LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

13th Assembly

Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours

Public Briefing Transcript

10.00 am – 1.30 pm, Thursday, 30 August 2018

Litchfield Room, Level 3, Parliament House, Darwin

Members:

Mr Jeff Collins MLA, Member for Fong Lim
Ms Sandra Nelson MLA, Member for Katherine
Mr Paul Kirby MLA, Member for Port Darwin
The Hon. Kezia Purick MLA, Member for Goyder

Witnesses:

- Mr Travis Wurst: Acting Assistant Commissioner, Police Fire and Emergency Services
  Ms Zoe Langridge: Assistant Director, Strategic Policy Division, Police Fire and Emergency Services
  Mr Neil Hayes: Acting Commander of Crime Command, Police Fire and Emergency Services
  Superintendent Scott Pollock: Superintendent of Drug and Organised Crime Division, Police Fire and Emergency Services

- Ms Carolyn Whyte: Director, Criminal Justice Research and Statistics Unit, Department of the Attorney-General and Justice
  Ms Anna McGill: Director, Policy and Strategic Planning, Licensing NT, Department of the Attorney-General and Justice
  Ms Leanne Liddle: Director, Aboriginal Justice Unit, Department of the Attorney-General and Justice
  Ms Ros Lague: Director, Programs, Services & Improvement, NT Correctional Services, Department of the Attorney-General and Justice
  Dr Natalie Walker: Acting Deputy Director, Offender Services and Programs, NT Correctional Services, Department of the Attorney-General and Justice

- Ms Cecelia Gore: Senior Director, Mental Health, Alcohol and Other Drugs Branch, Department of Health

The committee commenced at 10.09 am.

NORTHERN TERRITORY POLICE

Mr CHAIR: I welcome everyone to the public hearing into reducing harms through addictive behaviours. I welcome to the table to give evidence Zoe Langridge, Assistant Director, Strategic Policy Division; Commander Travis Wurst, Acting Assistant Commissioner, Crime and Darwin Command; Neil Hayes, Acting Commander of Crime Command; and Superintendent Scott Pollock, Superintendent of Drug and Organised Crime Division.

Thanks 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 protection of parliamentary privilege and the obligation not to mislead the committee apply. This is a public briefing that is being webcast through the Assembly's website. A transcript will be made available for use by 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 the committee to go into closed session and take evidence in private.

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

Commander WURST: Travis Wurst, Acting Assistant Commissioner of Crime and Darwin Command.

Ms LANGRIDGE: Zoe Langridge, Assistant Director, Strategic Policy Division.

Superintendent POLLOCK: Superintendent Scott Pollock, Drug and Organised Crime Division NT Police.

Commander HAYES: Neil Hayes, Acting Commander of Crime Command.

Ms NELSON: Could you remind everybody to turn their microphones on? I could not hear it.

Mr CHAIR: Would anyone like to make an opening statement?

Commander WURST: It is probably worth stating that there may be some operational business that cannot be spoken about in the public forum. If that is the case, we will caveat that. We can either discuss it at that time out of session, or we could do it at the end if that is more appropriate.

To set the scene, my role as the Acting Assistant Commissioner in Charge of Crime and Darwin metro. We are speaking primarily today from a crime point of view, but there may be some issues that relate to alcohol that I may still be able to assist with.

Neil Hayes is doing my role, which is ordinarily the Commander Crime. The remit of that area is crime as we know it, and drugs and organised crime which Superintendent Pollock is in charge of, and to be frank, the brains of the operation in relation to what comes to what we will discuss today.

Ms LANGRIDGE: To clarify, my role within the Strategic Police Division—we also oversee the Alcohol and Drug Policy Unit. We sit within the Office of the Commissioner and provide that policy advice and direction across the entire agency. So, that would be across alcohol and the illicit drug portfolio and then, obviously, where there are other crime intersection points. We work very closely with the command divisions across the agency as much as issues have similar drivers and the same practice that needs to be considered.

Commander WURST: By way of an opening to assist the panel, the Northern Territory Police is moving into a new strategic framework strategy to 2023. As part of that, our remit is about building safer communities. The primary driver there is around prevention.

Now, the drivers of crime in the Northern Territory are well stated, alcohol being the primary. We acknowledge that illicit substances, including alcohol and kava, can also be drivers of crime. Our role, from a law enforcement point of view, is about managing those drivers, mitigating those drivers, disrupting, and then reducing the risk that poses to the community in a general sense.

The work, particularly around illicit substances such as drugs—when I say drugs, we categorise the primary impact on the Northern Territory as cannabis, methamphetamine or ice as most people would know it, and cocaine to a lesser extent and MDA also from a social and urbanised point of view. They are the main substances we will speak of today.

On the scale outside of the drug spectrum, kava, alcohol and tobacco also exist. However, tobacco is not something that is—it is a legal substance, therefore it is not something we are involved in the management of.

We have information that can support the work the committee is doing about those particular elements. I know you are looking at the preventative aspects in relation to those addictive substances. The honest assessment from a policing point of view in the here and now is the amount of proactive drug enforcement work we are doing does impact on our ability to be engaged in the proactive educational space around informing the public about the risks, dangers and therefore, trying to prevent them from becoming engaged in that behaviour in the first instance.

Mr CHAIR: That is great from my perspective because I have the personal view that educational aspect would be a much better use of everybody's time, yours included.

Commander WURST: Correct.

Mr CHAIR: We have a set of questions that we have looked at, so we will be going through those. If, at any time, that prompts you to go off on a tangent, feel free. It might also lead us to some further questions as well. But I will kick off with the first one that we have.

Commander WURST: It is also worth noting that we have our draft response that is not due until post this forum today. Most of the information—we do not intend to go over most of what we have again. We are going to use the engagement today to inform what we have already delivered, and then enhance that as required.

Mr CHAIR: Okay, that sounds good. As a first one, police have a unique insight in to the types and levels of drug use in urban, regional and remote areas, which is often not captured by traditional data sources.

Based on police experience in the field, which drugs are of most concern to police and why?

Commander WURST: All our publicly released information around drugs seizures and the amounts, quantities and the number of arrests associated is publicly available in all the ACIC documentation. The 2016–17 report is currently in draft and will be released in the near future. So any information that we provide today will be reflected in this. If it is not then we will state that for you.

Ms PURICK: What does ACIC mean?

Commander WURST: Australian Criminal Intelligence Commission—what used to be the ACC (Australian Crime Commission). They amalgamated two years ago.

MR CHAIR: That is 2016?

Commander WURST: That is the 2015–16 report. The 2016–17 report is due out …

MR CHAIR: The 2015–16 is out, it is the 2016–17 that is …

Superintendent POLLOCK: It is available on line.

Commander WURST: As sort of indicated already, and I will provide an overview and I will actually hand over to Superintendent Pollock to provide some of the more nuance nitty gritty around the seizure activity. As indicated from an urban point of view we

have seen the ongoing prevalence of cannabis use consistent that has not necessarily changed. Our recent seizure rate in relation to cannabis shows that both urban, remote and rural that is not changing. We are seeing significant seizures within that space.

What is interesting for us, and it was highlighted through the first waste water analysis that was conducted through the ACIC that in the Darwin area, the CBD area primarily, we had a much greater MDMA and cocaine usage than we were aware of. Since that came out we have done a number of proactive operations targeting the supply networks, the distribution, the syndication, not the user category at the bottom, and that is identified with significant seizures—which I will have Scott speak to specifically—that then allowed us to identify that there were changes in drug use behaviour.

The use of ice—I would use the term ice instead of methamphetamine it is just easier to say, and the public understand what that means—is still an issue in its prevalence, but what we are seeing is the Northern Territory market, but the Darwin market specifically, is the retail product is more expensive here than it is in other places across Australia, and that impacts on people's ability to be able to access that drug as their drug of choice.

It is an addictive substance and there are people still using it who are addicted to that substance and we know that, but we have seen an increase in the prevalence of cocaine primarily because it is per gram cheaper to be purchased and it is not as addictive, or addictive at all depending on which health expert or document that you read.

That was a very interesting turn of events for us to see that that rose as a drug of choice and then that followed with some of the work that we did proactively throughout joint organised crime task force, a task force that is managed by Superintendent Pollock but includes the Australian Federal Police, ACIC, Australian Border Force as a collective partners who work primarily targeting ice, but we have had the opportunity to target syndicated trafficking of cocaine in to the Northern Territory as well.

MR CHAIR: Your efforts in picking up the distributors, do you see that as having an effect on a price on the street? Do you know anything about that and then whether that has any effect on usage?

Commander WURST: Can you speak to that specifically, Scott?

Superintendent POLLOCK: Yes, I can. The Northern Territory is high above average for illicit drugs because of their remoteness or the availability of the drugs or sometimes maybe even the demand, but it is a known fact around Australia that if you want the best price for your product go to the Northern Territory .

We do pay above average compared to other jurisdictions when we compare notes. That will be articulated in our submission, the actual prices that are paid within the community on average. When you consider a point of ice, point one of a gram, is on the market between $120 and $200. That is a significant amount for such a minute amount of drugs that people are prepared to pay.

Mr CHAIR: How long does point one of a gram last a user?

Superintendent POLLOCK: That is just a hit. A mild hit that might last a few hours. A heavy user will be in excess of a gram a day.

Commander WURST: Which is, therefore, an expensive habit.

Mr CHAIR: Yes, absolutely.

Commander WURST: At the user level.

Mr CHAIR: Then with other drugs I would just like to know what the—and I suppose it will be in your submission as you said, but that effect of cost on the street how that effects usage rates—that would be interesting to …

Commander WURST: As I said, it will be contained within here, but by way of an example, if you were to go to an overseas manufacturer, therefore a supplier, a kilo of methamphetamine ice can be purchased for around $5000 depending on the market place, and that if it was to make it on shore can then be broken up. Then if you look at point one of a gram is being sold for $150 and then you extrapolate that out to what a kilo is so there is the profit margin is extraordinary, hence the reason that there are so many people in the market, so to speak.

To use a vernacular if we take one out there are plenty more syndications willing to take that person, that syndicates place, and we have seen that time and time again.

An interesting—and talking urban still—find that we have encountered over the last 18 months through Scott's team and the joint organised crime task force—we started focussing upon express mail delivery packages through Australia Post with their support, and what that identified for us was this rather large and unknown supply network that was being delivered through the Northern Territory or to the Northern Territory via the dark net, the dark web, and again it will be provided to you but we seized an extraordinary amount of illicit substance—everything from cocaine, cannabis, MDMA and methamphetamine all the way through to non-prescription drugs, steroids are also a significant issue with the current social media culture and body image and those sorts of things—we are seeing a prevalence (inaudible) that is as something we are seizing on a regular basis and it took us a significant amount of work to be able to work through how it was coming in to the Northern Territory–and a lot of that is still unknown because of the nature of the dark net.

I am not sure if you understand the premise behind that but basically it is an anonymous illicit online marketplace that requires the use of cryptocurrencies to make a purchase; therefore, basically anonymous. The suppliers on those, whether they be onshore or offshore, will guarantee supply. So if you do not get it, it is interdicted by some form of law enforcement, they will then provide you the same. The prices are generally cheaper through that marketplace than locally. What we saw, interestingly, that it took out the need for your local supplier to an extent.

