LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

SUBSTANCE ABUSE COMMITTEE

Membership:

Ms M Scrymgour MLA (Chairperson)
Dr C Burns MLA
Ms S J Carter MLA
Dr R S H Lim MLA
Mr E McAdam MLA
Mr G Wood MLA

COMMITTEE BRIEFING

Tape-Checked Verbatim
TRANSCRIPT OF PROCEEDINGS

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Taskforce On Illicit Drugs

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Mr McADAM: Okay well we will make a start and I declare open this meeting of the Select Committee on Substance Abuse in the Community and welcome officers from the Territory Health and Community Services, Dr Shirley Hendy who is the Chief Health Officer with Territory Health and Community Services. Also, Linda Hipper, the Executive Officer of the Ministerial task force on illicit drugs and also Mr McLay who is a section head of the Alcohol and Other Drugs Program. All of the people aforementioned are appearing before this Committee today to brief it in relation to its terms of reference. If required copies of the terms of reference can be obtained from the Committee secretary. This meeting is not open to the public however. It is being recorded and a transcript will be produced which will eventually be tabled in the Legislative Assembly. Please advise if you wish any part of your evidence to be 'in camera'. The decision regarding this is at the discretion of the Committee. You are reminded that evidence given to a committee is protected by parliamentary privilege and for the purposes of Hansard records I ask that you state your full name and the capacity in which you appear today. So, perhaps if you would like to start that.

Dr HENDY: Dr Shirley Hendy, Chief Health Officer, Assistant Secretary of Health Development and Community Services in the department.

Ms HIPPER: Linda Hipper , I am the project manager of the task force on illicit drugs.

Mr MCLAY: Mr McLay, Section Head of the Alcohol and Other Drugs program.

Mr MCADAM: What we normally do at the beginning of each session is basically to ask people to give some background in respect of their experience or in relation to their appearance before, the experience ……..but we have done that previously with the exception of Linda so perhaps you might just like to give a brief background and then we will go straight into it.

Ms HIPPER: Okay. I have been working on the task force on illicit drugs for the last, or since November last year. I am just, prior to that Policy Officer of the Alcohol and Other Drugs program and prior to that for seven years I have been the clinical manager of the Alcohol and Other Drugs Services, which is based at Royal Darwin Hospital. My professional background is the……..psychology.

Mr MCADAM: Thank you very much Linda. How do you want to proceed, Shirley? Do you want to just give a summary or

Dr HENDY: I thought, I did not think I was going to do anything as time consuming as a summary. I thought to say that it is, I think the, it has been quite a substantial achievement to produce this report on behalf of the task force which had both local expertise and national leadership on it, and expertise in the field. I think the thickness and extent of the document tells you why it has taken quite some time. It is a very broad based wide ranging document that does not restrict itself to any particular aspect of alcohol or other drugs but really does a broad population approach to it. The results, the outcomes that you have heard and that are in the short set of notes that you have mainly relate to the immediate actions that government has decided to take as a result of the report. It then also refers to some things that, where further work needs to be done and you know, the resources have actually been provided to enable those things to be done. And you will also note that substantial number of the recommendations are not specifically in the alcohol and drugs field. They relate to things like supporting parenting programs and so on and so forth and……..the unit that is going to be the Office of Children and Families for example, so it cuts across a wide range of programs. The only recommendation that government has not really specifically commented on or said it is going to action in the near future or has called for more information about, is the one about setting up a coordination unit, and it is my understanding that that is in fact because of the existence of this very Committee. That it was felt that it would be quite pre-emptive to set up a coordination unit in the Department of the Chief Minister or any where else, when indeed this Committee is enquiring into these issues and it is your findings that will set the directions and the priorities for a comprehensive alcohol and other drugs strategy for the Northern Territory for the future. I think that is all I want to say. Really I thought, you thought you would probably have quite a few questions to ask.

Mr MCADAM: Do we have any questions?

Ms CARTER: With regard to the provision a maintenance program, I understand that GP's can become accredited to do that. Do you think you will have enough GP's because I also understand was that they would be allowed to take on a maximum of five patients, is that correct, or have I …….incorrect?

Dr HENDY: That is part of it

Ms CARTER: Then that raises the concern of, do you think you will have enough GP's wanting to take on that sort of activity?

Dr HENDY: Firstly the framework provides for any GP who is going to prescribe ……therapies in that, consistent with the national guidelines and the national situation must be appropriately trained and appropriately accredited and registered. What we want to avoid is exactly the same as every other jurisdiction wants to avoid and that is having many patients dependent on one prescriber and if he becomes ill or sick or leaves the system for some reason and then you have a situation where you have a large number of patients who suddenly have no prescriber. So we set some limits for five and 25, and five being a sort of base line for most people there will then be a clinical advisory power set up which will advise me as Chief Health Officer or the position of Chief Health Officer I should say, as to doctors that should be accredited to prescribe for more than that number, ie doctors who have undergone some further training and have special expertise in the area and obviously they need to cater for the doctor at the alcohol and drugs program who is a doctor. This does not just apply to GP's, and he may well prescribe for 25, 30 or 40 patients at a time in a different way from that which GP's would be doing. We know that there are GP's who will have a special interest in the area and they clearly should be permitted and able to exercise that interest and prescribe for a larger number, but those decisions will be made by a clinical advisory panel which will have doctors on it, the chief poisons inspector and I think a community member as well……..and so they all apply to that panel and that panel will say who can prescribe for more or less. We are still making it flexible enough that if there is someone who really needed to look after 30 patients because they are a sole GP for some reason or there is some other set of circumstances then 25 is not an absolute, we are just saying that as a sort of reasonable limit.

