LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

11.00 am – 11.30 am, Tuesday, 14 July 2015

Katherine Town Council

Members:	Mr Nathan Barrett, MLA, Chair, Member for Blain Ms Lauren Moss, MLA, Deputy Chair, Member for Casuarina Mr Gerry Wood, MLA, Member for Nelson
Apologies:	Mr Francis Kurrupuwu, MLA, Member for Arafura
	Association of Alcohol and other Drug Agencies
Witnesses:	Michelle Kudell: Executive Director Miranda Halliday: Program Manager

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 Association of Alcohol and Other Drug Agencies NT, Michelle Kudell, Executive Director, and Miranda Halliday, the Program 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 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 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 of 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 names and the capacity in which you appear?

Ms KUDELL: My name is Michelle Kudell and I am the Executive Officer for AADANT, the peak body for alcohol and other drugs in the Northern Territory.

Ms HALLIDAY: My name is Miranda Halliday, Program Manager for the Association of Alcohol and Other Drugs.

Mr CHAIR: Would you like to make a brief opening statement?

Ms KUDELL: Obviously, you have received our written submission. Today is a bit more attached to that around what we have heard since then or some of the issues that we hear coming up. We are concerned that there is a prevalence of crystal methamphetamine use, and perhaps the strength of our organisations to deal with that needs to be improved. However, at the same time other substances have an equal level of concern in the Territory, and probably just exploring around that capacity development and what is needed in the NT in regard to crystal methamphetamine treatment is what we would like to discuss today.

Mr CHAIR: What do you think is needed?

Ms KUDELL: We have some information and I will leave this with you – we have included the previous submission. We have also been working with Professor Rebecca McKetin from ANU, and she has forwarded her submission to the National Ice Taskforce and I have included those. She has allowed me to do that and said to contact her if you have questions regarding her research. Some of this is informed by her research too, and she has been looking at current treatment for crystal methamphetamine in particular nationally.

If we were to look at the key priorities I would say they are around workforce development and capacity. That said - and you will see it iterated in her research - there is perhaps some evidence that specific methamphetamine treatment services might have a place, but that the infrastructure cost in that is huge and cannot be duplicated across multiple locations. In the sense of the Territory, that becomes a challenge anyway with remote servicing. We need to be looking at how we up skill our agencies to deal with the emerging issues - not always methamphetamines, but in this case crystal methamphetamine. Sometimes that is about reiterating that they do have skills to deal with it, but they may not understand yet what new treatment modalities look like, particularly what has been successful internationally and in the rest of Australia, because it is a fairly quickly moving new substance in the arena,.

Mr CHAIR: We have heard from other providers and other people that there seems to be issues in treatment of people with drug issues. Much of that centres around detoxing and making sure the individuals are at a place where they have finished a proper detox process. Can you outline any differences you can see, or can you provide some information about what a detox looks like for, say alcohol or marijuana, and then compare that to what that looks like for ice?

Ms KUDELL: Probably the biggest difference is less about the periods of treatment. To get a picture of detox it is usually around three to seven days, depending on the level of dependence. Often it is related to how dependent the user is, how long they have being using and the dosage they are using. It might be that they are very frequent users, and then you will see that it takes a little longer for them to detox.

You have to be able to distinguish detox from treatment. The detox period can be quite short although it is variable - you are looking at three to seven days on average. If you look at best treatment practice for the actual treatment it would take up to three months - two to three months but requiring two to three sessions of intensive treatment a week.

The recommendations we are seeing from this research is that best treatment might look like cognitive behavioural therapies and contingency management treatment. We see some of our agencies – AADANT Program Manager, Miranda Halliday, has done a case management package recently. She did a lot of research with our agencies about the types of treatments they are using. We see some of our agencies using cognitive behavioural therapy, but it is not widely available. That seems to be perhaps some of the best treatment that is appearing in treating crystal methamphetamine usage.

Mr CHAIR: What is cognitive behavioural treatment?

Ms KUDELL: Cognitive behavioural therapy is a programing really, isn't it? You might be able to talk a bit better about that.

Ms HALLIDAY: Absolutely. Using different aspects, I guess, looking at the client's psycho-social environment as well.