What we also saw is lots of people who have no previous drug involvement saw it as a lucrative opportunity to financially benefit very quickly, and the operation yielded a number of arrests of people that we had never had engagement with previously in this place, and that in itself was interesting. They were not always users but they saw it as a market place opportunity. That will be an ongoing challenge. The way in which the drug world operates is when we manage one area, squeeze there, it bulges somewhere else. We have legislation in the Northern Territory that is very effective. It is under the *Misuse of Drugs Act* and is the declared drug area legislation. That has to be used outside of our metropolitan area. We use it primarily to interdict and disrupt illicit substances going into remote communities.

There is scope to expand that legislation, if the will was there, to allow us to use similar provisions to target not just the post office, because that is a federally owned and operated space, but other transport modes and networks such as transport companies, trucking companies, barges in and out of Darwin that are going to remote communities. That legislation would allow us to go in, own that space for a period of time. We have put up the proposals about that as well. That is a very effective tool for us. It does not always have to be based on us knowing that there is a significant amount of activity going on. We use it to support remote area events, for example, where we know the desire for illicit substances—at sports weekends for example—may require the trafficking to occur at a particular time.

The dark net aspect we have seen decline, but that just means the networks use other methods—air stream, mail transport by way of road—whether that be physically driving, using bus as their transportation method or courier trucking companies. That is not including material coming from offshore via the maritime channels either. So, there are lots of opportunities and options for those who wish to get it onshore and into our marketplace. We need to be able to bounce from one to the other. We use the tools available to us to the full extent, as best we can.

There is another element in that space. When I talk organised crime and syndication. Outlaw motorcycle gangs within the Northern Territory are still involved in that activity—the distribution and supply and the importation from other jurisdictions. We continue to target outlaw motorcycle gangs through our gangs' task force that works for Scott. We have had significant success in the recent past in not just drug-related

activity, but other activity that has disrupted their ability to maintain their business models that is based on profit, effectively.

Ms PURICK: I just did some calculations. You said 0.1 gram was about $150?

Commander WURST: $120 to $150 to $200.

Ms PURICK: There is 4.2 grams in a teaspoon. So, for a teaspoon of whatever—whatever.

Mr CHAIR: And if you are bringing in …

Commander WURST: That is methamphetamine as well.

Ms PURICK: Yes.

Mr CHAIR: $5000 for a kilogram.

Ms PURICK: So that is …

Mr CHAIR: Yes, it is an amazing amount of money.

Ms PURICK: Over $100 for just a little teaspoon.

Commander WURST: Obviously, there is a risk and rewards scenario. There are risks. Gaol is one of those, from a supplier's point of view. The user does not necessarily see it in that space at all. They are operating by different rules and personal drivers. But at that distribution level—the importation and distribution—it is all fiscally orientated. That is obvious why.

Ms PURICK: High return.

Mr KIRBY: You were just talking about the correlation between campaigns you run that put a stranglehold on perhaps the supply and the bulge that creates in other areas. Have you seen that right through the Territory? Is it mainly around—if you clamp down on ice or something like that, is it cannabis or cocaine that goes up? Is there a risk of …

Commander WURST: It is probably worth—when I say urban that includes the rural areas within proximity of the greater Darwin area. Alice Springs has similar urbanised drug use issues. It is probably now worth speaking remote because that is where I believe your question is going.

Cannabis is an issue in remote areas—it always has been and it is not going away despite our efforts. There was a job that Scott's team managed recently—correct me if

I am wrong, Scott—across the life of that syndicate there was 900 kilograms of cannabis that was trafficked into Darwin in a 12-month period …

Mr KIRBY: Nine hundred kilograms in 12 months?

Commander WURST: For which that syndicate has been charged. Not evidence-based, but anecdotally, much of that was destined for remote communities at some point. So, coming in, in bulk, and then distributed out through the pre-existing networks into remote communities where similar profit margins can be realised. Interestingly, the drug world operates imperially still. They talk pounds, half pounds. So, a pound of cannabis is $3600 …

Commander HAYES: Thereabouts, yes.

Commander WURST: … to $4000. In a remote community, they may break that all the way down to—I will go back to metric—half a gram, which may sell for up to $100. So, again, even in the cannabis space, the profit margins are still significant. Cannabis is an ongoing issue. Using the drug declared area—an example I used earlier—Scott and his team work closely with the Katherine—I am speaking now from—this is a Territory-wide example. Over an 18-month period, up until June of this year, we ran 114 of those drug declared areas. What that means is any vehicle that comes into that area, we have the ability to speak to the driver, the passengers and the occupants. We may or may not have a drug detector dog that will assist us. It gives us the power to search, seize and then prosecute as required. Of 109 of those, we have identified cannabis.

Obviously, we target these. These are not done on a whim. As I said earlier, if we know there is an event at a remote community that may attract illicit material going to that location, we will target it, particularly and specifically. It is labour-intensive and requires us to be on the road, so to speak, for an extended period of time, but at the same time, we are seeing the results—the amount of illicit substances being trafficked that can be a gram or pounds and pounds—you never know. Sometimes you stumble over other things you did not expect whilst you are doing those.

What we are not seeing in remote communities, from a police evidence-based point of view—anecdotally it may exist—is the prevalence of other illicit substances. When we talk *Misuse of Drugs Act*, cannabis yes, methamphetamine, no, MDMA, no, cocaine, no, and heroin, no. There is anecdotal information that suggests that illicit substances such as MDMA and methamphetamine have made it into remote communities from time to time, but we are not seeing it as accessible or its use as prevalent. It may be that people from remote communities might be accessing it whilst in an urbanised area where its availability is increased, but we are not seeing it in remote communities.

That said, when I say remote communities, if you have a non-Indigenous population, then you may see it. There was some media about six weeks ago, of some significant

seizures on Groote Eylandt, for example. Similarly, in the urbanised non-Indigenous population in Nhulunbuy you see it occasionally. In Yulara in Central Australia you see it occasionally. But that is not making it, necessarily, into the broader Indigenous community.

Mr KIRBY: Okay.

Commander WURST: Alcohol is a different story. Obviously, in some areas it is legally obtainable, others are dry communities but it is still making it in as an illicit substance. Then, speaking remote still, northeast Arnhem Land still has an issue with kava.

Mr KIRBY: Right.

Commander WURST: That has been a bugbear of mine for a long time, having lived there and worked in that space and seen the impact that has from a health point of view, also from a financial point of view—seeing the money. Previously, kava was managed in a particular way where the Indigenous corporations in and around northeast Arnhem land had the ability to bring that lawfully and legally and then sell that lawfully and legally to the community in a regulated manner, that meant that that money stayed in the community.

When the federal government changed the legislation in 2007, I believe it was, that meant that importation was reduced to only non-commercial amounts of two kilos per person coming from a supplying country—that is Polynesia primarily.

What that meant overnight that the lawful market ceased and the black market commenced again. So kava can be purchased for as little as $20 to $50 a kilo in other parts of Australia where it is not regulated and it is about $1 a gram or $1000 a kilo in a remote community. It stretches as far as Maningrida; Ramingining; Milingimbi; Elcho Island; Nhulunbuy; may occasionally pop up in Numbulwar—but not that often, that is a different sort of community group—and all the homelands in that area. It is fairly well contained to that particular part of the country.

Currently that legislation the *Kava Management Act* dictates that anything under 20 kilos in an offence but it is not punishable in any punitive measure, anything above that is trafficable up to 20 kilos and then above 20 kilos it is commercial. It is not uncommon for us to find 50 kilos plus being trafficked in to those particular areas—again for significant profit to be made.

The cohort that is involved in that activity is—and I do not wish to generalise necessarily—but evidence tells us that they are Polynesian people themselves who obviously have access to the market coming primarily out of Sydney and Brisbane is where the kava comes from, trafficking in two main ways, airstream and by road.

Mr CHAIR: And it is—I have not followed kava to be honest—so is kava legal to be sold in Sydney and outside of the Territory?

Commander WURST: It is not regulated at all. Under the Commonwealth's *Customs Act* you are allowed to bring two kilograms of kava in to the country lawfully. There is provision for therapeutic goods and scientific research provisions as well but obviously that is not necessarily applicable, now if you have a number of people flown back in to the country—and you can have it sent it in as well, it does not have to be brought in on your person it can be mailed in—if it is mailed in then that adds up over time and the cost benefit again as a risk reward that market places here, and they are doing it—there is a network, it is not just what is left over will sell to the Northern Territory they are doing it for a particular illicit purpose.

Health impacts on the Yolngu people in the Northern Territory is significant. It is a sedative, it creates lethargy and that then has broader impacts on a social point of view. That is another—from an addictive substance point of view and prevention we focus on the interdiction and disruption where and when we can but that is a challenge to manage that against ongoing priorities around other illicit substances.

Mr CHAIR: Are they using it instead of alcohol?

Commander WURST: They have done in the past and you will find that people who are kava drinkers may not drink alcohol. When kava is not available they may switch. Not often but they do. They combine the two but one offsets the other to an extent.

Ms PURICK: When you talked about the cannabis that goes to the Aboriginal communities or generally goes remote, why is it cannabis? If you can get so much out of a teaspoon of ice, why are they not selling ice in the Aboriginal communities—because they get a greater return than cannabis?

Commander WURST: It is an interesting question. Ice—and I am probably going to speak anecdotally here without having the evidence to support it—but we know that ice can be consumed in a number of ways. It can be consumed orally, it can be snorted, smoked or injected all of which are not particularly palatable if you are a first-time user. Indigenous people I know will not inject. That will not happen for them. That is not in their makeup. I have no doubt it has been out there at times. I have no doubt there are people who have tried it. Having spoken to users over many years, it is a very different experience and maybe one that they do not enjoy necessarily.

Ms PURICK: So, they use the cannabis because it is like smoking.

Ms LANGBRIDGE: It has …

Commander WURST: It is a sedative, as opposed to—they have two very different effects. One is a stimulant and one is more a sedative or hallucinogenic effect. I have

no doubt there are people who will try to push it—because of the profit margin, as you mention—into remote areas. We have seen it interstate where organised criminal groups, motorcycle gangs, have gone rural communities on the east coast, flooded the market with methamphetamine, ice, and created a cohort of addicted individuals and then started charging the going market rate for that product. They have created a marketplace for themselves.

Ms PURICK: Yes, okay. The other question was when someone's obviously getting it from down south, breaking it down and distributing it, is that generally people who do not live in the communities, is it urban people, or do they have a network combination of Aboriginal people or anyone else for that matter? Do you think? Or do you know?

Commander WURST: Evidence would suggest that there is a bit of everything in that mix. You might have syndicates from interstate that identify this as a marketplace. They may have a contact here that is already part of an organised criminal group, and they may link into that marketplace, that network. They may send someone up here to become the local face of their organisation. Or they could be long-term residents who have been here a long time and played in that space for a long time, and have developed their own local networks. They have very little to do with interstate markets at all.

As I said earlier, there are new people coming into the marketplace because of the risk and reward …

Mr CHAIR: Profit margin, yes. Anything else?

Mr KIRBY: Sorry about that. Is there anyway of tracking—from what you were saying, it is very intensive to track or frustrate anything going into remote communities. Is there an ability to track crime-related activities, if you know there has been a shipment go in and you have not been able to frustrate it or head it off? Is there a direct correlation between crime and access, whether it be kava, alcohol or cannabis or whatever the problem may be?

Commander WURST: That is an interesting question. The converse is true. We are able to determine success. If we interdict a significant seizure we know is going to a particular location, we can see behaviours in some remote communities change. If you have a cohort who are heavy cannabis users, for example, and do not have access to their regular supply of cannabis, their behaviour may change. We have seen that over time.

It is very hard to determine if we miss a shipment, as stated, what impact that has because cannabis, in particular, has been in remote communities in the Northern Territory since the 1970s. There are long-term users and lots of new users. There is a phenomenon we are seeing where users are younger. Something else I do not think I have seen anywhere in the material I have seen, is the issue of petrol sniffing.