The task force report itself is very clear that it needs a mix of public and private sector providers to do it. You could not possibly meet the whole needs just through the GP network or just through public service provision, that would not be sensible and that is not the way it is done in most other States. So it is a mix of both, and privately, task force recommendations again ……..policy directions either, we need to provide more training programs for people, but the training programs need to be simplified. There will be some distance modules. We can break it up and not just deliver it over a weekend, ……..been discussed with the division of general practice. So we think we will be able to provide a reasonable service over a period of time, recognising that we can not suddenly meet all the demand in five minutes.

Ms CARTER: So say at Royal Darwin Hospital who or which areas would you think would be doing this activity? Would it be ……

Dr HENDY: Oh, the actual manager, it needs to be the manager of the service…….

Ms HIPPER: Alcohol and Other Drug Services is now based at Building 9 at Royal Darwin Hospital and that is where you are looking……..through Building 9.

Ms CARTER: And if the person ……was then to take an oral medication would that be, could that be prescribed through the Pharmacy at Royal Darwin Hospital, or would they go to a private chemist.

Ms HIPPER: There is a mixture, we have actually commenced a dispensary out of Building 9 ……as of last week and so the clients can be stabilised through that dispensary and then be put out into the community pharmacies once they are stable. It is trying to lessen the impact on community pharmacies particularly while people are stabilising.

Dr LIM: Do you……drinking …….medication

Ms HIPPER: under certain conditions

Dr LIM: at the pharmacy itself…….discreet places……

Dr HENDY: That is really up to the individual pharmacy how they …….

Dr LIM: ……some pharmacies used to ……just walk up to the counter and get ……

Ms HIPPER: Because morphine has been recommended as a front line treatment it is a bit less obvious when people take ……..the morphine because they are putting tablets under their tongue rather than drinking ……

Dr LIM: ……sort of facilities would be provided for …….Tennant Creek and Katherine and places in between?

Dr HENDY: The task force findings were that there were not significant numbers of people who were …….dependent in those smaller centres and they recommended boosting of the resources only in Alice Springs and Darwin. Obviously GP's can be trained to provide that service there and I think that part of the ongoing work is to try and make some assessments of just what the numbers are there and have that need ……..reasonably met. But obviously the big thing in the first place is to meet the need that does exist in Darwin and Alice, those were the big, the big populations. Without wanting to neglect those areas, you stage things in.

Mr MCADAM: But, I mean there would be a provision in respect to as you say local GP's …….indigenous medical services as well.

Dr HENDY: Absolutely, I mean it does not have to be only doctors. We keep using GP's it is medical practitioners ……

Ms CARTER: In the past people have used morphine tablets and they could get a prescription for say thirty tablets at a time, say you lived on a rural block in Humpty Doo and did not have transport, would that person be expected to go to a dispensing area in Palmerston every couple of days?

Dr HENDY: ……..ask that question on the basis of how these things operate across the whole of Australia and what is expected.

Ms HIPPER: Yes, under the public therapy program it would be expected that it is in the daily dosing or if they are tolerating second daily dosing, but it does require a supervised dose. The take away provisions which means that they would have a dose that they could take away at home are very strict and we want to keep those minimal because it increases the high potential…….one of the risks

Mr WOOD: I ……have read this

Dr HENDY: It is a pretty big fat document, I mean

Mr WOOD: if I wake up in the middle of the night and the only thing to see is a black and white movie I will read this. No, I just noticed some of the issues, one was the needle exchange and of course it has been very controversial in Palmerston, and one thought was that if you are handing out 500 000 needles

Dr HENDY: 400 000 roughly …….

Mr WOOD: Yes, I thought it was 400 000, I think in here they actually said 500 000……don't worry we are supposed to be reducing this. But I think people's concerns were a lot of needles were not coming back and I know that there is a certain amount of concern about needles lying on the ground and the risk of getting HIV from that is still pretty low. Two things, are they looking at needles, syringes and one……..around and the other one is, is there any moves to try and get people to bring them back? There might be some practical difficulties, but you

swap for swap. I know people might not be in the state to do that of course, but to at least try and reduce or try and give a reasonable number back from people. 500 000 sounds like an awful lot of needles. Maybe I am seeing things in a different light but it sounds like a lot of needles.

Ms HIPPER: On the Commonwealth level there has been quite substantial money allocated for the practical……..program and I noticed in the weekend papers that they were asking for tenders and for people to say whether they had those types of ……products available at this point in time. One of the recommendations in here is definitely to look at the whole issue of disposal issues around…….and there is definitely some developmental work that needs to be done further and it will be taking place probably within the AIDS/STD Unit with a new policy officer who is Commonwealth funded for 12 months, looking at those issues to encourage safe disposal.

Dr HENDY: I think it is reasonable to add that we do not have a great deal of evidence that the vast majority of needles are not being disposed of safely.. The evidence would indicate that most of the needles are being disposed of safely even if they are not being returned to a needle exchange and they are much more provisioned programs of needles and syringes these days pretty much across the country. When we do get reports of them being…….found in a particular area then the ……..in the area we do try and take that quite seriously obviously…….discussions with people, so if you know there are instances where that is happening or where they are clustering we do like to know about that but the vast majority of them clearly are being disposed of responsibly.