Ms KUDELL: It is about reprogramming how they work within their own environment to deal with it. If you look at contingency planning, I always think perhaps you are an expert when you raise a child because it is about looking at the rewards rather than the punishment. What you would be looking at in a contingency planning model if a client disengages is rather than making that a focal point, you look at the positive steps and keep reinvesting in those.

There are models available and there are a couple of resources - not a lot around crystal methamphetamines specifically and different models of treatment. As an organisation, we have tried to start getting that information out there. We are a little limited, I will be honest, with human resources and funding, so that makes it challenging.

Mr CHAIR: Do you work in the detox and the treatment spaces?

Ms KUDELL: We service the agency so we are not practitioners; we are not providing service to clients. Our role is to support the agencies that are providing the services. What we tell you is from research or from what we hear from our agencies about their challenges in treatment. I guess some of the challenges, when you are looking at crystal meth, is that the research is showing a much younger demographic. Quite often those younger people have not had exposure to AOD treatment services before. This creates an access issue there in that they are unfamiliar with what it means to (a) ask for treatment and (b) engage in and remain in treatment. So that becomes an access issue.

When you talk about capacity, what are you talking about - the capacity of the client or the capacity of the public? Public education is helpful when we are dealing with a different demographic of people than perhaps injectable methamphetamine users.

Mr CHAIR: When you are talking about the capacity of your people operating, I am assuming the people you are representing occupy the rehabilitation treatment space, not the detox space?

Ms KUDELL: Predominately in the Northern Territory that is what we have. Banyan House is probably our predominant detox centre. I know we have one or two others that are starting to dip their toe in that area, but we do lack detox-specific spaces. Which is another prohibitive factor, in that some of our services that are residential rehabs might be abstinence models, so they are not going to take someone who is using. So, you have got a suitability-of-client issue, where they might be turned away because they are deemed unsuitable, and then we did a bit of think-tanking before about, who is unsuitable? How do we determine it and why is it a problem? Some of that is about a capacity and training deficit of agencies being able to determine that, you know what? Yes, a client might be coming in with a crystal meth issue, but maybe they are going to be okay because we have got the skills in place to treat that effectively. We have got enough access to aggression training, or de-aggression tactics, and they are not going to affect our other clients, so it might reduce that risk.

There is that lack of appropriate spaces, so specific detox or even, like I said, a specific methamphetamine centre, but I would not want to push that as the ultimate, because I think we have got some really capable

services. We just need to give them more education and training around how to deal with emerging substances.

Mr CHAIR: So, do you think the physical capacity is there, but not the training? We need to up skill our individuals to be able to help them?

Ms KUDELL: I think that is really important…

Ms HALLIDAY: In the Northern Territory we have 12 residential rehab facilities and only a couple of those have actual clinical staff on site. For a client to engage in pharmaco-therapy through the withdrawal period, predominantly administered by clinical staff, this is an issue. Being a non-clinical environment within our agencies I would say there is an issue in our agencies being able to access clinical staff to compliment withdrawal.

Ms KUDELL: And that said, pharmaco-therapy for crystal methamphetamine dependence is not really available. That would require some research around the pharmaco-therapy options for treatment. At the moment, there is nothing, in terms of pharmaco-therapy, that is really successful in working with crystal methamphetamine that we are aware of. That comes out of Rebecca McKetin's research.

Mr CHAIR: What I want to get to the bottom of is, I hear that there is a detox space, where somebody goes through this program, and at the end of that, they are in a much better space to actually begin a rehab treatment.

Ms KUDELL: Treatments. Yes.

Mr CHAIR: I am hearing that once they are in that position, it does not matter what the drug is, because it is generally the same process you are dealing with an addictive behaviour and what the source of it is.

Ms KUDELL: I would believe so. The research is showing the cognitive behavioural therapy etc as being perhaps the preferred model, so, up-skilling staff to do that would fit in with their..

Mr CHAIR: So, on this side, up-skilling staff is okay? What I am trying to get to the bottom of here is, on that rehab side once they are in the right space, they have gone through their withdrawal, they have gone through detox, they have had the pharmacological work done and all of that. We get them to the right space, what is the capacity like, post- that space, for services there? Is the physical capacity there, and is the skills capacity there within the existing framework?