Obviously, that is readily available item in all communities—regulated to an extent through *Volatile Substance Abuse Prevention Act*. However, that is still an addictive substance that primarily youth are engaging in using. It is still happening in certain communities to this day.

Mr CHAIR: Yes. Has the low aromatic fuel worked?

Commander WURST: In some areas it has worked well. That is more of a legislative fix to a broader problem. People who still want to sniff will do their level best to get their hands on it, so to speak. It is not addressing the root cause of why people which to engage in that addictive behaviour in the first instance.

Mr CHAIR: That is something we would like to get to the core of regardless of what the behaviour is. We are running out of time and there are some issues I would like to get to. Cannabis drug infringement notices—can you describe how the infringement notice scheme operates in practice?

Commander WURST: Certainly, and if I miss anything, Scott, please feel free. Drug infringement notices are such that anything that is under 50 grams of cannabis we can issue an infringement notice. That infringement notice is for $300 plus. It is not our practice to use that for the same person more than once or twice because there is more of an issue there obviously, and then we may on a second or subsequent time that someone is found is in possession of less than 50 grams of cannabis they may be issued with a notice to appear to attend court.

We have seen an increase in the drug infringement notices issues Territory wide. That will appear in our report. They are effective for us because what that does it creates an immediate punitive effect, it is a fine issued on the spot and it means that that individual, if it is their first time, does not have to go to court, does not have to go through that process. There is time and effort and work load associated with that for us also, but that creates an opportunity for that person not to have a criminal history and then to seek reform if that opportunity exists for them.

Mr CHAIR: The Act does not mandate that the officer issue them—are there any instructions about when you do issue them or is it just a blanket thing that first offences …

Commander WURST: Policy based—we use them where and when we can.

Mr POLLOCK: Preferably to issue the drug infringement notice and that is the instruction to my members is that keep away from the court where ever you can but if it is recidivist offenders then examine your options thereafter.

Ms NELSON: I have a quick question and I do not know if it was asked already or not. What is the actual break down of drug offences per region? Is it greater in the northern suburbs than it is for example in the Katherine region or Arnhem region?

Commander WURST: I do not have that information right this minute, however, we can provide additional information on our written submission that may support that particular question, if that is okay?

Ms NELSON: I would really appreciate that. The thing we are looking at is harm reduction strategies and we do need to—for me personally I would like to get an idea of how big the problem really is in my region and how I can—where we need to be focussing on.

Commander WURST: Certainly.

Mr CHAIR: Can you give an overview of drug diversion programs?

Commander WURST: I can. That falls in to two categories. Youth diversion opportunities exist to divert youth and some young adults who may have been found in possession of—as we sort of were indicating—anything that is for youth diversion that needs to be less than trafficable because of—anything that is commercial—we do find youth engaging in serious commercial activity from to time, unfortunately.

All the statistical information will appear in the report, but from a drug diversion point of view for adults, police have little engagement in that space at all, and previously there has been programs run through the courts, drug court process, but there is not a great deal of drug diversionary activity for people who do not receive a custodial sentence or appear on bail prior to being sentenced for example—as I understand.

Mr KIRBY: In your experience are there other jurisdictions around the country that have had good results from those type of programs, if we do not have much of that evidence here that you are aware of?

Commander WURST: We do have the COMMIT parole program. That does exist in the Northern Territory and that is about managing those who come into custody with some form of substance abuse as a driver of their criminality in the first instance. That, I believe, has had significant success in the Northern Territory, for those who are convicted and sentenced for crimes that attract a parole condition or period.

In other jurisdictions, I could not comment specifically. I know that in other jurisdictions, some have had success and some not so. We probably need to seek out their direct input about those successes. We are still working through the youth side of the house following the royal commission outcomes. We will continue to work on the recommendations from the royal commission and will consider addictive substances in the work we are doing on managing youth going forward.

Commander HAYES: Others have had the diversion linked to the infringement side of things, particularly about cannabis as well. Where a cannabis infringement is issued, rather than a financial penalty, there is an option of a diversion—a short course that will remove the cost then, if they do not pay. It is not recorded as a conviction …

Mr CHAIR: It is an educational process of …

Commander HAYES: Yes. That is again, early intervention for early users.

Commander WURST: Break the cycle, if possible, early.

Mr CHAIR: If you were adopting that program—you were saying before about how you issue one, possibly two, but then after that it is a court attendance notice. If you are having a diversion program, would it be more likely you send people to that, rather than issue the court attendance notice?

Commander HAYES: In that jurisdiction, yes, that is the option. The first time, if you are given an infringement, your options are to pay the fine or do an education program. That is the recipient's choice to go either way. Either way, it is not recorded as a criminal conviction in these jurisdictions. But it gives that early intervention and it is still only a one-off. Once you have been through that process you do not get the opportunity again—you have had your education, you paid your fine, next time you go to court.

Mr CHAIR: Okay.

Ms LANGRIDGE: A complexity to that item as well would be what the substance was and what would be the facilities that were available. In the Northern Territory, some of the issues around the treatment or the referral pathways might be that the substance or situation you have is the facility is not available there. That is of particular impact when you are looking at your Indigenous communities, because, obviously, culturally that association with place is very important. So, successful treatment or referral—if you are then taking a person into a completely different—particularly around a homeland situation—has been something the Northern Territory has been mapping out against where programs can be referred to and what that means to—as the assistant commissioner said—to intervene within that cycle and find the best possible way to do so.

Commander HAYES: And if you do those programs, they need to be timely. It needs to be delivered very quickly, otherwise it loses the impact.

Mr CHAIR: I understand that. Anything else? Drug driving. Can you give us an overview of drug driving testing in the NT and how people are identified, tested and then charged?

Commander WURST: This is something we had a conversation about this morning. Historically, drug driving people have been using illicit substances for a long time. But up until recently, we never had any drug driving legislation. So, under the *Traffic Act,* if you drive under the influence of psychotropic substance meant that you may be taken to court for being under the influence of cannabis or any other illicit substance.

When the drug driving legislation came in that was a move forward, but initially the testing capability we had was very expensive—it was around $20 a test. That has decreased over time and our ability to test a broader spectrum of drivers has increased, from a cost-analysis point of view. However, from a strategic point of view, we do not necessarily have policy at this point in time. We will provide you more information in a written—because this is something that falls into a different area of responsibility. We have our own standard operating procedures. We will test the people we either know are users or are illustrating behaviours that are indicative of illicit substance use. We will not test the entire cross-section of the population. If we have a random breath testing station, for example, and we have 400 people come through that in a three-hour period, it is highly unlikely we will test everyone because it is an onerous process. There are select individuals who will be targeted, if that makes sense.

Mr CHAIR: Yes, okay.

Commander WURST: The penalties in relation to drug driving versus drink driving are different. Blood alcohol concentration offences relate to low-range, medium-range and high-range, immediate licence disqualifications and significant penalties. Licence disqualification imprisonment whereas drug driving is from a legislative punitive point of view has a lesser spectrum attached to it around the offences you are committing and the impact that it will have on your licence and financial or imprisonment penalties.

Mr CHAIR: Does that have anything to do with the inability to actually test the physiological …

Commander WURST: I can only assume so. We had that conversation—we are not entirely sure why there is a difference and it is something the second reading speech may tell us. We have not got that far yet because that is the last thing on a list that we are reporting upon.

For a deterrent point of view we are wondering if that has any impact. We know that being affected by an illicit substance has deleterious effect on your ability to maintain normal control of the motor vehicle which is why it is an offence. How does that equate to—there is lots and lots of empirical studies that talk about the impact of alcohol as you move up the blood alcohol concentration spectrum. I do know if the same exists in relation to illicit substances.

Mr CHAIR: That is my understanding, that you cannot actually test that and what that effect is. Has thought been given to—and goes back in time—a practical cognitive test of drivers so you are actually testing their physical ability to operate the car?

Ms LANGRIDGE: The US model? Is that what you are talking about?

Mr CHAIR: Yes, the walk the line type of thing, but just in the sense that medicinal cannabis is legal. You are going to have people out there who are potentially using one of those substances …

Ms LANGRIDGE: Medicinal cannabis firstly will primarily be CBD as opposed to THC. The THC is a psychotropic component so a person who is taking a high CBD would not be registering under a THC testing framework and that is because this one is medicinal and has therapeutic purpose, this one is psychotropic and will impair you.

With respect to the range from a consumption of alcohol a lot of work over, I think nearly three decades, is what formed the basis that we have today to identify your cognitive impairment across .05,.08, .15 et cetera the issues that you have when trying to applying that same framework around illicit drug actually can very simply go back to—an illicit drug can be manufactured in a multiple different range of ways, hence the high level of harm, particularly around a lot of our stimulants you do not know what is in it and how it has been made.

Because you cannot guarantee that in the same way that you can with alcohol that is manufactured through a particular process in to a specific recipe or with medicinal cannabis that will be done to a pharmaceutical framework you cannot then identify what your impairment would be because you cannot guarantee and provide any assurance or safety around the manufacturing process of these particular substances.

Even cannabis when you are looking at the THC concentrations being seen nowadays compared to the variants that were available 10, 20, 30 years ago that in itself is also going exponentially higher. Again, it is not a like for like with respect to the alcohol. If you wanted to summarise it neatly it comes back to—one, you can guarantee how it is made, the other one you absolutely cannot.

Mr CHAIR: I clearly understand that. I would just like to see whether there is any potential for say testing somebody and if it is not in fact impairing their ability to drive, the equivalent is somebody who is driving with blood alcohol concentration of .02.

Ms LANGRIDGE: I think what is unfortunate with that is we will have people who are registering incredibly higher blood alcohol who will tell you they were perfectly fine to drive despite the fact that they had just demonstrated that they clearly could not.

Commander WURST: The testing does not determine whether it is residual or current. I assume that is where you going?

Mr CHAIR: That is the point I am looking at, yes. If it is impairing their cognitive ability, I understand, proceeding with the normal fine process. But if it is a residual amount you are detecting in their bloodstream, or something like that—or however you are detecting.

Commander WURST: What that does, however, is still create a deterrent effect that, regardless of whether it was recently consumed or consumed the night prior, still may have an impact on your ability and you should not be driving at all. You should not be consuming that substance at all and then trying to engage in normal day-to-day activity.

We are talking illicit substances here. There are lots and lots of prescription medications that can have a similar effect, unfortunately.

One substance we have not discussed that will appear in more detail in this, is the synthetic cannabis availability in the Northern Territory. I am not sure how much you know about that, but it is an analogue, so it basically synthetically creates THC component of the psychotropic substance of cannabis and is sold in such a way that when you break it down to a metabolic point of view, it actually does not hit the component of THC—it has the same impact, therefore it does not create the offence.

Mr CHAIR: Okay.

Commander WURST: We are seeing that on a recurring basis. If one particular substance that is synthetic cannabis becomes a scheduled illicit substance …

Mr CHAIR: They change it.

Commander WURST: … there is another one to take its place, and so on and so forth. Synthetic cannabis, we acknowledge, is available from time to time in the Northern Territory. Because it is chemically based and manufactured—the process is unsure—where it comes from and what it contains and therefore, what the impact is.

Superintendent Pollock was saying on the way in that there were some overdoses in New York recently from synthetic cannabis consumption, so it is a dangerous product …

Mr CHAIR: So, we stay …

Commander WURST: … we also acknowledge.

Mr CHAIR: How do we—or how do you—stay on top of that?