Ms HIPPER: The consultations held with……..were indicating that they had a variety of ways of disposing of them, putting them into…….containers and putting them in the trash, and that type of thing so that they were not going to be a risk to anybody else.

Ms CARTER: On that…….the needle exchange I have had an experience here in the CBD of a building site having a lot of syringes in them. When the building owner contacted the needle exchange program here he was told 'oh it is your problem you deal with it. Who should we contact. You have just mentioned ……that you would be interested to know when that sort of thing happens. Contact the drug and alcohol program……..

Ms HIPPER: In regards to needles being disposed of, those types of things from a refuse site, the actual Darwin City Council has a pretty good program which

Ms CARTER: I think this person was concerned that the needle exchange program appeared to him to be somewhat indifferent. He obviously drew a conclusion that ……..from that program.

Ms//////////////////: Where it may not have been…….

Ms CARTER: But you just said then that you would be interested to know and I was just wondering? Contact you if it were to happen again or are you saying we……..program……

Dr HENDY: I think it would be, we in the alcohol and drugs program of the Department of Health would like to know when that sort of thing is going on. No we do not go out ……but no, otherwise it is a question of the feedback that we get. The information we have is as good as the questions we ask and the information that we get from other people. So it is always useful and of interest for us to know exactly what is going on around the traps so we can get an accurate picture of what is happening.

Ms CARTER: Not that it is frequent.

Dr HENDY: No it certainly does not appear to be. I do not see that we have a problem with……. I mean it is unfortunate that there is an appearance of indifference and that is all I will say about that, but I do not believe that ……..anybody is indifferent to the issue because they know that public feeling on the matter and as well as the actual fact that if needles are there is not a good thing to have, it is not good for the safety of the community.

Dr LIM: What is your pool of medical practitioners available in Alice Springs and Darwin……..

Dr HENDY: At the moment there are two in Alice Springs, that is right isn't it, and there are

Dr LIM: …….hospital based?

Ms HIPPER: ……community based and there is…….

Dr HENDY: How many are there apart from me in the Top End?

Ms HIPPER: Six excluding Shirley…….in Darwin

Ms CARTER: And how would the user find out who to go to?

Ms HIPPER: Ringing up either of the Alcohol and Drug Services. One of the other initiatives which has been announced is the Drug and Alcohol……Information Service which is a 24 hour telephone information service where they……on line……information, and through their GP's . GP's are the informed……..as well, as well as any of the other service agencies……..

Dr HENDY: We are trying to sort out exactly all the parts of the network because we have been very clear in the public arena about it is GP's who should refer to alcohol and drug services, but we do not obviously want to limit it only to GP's. I mean there are counselling agencies out there on hand……..and so on and so forth, and the AIDS Council, and so it is right and proper that they should be able to refer to alcohol and drug services for assessment as well. Or indeed to one of the GP's who is happy to have that happen. So it is really a question of getting that network really sorted out and working well over the next few months, and the division is immensely interested in it and I have actually taken a very personal interest ……..You know there has been a lot of discussion to move the whole agenda along, because it has been a long time coming for ……therapies to be available……

Ms HIPPER: And to allow us to …….come into operation, we are looking at initially the stabilisation of patients to have…….public systems so that again it is not a large impact on some …….GP's…… Until the pool of experience is raised as well.

Dr LIM: Are there community based medical practitioners going to charge fee for service or are they contracted to government for……..?

Ms HIPPER: No…….usual fee for service……..

Dr HENDY: I mean as much as possible the idea is to normalise the experience that people have. One of the whole reasons for having ……..therapy available is a maintenance treatment is that it does enable people to get their lives under control and to normalise their lives, and to go to work and you know, you do see some fairly unspectacular changes in people when they get…….stabilised on ……and you see people who are able to go to work and function normally, rather than be in a degree of sort of distress and crisis for most of the time.

Dr LIM: ……community based medical practitioners ……..I ……consultation ……..therapy ……on a regular basis.

Dr HENDY: ……..need to see their doctor on a, you know every few months once they are stabilised. It is in the initial period that in fact you come and see a doctor much more frequently and alcohol and drug services having done this very recently in fact, having run the service while we were trying to recruit a doctor, you will sometimes see them twice on the first day, but generally the second consult is not with the doctor, it will be with one of the other staff, and you would see them two, sometimes three times in the first week, maybe a couple of times or once in the second week and then you only see them weekly. So you know, as they stabilise they do not have to see a doctor all the time.

Dr LIM: Good, but a patient presented to ……the person sees, it still costs the practice some resources. How is that compensated?

Dr HENDY: It does not appear to have dissuaded people from going to see GP's to actually get these therapies once they are available. I mean they appear to be, sorry, I …….switch my phone off at the right time, they seem to be happy to access the therapy and are able to do that and it does not seem to create ……That is the only other answer I can give you on the basis of the experience in the rest of the country, and that is obviously, these are things we have talked to GP's about. But GP's have already been prescribing …….for withdrawal. A very small number have been prescribing methadone. They have pregnant women on their books and ……..with HIV. So this has already been happening. None of this actually new, it is just a …….issue and the maintenance is……..for people. If you think about it the actual increased workload that the maintenance creates is much more infrequent consultations on a much more longer term issues, so it is still the early period that is the most intensive and as much as possible we are trying to do that for a whole lot of the GP's in the public service. That is what the public service will be there for so that they are stabilised and then they are moved out to the GP network. So we do not anticipate that really being a ……..