Ms KUDELL: Yes, but I think physical capacity could be improved, definitely. It is an interesting one and we had a think tank on this because some of the feedback we get from clients differs from the data - specifically I can recall talking to a client in a sobering-up shelter who said he wanted to be collected (this is alcohol story) by the AMT (Alcohol Mandatory Treatment) because he could not get a bed in a rehab facility. Yet, if you talk to the Government they will say that the stats do not show that as a problem. So we were both questioning as to why are the stats different when we have got clients saying that they cannot get in because of the waiting list? We hear our agencies saying that they are at capacity, if not over capacity, in terms of waiting lists and yet it does not seem to reflect this in the data.

The conclusions we have come up with is that often there is a deficit around the ability to correctly input data and that will reflect in the statistics. Sometimes we are looking at services that are understaffed, not always a funding issue, sometimes that is because of issues with recruitment and retention. There is a lot of organisational churn in the NT. If you think about the investment in making these organisations really healthy you are probably going to retain more staff, reduce stress levels and increase the capacity to fully house clients. That said, considering the issues we have in the NT there should perhaps be more infrastructure investment in treatment services and strengthening the AOD workforce to match.

Mr CHAIR: In the rehab space?

Ms KUDELL: In the rehab space, yes, I think so and the referral pathways because that is a real issue too. We often have people saying there is nowhere to go but it is really a lack of clear direction. It is a lack of strong referral practices, not necessarily from the agencies because they know what they are doing but there is currently an unclear view of where to refer to and who is the best fit for the client. Mapping that area (referral pathways) would be really productive. There is also a gap in referrals between psychiatric services or allied health and Emergency Departments through to the NGO sector, who are primarily

responsible for running the rehab and treatment facilities. Looking at how we strengthen referral pathways and make the client journey a little easier would be beneficial

Mr CHAIR: If I can go to detox, as the peak representative organisation how do you see that? Do you see issues there before they are ready for rehab?

Ms KUDELL: Other than availability of services, because that is the problem with detox spaces here, I do not see an issue. Holistic servicing of a client is ideal, particularly here when we are dealing with Indigenous clients, relationship building and the cultural considerations that sit behind the issues, if we had holistic servicing spaces that catered to the whole client journey, it would make the process more effective and seamless.

Mr CHAIR: What does that look like?

Ms KUDELL: that is a really good question and we have thrown that idea around but maybe hub centres where you could have a detox and withdrawal all sitting in the same space. It could be a multipurpose centre. Rather than go – and this is just my opinion – rather than handing money to five different organisations just build one site where they all service at the same time. It means you have spent only one bucket of money on infrastructure but there is a multiple servicing option in a shared care space. I cannot give you an example of there that might be working, this is just spitballing – if you like, just a concept. If you are thinking of the care of the client then that client has a much easier journey through their issues because it is all there where they have developed relationships with the groups that are co-servicing. It requires collaboration and that can be challenging at best.

Ms HALLIDAY: Quite often there seems to be a divide, not a deliberate divide but one based on organisational parameters, between clinical and non-clinical staff. Transfers from the clinical detox facilities into community-based non-government organisations and the parameters around the sharing of information pose an issue for some of our agencies.

Ms KUDELL: Yes, and they articulate quite strongly that often, unless they have a clinical staff member, there is a reluctance to share information. We have challenged this with the government by saying, 'We are not talking about highly personal or confidential clinical information'. Our agencies understand that, but if we have a client with a potential heart issue or something, that type of information is clearly valuable regardless of whether you have clinical staff – just around the safety and care of the client through their journey to understand what their issues are and be able to manage that effectively.

Ms HALLIDAY: I guess what we are trying to reiterate is that we would like to see a client's, presenting with crystal methamphetamine in this instance, engagement with treatment as a continuous journey. The client is not jumping from one service to another, that treatment is more holistic so it seamless between the services. We are working on ways to improve referral pathways. It is not that our agencies don't have the capacity to deliver, they require the support to deliver.

Ms KUDELL: They do not have the skill level is what I think Miranda is saying.

Ms HALLIDAY: There is definitely a capacity …

Mr CHAIR: Where? Because we are all new at this, if you say you do not have capacity you have to tell me where.

