LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

9.15 am – 10.00 am, Friday, 19 June 2015

Litchfield Room, Level 3, 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:

Department of Health

Professor Dinesh Arya: Chief Medical Officer and Chief Health Officer

Dr James Fordyce: Deputy Director of Emergency Medicine, Royal Darwin Hospital

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 Department of Health, Professor Dinesh Arya, Chief Medical Officer, Royal Darwin Hospital, and Dr James Fordyce, Deputy Director of Emergency Medicine, Royal Darwin Hospital. Thank you for appearing 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 to 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 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 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?

Dr ARYA: Good morning, and thank you for the opportunity. Dinesh Arya. I am the Chief Medical Officer, for the Department of Health, Northern Territory Government, not Royal Darwin Hospital.

Mr CHAIR: Right.

Dr FORDYCE: Good morning. Thank you for having me here. My name is James Fordyce and I am the Deputy Director of the Emergency Department at Royal Darwin Hospital. I look forward to sharing some views.

Mr CHAIR: Thank you. Do you want to make a brief opening statement?

Dr ARYA: Yes, I do.

We are hearing anecdotally that the use of Ice is increasing and we are also hearing through our clinics, our health centres, and through NGO providers who provide alcohol and drug services, that there has been an increase in and use of crystal methamphetamine or Ice. As we stated in our submission, we get information on amphetamines, and in particular Ice, through a number of sources. Those sources were listed in our submission and include the Illicit Drug Reporting System and through the Alcohol and Other Drugs client data that we manage internally, the National Drug Strategy Household Survey, and through Emergency Department presentations in our public hospitals as well as patients who are admitted to the hospital.

In response to the concern that use of Ice is increasing, with our partners, with NGOs, and with other Northern Territory Government departments, we have created two interagency groups. One group is now working on developing education and information resources to deal with this increase. The second group is made up of the Department of Health and the Northern Territory Police, and we are hoping we will have an Illicit Drug Summit in July this year to focus specifically on Ice.

In regard to assessment, treatment and rehabilitation services, we provide outpatient or community services. We have residential rehab services in the Northern Territory and provide treatment services to people who need assistance with Ice addiction. We provide funding to a number of non-Government organisations to provide residential rehab and also outpatient services. We also fund the Northern Territory Aids Council to assist with the needles and syringes program, and we are continuously assessing and monitoring the impact of Ice on our community.

Ms MOSS: In the submission you talk about different data sources and NT ADIS, the Alcohol and Other Drug Information Service, and I have some specific questions about that because I know that service is manned from Melbourne and understand the reasons behind that. What do you see is Government's role in being able to promote the availability of those services more? I understand local services have to opt to ring and provide their details as a referral point for something like NT ADIS. Is there a better way to promote local services to become referral points through NT ADIS and those national hotlines?

Dr ARYA: In regard to availability of services, from the numbers we are getting at the moment we feel that one central helpline or port of call is probably the most appropriate way of providing information to disseminate information. The agencies we fund to provide addiction services or assessment, treatment or rehab services are all listed on the web. All the helplines, all our referral sources or referral partners are

aware of services that are funded and are available. As and when other charitable or community organisations not necessarily funded by the government make their services available we include their information on the website.

Ms MOSS: Where a hotline is manned outside the NT, which many of these are, do you think there are things that we can do to improve their knowledge of the NT and the complexities that come with it?

Dr ARYA: Yes, and that is one of the key tasks for the interagency committee I was referring to before. They are in the process of developing educational and informational resources that are very specific to the NT. Once that resource package is developed and available we will make our helplines and other referers aware of those resources.

Ms MOSS: What is the time frame around those resources?

Dr ARYA: I would suggest July/August because we are very keen to have resources prepared by the time we have the Illicit Drug Summit in late July.

Mr CHAIR: You have said there are no broadly accepted medications that are effective for treating methamphetamine, but there are a couple of things being done in other jurisdictions that are having some success. Have you considered these for use in the Northern Territory, and do we need a legislative change here? What would you require to begin that work here?

Dr ARYA: I think the two drugs we mentioned in our submission are drugs that are being tried. The evidence is not that convincing and there are pros and cons for using both these medicines in treatment of addiction. If we wish to use these drugs in the Northern Territory there is no need for any amendment or new legislation. We will be able to use these drugs for addiction if we need to.

Mr CHAIR: Have you guys looked at whether you would like to start trials here in depth, or is it more wait and see?

Dr ARYA: Yes, we are just looking at the evidence at the moment. We are not doing any trial locally at the moment.

Mr CHAIR: In the data collection you guys do, particularly in A&E on people presenting with methamphetamine cases, has there been a move towards a more clear delineation of people presenting with these drugs? How good is the data collected to give us a clear picture on Ice?