Mr MCADAM: I have just got one question and I just can not find it at the moment, but I think you refer to in the report to there is still a lack of information in respect to the provision of different service provider programs of alcohol and other drugs etcetera. I mean can I ask why he was not able to actually identify the provision of services …….the Commonwealth the Territory in this exercise, because it seems to me we will have to go back and do that?

Ms HIPPER: The task force is very much of the opinion that they were able to get, you know this services, this services here. What they were not able to judge effectively was the effectiveness and the interventions that were actually provided by those programs and that is the suggestion of the task force members in terms of the mapping project to really look at what is happening in those, because the information we were getting seemed to be very focussed from the agencies themselves, you know we do this and we do it very well, but there was other agencies that we were very aware of as well that were there but we were not hearing very much information, we only had the basic information about what they may do.

Mr MCADAM: So have you had any indication as to whether that will occur shortly?

Ms HIPPER: Yes, as a matter of urgency. ……..resourced out of the $500 000 and various funding ……..but

Mr MCADAM: And when does that actually get underway?

Dr HENDY: As soon as we get the job description written and a person hired to do the job. It really is a matter of trying to identify exactly what interventions are being delivered, to what client groups, when, how often, with what frequency, to what standard of quality and are they evidence based. Which is a much more complex kind of thing to try and …….what are the names of the services and what are the things that they say they are delivering. And that is really where we need to get, particularly with the issue with young people.

Mr MCADAM: Yes, and the other thing that I just wish to comment there is that I suspect it will be covered, but sometimes there is a tendency to do a big power approach, the big picture approach, ie Alice Springs and Darwin so I would very much like to see the approach undertaken to incorporate ie Tennant Creek as a region, a discrete region in it own right and how those linkages occur in respect to say Ali Curung or Borroloola in the case Katherine, Borroloola etcetera. Cause we have to get down to that level and far be it for me to tell you how to do your job but in the past there has been the tendency not to get down to that level, and I think that is very important because the future for these sorts of programs outside of Darwin and Katherine very much depend on that information and the utilisation, the maximum utilisation of those resources and where necessary they should be restructured to meet the actual requirements.

And the reason why I say that is because when you talk about a lot of education in the classrooms in the school systems which I think is critical not only in like Alice Springs and Darwin but in the other smaller communities as well, and the only group you have got doing that at the moment is a few teachers who have an area of interest, and also you have the school based constables. In the case of Tennant Creek, one school-based constable can not do justice to the issue. So somehow we have to restructure the resources so as to ensure that there is a proper, I mean the kids in the bush are accessing

this critical information because we heard from Rob Parker this morning in regards to a particular community who are sort of saying that maybe the community is, I do not know exactly how he put it, but I just got the impression that the community did not know how to deal with this sort of issue. They felt powerless etcetera, etcetera, etcetera. And I found that very, very concerning given the fact that indigenous communities have been dealing with these issues for a long, long time. So, that is the point that I make with that, it has to be down, pretty much at a community level, a regional level and a service should not always be seen to be subject to Darwin/Alice Springs. You can restructure in a way that meets part of the requirements from a regional level, so I think that becomes important.

Dr HENDY: I think we would absolutely agree with you and we would, I mean we are hoping that that will be a very strong recommendation of the Select Committee. We have no doubt that if you are going to spend time in communities as you are, that that will come out very strongly, and it is, communities have made it very clear in the past to us that they do not want outreach programs from everywhere else, and they do not want to send their people in to programs and just to send people in to town to get things, they actually want, they need things in their own place, and so we think so as well.

Mr MCADAM: And just one other comment that I want to make and that is that ie in the case of petrol sniffing, there is a feeling I think within the bureaucracy, and maybe amongst other - that just because indigenous people say it is a white fella problem we do not know how to deal with it. I do not accept that. I do not accept that, that it is a white fella problem. I think it is an issue that can be resolved if the input of information is there, if you know what I mean. So we have to get away from this thing which says 'grog is a white fella problem' because that is not true, nor is any of the other drugs, nor is petrol sniffing, nor is alcohol, so we have to try and change that around.

Mr WOOD: I might, I just had it here but I can not find it because it is only a very small area, and I have probably mentioned it many times before but on prevention methods you talk about the families, which is good and drop-in-centres and I think it mentions, it just talks about sporting events and musical events that, except I would not call them events I would say things like music and things like sport are on-going activities and I just did not see a lot of emphasis because I still regard, certainly not on its own, but I regard that as an important priority. I did mention the other day at the Estimates Committee I just mentioned to the Deputy Chief Minister about whether we could have permanent music teachers at school, say one teacher did three schools or something like that, and of course the argument would be that we have not got the funds for that, but the argument may be that if we can get funds from another source which could be Crimesafe or could be money that is received from the levy from the Commonwealth so some other program which while you are teaching music you also have a never alternative in the back of your head as to why you are doing these things. Was there much emphasis put on that type of thing as a prevention program?