Ms KUDELL: In general, if you look at recruitment and retention, for example. A great reason for people to move on, quite often, is organisational health, if you like – around governance and good management skills, policies and procedures. This basic capacity could use support and strengthening. There is also the issue of access to training and professional development. Quite often agencies are funded a small amount, and when you consider the Northern Territory someone from Borroloola who wants to attend training in Darwin is looking at a minimum of five or six days travel time including accommodation so there is a limit. You are also raking someone out of a high impact service for a great period of time for training. Quite often it just doesn't occur.

We have been strategising about what that looks like and how we can deliver that on-site in an agency, rather than expecting those agencies to release people. What sort of mentoring and exchange program could we put in place where we can put skilled staff into that agency and swap out a staff member so we build some skills but we do not lose the staff members? It is about retaining the manpower so we do not

lose the ability to service and capacity around that. We have some high-skilled and clever people working in the organisations, but often it is those types of areas of capacity, in a time-poor environment that suffers.

Being able to access research, unpack a policy and unpack a report from the government is time consuming. That is where we try to assist by saying we will try to unpack it for them. We have our own issues with capacity and funding to be able to respond to that. If we could address that area effectively; sot there is up to date research and information, training is accessible to provide governance support, talking to agencies about how that looks and how they can unpack policies in a productive way, so that people are constantly aware, they you have a strong organisation and people tend to feel less inclined to jump ship.

Funding is an issue. Sure, we have a lot of agencies struggling, with low-competitive salaries. A smaller agency might be a very functional agency. Often our smaller Indigenous agencies that are well suited to servicing the client cannot match the salary of a government service, so its staff members will disappear. That is an issue in itself; it is a struggle in that sense.

I have tried to articulate that in the submission, so the information for you to read through talks about what that capacity looks like. Rather than just that overarching statement, we have gone right down, in the back, to give you some solutions - tangible recommendations as I have called them - in that this is a project we think would work, here is a way to solve this - rather than just telling you the problem is capacity, skills and training. We have articulated here for you some examples of what that might look like to assist agencies to respond, not just to crystal methamphetamine but any new or emerging issue that comes up.

One thing I would like to say though is that data is an issue. I know that was on the terms of reference. We have responded to that previously. It remains an issue insomuch as our agencies are providing data but often there is not a lot of feedback. What they get back is not as beneficial as it could be jurisdictionally. Recently, I spoke with the Director of the Department of Health and said our agencies are asking for jurisdictional data - not service-specific data but jurisdictional data. They can say that they have only seen one client, but they do not know that next door has seen 10 and there is potentially quite a problem building in their area, regardless of the substance.

That kind of data that sits around the local space they are servicing would be really helpful to be collected ...

Mr BARRETT: The trends and patterns.

Ms KUDELL: Exactly. We recently had our forum in Alice Springs. We asked for a presentation on jurisdictional data and we got data from the Bureau of Statistics and the AIHW which is all publically accessible, so it is not something our agencies did not know. It is like, 'You have missed the mark; we really wanted to see jurisdictional data. These people are hungry, they want to service their clients effectively and they are inputting a lot of data and not getting anything back as a collective, if you can understand what I mean? They can look at their own service data but they cannot look at a group. It is not that they want to identify the information or its source but understand collectively what is happening in their specific jurisdiction.

Mr BARRETT: Just aggregate it.

Ms KUDELL: Yes, aggregate it. This is what is happening in Katherine, in Alice Springs, in their community wherever what that might be, so they can better service their clients.

Ms MOSS: I would like to ask a question about data.

Ms KUDELL: Sure.

Ms MOSS: It is obviously a major part of your submission about reliability of data.

Ms KUDELL: Yes.

Ms MOSS: What do you see as the starting point? Where do we need to be starting that data collection? What is it we need to be collecting data on, as you see as the major gap? Obviously, there needs to be a starting point. What is that point?

Ms KUDELL: To be honest, the starting point is mapping what that looks like, insomuch as putting together a project and using proper research tools to talk to all of the agencies and ask what it is that they want to know. We have done that to a point through a survey. It is not as effective as it could be, by all means.

Start with a project that looks at mapping, what it looks like and whether there is a way we can develop a platform or integrate into existing platforms. There is a lot of data to input, and let's face it, we do not want people having multiple platforms – 'I now have to input my meth data and then input other data.' I would start with a mapping project to accurately determine what it is we need to be collecting.