Commander WURST: When the information supports us targeting it as an issue in a particular location, we will do so. But the challenge for us is then the prosecution aspect, post-event—proving that it is a scheduled substance and then prosecuting it accordingly.

Mr CHAIR: Right.

Ms PURICK: Was that the one called chronic?

Commander WURST: That is one. Pineapple express and so on and so forth—there are lots of them. Generally, they are labelled as incense and not for human consumption, but that is just a ruse on …

Ms PURICK: What they are.

Commander WURST: … what they are. They are legally available in some countries and are sold, from time to time, at various premises in and around Darwin and elsewhere in the Northern Territory.

Mr CHAIR: Okay. Last one, unless anyone else has anything. What role does the police department play in development coordination and implementation of harm reduction strategies in the Territory and on a national level?

Commander WURST: I will pass over to Zoe. We are part of the national ice strategy, from an ice point of view, and then we have our localised strategy. I will have Zoe speak more specifically to those.

Ms LANGRIDGE: The Northern Territory Police are members of the National Drug Strategy Committee, which was formerly the Intergovernmental Committee on Drugs. That committee is responsible for administering the national framework—the national drug strategy. That is auspiced under the Ministerial Drug and Alcohol Forum.

The Northern Territory Police, at the national level, also work very closely with other law enforcement agencies. This can be through the Australian Criminal Intelligence Commission, ANZPAA and several other bodies. We can identify those in a submission for you in greater detail.

But the harm reduction construct primarily is an underlying policy intent. Whilst a straightforward approach, for example, on interrupting illicit drug supply might be seen very heavily as law enforcement targeting only the supply mechanisms, it will also be about whether there are strategic partnerships with the Health Department, our corrections colleagues, et cetera, and identifying what the harm reduction components are within there.

Some of the items that have been looked at in other jurisdictions are where police have had a very heavy involvement. We would regularly contribute to forums in relation to drug testing methodology, the sites where they are looking at, whether there are safe mechanisms for use and what the implications are for law enforcement, the availability and working with our national data collectors to ensure we are providing seizure, arrest data and having that correlated across user data self-reported and coming from other areas, then the waste water and what have you.

The harm reduction across all of those will be—for example the assistant commissioner spoke to looking at amending a component of the *Misuse of Drugs Act* to increase the drug declared area. The harm reduction component of that is to increase the capacity to identify and intercept that illicit substance, but it would also be about the connections with Health, treatment providers or referral services. No mechanism is done in isolation. We would not look at it from a supply-only perspective, but as how we can reduce that harm.

We are looking at prevention, treatment options and other pathways that can be considered. It is particularly important for us given the size of our jurisdiction. Whilst the landmass is quite impressive, the fact is it is still a very small population so those strategic partnerships to ensure that is the underlying policy is critical.

Mr KIRBY: Just about the understanding of the constrictions faced in the Territory, as far as those harm reduction strategies go, is there anything your department would particularly like to do that we are not able to and would have a significant affect or improvement? It is broad.

Ms LANGRIDGE: It is.

Commander WURST: Yes, it is. A couple of things in the here-and-now—the waste water analysis has told us that per capita we are leading Australia in much illicit substance use. There is an issue in relation to the ongoing funding for that process. We have found that is a valuable tool to inform our business. It also informs government. It assists Health in their understanding of what the issue is in the Northern Territory.

Currently we are only sampling two sites, Ludmilla and Alice Springs. Other sites could be sampled. Of the four tests that have been conducted thus far, we have only participated in three. The first, third and fourth. There is a challenge going forward regarding funding. It is an ACIC-delivered project that is only funded insofar as the scientific examination and then reporting. It is not about the collection. The collection is an issue for us because of our infrastructure; it is expensive.

That will be a challenge for us. To be frank, we need this to continue because it shows if we are having an impact, where it is occurring and if it is occurring the way we think it is, that squeeze and bulge or if it is popping up in other locations. At the moment, the

data we have is specific to the CBD and Alice Springs so it does not give us data around Palmerston, the rural area or any remote location in the Northern Territory.

Ms LANGRIDGE: Around the waste water I will reinforce—I think this goes back to your earlier question regarding substitution or the difference changing. The other issue we face is that a lot of the user data is based on self-reporting. Most people do not tell their doctors how much wine they drink or cigarettes they smoke. Illicit drug users are no different. Some with the best of intentions may be underreporting and do not necessarily always know what they are taking, particularly those taking synthetic substances or what they think is MDMA but may be something else. The waste water is critical for resetting some of those assumptions around what the user data is telling us as to what the size of the problem is.

As the assistant commissioner spoke to, the rates that were being seen in the waste water were unexpected. That is a clear indicator there are cohorts of people engaging in high levels of illicit drug use but not coming to the attention of police. The drug market cannot be solely based on the offence seizures alone. Waste water is a critical component to start filling some of those gaps and tell you exactly what type of problem you are looking at.

Mr CHAIR: So you are saying there are two sites currently being used in the Territory. How often do they take samples from them?

Commander WURST: Quarterly.

Ms PURICK: To add to that, they are then missing a big chunk of the top population because the rural area is all on septics.

Ms LANGRIDGE: Indeed, the other issue was …

Commander WURST: That is out of scope, unfortunately.

Ms LANGRIDGE: This testing …

Commander WURST: That is out of scope unfortunately unless you want the job to dip sample everyone.

Ms LANGRIDGE: The other issue with that too was that the funding was made available in relation to methamphetamine strategy, so cannabis has been excluded. If you look at South Australia which has been running a wastewater testing regime for many years theirs comprehensively goes across pharmaceuticals, cannabis of which they do share a large market of demand. Whereas, the national wastewater has actually been silent on what is more and more an issue.

Mr CHAIR: Is there anything else you would like to say?

Commander WURST: The things we want are ongoing legislative reform. Something we have not discussed today is fentanyl and carfentanil which is a substance that is on the rise. Certainly, it has taken hold in Europe and the US. Fentanyl or carfentanil it is an opiate that is 1000 more times potent than morphine. Where I am going with that is we need to regularly look at our scheduled substances within our act in conjunction with health because health actually own the act and make sure it is up to date so we can manage the ongoing changing so societal behaviours.

Ongoing consideration of the penalty structure, the punitive aspect of this—we have the judiciary support currently around, and the current chief justice has set some particular tariffs in relation to drug suppliers and that is very important for us because we sort of know where we are going and what sentence people are going to get, and as that permeates in to the community, the drug community particularly, that creates a greater deterrent effect as well. Specific and general deterrence as the courts try and achieve.

Ongoing tools for us we talked about the drug declared areas—legislative reform around expanding that scope in to other transport modes as indicated and we have provided paper work for that previously. When you see that you will have a greater understanding of why.

Managing outlaw motorcycle gangs—we have some legislative frameworks at the moment that are no longer applicable to our business and they are not viable in our current environment. We are looking at anti-association scenarios similar to other jurisdictions around managing those individuals in our society and the impact they have across all sorts of illicit behaviour, including the supply and distribution of illicit substances in our community.

Mr CHAIR: Thank you all very much for your time. It has been very informative.

The committee suspended.

ATTORNEY-GENERAL AND JUSTICE

Mr CHAIR: Welcome everyone. On behalf of the committee I welcome you all to the public briefing into reducing harms from addictive behaviour. I welcome to the table to give evidence to the committee the following representatives from the Department of the Attorney-General and Justice, Anna McGill, Director Policy and Strategic Planning, Licensing NT; Carolyn Whyte, Director of Criminal Justice Research and Statistics Unit; Dr Natalie Walker, Acting Deputy Director Offender Services and Programs, NT

Correctional Services; Ros Lague, Director Programs, Services and Improvement, NT Correctional Services; and Leanne Liddle, Director of the Aboriginal Justice Unit.

Thank you all for coming before the committee. We appreciate you taking the time to speak to us and we look forward to hearing from you. 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 briefing and is being webcast through the Assembly's website. A transcript will be made available for use by 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, please make us aware. We can look at going into a closed session and take your evidence in private.

Could each of you please state your name for the record and the capacity in which you are appearing?

Ms WHYTE: Carolyn Whyte, Director of Research and Statistics.

Ms McGILL: Anna McGill, Director of Policy and Strategic Planning.

Ms LIDDLE: Leanne Liddle, Director Aboriginal Justice Unit.

Ms LAGUE: Ros Lague, Director of Program, Services and Improvement with Correctional Services.

Ms WALKER: Natalie Walker, Acting Deputy Director of Offender Services and Programs for Northern Territory Correctional Services.

Mr CHAIR: Thank you. Would anyone like to make an opening statement? You can each make one if you like. Nothing in particular? We have a series of questions we have gone through and will run past you. As I said, if they lead you to another area, that is fine and may lead us to other questions.

I will start where we finished with the police who were before you, about diversion programs. Can you provide an overview of drug diversion programs run by each of your departments but in different areas, and include pathways into diversion programs, interface with police, eligibility criteria and the extent to which referrals are governed by guidelines or discretion of officers?

Ms WHYTE: Have you asked part of the question?

Mr CHAIR: The extent to—do you want the pathways?

A witness: (off mic – inaudible).

Mr CHAIR: The last one was the extent to which referrals are governed by guidelines or discretion of officers?

A witness: (off mic – inaudible).

Mr CHAIR: Yes.

Ms LAGUE: Good morning. I will do my best. From a Correctional Services perspective within the Attorney-General and Justice, we see ourselves as part of a justice continuum. Matters will start coming to the attention of police, be fed through the court system, with due process being applied with then offenders being referred through to Correctional Services.

Those referrals can take the form of a community-based order—sorry?

Mr KIRBY: Sorry. Sandra texted me before saying people are speaking softly and she wanted to hear.

Ms LAGUE: Sorry. I spent my childhood being told, ‘Everyone is in the same room, be quiet’.

Those referrals to Correctional Services may take the form of community-based orders supervised by Community Corrections in community or they may take the form of custodial orders, which then commence often within a correction centre and may then transition through a probation period back into community supervision, or in fact cease with the completion of their custodial supervision order.

In the pathways through to diversion, we look to—when an offender comes into custody or under the supervision of Correctional Services, assessments are done. They are informed by the sentencing remarks and orders of the court. Sometimes in those sentencing remarks we may receive guidance from the court in suggestions to different programs or matters that should be addressed in offence—based programs. In the community orders, we may also tap into and refer people across to community-driven programs. They are under supervision in the community, so we will tap into community services for those.

In addition to that, pursuant to the funding we receive for commit, we have also secured and funded additional beds in organisations such as Venndale—they are existing community-based alcohol and drug rehabilitation services. We fund additional beds for people who are serving orders to then receive those services. We are not competing for the same skills set or against each other for those clinical services, we coordinate things together.

We work closely with the police and courts in the remarks and sharing of information that comes in. We also will provide assessment reports and pre-sentencing reports to

the courts for an offender, based on different assessments or histories we have and are aware of.

In the offence-based programs, Correctional Services will provide offence-based treatment programs—those programs that are targeting the nature of the offending behaviour, having an offender identify or recognise their offending behaviour, the consequences or the victims that result, as a result of that. We work with them on addressing or identifying alternative strategies—things they could do differently next time—different decisions they could make or different skill sets they can have.

With all of our assessments, we apply what we call the risk needs responsivity matrix. That is a recognised national—indeed, probably international—tool. It identifies eight criminogenic risk factors. They are internationally recognised factors they believe significantly contribute to someone's offending behaviour. We then look to the programs we provide for offenders, based on those offending behaviours and strengthening in responsivity to those risk factors in community.