Ms HIPPER: The emphasis was definitely there for the need for alternative activities. It came up a lot in the community consultations right across the Territory, that young people particularly needed something else to do. In particular it came up very strongly in Tennant Creek through the consultations in Tennant Creek

Mr WOOD: So what was that on - they knew you were readying something.

Ms HIPPER: no the need for alternative activities, those sorts of things. There was a particular representation from TC Raiders about the work that was being done down there, the good work that was being done down there by a sole individual who was really doing it out of the goodness of his heart, that sort of thing. But that came up as a strong message in every community, the need for alternative activities, and not just sport, but other things as well.

Mr WOOD: Did it come out that that was an age of principle I suppose and boredom causes problems. I mean people with nothing better will get themselves into

Ms HIPPER: That was one of the elements that was in there definitely.

Mr MCLAY: And we certainly had ….……that the creation of meaningful activities is going to have a resounding effect on the overall effect of ……drug taking etcetera. With regards to like some entertainment and music and stuff I mean that it certainly has got its value as far as keeping people happy when they have an activity to do but there was also

another…….recommendation……that more emphasis should be actually placed on the use of entertainment as an educator process towards information sharing, health education or whatever. Tennant Creek was a classic example. A lot was done down there over the years and it is actually good to hear that……..obviously it is well remembered, so it is ……..and being able to use those strategies……..and not……..you can provide a music teacher and that could do music but that is only one small component of it. You also have to think about where else are we going to use this music, where is it also going to be provided so that they get supported outside of the school structure as well. And we can not just continue to do things ……so……..

Mr WOOD: ……..and that is why it should be part of the school curriculum. Some of us would argue that music is actually, should be a basic educational, should be basic educational training because it actually teaches mathematics, it teaches English, it teaches rhythm, it teaches other things, not just, it is an influence that goes right through your life, and you can use it at any time you like if you have learnt to play a musical instrument. So you can pick it up. I mean people who have given it away when they are teenagers sometimes pick it up later in life, so it is one of those, it would be part of the group activities and the only other thing I would say about sporting programs of course you have also got to watch that in some cases some of our sporting clubs are not exactly the greatest leaders in the old……

Ms HIPPER: Role models

Mr WOOD: Role models yes, and I think that is an area that perhaps needs to be looked at as well. If one does not play sport……what happens in the activities afterward. Just one other question. I suppose in a lot of these issues we talk about harm minimisation, and to some extent you can get the feeling that well, well people may see harm minimisation as the impression that we think it is okay, that we will just keep it down to a livable level. But is there, will there be just as much sort of emphasis on saying look you know abstinence from these things is quite okay. You know you do not have to have it. You can get your kicks out of other things in life. So, because sometimes the emphasis is on hearing about needle exchange, and hearing about methadone programs and hearing about all of this and they are all fix-it type of things, but I sometimes feel that they have really got to be the alternatives, not 'it is cool to abstain'. And that came out ……some of our petrol I think at Yuendemu, about the petrol sniffing and trying to stop them saying 'it is cool to be a petrol sniffer', and reverse that.

Ms HIPPER: And I think one of the strong messages that came out of the task force consultations was that the level of drug use is still to some degree in its infancy in the Territory. In some areas it is more so than others, and we have a real opportunity to put the prevention stuff in now to stop it getting to the scale that it is in some of the other jurisdictions in Australia. So that is where the emphasis really, we need to help those people that have got into trouble, but we also need to put equal emphasis into preventing people ever getting near having harm with drugs.

Dr HENDY: ……I think the reason we hear more about those little things is because they conflict, because people argue about them, so they argue about this evidence to support them but then have views about the fact that they should not be available and so you get, you know it's the conflict. It is the conflicted things that are debated in the media and in the public arena, not the ones that everyone would agree with……..

Ms CARTER: With regard to the dispensing of the drugs…….what would you do if for example a 16 year old turned up, a street kid basically, does not want any parents knowing about what is going on?

Ms HIPPER: We have pretty strict protocols. Anyone under 18 is a tricky situation to put them on on-going therapies. As you were saying in terms of a street kid, those types of things, there is a legal……..that goes along in those types of things too in terms of a parent or guardian …….It is not an easy situation by all means. It is also to some degree contra-indicated, young people to be put onto maintenance ……therapies because you would hope that their drug using career is not entrenched by the time they are 16. It can be definitely, some people start when they are 12 unfortunately. That has not been the case in the Territory so far.

Dr BURNS: I have some questions about my old friend morphine, so in terms of I guess, just to lead off what is the state of play of morphine consumption or prescription let us say in the Territory at present? I know the last time I sort of really looked hard at it, it has dropped once the HIC intervened from about four times the national average to just below double. So, where does it stand now? And I guess the supplementary question to that is I guess it is important to monitor the changes that are going to occur with the introduction of pharmaco therapies, so can you just fill those gaps in for me please?