What the agencies are talking about is the numbers of people being serviced in their community - not from their own perspective but from every organisation that might have service options in town – and who is out there servicing. As much as that probably does not seem like relevant data, it is from that referral process. How many people are travelling to the hospital who might not be caught by the NGO sector - government and NGOs looking at all of that data rather than as separate entities? What successes are people having? That again is a bit outside of data, but if we know we have 10 closed episodes in this service but only one in this service, we might be talking with this service to learn, being proactive as an agency. I would. I would be saying, 'Wow, they get 10 closed episodes. I am going to talk to them about their processes.' What is it they are doing? Is it 10 real closed episodes? What is it they are doing so I could then get my staff up skilled in a way their staff obviously are?

Ms MOSS: So the start is getting out there and saying, 'What is it that we need to know'?

Ms KUDELL: I agree.

Ms MOSS: What is it that you are collecting? How can we have a common language across agencies?

Ms KUDELL: Absolutely. Also what you want to hear back on too, because they might want to collect certain stuff, but you do not really care. I want to collect that information because I know it is important, but it is important to the government. What is important to me as an agent is this and seeing what is happening. 'Jurisdictional' is what they say to us all the time. We want to know what is happening locally. We do not want 'the broad NT has 2% increase' or something. They want to know locally, because quite often that is very different and it does flavour how they are going to treat their clients, or what they might go to the government with in terms of projects or funding requests. If we understand what is happening, we can target it much better and we can get funding channelled into the appropriate places.

Ms MOSS: Do you have a view on who should lead that kind of work in agencies?

Ms KUDELL: This sounds like a funding grab. The peak is in a position to do that insomuch that every NGO agency is currently a financial member of AADANT. We also have a few various other agencies, but we also talk significantly with other services across the sector. From the point of view AADANT we also sit on a sector development network which is national. I also sit on the national AOD peak's network which offers collegiate and collaborative support and action.

There is a lot of support from that nationally to see what other jurisdictions are doing from that perspective and how we can better apply ourselves here. We have that expertise we can pull in from some of those high-functioning states that are well-funded, and start to develop.

You need an independent body to do that. I find that agencies can often get caught up with competitive funding and there is a little bias. We do not care; we service all of our agents. We do not have a particular bias. It means that we can fairly look at all that information, pull it in, then start feeding it back. Plus we have the access to the services, which makes it very helpful.

Ms MOSS: Thank you. I know Gerry has some questions too.

Mr WOOD: Are you finished?

Ms MOSS: I just want to make sure you get a go.

Mr WOOD: All right. Thanks for that.

Ms MOSS: You just mentioned that you are on the sector development network, it is national and you are getting to see what all the other jurisdictions are doing. Is there anything that sticks out to you that other jurisdictions are doing that you then would translate back here?

Ms KUDELL: Yes. Miranda is on that particular network.

Ms HALLIDAY: Yes, absolutely. I sit on the peak's capacity building network which is the program managers or project managers from all of the AOD peak bodies across Australia. We get together once a month and discuss what are the hot issues in every jurisdiction. We have a think tank as to best practice from different states and how we can work to overcome some of the issues that are presenting themselves.

Crystal methamphetamine, yes, is a topic we have all been discussing. What that looks like in every jurisdiction at the moment is different in data and emergence etcetera. Right now we are working on a joint project where we are collating all of the resources nationally and internationally that we can get our hands on to develop a comprehensive suite of resources for our agencies that hopefully will work towards providing a bit of consistency across the nation, as well. That will go out to all of our membership, as a starting point if nothing else and so we are all taking the same language.

Ms KUDELL: Yes. For crystal methamphetamine, it is quite new in the sense that methamphetamine has been around for a long time, but the specific focus on that is something we are looking at and working on developing projects. Some; of the projects that stand out – NADA did a great mapping project and they have offered us the tools to do the same in the Northern territory, but we have not received funding – this is the way we are going.

We are not in a good position at the moment with funding. We do not get federal government funding. Previously we were auspiced by another organisation. They announced a 12-month extension on the sector development funding which has not translated into our sector. The other organisation was offered it by mistake and they have accepted it which is not, in my opinion, very ethical. I do not really want to raise that here, but we are working with these groups and organisations to do something really positive in the Northern Territory, but we are beating our head against a brick wall when it comes to funding. Our output does not represent something that is not worth investment.