Dr FORDYCE: The data at the moment is not strong because the coding system used for the emergency department diagnosis is based on computer software which is old. We are in the process of going for a large redevelopment of the computerised medical record in Health for the Northern Territory. That is a long-term project with an estimated completion date of years away.

In regard to Ice, there are barriers to us identifying which include coding issues and then the broad range of presentations which can be related to Ice, whether it is domestic violence, trauma, motor vehicle, acute psychosis, irate behaviour etcetera.

Mr CHAIR: Have you looked at anything we can set up in the more immediate? Obviously data is the marker of what we do, so whatever recommendations are put forward or whatever Government does the hospital system is a key data point. We need to know where we are going and if we are heading in the right direction. Can anything be done in the immediate term to improve the data, both within the Department of Health where it relates to services, service referrals and things like that, and at the emergency end? Is there something that we can do to improve data at either end? I will ask both of you to respond in relation to your different areas.

Dr FORDYCE: In the Emergency Department there are two particular avenues. We would be looking at data coming out of the specific group of Alcohol and Other Drugs workers who are in the emergency department seeing these patients. At the moment that is a 40-hour a week service, but that is an opportunity to capture information and ongoing audit of what they are doing.

Improving the coding would be beneficial in regard to Ice and a number of other factors. It would involve staffing to provide the support to get the increased and accurate information. I would suggest personnel. The programs in place for data entry are effectively obsolete and are at the limits of how they can be tweaked.

Mr CHAIR: Dr Fordyce, would you be able to submit to the inquiry in writing, or take the question on notIce, what the requirements would be in order to improve the data collection and what resources we are looking at?

Dr FORDYCE: Yes.

Dr ARYA: There are perhaps three strands of work that may be worth mentioning. One is as Dr Fordyce mentioned, we are trying to make sure we collect information on amphetamines-type substances, methamphetamine and Ice separately. That information will start going into our systems.

For alcohol and drugs in the Northern Territory, we also have an information management group we have set up to look at how this data should be collected and a good way of recording this information so it can be used more meaningfully.

The third piece of work we are doing is with the National Drug and Alcohol Research Centre, the agency that leads data collection for the illicit drug reporting system. Previously, they have only collected information from Darwin, and we have been working with then to see how we can expand that data collection so we have a better impression of the use of amphetamines, methamphetamines and Ice across the Northern Territory.

Mr WOOD: In relation to how the hospital runs, have you seen an increase in violence, especially against staff, related to the increase in Ice use? Is there a need for an Ice house or secure room at the hospital, or do you have something sufficient for that purpose?

Dr FORDYCE: I will talk to that. Within the limits of the data which has already been mentioned we have been getting increasing numbers of patients presenting to the Emergency Department under the influence of Ice or amphetamines. A proportion of them will become aggressive and violent, which may or may not be associated with psychosis - often severe agitation.

There have been infrequent episodes of violence. I am unaware of significant physical harm to staff. I would say, in relation to your comment earlier on alcohol, the most aggressive incidents in the emergency department are still due to alcohol.

In regard to processes we have in place in the Emergency Department and the question around an Ice room, we have a behavioural disturbance room which is often used for our psychiatric patients but is also designed for safe use in agitated aggressive patients, which what we would use these patients. In some circumstances these patients need increased action where they cannot be allowed to - where for their safety and the safety of staff they need to be further restrained. Our preference is to do that with chemical sedation rather than physical restraint because we are obviously not prison set up.

Mr WOOD: Does the Government need to help in this area? Do you need more resources or more facilities?

Dr FORDYCE: In the Emergency Department we are not in favour of having a stand-alone Ice room. We feel the facilities we have in emergency are suitable, with a psychiatric area, with our - if it escalates we have a resuscitation area, which is where they should be. We have training for all staff in aggression management. There are clear guidelines around de-escalation and how to handle the de-escalating patient. The Emergency Department, as the front door of the hospital, has reasonably good systems in place for this.

Mr CHAIR: In regard to the interagency working groups happening at the moment around this issue, is anything coming to light you can share with the committee about things that might lead to recommendations from this committee? Do things need to happen which go beyond the scope of things happening within the existing structures that the Health department would like to express? What else could be done?

Dr ARYA: Nothing in particular comes to mind. Our focus remains on education, training, preparing staff, preparing consumers, families and communities to deal with this problem. That resource development is progressing and there is very good cooperation between agencies and providers.

Mr CHAIR: With regard to the cognitive behavioural therapies you mentioned that are specific to methamphetamine - Turning Point, Methamphetamines Dependence and Treatment Approaches - are any of these within the gamut of things the Health department will look as ways of dealing with assessing the

social impact of this and educating people? Are we moving towards putting these programs in place? If not, what could be done? Are they effective? If they are effective, are we using them? If not, why not?

