LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

3.30 pm – 4.00 pm, Friday, 19 June 2015

Litchfield Room, Level 3, Parliament House

Members:
Mr Nathan Barrett, MLA, Chair, Member for Blain
Ms Lauren Moss, MLA, Deputy Chair, Member for Casuarina
Mr Gerry Wood, MLA, Member for Nelson

Apologies: Mr Francis Kurrupuwu, MLA, Member for Arafura

Witnesses:
Banyan House
Chris Franck: Chief Executive Officer
Paul Gibbs: Board Member, Forster Foundation
Richard Michell: Clinical Services Manager

Mr CHAIR: On behalf of the committee, I welcome everyone to this public hearing into the prevalence, impacts and government responses of the illicit use of ice in the Northern Territory. I welcome to the table to give evidence to the committee from Banyan House, Chris Franck, Chief Executive Officer, Paul Gibbs, Board Member Forster Foundation, and Richard Michell, Clinical Services Manager. Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and obligation not to mislead the committee apply. This is a public hearing and is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you say should not be made public you may ask that the committee go into a closed session and take your evidence in private. I will ask each witness to state their name for the record and the capacity in which they appear. I will then ask you to make a brief opening statement before proceeding to the committees questions.

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

Mr FRANCK: Chris Franck, Chief Executive Officer of Banyan House, which is the Forster Foundation.

Mr MICHELL: Richard Michell, Clinical Services Manager, Banyan House - Forster Foundation.

Mr GIBBS: Paul Gibbs, I am on the board of the Forster Foundation. I also chair the Clinical Governance Committee for Banyan House.

Mr CHAIR: Mr Franck, would you like to make an opening statement?

Mr FRANCK: Mr Chair, thank you very much. I will read a very short statement.

Thank you, Mr Chair, for the invitation and opportunity to inform the select committee on the prevalence, impacts and government response to illicit use of the drug crystal methamphetamine in the Northern Territory from a rehabilitation perspective.

I will shortly highlight a few observations, tabled and not tabled, today. I will not reiterate what has been raised in our submission to the select committee. In the first instance, in the context of ice use I do not believe Australia is dealing with an epidemic as at times sensationalised in the media, but it is a matter of significant social concern.

We are dealing with a different type of presentation as ice, as a stimulant, involves a different neurobiological context than the traditional drugs we are used to, including alcohol. Crystal methamphetamine affects different parts of the human brain, the limbic system, which causes easy arousal with more difficult de-escalation, and the prefrontal cortex of the brain - unpredictable emotional responses and profound personality changes. This highlights a more complex approach to a significantly more complex higher-end psychiatric series of conditions.

The mainstream and NGO services in the Northern Territory predominantly are positioned and geared to deal with suppressant-type drugs and not stimulant-type drugs. Most services predominantly use staff with lower-end qualifications, example a Cert IV in drugs and alcohol, whilst the complexity of this drug requires a far more complex and different treatment approach probably with a different skill set. Most services currently funded are funded to employ very operationally-qualified staff.

At that point my computer died and I cannot read any further. We will leave it to the committee at this point in time to ask any questions. **Note:** Copy of opening statement is attached at the end of this transcript.

Mr CHAIR: I am very interested, given you do a lot of work in this area, to get your opinions on what you think about the other submissions you have heard today. It is great you guys have sat through them today, and I would like to get your thoughts and feelings on what has been presented today and the balance of it or not.

Mr FRANCK: Mr Chair, our presence here today to learn from other Stakeholders demonstrates our commitment to address this issue in the Northern Territory because we believe it is a significant social concern we are dealing with.

It was very informative to listen to some of the presentations. Some of them were almost entertaining, if I may have the liberty of using that word. Some of them raised eyebrows to question if that was all true. We have not seen significant evidence of some of the information that was shared here today. It does not mean it does not exist; it is probably people are just not aware of it. That is the value of us being here to learn and see what is going on at various levels in Darwin.

Some of the presentations were technically correct but non-technically somewhat misleading, which is probably a cause for further conversation at a later stage.

Mr CHAIR: I want clarification on your recommendation 4.2. Where are you going with 4.2 which says

> *Make recommendations toward ensuring a significant shift enjoy executive sponsorship ensuring the majority of resources are …*

I am not entirely sure what that means.

Mr FRANCK: Mr Chair, the essence of that recommendation relates to the announcement of the Northern Territory Government - when they announced the select committee. From a layman's perspective, when you observe on television the Chief Minister and the Minister for Police announced the creation of this Select Committee, it immediately raises an alertness that, 'This will be a policing only drive with the emphasis on the criminal context'. The immediate question is where is Prevention? Where is Education? Where is Health? The statement I attempt to make was to request this Committee to ensure sufficient shift so it is not only a policing matter but definitely a matter of prevention, education, and health (interventionist/treatment) that would investigate the global impact if this insidious drug as well.

