first aid. We are strong on first aid, but drug use and abuse or awareness - there could be some program into the curriculum. Under ours, we would be more than interested in looking at how we could deliver a message. We believe if the product is available at the right price there will be users. We believe we have to educate people on how to make the right decisions when they are confronted with the issue. It could work.

**Mr CHAIR:** People respect ambos and you have a message. You are well situated to be key in providing that message to the public.

**Mr COBURN:** Mr Chair, we deliver a first aid component through the Choices program for kids through the school system. That is for drivers and there can be a focus on that. We have a really good chap who does that for us. That is another area where we could highlight those issues, but it is around driving. There is an opportunity there as well.

**Dr JOHNSTON-LEEK:** St John has a somewhat unique situation in that we are dealing with people who have never been exposed through the education program. If that can be expanded and enhanced for all drugs so we capture those people before they are exposed to it, plus we have, through ambulance operations, the people are obviously acutely affected and somehow we can work with those.

**Mr CHAIR:** Are you seeing an increase in not just people having a psychotic event and someone has called an ambulance, but people who would have classed themselves as a non-dependent user and something has gone wrong?

**Mr McKAY:** We see a lot of those presentations at our major events. People who have – the classic you mentioned, *BassintheGrass*, where they bring the drug dogs in, they walk through and people ditch all their

drugs. We get people who do not use the drug but see a blue tablet lying on the ground and wonder what it tastes like. We might all think it is silly, stupid and you would never do it, but people do. They then present to us, and it is not just at the V8s where they have a concert afterwards, any major event not just limiting to those. The Darwin Show in the evening …

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**Mr CHAIR:** Are you seeing not just an increase in dramatic things, but an increase in people who would not class themselves as usual users? Are you seeing an increase in …

**Mr McKAY:** We certainly do.

**Dr JOHNSTON-LEEK:** People who have inadvertently taken a bit too much or it is a bit too strong and they have been using a relatively …

**Mr CHAIR:** Then they get scared and call an ambulance?

**Dr JOHNSTON-LEEK:** … and someone else has called the ambulance.

**Mr CHAIR:** Any data on that?

**Mr McKAY:** Our data extraction has not been great. In the last 18 months it has improved significantly, and we are still working on building it to get a good database behind us.

**Mr COBURN:** Going forward I think we will be able to …

**Mr McKAY:** We will definitely be able to.

**Mr CHAIR:** We need tons of information about dependent users. We have hardly anything about non-dependent users. How big is the market of people taking it because it is fun or to stay awake at night? We would love any information you have on that you could share, whether that is now or if you send something to us.

**Mr COBURN:** We do not have the data now so we can have a look at that.

**Mr McKAY:** We can definitely provide whatever we have.

**Mr COBURN:** I was talking to an employer the other day and one of his managers was a six-year user of ice. He did not know about it and could not identify it until he had to be tested for a contract. He was only a social user so to speak. He operated normally for six years. You can talk to an ambo who will say, 'I was refuelling the car last night and there was a car load of meth addicts scratching their faces, their lips were bleeding because they grind their teeth down'. You can spot them a mile off, but they are the ones who have been long time addictive users.

**Mr CHAIR:** Whilst we need some strategies to deal with people who say, 'I've been using for six years, it doesn't affect me, it's not my problem, I'm not hurting anyone'. How do we deal with that?

**Mr WOOD:** You mentioned multidisciplinary training for paramedics and said you need more money to that. Is that something this committee can put to the government - that you need to be doing your job properly, especially as you do not know what will occur. I presume you need people with multiskilling to handle different problems.

**Mr McKAY:** Our paramedics are well trained. It is the particular training where we need to release them to train with other agencies. We do in house training, but it is more getting them – we have obligations, but if we want to send them off to train with police that is additional training we need to find for staff.

**Mr COBURN:** You are right, Gerry, it could help us.

**Mr McKAY:** Yes, it would definitely help.

**Mr WOOD:** I sometimes hear from police and the firies, 'We are first there and the rest come afterwards', but I presume you all try to work together.

**Mr McKAY:** Yes.

**Ms MOSS:** Was there anything else you wanted to tell us this afternoon?

**Mr COBURN:** We would just like to reiterate we like the education before use. It is a strong area for us and we would be more than happy to work with anyone to help deliver that. We will deal with the rest as it comes, and we are teaching our guys – Gerry touched on it then – different ways to address patients. One in five of our patients have a mental illness nowadays, so your training has to change significantly on your bedside manner with those patients. It is certainly a challenge, but it is something the guys are pretty good at aren't they, Mick?

**Mr McKAY:** We do not want to teach them self-defence tactics, we want to teach them disengagement tactics and better strategies to not get into it. We want better situational awareness and de-escalation, not going in with a heap of tools where if someone gets aggro we can take them down. We do not want that and that is not our role.

Unfortunately we deal with consequence management all the time. Rarely do we get to deal with preventative. If we have the opportunity at major events to deal with preventative, even if it is at that acute presentation stage with family, that is a great opportunity too. Currently that is something we do not do, but it is an area we are interested in getting into.

**Dr JOHNSTON-LEEK:** For acute presentations the training is very good, it is excellent, and we are using the all hazards approach in trying to identify the toxidrome - what it is. Ice is just another drug in the long list of the drugs that have come before and the long list that will follow. This one just happens to have little nuances in that it is more concentrated, more addictive and the pharmacology is fascinating if you are interested in that type of thing.

The big thing we have found with this particular drug is the total unpredictability of behaviour. That is the nuance that is the further education, particularly dealing with people like police in how you handle this particular person when there is a high probability there will also be an associated illness, mental or whatever.

**Mr WOOD:** Ross was saying he met a man who had used for six years. Will there be long-term effects of that?

**Dr JOHNSTON-LEEK:** We do not know.

**Mr WOOD:** Will he die at 50?

**Mr CHAIR:** Thank you, gentlemen. It was very much appreciated.