Dr HENDY: I think there are a number of parts to that and Linda I see has just turned to the page that has the various tables on it, I mean it was about mid 1998 when we really hit a substantial peak

Mr MCADAM: What page was that

Ms HIPPER: On page 56

Dr HENDY: and in ……prescribing in the Northern Territory. And as well as the HIC going to see people I think it is worth, we do not talk about it a lot, but there was only, you in fact know about it because you were part of that group of people who together with the Division of General Practice were having those S8 group meetings and so on and so forth, where in fact as a result of that the voluntary contract system came into place and we were not able to make it mandatory or compulsory at the beginning because the national competition policy review was ongoing at the same time……..But I think it is fair to say that it was, that the levels are coming down, where as a result of not only the HIC going and seeing a number of people but also the contract system had in fact probably more to do with it because it did in fact prevent the 'doctor shopping'. The fact that, then you have two aspects to it really, you have the fact that people were shopping around a number of doctors and we were not able to get information out of people quickly enough if you like, to prevent that sufficiently, and the voluntary contract system could do that. Just about every GP took it on, and then there was then some discussion with doctors about perhaps they might like to take look at the level of prescribing and be really very careful about it. So it has come down very substantially. I mean there has been a what 70% drop to my recollection from……

Dr BURNS: But it is still substantially higher than the Australian average.

Dr HENDY: It is still highish, and I mean what have we got? We have 200 people roughly on contract, it varies around 197 to 206, and that is not exactly a huge number of people if you actually look at the number of people and when you in fact take that number of people in a small population like that you are getting some statistical issues creeping in there. That does not mean that I am trying to say we do not think there is more that can be done in there. What, I mean all the doctors will tell you, quite clearly is that it has been very difficult for them in a situation where maintenance pharmaco-therapies have not been available until July of last year, August of last year. There was not even the option of ……..morphine for three to six months available, for six to twelve months available. So you of course had patients who felt that they very badly needed, who were opiate dependent and needed to continue getting opiates, becoming highly expert at telling stories about chronic pain to people, and again I am aware that this is not an 'in camera' discussion that we are having

Mr??????????????: Well, you could make it 'in camera'.

Dr HENDY: I did not at any point in time, now I will just put this clearly on the record that I am not in any way shape or form saying that all patients who are going to GP's or having ……..prescribing was being done was not for genuine chronic pain ……..so I do not, I know this is a very difficult area, and there are a lot of people out there who are, who have chronic pain, who feel that their reputations are a bit sullied in a way that they find offensive because they feel that they have been labelled and suspected of being, you know I do not use the word 'drug addicts', I think it is perjorative ……being dependent on opiates. So I think you have had a very difficult situation where some people have had only a pain syndrome. You have other people who have pain and dependency and then you have other people who probably have had primarily dependency but who have had a history of something that could cause them pain and they have actually then been able to access the drugs that they needed for their dependency through a pain mechanism. So, that is clearly coming down, we saw a slight rise I think this year and we believe that that was probably due to the prescribing patterns of the one prescriber whose prescribing rights were recently suspended for S8 drugs by both myself and a medical board, and we expect to see those levels coming back down. And this is the

situation where the system is so small that one prescriber starting to prescribe very large quantities will in fact show you quite a significant statistical rise. So it is coming under control. We would think that it will probably continue to fall further now that there will be a group of patients who will say that okay, I can now see that probably my major problem here is dependency rather than pain and who will opt to now take up the option that has become available of being able to get a maintenance pharmaco-therapy. So I think we will begin to see, we will see a still further fall in the levels of ……..that are being sort and therefore prescribed by doctors in the Northern Territory.

Dr BURNS: The law remains does it not that it is illegal for someone to prescribe morphine for the purposes of addiction?

Dr HENDY: Absolutely it always has been, yes. That has not changed at all. It is illegal for them to prescribe morphine for the purposes of addiction.

Dr BURNS: So one would expect if there is the avenue for doctors to now say to some of these patients in the group that you outline, the avenue now exists for you to be on maintenance therapy. One would hope that these numbers would continue to fall.

Dr HENDY: Yes, I believe, that is what I am saying, I believe that they will, we will see a small, we will see a certain continuing decrease. Given that the total number of people we are talking about you know, when you talk about rates and levels we are talking about a total number of somewhere around 200 people.

Dr BURNS: So is there a role for the Health Insurance Commission in this as well?

Dr HENDY: The Health Insurance Commission has had an ongoing role which it has never kind of backed away from or come on strongly any more than. It went to see doctors in 1998 and it has continued to visit the Northern Territory and to go back and talk to doctors and the Health Insurance Commission will continue to highlight any individual prescribing that they think is outside the parameters that are acceptable to them when they are looking at the figures that they peruse.

Dr BURNS: I see in Recommendation 5.7 that an up to date prescription, that is on Page 23, that an up to date prescription monitoring system be established. So have you any idea about how that is going to work? I mean, I suppose I will be critical here. I think this has been on the books for far too long. As you say I was involved with the Schedule 8 committee. My recollection goes back to at least 1997 and probably even before that. As you said it is not an infinite thing that we are talking about here, we are talking about a quite small jurisdiction and I hope not that this is on the books it is going to be implemented and it is going to be an effective system. So have you any ideas about what shape it is going to take?