Mr CHAIR: When you talk about those types of factors, most of those offenders would be involved in other criminal activity, other than simply use or possession of drugs?

Ms LAGUE: Yes, it could be a range of behaviours. It could be an offence that is committed that might be a violent offence, but you might have an offender who is under the influence of alcohol or other drugs at the time of that offence. Necessarily, when we are doing that assessment, we may identify, for example, that offender will be offered and participate in a violent offence-based treatment program and they may also be involved in an alcohol and other drugs program. An offender may do a couple of programs.

Generally what we find when within Correctional Services within programs that we offer we will cross across and make sure that all of the programs usually include an element of working through drug and alcohol impacts because of the prevalence in offence related activity.

Mr CHAIR: Somebody raised with me at one point the difference between offenders who have other criminal activity as a result of their drug addiction or drug use and then you have a different category—the criminal activity is the prime responder and the drug use generally comes from the criminal activity. Do you identify people in that sort of way?

Ms LAGUE: Usually our assessments—when we are working through that is quite a detailed assessment process and we will either look at the co-mobility factors or alternatively we might identify that one factor is stronger and leads to a consequential factor.

Across the board though, what we do with our programs is endeavour to actually work on those factors. For example, the Correctional Services programs will work on the offending behaviour in identification of the offence based behaviour. What we will then do is work with Department of Health, for example, on things like treatment programs that might be more around the addictive behaviours. Within the correctional centre the Department of Health actually receives funding directly to provide health services within the correctional centres. Department of Health provide clinical services, forensic mental health services and others.

Mr CHAIR: What about the others? Corrections are obviously getting people after they have been charged and convicted and gone through the system. What about other diversion programs to try to stop them actually getting to that point?

Ms LIDDLE: I can talk about something that we are going to be offering next year. It is quite unique and that is a result of funding that we received from the Northern Territory Government—$5.5m over three years. It is a purpose built facility, it is going to be placed in two locations. One out of Alice Springs and one in Arnhem Land.

The one in Alice Springs is an already established facility. The one in Arnhem Land we are currently working with parties to build that facility, but it is a purpose built facility where clients will be able to go to receive, firstly, assessment of medical needs and assessment of cognitive and other disabilities from areas around FASD for alcohol syndrome, cognitive disabilities and address trauma historical and current—all those issues that influence a person's criminogenic factors.

Then we will be looking at tailoring and targeting rehabilitation programs that actually target the offender and the client or who is a client but also their family as well in a package type, almost case management type arrangement, almost similar to a work cover type of model where people can received competent and targeted rehabilitation that will enable them to complete the programs and be able to return back to communities because these facilities are specifically for Aboriginal clients—most from remote communities so that they have no reason to reoffend.

The length of time that people will stay in the facility will be dependent on their specific needs and their achievements and progress. It is a unique space in that we are involving the family units so it may require people to do overnight stays back at community to test the levels of resilience, to test the levels of impulse control. Realistically, they are some of the programs that communities have been telling us are missing out of our 80 plus consults that we have done across the Territory so far to work out why Aboriginal people are the highest numbers people within our prisons in the Northern Territory.

This is based on data we have collected and has been analysed by our statistics section, Ms Carolyn Whyte at the other end of the table. We see this as a significant step in the right direction to address some of those holes people are slipping through.

We hope to have this in place by at least mid-next year, the one in Alice Springs. The one in Arnhem Land will take some time. The cohort of clients is quite different. The one in Alice Springs will be looking at Aboriginal female adults. People can be self-referred, deflected out of the courts or prison system. It is intended to not be a prison. It will be run by a non-government organisation under the control and auditing requirements of correctional services.

There will a high level of use of electronic monitoring and other requirements from compliance and auditing of court orders and so forth. This is an opportunity for people in their early stages of offending—all those at risk of entering the criminal justice system—to turn their lives around and have a unique opportunity to achieve that.

Mr CHAIR: That is what I was going to ask further on.

Ms LIDDLE: Just adding to that, we are not working on this alone as the Department of Attorney-General. We have been working closely with a whole-of-government and NGO approach. We are working closely with the Northern Territory Police and the Department of Health. Aboriginal people are not accessing some of the programs on offer. They have identified to us why people are not accessing those programs. This is addressing some of those concerns.

Mr CHAIR: We heard before about cannabis use in remote communities. Will this sort of facility be able to deal with young users first and foremost?

Ms LIDDLE: The issue around access and who the client target group will be, at the moment, we are looking at Aboriginal females in Alice Springs. The decision has not yet been made for the one in Arnhem Land. There has been discussions about young offenders. It is really based on the profile and data we collect from the regions to see where the greatest need is—the need to have success in this space.

Ms Whyte will be able to explain the current profile and picture in the Northern Territory with clients in the addictive behaviour space, which may be helpful.

Mr CHAIR: Sure, that would be great.

Ms WHYTE: Some of the types of data available that indicate the involvement of alcohol and drugs, when police file an apprehension report for arrest or summons, they can flag it as involving a particular substance—alcohol, drugs, some other substance or nothing. That flag only takes one value. In discussions with police, they have indicated that where there are multiple substances, alcohol is usually the one preferentially indicated.

That is one way we can identify the involvement in a substance in an offence. For instance, if somebody has committed an assault, which is not necessarily substance-

related, police can flag that apprehension as involving alcohol or drugs. For any apprehension, the types of offences are also recorded. The types of offences may indicate that alcohol or illicit drugs are involved. For instance, high range drink driving involves alcohol whether or not the flag is there. Using of possessing illicit drugs, drug trafficking, those types of—we know they will involve drugs.

Also, the charge wording for illicit drug offences usually mentions the type of drug involved. That charge wording is a text-based field. The drug name is copied and pasted in. Sometimes it is a common name like cannabis, sometimes it is quite a long chemical designation. You have variations—methamphetamine, methylamphetamine et cetera. That is not categorised and I believe that is quite a difficult area to standardise also, due to the rapid evolution in drugs, drug analogues, et cetera.

For that, we also know the offence location and the date of the offence. So, we can track that. Over time, you can identify it down to place. I think that is what Leanne was getting at—we can identify the main types of drugs for which there is an apprehension record established which is different than what, perhaps, the drug use monitoring survey might return.

We also have data on court appearances, the court orders that are made, whether people get bail or remand, they end up in the corrections system. Then there is a lot more data available on drug testing for people who are in community and the types of programs that people are participating in. We have data available on a lot of the things that Ros mentioned.

There is also a bit of information—when a person is received in custody there is an immediate risk needs assessment questionnaire completed. Some of the answers there also relate to the involvement of substance—in other words, was the person under the influence of particular substances when the offences were committed. There is another set of questions: was the person committing the offence to support a habit of substance abuse. That is something we would not normally see in any of our other data. It is prisoner self-reported, so you have to take it with an element of caution. That is also data we have available that can be reported over time.

Ms McGILL: It is not directly relevant to your question, but it is probably worth noting the information I am able to bring to the table is not necessarily related to the referrals from corrections systems.

Licensing NT administers funding programs that are primarily focused on gambling-related activity and addictive behaviours relating to that service or activity. So, the referrals or programs we fund through the statutory Community Benefit Fund are not precisely linked to correctional activities. The way we receive reporting will not necessarily link it to correctional offences or involvement in the corrections system. But it gives some context to the information I am able to bring to the table today. It is more in that gambling-related activity space and the amelioration and research we are able

to do, as opposed to some of the other things my colleagues are able to bring specifically about drug and alcohol and correctional activity.

Mr CHAIR: What sort of programs are run for gambling?

Ms McGILL: Through the Community Benefit Fund, which is the statutory fund established under the *Gaming Control Act*—the purposes of that fund include provision of funding to programs—we refer to them as amelioration programs but it is about treatment, intervention as well as community awareness for people experiencing harms with their gambling activities, or people associated with those who are experiencing difficulty with the gambling activities.

We fund a range of organisations that provide either direct interventions or public health and educational programs. Some examples are Somerville Community Service, which is a financial counselling provider, Amity Community Services are funded for a harm minimisation and education program which incorporates not only direct interventions—face-to-face interventions, phone interventions and a range of other types—but they also deliver a range of community education programs and training with industry to help support industry to better comply with a code of conduct relating to responsible gambling.

In this most recent round of funding, there is also Aboriginal Resource and Development Services, which has been funded to develop some specific Yolngu gambling dialogue educational material. There is a range of others. Holyoake Alice Springs is the other direct intervention provider in the Central Australian area that provides support for gambling-related harms. Those supports are provided to people experiencing difficulties in managing their gambling activities, but also families who are affected and harmed as a result of those activities.

Mr CHAIR: Is it all self-reporting? How do people get into the programs?

Ms McGILL: A lot of it is self-reporting. Recently, following a pilot program that was undertaken by Amity in relation to a cross-venue self-exclusion program—we have moved to more of an industry-supported program. Through that, individuals will be able to self-exclude from venues where they are having trouble with their behaviour. That process will also allow a referral to an amelioration or treatment provider to assist with that. In the past Amity has worked with GPs and health clinics to be able to increase awareness of services available for gambling-related harms.

At the moment we have a research project under way called the NT Gambling Project, which has picked three Aboriginal communities—two in Central Australia and one in the Tiwi Islands—to look at the range of harms associated with gambling activities and looking at developing public health promotional responses and integrated service delivery across a range of different agencies in response to those harms.

That project is due to finish in August of next year. We hope there will be some interesting learnings about how we can improve integrating responses to gambling-related harms and improve our understanding of those things.

Mr CHAIR: Do you think self-reporting is getting to enough people or are there better ways of—responsible service of alcohol puts obligations on servers. In gambling venues are there …

Ms McGILL: There is a gambling code of conduct that relates to responsible gambling. Part of that is having people within venues being aware of what we refer to as red flag behaviours. There are certain types of behaviour that may be displayed by individuals and may suggest they are having some difficulties in managing their behaviour. Training is delivered through Amity to support venue staff to interact with those people and then allow them to provide information about different service providers.

One of the other research projects under way, funded through the Community Benefit Fund, is a review of that code of conduct or practice. The review is being done externally so we hope there will be some improved learnings regarding that code and changes to the way it operates. It will improve the ability to have an interaction in an empathetic way with someone who may be having some difficulties managing their behaviour and how we get more effective referrals and uptake regarding taking action to gain control over those.

Mr KIRBY: Is that specifically related to staff for those education programs at the moment?

Ms McGILL: The education programs delivered by Amity include community programs, particularly through this month. They have run some different programs to raise awareness about gambling behaviours and what may constitute—or where people can identify if they are having some difficulties, if their family members are having difficulties with their gambling and how they can find support.

Amity also provides specific training to venue staff to help venues comply with their obligations under the code of practice around identifying potential problems and having an interaction with those venue clients to be able to give them information about referral services. Amity's program covers venue staff as well as the community more broadly around improving awareness around gambling activity and what might constitute harm.

Mr KIRBY: That helps answer the next part of my question, which was going to be around whether it is just through self-acknowledgement, is there a system for family members—because sometimes that is how it comes to us as local members. Somebody puts their hand up as needing assistance. When you contact their family, you find out it is because of a gambling issue or another problem.

Ms McGILL: Those people are certainly able to get assistance through Amity, Holyoake and Somerville for example. There is also a website call Gambling Help Online. It is an interactive website chat ability with online counselling as well as a phone service, and that website is funded through the CBF. It is a national resource, but that also has some excellent resources for family members, not only about identifying possible harms or possible behaviours which might indicate that there is some difficulties with managing behaviours but also resources in terms of how do you have a conversation with family members to raise the issue or where can they go to look for some more information and more assistance. That is certainly a very useful resource that is available to Territorians.