Miranda has just finished a case management package that has been so well received nationally – people are starting to use it nationally. That has come from the NT, so it is a bit of a shame really. We are core funded by the Northern Territory Government but that is it. I lose Miranda in two weeks' time because of lack of funding.

Mr WOOD: The word epidemic has been used a number of times, mainly in the media. Some people use it in their reports, but do you see the so-called increase in ice being more relevant to existing drug users rather than new drug users?

Ms KUDELL: I have been reading a bit on this, particularly through – you will see a reference to that in Rebecca's research. I think there is definitely a tendency for somebody who has used drugs previously to find it, but because it has a sense of a party drub about it at the moment I think we are seeing new users, younger females in particular. There is also that demographic who see – because it is an upper – that you can get more out of your day and are a bit happier and you are great in the first instance.

Bearing in mind that it is highly addictive, as the trail goes on the story looks a lot more depressing. In the first instance, it will give you plenty of energy, you can burn the candle at both ends, you can hold down two jobs, sexual function improves and there are lots of positives. Unfortunately - I heard this on *Sunrise* a month or so ago - it gives you super-human powers. For young males to hear that - you will attract a new user definitely to that kind of substance. If they think they will be super human, they will be highly sexual and will be able to function 300 times greater capacity. There is a potential, I believe, for new users to be attracted to that as a drug. I do not know if there is any evidence to suggest that is specifically the case in the Northern Territory, but we certainly have a younger demographic showing up, which would indicate that on the party scene it is quite a popular choice.

Mr WOOD: Is there a risk that we might put too much effort into an epidemic and not deal with the issues you raise - that alcohol and cannabis are still the number one drugs?

Ms KUDELL: I think definitely. Absolutely. We are certainly not at epidemic stages, but it is certainly something to watch. The issue that you have with anything like that, particularly a highly addictive substance, is if we do not do something we will end up with a much bigger problem later that is a lot harder to solve. This is why public education - you start to look at your prevention strategies, look at supply issues, and that is a policing issue but also something to focus on, and making sure that your agencies are able to cope with treatment of the clients they have. If we can get positive public education out, and not necessarily the scare mentality education, I think you will have more success. I think that is a bit damaging because it is not the junkie in the street that is always the crystal meth user. It can be you or I sitting around the table with a secret – eventually, long term, when your dose increases and your need increases and you

become highly dependent, clearly then there are manifestations that would show. You cannot hide it forever.

Ms HALLIDAY: Can I just add, from a consumer perspective which is our ultimate client, I think stigmatising crystal methamphetamine would significantly deter some clients from wanting to access services. Therein lies a massive issue with people who are abusing crystal methamphetamine and not wanting to access services for fear of the stigma attached to the use of ice.

Mr WOOD: One of the stigmas you mentioned before - not focusing too much on punishment but on working on the positives – is one of the problems with this drug is violence, especially domestic violence. I would presume that people who committed crimes still would, even if it is under the influence, be liable for punishment.

Ms KUDELL: Punishment, you would think so. The violence is relative to the dose rate. In the research - and again it is articulated in Rebecca's research - over treatment times, what they are finding is as the dose reduces, the possibility of harm is also reduced. So a lot of violence is from a long-term, high-frequency user. She has in her findings 11 – I will tell you because I wrote that down. It is 11 times higher prevalence of psychosis in the user population as to the general population. So it is 11 times higher to give you a reference point, if you like.

The violence is primarily responsive to dose so that should reduce once the dose is. When we look at the dose rate, in the research they have done we are talking about 16-plus days a month of use is what you would term a high user, one to 15 days per month, then zero days a month. When they were measuring in those three different categories they noticed that the violence decreased in response to the dose decrease. That is an interesting bit of research. It encourages us to want to provide treatment and be able to reduce that dose or that need.

Mr CHAIR: We are out of time.

Ms KUDELL: I will leave this. Obviously, it has a lot more information in it for you to have a look through, and some further recommendations by us. Again, they are tangible recommendations and we have a solution-focused person, rather than just the concepts.

Mr CHAIR: Thank you for presenting to us. We very much appreciate it.

Ms KUDELL: Yes. Get in touch with us at any time, if you need any information.