Dr HENDY: I think there are a number of things that we can say about that. One of the deficiencies, the deficiencies in the legislation and the ministerial guidelines that we have had in the Northern Territory up to now……nor do they make maintenance pharmaco-therapies available, nor did they provide for adequate and reasonable controls on scheduling, drug prescribing otherwise. So what is actually going to happen now is that in fact we will be, the immediate change has happened, it is a change of ministerial guidelines so that pharmaco-therapies can become available. What is already beginning to happen is we are beginning to draft up amendments to the legislation, and the task force report very clearly says the legislation needs to be changed. It needs to be changed to do both things, to make the pharmaco-therapies available for maintenance purposes and also provide better control of S8 drugs otherwise, and that is exactly what we are doing. I mean, we have not kind of been waiting for the task force to come out we actually had a couple of people come over from Queensland. They have done a review of sort of what happens across Australia and they provided us with some information that we were in fact working if you like, knowing that the task force report was coming out. We were already preparing ourselves to have a system that would be ready to come in given that of course the actual legislative changes had to go through a proper parliamentary process which can not happen until after the government has endorsed the report and then made it public. So we are hoping that those will come on stream around January/February of next year just depending how Parliamentary Council and processes and so on and so forth. But that will actually allow S8 drugs in general to have adequate controls placed on them which our current act does not enable in fact to happen. It is quite a complex new regulatory system in some ways that is going to be brought in. The elements of it if I just

try and think, it is quite complicated, and you just correct me if I miss one of the steps in this Linda, is that there will actually be a new either an amendment or even possibly we may have to bring in a new act because the amendments are so extensive, but the amendments will allow the establishment of this clinical advisory panel and the provision of a regulatory framework for all S8 drugs. As I said the current one only allows control drugs prescribed for the purposes of addiction. It does not allow us to control adequately drugs prescribed for the purposes of pain otherwise okay, that has not existed in our legislation previously.

Dr BURNS: I find that incredible.

Dr HENDY: It is true, the task force says so.

Ms HIPPER: The biggest difference for the Northern Territory as a jurisdiction is that every other jurisdiction in Australia you have to get a permit to prescribe a Schedule 8 medication. You do not have to do that in the Territory.

Dr BURNS: But in terms of the monitoring, the physical monitoring of every script that is written for a Schedule 8 drug, I mean every script is sent into the Health department

Dr HENDY: But you then have to have powers to do something about it, and that has been the issue. We have had very little power to actually do something about it

Dr BURNS: I understand, but there is a sort of parallel thing in that as I understand it or have understood it over the past 5 to 7 years is that the person who wades through those prescriptions that are sent in at the end of every month, it is a clerical position, so in other words if you get someone 'doctor shopping' and then it is not really sort of picked up.

Dr HENDY: No, no, no absolutely not.

Dr BURNS: That is not so.

Dr HENDY: Ever since the contracts have been in place, a GP, mostly the contracts are faxed to Poisons and Dangerous Drugs the same day they are done. If they are not they are generally sent by the end of the week. ……..actually, the clerical person might actually check them but she brings them to the attention of the Chief Poisons Inspector who will then phone the GP if they see that a patient who is already on a contract with a doctor is now entering into a contract with someone else and the other thing that has happened is that the GP's can phone directly to Poisons and Dangerous Drugs with the patient in front of them and say I have got so and so sitting here in front of me I am going to enter into a contract with them, can you let me know if they have a contract with someone else, and they will go to the database and say yes or no. Obviously at the weekend you can not do that kind of real time thing so that has actually been in place for some time and the number of people until the particular prescriber whose rights we recently had to remove was on deck and one of the reasons that we took action there and there was a complex of reasons there, it would be easier if I could do this 'in camera', I am just aware that I am having to be incredibly careful about every word that I am saying, so that I do not inadvertently say something that can prejudice a particular individuals' situation in the public arena.

15 minutes 'in camera' - nothing taped

Ms CARTER: When people use or are prescribed say methadone or ……..do they get a high out of consuming it? Like is it a pleasurable experience to have it, or is all it does overcome the craving?

Ms HIPPER: Basically for both of those drugs on a maintenance basis they do not get a…….effect. It negates the withdrawal symptoms and cravings.

Dr HENDY: And it is actually…..……so that is exactly what it does. I mean some of the early deaths from methadone were the reasons methadone got a bad name which was quite undeserved, is that there was not enough of an understanding of the fact that you had to start them off on a low dose and then work up to a dose, and that sometime people would quadra-dose that they thought were taking

but they were not really taking it so in fact some of them did die of overdoses but that has not happened for a very long period of time now. So you actually start on a very low dose and then you titrate up to it, but ……you observe when the person is having withdrawal symptoms when they come in and you titrate up to a dose that controls the withdrawal symptoms and controls the cravings.

Ms HIPPER: And the guidelines that are about are quite sophisticated these days. They are quite conservative. People start on low doses. They are generally not, like their withdrawal symptoms or their cravings may not be ……for a couple of days and those types of things but you err on the side of safety, because it is that issue about some people over inflate how much they have used.

Ms CARTER: Can people be admitted somewhere for a few days while it gets sorted out? The concern there is that if the cravings are not overcome rapidly they might succumb and use another drug again. Can they go somewhere for a few days?

Ms HIPPER: Generally not, that is generally not normal practice and of course some people will sometimes use during that early period as well but that is what you are trying to get away from, getting them away from using intavenously and stabilising.

Dr HENDY: ……is unusual ……use once or twice in the early days because they just want to see what it feels like anyway. I mean ……do that, that is in no way a reason for ceasing the program or for having a go at them. In fact what we say is if you have felt the need to inject we will not throw you off the program for that, we will not tell you off, you need to tell us so that we know what is going on, and you are really trying to do something that is often it is the first time for many people who are opiate dependent intravenous drug users, often the first time anyone has treated them like a decent human being and sort of had a culture of honesty to say look if you are honest with me you will not be punished for being honest. That is a very powerful thing and it is very important that there is an atmosphere of honesty between the doctor and the psychologist and the nursing staff in dealing with the patient, and the patient and the people feel …….to tell the truth. Not that we surreptitiously doing urine tests to see if you were lying to us, and in fact urine tests are almost never used in that way, ……..anymore, only when people are on…….