Dr ARYA: These programs are in place, and the mainstay of rehabilitation, assessment and treatment remains psychological and behavioural treatment rather than withdrawal with use of medication. Those programs are in place and are reasonably effective. Even though relapse rates are high, there is enough education and training within the sector to deal with both treatment as well as relapse.

Mr CHAIR: Part of the Department of Health deals with patients that come in expressing psychotic behaviour or various signs of psychosis. Are you seeing an increase in that as a result of Ice as compared to things like heavy abuse of cannabis or other reasons why that might occur?

Dr ARYA: Yes, we have had patients admitted to our hospital we could clearly identify were Ice-related - people have presented with aggressive behaviour, violence and psychosis, which was clearly secondary to Ice. Looking at the pattern over the last few years, presentations to our hospitals with psychosis as a result of substance abuse have been increasing. Whether the increase with Ice is disproportionate to that number is probably too early to say. The number of people being admitted with psychosis secondary to substance abuse is still relatively small.

Mr CHAIR: With the increase in people coming in, although the numbers are relatively small, are the resources allocated to that area that deals with psychosis sufficient?

Dr ARYA: In Health there is always the need, desire and expectation for resources to increase to deal with the demand and deal with growing problems, but at this stage we do not have a situation where there is either a waiting list or we feel we are not able to respond to the demand coming through our hospitals and community centres.

Mr CHAIR: In the broader Northern Territory context, in your regional health clinics and in communities, are you getting documented reports of cases where Ice is presenting as an issue, either through people presenting in outlying areas with psychotic incidents or instances where people are turning up and wanting treatment because of a heart palpitation, cannot sleep or nutrition problems related to Ice? Are we seeing that in clinics and regional centres?

Dr ARYA: Both for amphetamine-type substances and methamphetamine we are collecting data. Anyone and everyone who presents with either use or a psychotic illness - the information goes onto the database. The question is always if it is Ice related, Ice precipitated, or whether it is because of other substances people may be using. That element of uncertainty remains. I do not feel our data is grossly incorrect in use of Ice or in notifications of Ice-related illnesses.

Ms MOSS: Something often raised with me on this issue is the availability of rehabilitation and treatment services. I am interested in your views about what gaps exist in rehabilitation and treatment services? Young people have been identified, but I acknowledge they are certainly not the only user group.

Dr ARYA: In the Northern Territory we have a community response, community rehabilitation or outpatient rehabilitation, and in many centres we also have residential rehabilitation services. Many residential rehabilitation services are also available for young people of 12 years and beyond. At the moment and in regard to demand and our ability to response, we are not hearing there is a waiting list or people are having difficulty getting into residential rehabilitation programs.

Over time and as the demand changes or the numbers begin to change, we will consider whether we need to develop more services or look at funding in a different way.

Mr CHAIR: Do you have data on the number of people trying to access residential services?

Dr ARYA: We have data on people in rehabilitation services. As I said before, we are not hearing there is a long waiting list for people to get into rehabilitation services, so I am presuming that people who are trying to access services are getting in.

Mr CHAIR: The committee might like that data to get a picture of how many people are accessing that service through the Department of Health as opposed to through NGOs that would probably offer a similar service.

Dr ARYA: Yes.

Mr CHAIR: Such as how many places exist for that?

Dr ARYA: Yes, we can provide data on how many people are going to residential rehabilitation and community rehabilitation - which is non-residential - across the Department of Health and NGOs. We have both sets of data.

Mr WOOD: One issue is people who do not go looking for rehabilitation. The only way they will be rehabilitated is through the prison. Do you work with the prison in relation to people who are affected by drugs, especially Ice?

Dr ARYA: A lot of effort and energy goes into making sure there are community information resources available to people who may be hesitant or not know help is available. That aside; if someone is in a correctional facility we have alcohol and drug clinicians and staff who visit prisons and provide services there.

Mr WOOD: Do you work in conjunction with Correctional Services? Do they give you feedback as to the type of person now in prison and the possibility they may have been affected by Ice or any other drugs?

Dr ARYA: Yes. There is a referral process in place from Corrections to Health, and we have Health service staff based in prison and they are accessible and provide information as well as help.

Mr WOOD: Does that include the youth centre, the one that has been in the news a fair bit? Are there medical people at the Don Dale Centre?

Dr ARYA: Not based in Don Dale, but they do in-reach into Don Dale to provide services.

Ms MOSS: What do you see as the awareness level of services available to families around these issues?

Dr ARYA: It is difficult to judge how much information is available, but we try to make as much information available through all our health centres, our hospitals and on the web. It is difficult to judge whether that information is sufficiently available, accessible and disseminated, but that is something we can, perhaps, do a bit more work on.

Ms MOSS: My other question was around co-morbidity and where you might have a pre-existing mental health condition, or similar, which coincides with drug use. Do you think services are quite well integrated at the present time? Can more work be done around the integration of services where there is co-morbidity?