Ms LAGUE: If I may add, it is something I probably neglected to also say earlier—within the correctional space often when we are working either doing our clinical assessments with people or alternatively through the programs that they are engaged with within the correctional centres, they may also identify gambling as a problem. We will then also tap in to the services that exist. For example, Amity may visit the prison provide services to people within or again through community corrections that we supervise in community, we will do referrals across to participate in those types of programs.

Mr CHAIR: The diversion programs through the courts—before it gets to you—does anybody have any knowledge about the drug diversion programs—so at first instance?

Ms LIDDLE: That is probably a Department of Health issue that needs to be directed to them.

Mr CHAIR: Okay. We have a whole lot of questions that we have touched on as we have gone through. Does anyone want any clarification of any of those in particular?

Mr KIRBY: A broad question—you mentioned data—your access to data and the ability for sharing of data between groups. Is that something that needs to be improved on or would there be significant gains from improving that? Or do you have access to the info that you need at the moment?

Ms WHYTE: Within the Department of the Attorney-General and Justice, my team will access the administrative data from the courts process, starting where police make an apprehension because that is also the start of the court process and then going through in to the Corrections space—we have access to our administrative data.

We also do some work for police on the publication of the crime statistics. We get a regular feed from them on the offence statistics that they record. In terms of data sharing, more broadly, I understand there is work happening now on an open data sharing framework with NT Government agencies, but there is no set change at this stage in terms of how data is shared more broadly.

Mr CHAIR: This probably continues on matters and to some degree what the police were saying at the end of their section. We have reviewed a number of data reports and tables on illicit drug use. Some are at a national level and some are more specific to the NT.

We note there are significant limitations to the data sets in terms of establishing scale and trends of illicit drug use in the NT. What NT specific data reports and tables are available from A-G and can the committee access those?

Ms WHYTE: We do not have a set of published data that we are currently releasing relating to illicit drugs but I have prepared some material that will eventually come in our submission in terms of the types of information that we can prepare on request, say for the committee or for an evaluation.

Some of the information takes quite a long time to prepare so it is not done on a general basis all the time, but it is certainly available for evaluation or for work like Leanne or when Corrections are doing some program analysis or things like that. I do not know if you care to have this now or …?

Mr CHAIR: We are more than happy to have a copy of it now. Thank you.

Ms WHYTE: What I have done is provided some charts on patterns of apprehension. Again, in the criminal justice system, we are looking at the level of crime which is known and detected—either in the police offences that they have recorded. In the justice system it is where an offender has been brought into the court system or perhaps given an infringement notice.

It may differ in trends from things like the waste water survey which is getting at a broader issue of use. We only look at what we know about. There is how much is not being detected. That happens with other areas of crime as well.

In what we know about, we can look at the individuals—the characteristics of people who are being brought before the courts for different types of drug offences—whether Aboriginal, non-Aboriginal, adults or youth. This is for people charged. This is not including youth who are diverted out of the system, but where they are actually charged with a drug offence.

We can look at the type of drug, to an extent. I mentioned earlier that there are some challenges with the type of drug. But cannabis, methamphetamine, all other types of drugs would be the three main categories. I have provided a couple of charts there, looking at that over time.

We can also look at those type of offences by whether a person is Aboriginal or not. I have provided a couple of charts. One shows that for cannabis offences that has been a more frequent offence type for Aboriginal defendants. Methamphetamine is a much

more common type of offence for non-Aboriginal defendants. There are some changes there that can happen.

We can look at that by region of the Northern Territory—the same types of regions we use for our crime statistics. We could say the number of apprehensions or offences recorded in the Darwin area in the Northern Territory balance and break that down further in, say, the Arnhem region or Barkly region, that sort of thing, Alice Springs, Tennant Creek et cetera.

Mr KIRBY: Sorry.

Mr CHAIR: Yes, go.

Mr KIRBY: Quickly while we are talking about that data, all of those early graphs show a drop-off in 2016-17. Is that easily explained here?

Ms WHYTE: The reason behind that would be better—we discussed that with police in their views, since it is being driven—especially the apprehensions—directly from their data. Yes, there is a noticeable decline in apprehensions over the last year.

Mr KIRBY: Yes, that is all right. I wanted to check it was not through a change in the way the data was collected or anything like that—it is a genuine drop.

Ms WHYTE: I am not aware of any changes in the data collected. Yes, any type of statistic will be dependent on police focus and that sort of thing.

Mr CHAIR: It is all those cashed-up INPEX workers leaving. Do you have any statistics you are aware of on incarceration rates of users of drugs?

Ms WHYTE: Let us see. On the last page of …

Ms LIDDLE: You do not have this page—oh, you have?

Mr CHAIR: That one?

Ms WHYTE: Yes. There is a count of individuals imprisoned for a serious offence involving illicit drugs. That is a count on the last day of each month over the last five or six years. The first chart shows by Aboriginal and non-Aboriginal. For the offences that are leading to people being incarcerated, non-Aboriginal people are the majority there.

Then the second chart is by sentenced and non-sentenced individuals.

Mr CHAIR: But does that include another offence as well? I am sort of …

Ms WHYTE: This is where they have a most serious offence involving illicit drugs. That may be their only offence or they may have other less serious offences …

Mr CHAIR: Oh, right.

Ms WHYTE: If, say, their most serious offence is homicide and they also have a drug offence, we categorise those with the most serious offence of homicide.

Mr CHAIR: Okay. But this could be trafficking as well.

Ms WHYTE: Yes. This is where the drug offence itself involved illicit drugs. Not say an assault committed under the influence of drugs, but supply, possession, trafficking—those sorts of offences.

Mr CHAIR: Are there any other questions?

Ms NELSON: I am not sure if this is the right time to ask or not, to the Department of Health. Is there a multidisciplinary drug rehabilitation centre that addresses both the drug or alcohol and gambling addiction?

Ms McGILL: It is my understanding that there are generally funded for purposes. While I think there is a strong likelihood that someone being treated for a gambling addition through one of the programs we fund through the CBF, they also may be dealing with a comorbidity issue around drug or alcohol-related issues. I do not think we are aware of any one-stop shops regarding gambling. I do not think it is dealing with all those issues concurrently.

Mr CHAIR: We have a question from down the back.

A person in the audience: Just on that point, how many community services (inaudible) patient services. They have (inaudible).

Ms McGILL: The issue there would be that the funding is separate. Notwithstanding that, they do. There is probably a way they are able to approach clients in a similar way with similar programs and tools to help them work through their behavioural issues. From a funding perspective it is separate so they probably record things slightly separately.

Mr CHAIR: Anything else? Thank you all for your attendance. It has been informative. Thank you very much.

The committee suspended.

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DEPARTMENT OF HEALTH

Mr CHAIR: I welcome you to this public briefing into reducing harm from addictive behaviours. I welcome to the table to give evidence Ms Cecelia Gore. Thank you to 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. It is a public briefing being webcast through the Assembly's website. A transcript will be made available for use by the committee and maybe 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 the committee to go into closed session to take your evidence in private.

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

Ms GORE: My name is Cecelia Gore. I am the Senior Director for Mental Health, Alcohol and Other Drugs Branch for the Department of Health. I am here on behalf of the department to provide information to the committee.

Mr CHAIR: Thank you very much. Ms Gore, would you like to make an opening statement?

Ms GORE: To frame this, the Department of Health will be making a written submission, but we felt it was important to be informed by the things the committee was interested in prior to finalising that. I will be taking your questions as part of our guidance as to what we should put in writing.

The overall approach of the department is that we welcome this inquiry. We have lots of programs that demonstrate our commitment to harm reduction and harm minimisation. It is useful to put some of that evidence into the record. We are very happy to talk to whatever questions you might have.

In the things which have guided the things I have prepared, with the support of my colleagues, we have information about existing NT frameworks for reducing harms, which includes legislative frameworks and existing harm minimisation initiatives. We have addressed some of the issues of what data we can access, some of which is through the national processes, and some is collected locally through services.

There is information about where we are currently funding treatment services and interventions for both adults and juveniles across different settings, a range of different system modalities, including residential treatment, coordinated programs and continuing care, then trying to address the committee's questions about what emerging issues there might be and what some possible solutions to those are, and the interface between prevention initiatives, including demand reduction and what we can do to reduce harms. I am happy to talk to any and all of that.

I was also going to say that the only piece of paper I was planning to give to the committee this afternoon was an extract from the National Drug Strategy and the draft National Alcohol Strategy because they describe the governance relationship and that was one of the questions. What is the interaction between the Commonwealth and the Territory? If I could bring that to your attention so we can decide if it is of interest or not.

The first page outlines various governance structures that currently inform national approaches to reducing the harms of drugs and alcohol. There is a Ministerial Drug and Alcohol Forum and the National Drug Strategy Committee. What characterises those two bodies is they are joint Police and Health representatives. The law enforcement and Health response happens together. The NDSC oversees the development of the National Alcohol Strategy, the tobacco strategy and a range of other groups.

The second page of your handout describes the National Drug Strategy at a glance and talks about harm minimisation being made up of —demand reduction, supply reduction, harm reduction—and then the strategic principles. For us, we would say that NT strategies have been embedded and followed those clear structures and evidence-based approaches in this area.

For your interest, the National Alcohol Strategy, which is still a draft—we are hoping for it to be finalised by the end of this year. It also has an at-a-glance lovely piece of graphic design. It puts this stuff together as a holistic approach where promotion of healthy communities, improving community safety and then responding to harm and the system response of supporting individuals. All four of those things are necessary. That is how the Territory has framed its Alcohol Harm Minimisation Action Plan, in those domains of action.

We are aligned with national processes, which is useful in terms of learning from our interstate jurisdictions. In some areas, we are leading the way, which is good as well.

Mr CHAIR: We have a series of questions we developed. They have a tendency to lead into other areas and you will find that you answer other questions or we end up with similar questions. I will kick those off.

Regarding the frameworks and strategies, does the department have a current alcohol and other drugs strategy? If not, when did the last one expire and what work is being done to the new one?

Ms GORE: There is an old alcohol and other drugs strategy. My understanding is that it was dated from 2015–18. In the last two years since the change of government in 2016, a large amount of effort put into commissioning, for example, the Alcohol Policies and Legislation Review. That has guided the work of the department to date.

I think following the Alcohol Harm Minimisation Action Plan release and its progress report, we may continue the work towards developing a separate alcohol and other drugs strategy for the Department of Health. What we are seeing, as evidenced from other jurisdictions, is that a whole-of-government approach to reducing harms is probably a more useful document.

The other work that has emerged since the last strategy was written is the rise of the NTPHN as a commissioning body for services as well. We are keen to work alongside them to make sure all sectors are adequately represented before we get to the next strategy, if that makes sense.

Mr CHAIR: Sure. Has the department developed any other strategies, action plans or programs in relation to illicit drugs?

Ms GORE: The other existing strategy is the ice strategy, which came out of the Select Committee and then the National Ice Action Plan, I think that one is 2015 to 2019, so it is still technically current. We are not developing further strategies and plans at the moment.

Mr CHAIR: With the work that is going to alcohol what is the department's harm reduction priority areas for 2018–19?

Ms GORE: Sorry, could you say that again.

Mr CHAIR: What are the department's harm reduction priority areas for 2018–19?

Ms GORE: The overwhelming priority for harm reduction is alcohol related harm. It represents the largest burden on the Territory both economically and socially and the work that is occurring there is detailed in the Alcohol Harm Minimisation Action Plan, which I will not go through in detail.