Ms HIPPER: Generally we are using urine tests to make sure that a person is opiate dependent before we start.

Dr HENDY: There is the occasional documented case of someone saying that they were using opiates when in fact they were not and you can not ……someone if they ……and you start them on a pharmaco-therapy, even at a low dose……..…..

Ms CARTER: If you were using an opiate and you took one of those drugs would that give you a high?

Dr LIM: ……..has got both……..and antagonist effects.

Dr HENDY: People often use them in place of prescribed, no they are both pain relievers. I mean what you would get is the effect that you would have if you swallowed a big dose of …….. I mean ……

Ms HIPPER: ……would go to sleep.

Dr HENDY: Yes , I mean I have had pethadine post-operatively, you do not sit in your bed having a high. You just do not feel as bad about life as you otherwise might. You get or what you do not get is what they describe as three day blues when they take you off it and you suddenly are getting the pain and the discomfort. I mean you do not get a high from a dose of methadone or a dose of …. The joy of getting, whether the freedom from pain or kind is euphoric for them and hence the desire to have more. I would assume that would have exactly the same effect.

Dr HENDY: ……is available as you know in the ……

Dr LIM: ……..trying to respond to Sue's question ……..I think to be accurate then surely the person initially on ……..and perhaps been treated with methadone would get some ……..effects before the antagonist effects come into…….

Dr HENDY: I think perhaps what we are talking about is the distinction between an agonist effect and a high, and when you are saying high, I thought you meant

Ms CARTER: I meant ……

Dr HENDY: and I do not think that it is, I am not saying that if you take methadone …….. and you inject them into yourself that it is impossible to get a high if you do that by giving them to you intravenously, but if you are talking about taking an oral dose then ……is of course available as a pain killer as Temgesic. Patients do not come back to doctors and say 'wow I got a high when I took my Temgesic tablets last night for pain' That does not mean that you could not get some slight euphoria if you poured a whole pile of painkillers down your throat, but you are probably more likely to over dose before you get the high. And it is, yes it…….a lot of people worry about……..all the time you do not suffer the normal aches and pains of everyday life……..

Ms CARTER: It is joyous.

Dr LIM: Wait until you get to may age……..

Mr WOOD: Pass the violin please.

Ms CARTER: No that is his own fault for having been so inactive. I have not done that so I should be alright.

Mr ?????????????: I did not know table tennis gave you that much pain.

Dr HENDY: We all suffer at different levels and different kinds of pain, any day, different people, you know some people suffer emotional pain rather than physical pain.

Dr LIM: But ……..a similar effect…….as heroin. Does heroin have a euphoric effect as well above what you can offer and all the others can give you?

Dr HENDY: Thinking about…….if you shoot it up you obviously get something different, but thinking back to when I was in England when in fact diamorphine or heroin was a perfectly, I mean we used it in hospitals as a first choice for a patient coming in with heart attack. It was considered to be a better drug than morphine or pethadine, and I was quite shocked when I arrived in Australia and found that heroin was the Big H and an evil word because I was quite used to prescribing it. In fact 10 milligrams for a patient in the middle of the night having a heart attack was, they did not get euphoric they just actually felt a lot better, …….pain away, felt better. I have no experience of giving it to someone in anything other than a therapeutic sense and we know it gives them a high if they take it intravenously cause that is one of the reasons they take it.

Ms HIPPER: Most things taken intravenously will give you a high ……taken. There are other drugs that can make you feel quite spaced out……..

Dr BURNS: I have a question or a request that is sort of a little bit unrelated but I am hoping you might be able to help me with it. Shirley, it relates I guess we have, we are going out to East Arnhem to have hearings in a few weeks and although I am there as an absentee I am still going to try and make it if we can re-arrange that schedule, but as a back ground to that I know that a number of years ago that the Health department undertook what was called the Kava Sentinel System project where data was gathered about drug use over a whole range of communities in East Arnhem and my understanding at the time is that it was going to be published and also for the benefit of the communities that were involved, and I am just wondering whether, I guess that is still the Health department's call about the public side of it but I am asking whether it might be possible to, for us to get a bit of background by having a copy of that KSS report?

Dr HENDY: My recollection is that the results have been fed back to the involved communities. Where the rest of the, what we have done about it otherwise and where the report sits…….would you be

Mr MCLAY: I am not sure where it is because it was done before I came into the program, so

Dr HENDY: I think we would have to search some of our files and talk to Dr Ian Crundle who actually handled most of that, and I will be quite honest it is not one of those things that I have a clear recollection of exactly what happened a couple of years ago when, I do know that the results were fed back to the communities, and that they were sent over to the Licensing Commission. I do not have a clear recollection of what else we planned or did do with them and I can just check back.

Dr BURNS: Alright, thanks Shirley.

Mr MCADAM: On behalf of the Committee I would like to thank you for coming in this afternoon and obviously perhaps on some occasion in the future we are going to have to ask for you back because as a result of the report obviously there needs to be further consultation between both committees particularly on the importance of some of the work you are carrying out, so thank you very much.