Dr ARYA: Mental health and alcohol and drug services are reasonably well-integrated. In regard to cross referrals and managing co-morbidities, both mental health and alcohol and drugs are very aware of the high levels of co-morbidity. There is co-case management when people are accessing services from both services.

Mr KURRUPUWU: We have just had our first few meetings regarding Ice in my community of Wurrumiyanga on the Tiwi Islands. I am not familiar with the health centre - if they deliver a program on Ice. I would like to see things happen in my community and parts of my electorate.

Dr ARYA: I am happy to explore what services or in-reach is provided to those specific communities. I know we have a Remote Alcohol and Drug Program and clinicians from that program in-reach to almost every community to provide help, assistance, training and education to staff. I will specifically explore, and if you allow me, I will get back to you on what specific input is provided to those communities.

Mr CHAIR: The committee understands the Department of Health is responsible for drug testing in correctional facilities, whether that is Don Dale or the adult prison. We need to ask a couple of questions about that. What regime is in place? Does that regime need to be improved in the type of testing being done and the frequency of testing?

Dr ARYA: We need to confirm this, but my understanding is that we get involved in testing when a request is made by Corrections. We do not necessarily screen all prisoners…

Mr CHAIR: So, they are screening them there and then if they pull a positive result they are going to you for testing? Is that what you are saying?

Mr ARYA: That is right.

Mr CHAIR: Okay. So, you are not really in charge of the regime of how it happens?

Mr ARYA: No. I do not think so.

Mr CHAIR: Just doing the pathology work?

Mr ARYA: Yes.

Mr CHAIR: Many kids are presenting at the Don Dale Centre saying they take Ice and writing that on forms as part of their entrance interview. Can you clarify for the committee the Department of Health's rationale for advising Correctional Services if self-reporting is an acceptable means of collecting data and the reasons why young offenders are not currently tested for drugs on reception to correctional facilities? A recommendation was made that if they say they are on Ice that is okay. Is there a reason why we are saying okay and running a test on them?

Dr ARYA: Self-reporting is encouraged. We say to young people, and to everyone, that we need that information. If someone is unwell we need to know whether they have been using Ice or not. Specific testing for methamphetamine, or Ice, is sometimes useful but not always terribly beneficial. If someone is already reporting that they have been using Ice our treatment strategy is developed on that basis.

I may take the opportunity to describe the complexity in testing. When we test for methamphetamines we often have to do a screening test first. A screening test suggests to us that there is some kind of amphetamine in the urine or in blood. To find the specific methamphetamine we need to do another test. Often when you are implementing a treatment program, by the time the screening test and the other test is done half your treatment is under way. The test for what kind of amphetamine was in the urine or blood is not necessarily terribly useful from a treatment perspective.

Mr CHAIR: They are doing the screening test at the correction facility anyway?

Dr ARYA: They can, but again it is not always done. If someone is self-reporting then a treatment program often is developed on that basis.

Mr CHAIR: I guess the committee is concerned that there is a lot of anecdotal evidence around, but in regard to hard data there are gaps. We would be looking at ways to close those gaps.

Mr WOOD: I am not sure if it is in your area, but my understanding is if someone takes methamphetamines they can disguise it after a certain number of hours. For instance, it might not come up in breath test or when someone is working on a job. Is that similar to the issue you have - trying to test someone after they have been brought into custody and the drug is difficult to detect? Is it different than having cannabis or alcohol in your bloodstream?

Dr ARYA: Amphetamines or methamphetamine can be found in body fluids for up to 72 hours. If we do a screening test and find amphetamines or methamphetamines it helps us substantiate the diagnosis. However, if someone says, 'I have been using amphetamines or Ice', and we find this person is becoming agitated or wild or psychotic we would start the treatment we would give anyway, irrespective of whether the test proves the person has used methamphetamines.

Dr FORDYCE: The difference is the information on screening is of benefit from a community point of view in documenting the prevalence of Ice, but in regard to the specific individual the information from screening is of limited utility. Therefore, decisions need to be made around whether a test should be done on an individual which will not specifically help the individual, and what sort of consent should be obtained or is this information needed for the greater community good and should it be mandated on that premise. There needs to be a distinction between what is good for the individual, which are the therapies Dr Arya is describing, and the community benefits of screening.

Mr CHAIR Are there any other issues you would like to raise with the committee around Ice, and any other strategies or plans you think would be good to implement in your departments that are not in your submission?

Dr ARYA: I think our focus and the general consensus is that education, training, information and harm reduction strategies are probably the most useful investment to make. Our focus over the next few months will be on facilitating that information in the community. The more information we can disseminate and the more avenues we can find to disseminate that information would be the most effective strategy to deal with this problem.

Mr CHAIR: Thank you, gentlemen, for your time today. I appreciate the information you have provided to the committee.