The other area which is of most emphasis at the moment is the work around volatile substance abuse. The Territory is quite unique in that we have a piece of legislation which no other jurisdiction has, and it is a very comprehensive harm reduction piece of legislation, which does not criminalise use but looks to work in a prevention, community development and enforcement of supply restriction way.

It is an area, however, where we see occasional break throughs of activity and so at the moment we are working with communities where there has been some recent activity to look again at what is the best form of treatment programs and intervention program.

We have very good models in Central Australia of prevention and community engagement. They are less well developed in the Top End, but most importantly, is that we really need to examine our system capacity to respond when people need actual interventions. We are doing some work at the moment with communities, engaging with community members, with community controlled Aboriginal organisations, with the health services and other departments to work out what is the best way to build capacity to address these issues.

Mr CHAIR: So they are local community based responses. Have you used those in any other areas other than volatile substances—that is petrol sniffing—have you looked at broadening that, the use of those sorts of …

Ms GORE: Yes. There has been some other initiatives happening in the Territory in the last 12 months through the Alcohol and Drug Foundation. They have been rolling out what they call LDATs, Local Drug Action Teams, where local communities can come together and say they would like to as a community work on whatever the issue of concern is.

They have a range of different funding rounds. About May this year they announced that they had funded an LDAT in Palmerston and one on the Tiwi Islands based in Wurrumiyanga. That is a small amount of money which allows community members and services to come together to come up with a plan of action for a set of local issues. We support that and our health services get involved in it.

In terms of other action plans or things which are going on we have through our remote workforce—they often will bring people together to plan what ended up being called Alcohol Action Initiatives, which they do not have to be alcohol specific. They are designed to try and address the reasons that people might make unhealthy choices, which obviously impacts across a range of substance use, particularly for young people.

There have been about 200 of those projects commissioned in the last three years. Some of them are one-off events, some of them are a program of activities over the school holidays, but they are designed to allow communities to say—the biggest thing that is bothering us at the moment is FASD so we want to educate our teachers and young people about that.

Another community might say we have a large group of young people who are getting in to smoking marijuana and behaving badly. We would like to get them some culture camps happening.

We provide a base of—these are things we know work and what do you think would work in your context?

Mr CHAIR: Giving them flexibility for them to adopt what they think would work and what capacity their community has to deliver or to bring people in to help them. They are the kind of approaches …

Mr CHAIR: Okay. And reporting on those? Where will we find that?

Ms GORE: The project descriptions are on our website so people can have a look at what kind of projects there are. Then we also report through to the Commonwealth—the Australian Government because those programs are part of the National Partnership Agreement—on how they have all gone, what outcomes we are seeing and recommissioning for the next round.

Mr CHAIR: Okay, good. Anyone else want to ask any questions?

Ms NELSON: What is the Department of Health's involvement when people are in front of the court and they are being sentenced? Are you guys involved in that whole process? Is there anyone present in the court—that sort of thing?

Ms GORE: No, not directly. The first thing I need to say is that within Health, the department behaves as the system manager and commissions services. Then the specialist AOD services are provided by Top End Health Service and Central Australia Health Service.

They do not routinely have clinicians sitting in the courts. The usual process would be that the court would refer a person who is before them to either of those two services for assessment and recommendations.

Over time, there have been different models that have been tried for that. One of the things we would say that attracting appropriately qualified skilled clinicians into the Territory and retaining them has been difficult. Having a clinician sitting in the court waiting for a 'maybe this might happen' is not the best use of resources.

But courts do make referrals to those services and assessments and reports can be provided for the court's consideration.

Ms NELSON: Are people assessed when they are picked up by the police? Are they assessed at any time before they actually go to court? Is there any …

Ms GORE: In their suitability for therapeutic programs, I do not think it is a routine part of what the police do. Sometimes …

Ms NELSON: I know it is not what the police do, but is there a process? If I am picked up and am high on whatever, and they take me to gaol for the night and the next day I am told I will be charged, so I need to stay in gaol, is there an assessment that happens between the time I am picked up and when I go to court and am sentenced?

Ms GORE: The police would do an initial risk assessment about your safety if you have been picked up while you are under the influence. But after that, it is very much up to the—no, it is not a routine part, it would be up to your lawyer to make that suggestion that that should be something that happens before you are heard. Separating the two things, someone's physical safety around their drug use, then whether that is a mitigating factor to any sentencing is an issue for the courts.

The services will accept referrals and undertake assessments and provide a brief, if you like, about someone's suitability, but it is not a routine service.

Mr KIRBY: You mentioned clinicians not being available for some of those proactive assessments throughout the Northern Territory. In the larger centres, as well as remotely?

Ms GORE: What I am suggesting is we often have periods of workforce shortage. It is not that they are not available—this government has made a significant investment in increasing the availability of clinicians and the resources to have them do assessments. It is just having enough workforce to fill all of the vacancies.

We have in the Territory what is called the remote AOD workforce. It is, again, funded under the National Partnership Agreement. There are about 59 staff are employed through a range of either Aboriginal community organisations or the health services to work in the most remote communities. They are often people from those communities—I think their workforce is about 98% Indigenous. Their ability to go out into communities and see people face-to-face and talk to them—we have pretty good coverage. It is more in the psychologists, addiction specialists, the more medical qualifications end of the spectrum that we struggle often to keep and hold in the workforce in the Territory.

Mr CHAIR: You alluded to the national ice strategy—which I guess is probably concentrating a bit more on the urban side of things through Darwin, Palmerston, Alice Springs and other areas. Are there other jurisdictions that you know of that are having good health outcomes that we do not have available or access to as yet? Are there things we would like to be doing up here that we have not been able to start yet?

Ms GORE: Not to my knowledge. We do not have a long increasing line in methamphetamine use. It is still is only about 14% of what we know about illicit drug

use in the Territory. We would say that most of our treatment services are well equipped to manage ice as a substance abuse, because it is often in combination with other drugs anyway.

Obviously, we can always increase staff training. Where there is a complexity of behaviours that is an issue. Overall, our biggest gap is prevention. We are not being able to invest as much resourcing into the prevention and demand reduction side we would like to be able to see. That is across the board of all of our drugs of concern.

But I do not think we are failing to offer appropriate treatment in the Territory. We are, for the population we have.

Mr CHAIR: What do you think are the most effective means of prevention and demand reduction?

Ms GORE: People who have lives filled with purpose, meaning and hope.

Mr CHAIR: Okay, we have that answer.

Ms GORE: What we know is that where people have employment or are in education, they are less likely to get into difficulties with drug use because they have competing priorities. Focusing our attention on the ways that people can connect with their communities, how we ensure people have cultural connections which are positive for their resilience, and then meaningful employment, appropriate training, opportunities to do things that matter are our biggest levers.

Then, post that, yes, we need to educate people about making healthy choices and what the harms of drugs specifically are. There is a step before that, which is that people have to value themselves and their communities enough not to just throw that all away.

Mr CHAIR: Is that on use generally, or addiction—taking that extra step towards misuse or abuse?

Ms GORE: Yes, I think the framework of addiction—and there are many. The one I most reference is the one which is the person, the substance and the context. Drug use in and of itself does not necessarily need to be harmful, except for cigarettes, because there is no safe cigarette use. Where people are then using substances where they lose control—which would be another way of defining addiction—the substance itself is not powerful enough. If that was the case, it would get everybody whoever used it. So, it is an interplay between the person and the substance and their context.

If we can do some more work on the context, we have more likelihood of then addressing some of the individual factors that someone might have that makes them more likely to be addicted—if that is a helpful way of using that term.

Some of the evidence around is many people age out of drug use, particularly illicit drug use. Heroin is a classic example. There are not very many old heroin users. There is a point where people age out. If we can keep them alive long enough through needle exchange programs or opiate pharmacotherapy, then they will eventually find their way out of that. Often, it is because they have a job, family or other choices. Some people will continue using drugs, but that harmful, problematic, socially inappropriate use is work that happens in a context and we should address that.

Mr CHAIR: That leads me to another one that is perhaps more of a comment. Do you think criminalisation is an impediment to users or misusers for self-presenting for treatment?

Ms GORE: Yes. The two barriers around presenting for treatment are fear of criminalisation. Although, I think most people in those communities understand that is unlikely to happen. There is also a stigma and discrimination issue that remains, particularly for the illicit drugs. There are still labels.

What has made the VSA Act more successful is that it did not criminalise use, it criminalised supply. If you provide volatile substances or fail to secure them appropriately, that is an offence. The use of the substance is not. That means people can come forward without fear.

Mr CHAIR: I have not looked at the volatile substances Act but I am now going to do so. It fits with my line of thinking. We have perhaps touched on this in talking earlier. Can you provide an overview of the alcohol and other drugs treatment service sector in the NT, including the types of services provided, the client base, geographic coverage and availability of culturally appropriate programs?

Ms GORE: Yes. The alcohol and other drugs services sector in the Territory is characterised by three sectors. The first is the specialist AOD services provided by Top End Health Service and Central Australia Health Service. Both centres provide withdrawal services. In Alice Springs that is through the hospital. In Darwin it is through the hospital and AOD Stringybark withdrawal service, which is in Berrimah. Both of those services also provide counselling, psychosocial assessments, opiate pharmacotherapy programs—what most people would understand is a specialist AOD service.

The second service sector is the non-government treatment providers. They provide residential services for adults and youth, sobering up shelters and then psychosocial interventions, counselling, group programs and support for recovery. I have a full list of

all the various services and where they are located. I am not sure what the best way to get that information to you is. I can give that to you in writing.

The third sector is those general primary healthcare services provided by primary healthcare providers, whether they are general practitioners or the extensive programs run through the Aboriginal community-controlled health organisations. Sometimes they are called social and emotional wellbeing programs. Sometimes they are called AOD assertive outreach. Essentially they are holistic approaches to the person, which are early interventions in AOD concerns.

In terms of the Territory, we have five sobering up shelters—Alice Springs, Darwin, Tennant Creek, Nhulunbuy and Katherine. There are 10 adult residential rehabilitation services spread through the Territory in Darwin, Katherine, Alice Springs and Tennant Creek. We have four youth residential specialist AOD services in Darwin and Alice Springs. We have continuing care coordination services that look to provide case management and wrap-around support for people who have come out of residential treatment to try to increase the likelihood of success.

There are lots of counselling services. They are not necessarily location-specific. People can be offered a phone service or an internet service. That is probably enough of an overview, but happy to answer any specific questions.

We will give you a full list by region for the submission.

Mr CHAIR: What does the department understand to be the main barriers that people face when trying to access treatment service to address addictive behaviour and do the barriers vary by population group or geographic location?

Ms GORE: Yes. We understand there are some really specific challenges for providing services in the Territory, which are about sparseness of population across really big distance. So it is difficult to provide the same cookie cutter approach to services in every location because there is not necessarily a population base that enables that to be supported.

For individuals the biggest barrier is acknowledging that you have a problem and wanting to do something about it. Also back to the comment about lives filled with purpose/hope, it is the belief that there will be a change at the end of that process.

There have been lots of reviews over the years around the specific barriers for Aboriginal people around services being culturally competent, access to interpreters and in smaller communities, confidentiality and privacy when people seek treatment.

One of the current issues for us is that people are asking us for service models which include their family members and that is not a large area of practice. We are trying to increase that because we recognise that strengthening the family strengthens

community which provides a better context, but there are not people who have a specialty in that in big numbers in the Territory.

Some of our Aboriginal organisations are developing some really powerful models in that way and we would like to get some more information from them and support that. The other area that we are also working on at the moment is looking at FASD as an issue—Foetal Alcohol Spectrum Disorder. We would like to be able to target pregnant women as a key group to engage in treatment and make sure that best possible chance to stop using.

There is not a residential rehab that can take children at the moment, so we are looking for ways of trying to be innovative in our models to enable those women who this may be the second or the third child to actually be provided a service that their children are safe and cared for while they are seeking help for their own problems.

They are the biggest ones in terms of barriers.

Mr CHAIR: What sort of services are available for children?

Ms GORE: Our youth focused AOD services have a target population of 12 to 25 year olds. They run structured programs which look to engage young people with life skills, to give them greater understanding about the choices that they make.

For children under 12 we do not have any specific services, but for children under 12 our current evidence would suggest that what they need is a supportive environment which is safe and adults who can work with them so that they find other ways to act out of whatever is causing their use.

For many of those children it will be a trauma response. It will be a response to trauma and trying to heal the trauma is more important than trying to pretend it is a drug problem. There are three funded services in the Territory for young people specifically that provide residential programs.

Mr CHAIR: Does the department run or provide any funding for needle and syringe programs or medically supervised injecting facilities?

Ms GORE: Yes, there is a needle syringe exchange program, which is run out of NTAHC, Northern Territory AIDS and Hepatitis Council. In fact, one of the things we will provide is the evaluation of that program that happened in 2011—very positive. We do not fund a medically supervised injecting centre in the Territory. We do not believe there is the population level that would support that.

Ms PURICK: I know you can inject ice, but the only other one would be heroin, would it not?

Ms GORE: Yes. That is what led to the development of those services in Kings Cross. It was an overdose prevention initiative to start with.

Mr CHAIR: Heroin is not a particular drug of choice here?

Ms PURICK: No, the police said it was very low.

Mr CHAIR: Pill testing as well. Has any consideration ever been given to pill testing?

Ms GORE: The department wrote a discussion paper on pill testing in 2016. The recent trial in the ACT provided some further evidence. We know the biggest harms at music festivals are caused by alcohol. We have been directing our efforts there.

The police have made it really clear that they have no interest in supporting pill testing. In that light, we would rather work cooperatively with them on the things we think can reduce harms, rather than focusing on that issue. We would be concerned about the false sense of security it may give festival goers. Some of the reporting out of Canberra was also that people got the results of their tests and took the drugs anyway

Mr CHAIR: You cannot stop that. We get that. I also heard that the police ended up with some information about dealers. When some of the concert goers found out what was in the pills, they were pretty happy to …

Ms GORE: Dob on them.

Mr CHAIR: Yes, that is right.

Ms GORE: That could be a useful intervention.

Mr CHAIR: Yes, that is right.

Ms GORE: No, it is not a key policy priority for us at the moment. Again, in part informed by the smallness of our population, but also in trying to get best results from the resources we have, we need to target alcohol use.

Mr CHAIR: Yes. No, I get that. Are there any jurisdiction specific, national or international trials or new approaches to address addictive behaviour that you are aware of?

Ms GORE: One of the recommendations from the Riley review was for the Territory to trial a residential managed alcohol program. Some people call them wet houses. As part of our approach to try to scope what that might look like—because houses can be everything from a service which provides the alcohol direct to clients like a methadone program, to simply an accommodation service that allows people to stay there when intoxicated, and a range of services in between.

We have discovered that Canada is doing a large amount of work in this area in a context which is similar enough to what we would be looking at in the Territory that we could learn from. We have chosen to ask Aboriginal Peak Organisations of the NT (APONT) to lead the work in writing up the feasibility approach. Clearly, the majority of the potential users of such a service would be Aboriginal people, so we thought it was appropriate to ask APONT to lead the discussion and do the consultation. They have just started that work. We are directing them to Canada as well—we could learn from there.

There is, in that same space, some work that is occurring in South Australia. That is probably the area where we think there is stuff we are not doing that might be useful. But we do not have any other big ticket items at the moment.

Mr CHAIR: Okay. Something else to ask when in Canada.

Ms GORE: Yes.

Mr CHAIR: Are there any particular industries, occupation types or population groups that experience high levels of harm from addictive behaviours?

Ms GORE: It is a tricky one, because once we start listing the various population groups we end up covering the entire population eventually. It is very much regionally driven. There are trends in different areas. Everyone can experience harm from addictive behaviours. We know in the Territory the overwhelming amount of alcohol-related harm is disproportionate in Aboriginal communities, but it is also across the whole community.

We have been doing work recently on the suicide prevention plan and addictive behaviour is part of that as well. Those plans continue to show men as being more at risk, often because of the behaviour that results from the drug use, not the drug itself.

No, not in terms of an overall approach. When we talk about prevention, we would be looking at a universal approach and then intervening earlier with those social determinants we mentioned before—people living in poverty, disconnected, unemployed or do not have sight of health and purpose.

Mr CHAIR: Sure. Does the department have a research strategy to identify gaps in service provision? If so, what research both internal and external?

Ms GORE: The department has recently commissioned what we are calling the demand for alcohol treatment study. It arose from the Riley review as a direct recommendation. We have commissioned the Menzies School of Health Research, which is working in partnership with the National Drug and Alcohol Research Centre to undertake that project. The Drug Policy Modelling Program, which is part of NDARC,

have done jurisdictional and national studies in this space that look at demographic issues, what we know about the statistics to develop a blueprint for what should be available in the Territory based on population modelling and contextualising through interviews with stakeholders.

That work is under way and it is expected that the first phase will report at the end of this year. Then it will go through a second round. We have also just commissioned a review of the sobering up shelters as a recommendation from the Riley review. We are looking to shift the focus of those services from being in the colloquial spin-dry to seeing them as the entry point to the treatment system. What opportunities are there for brief intervention of case management responses when people come through? Even if we had 10% of people it would be an improvement on the current situation.

Both health services undertake service-level planning regularly based on what demand they are getting for their services, what portion of their staff is in Nhulunbuy as opposed to being in Darwin. That is a regular process they do every six months to make sure they are staying on track. The other work the department participates in is led by NTPHN where they have done some work on workforce needs mapping, as well as where the service gaps are. They have produced reports for both of those, which are really valuable in this space.

Those are the kinds of key pieces of work we are doing in the research space at the moment, trying to work out whether we have the mix of services right.

Mr CHAIR: My next couple of questions were about drug diversion programs, but I think we have dealt with that previously. What internal and external reviews and evaluations of programs or service models dealing with illicit drug use have been undertaken over the last five years? Can the committee access those?

Ms GORE: Yes, we will happily provide the ones we have. There was a review of the needle syringe exchange program. There was also a review of the Opiate Pharmacotherapy Program, which happened in 2013 so just inside the five years. We will happily give you that. An evaluation was also undertaken of the alcohol mandatory treatment program in 2015. The Banned Drinker Register evaluation has just occurred. There are a few others that are looking at the role of alcohol management planning.

Most of those are on the website, but we will provide you with physical copies with our submission.

Mr CHAIR: Fantastic. Monitoring, reporting and evaluation frameworks are in place to assess the effectiveness of the programs.

Ms GORE: For the non-government services we fund, they have service agreements that identify KPIs and include reporting through to the National Minimum Data Set. That tracks client outcomes, drugs of choice and a whole range of different indicators.

Those are reported on depending on the organisation, either three-monthly or six-monthly. The Territory also provides that information through to the Australian Institute of Health and Welfare which produces the reports about what we know about treatment and treatment outcomes.

I guess that with this government's really strong increased commitment to therapeutic services, we have been putting lots more attention into our own interrogation of that data, looking at what the client pathways are and what happens—how many times someone comes through treatment, how long their treatment stay is—to make sure they are getting (1) the utilisation of the services we fund and (2) that they are actually delivering change.

All of our service contracts have six-monthly reporting cycles, so we review that data and provide that feedback then.

In the government services, the service delivery agreement—the SDA—between Top End Health Service and Central Australia Health Service has some KPIs from Alcohol and Other Drugs. Those are checked off through budget cycle and estimates as to how well that is going. They would be our main frameworks.

Ideally, our evaluation framework is we would like people to have achieved lives where drug use is not their major focus. Successful completion of a treatment program is one part of that story, but we know that for most people—a bit like trying to give up cigarettes—it will take them more than one attempt. So, it is not necessarily a bad thing if someone comes back to a service, having successfully completed the 12-week program, for them to go through another round, or another round. That they have remained engaged is a positive step.

Mr CHAIR: In conclusion, about health promotion activities. What health promotion activities are currently being delivered with a view to preventing or minimising harms from addictive behaviours?

Ms GORE: There are many different things. Genuinely, there are universal programs. Many schools will provide basic drug awareness, drug education—some of them through curriculum programs and some through awareness days. That is a great place to start.

Another outcome of the Riley review was the reinstating of the PARTY program at Royal Darwin Hospital, which we are now extending to Alice Springs and Katherine Hospitals. That is an opportunity for …

Ms PURICK: Could you tell me what PARTY is?

Ms GORE: Yes. PARTY is Preventing Alcohol-Related Trauma amongst Young people. It is for high school students. They are brought on field trip to the emergency

department. They are taken to an exposure to a range of things, then they are taken to the rehab wards. It evaluates overwhelmingly positively for young people. We think once it extends out to Alice Springs and Katherine, about 200 young people a year will have that opportunity—usually Year 11 and 12 students.

In Royal Darwin it is being run by the National Critical Care and Trauma Centre. They are fantastic, highly committed group of people.

There are those kind of programs. As I mentioned before, there are the Alcohol Action Initiatives funded through the various communities. They have a wide range of diversionary activities. They might be school holiday programs, culture programs, canoe building—whatever. There is lots and lots of stuff that is happening.

Then, in both services—Central and Top End—they have community development officers who go out and educate people about the harms of drugs and treatment services that are available. They run awareness days—lungs that they can show filled with stuff from smoking, beer goggles so you can see the impacts of alcohol—a very engaging way of working.

We would like there to be more because it is an area where we will get the greatest impact at the time. But there are really good people out on the ground doing their best at the moment.

Mr CHAIR: That is probably an answer in that as well. What activities are being delivered in partnership or in collaboration with other agencies?

Ms GORE: Most activities—particularly once you leave the urban centres—are done in partnership. They will be a partnership between the school and the local health clinic, or between the Aboriginal community controlled organisation and the police. Yes, it is not possible in those centres to do stuff without support.

Having said that, we also have good relationships with the NTPHN, which commissions specific services out in the areas. Then, there is a range of ways in which those work. People are using what resources they have got together, which is really helpful.

Mr KIRBY: People talk about diversion camps and you have touched on bits and pieces of those. If there is anything else that you would like to elaborate on given the opportunity and if money was not a factor?

Ms GORE: The two biggest things for me are when people enter in to this space voluntarily they get better outcomes. It is really important to keep working on making people want to get involved in treatment but in the absence of them wanting to, making them do it might make us feel good but it does not achieve a longer term outcomes. That would be part one.

Part two for me is we really need to walk the talk of listening to and resourcing what our Aboriginal brothers and sisters and organisations are saying they want to see in the models. There are some really powerful learnings that their programs deliver and we need to know that the evidence tells us that connection is a really important part of recovery and also prevention and cultural connection is one of those connections, as is community and family and connection to employment.

Genuine partnerships with those organisations in service co-design for the future is absolutely key for what we are currently trying to do and what we need to keep doing in to the future.

Mr CHAIR: Thank you. I look forward to seeing your submission.

Ms GORE: Thank you.

The committee concluded.