Mr CHAIR: You will be happy to know part of what we have is go on the same pillar strategies the NDS does and look at not just demand and supply, but harm reduction as well. Also, that we need to have a balanced approach in what we do. All the things you mentioned we are aiming to make solid recommendations on.
With that in mind and looking across your recommendations, you speak about considering funding dedicated rooms. The Health Department does not seem to think that is necessary. You have a conflicting view. How so?

Mr FRANCK: I can comprehend the Health Department's stance regarding an ice room or a specific dedicated facility at the hospital to have a potential financial and governance impact. The public service might at times be ill-advised, or lack credible data (data integrity) to base decisions on. However, in a community rehabilitation context – which informs our perspective, I suggest the probable magnitude of this drug problem warrants a specific focus on a practice-informed research capability. At this point in time - as you would see in our submission, we provide withdrawal services for the Health department. People being admitted for withdrawal poses real life challenges in general – mostly with a number of unknown factors in presentation. It takes time to unravel the true scope of their condition – there are many unknowns involved and close scrutiny/supervision is required – Richard, you can come into this conversation as well – exactly what is involved in withdrawal regarding poly-drug use? Our experience informs us that rarely are clients admitted for one drug problem only – most struggle with using multiple drugs, of which alcohol plays a central role. We see multiple drugs being abused, so from a research and appropriate intervention perspective, and to gain evidence based experience regarding withdrawal – a dedicated capacity is required.

The more traditional drug, including alcohol withdrawal generally requires a 10 to 14 days withdrawal window before the person is ready to effectively enter a rehabilitation program. International research informs that ice withdrawal can take up to 70 days, and that is a totally different picture. If one's resources are geared for a 14-day cycle, a significant increase in ice withdrawal - as was presented here today - will place us in a difficult position. Our resources would not be able to cope with a significant increase in numbers and duration of withdrawals. There is also the increased risk in ice withdrawals – it will require a different approach and methodology – thus, a dedicated capacity to do research, examine the individual presentations towards developing contemporary insight, understanding and knowledge is required and would add significant value. Banyan House is eager to get involved in research though partnership with the Health department, academic institutions and Industry.

Mr CHAIR: How have you seen what you are doing at Banyan House change? We have seen some data which suggests since the legislation changed and made it a Schedule 1 drug there has been an increase in legal representations - an increase in the justice system dealing with people. We have heard anecdotal

evidence that over the last few years it has been going up. Paramedics tended to think that has been the case over the last few years. Have you noticed a similar trend in your operations?

Mr FRANCK: Mr Chair, yes. In the last six months we have seen a 115% increase in people seeking treatment for drug abuse, of which ice plays a major role.

Mr CHAIR: Can I ask from what to what? Numbers?

Mr FRANCK: The specific numbers are in the submission, but I know from January this year it was 115%. If you go back to September last year it will reflect a different picture.

Mr CHAIR: No, I am just after the numbers. Are we talking 30 to 75, are we taking three to seven, or are we talking 1000 to 2120?

Mr FRANCK: From our capacity to accommodate 26 residents at any one time, of late we have between 15 and 17 residents reporting ice as their drug of choice or the drug they wish to rehabilitate from. In 2014 our data show that we had between 1 and 3 residents reporting ice as the drug causing challenges.

Mr CHAIR: Are ice related.

Mr FRANCK: Yes Mr. Chair … over a one year changing cycle. These are significant increases.

Mr CHAIR: It used to be six or so and now you have 15?

Mr FRANCK: Last year it was between one and three. In September it was three according to our data. In January there were five and a fortnight ago (last data-count) we were on 14. It changes as they come and go, but that is where we are today.

Mr MICHELL: Can I add to that, with the increase around policing and enforcement and the focus on methamphetamine, we have definitely seen a rise and pressure from forensic services about taking more and more clients. Quite often now referrals are coming through that system rather than the voluntary. That puts stress on the overall system because it leaves less space for your voluntary clients, which is what we are mandated to do.

Mr CHAIR: I hear that is the problem too. If people are placed in your facility, often against their will, they are just biding time until they can get out and go again. You would be less effective than for people who are self-referring and wanting to change.

Mr MICHELL: Yes, and from information gathered from our clients as well, a lot of them see residential rehabilitation as a 'soft' option. It affects the way our service operates because we have a number of voluntary clients and if you bring in a number of involuntary clients not necessarily wanting to be there it changes the dynamics within the therapeutic community.

Mr CHAIR: Can we talk about that soft option from a court system. Do they say, 'I will go to Banyan House' and get a lower …

Mr MICHELL: From our information, yes. That is how it is operating at times. There is quite a strong focus, which we understand, from the legal profession, for people to not be incarcerated for drug use. We would also promote that incarceration is not always the best option for someone struggling with drug abuse.

Mr CHAIR: That does not necessarily mean you take the place of corrections.

Mr MICHELL: No, exactly.

Mr FRANCK: Richard alluded to the fact that it causes tension between us and the Department of Health. The Department of Health is quite explicit in that it funds us as a health facility to accommodate alcohol-mandated, volatile substance abuse and voluntary clients and explicitly not to accommodate forensic and corrections clients. Our funding model is geared not to accommodate the latter, but there is significant pressure from that source to accommodate them. We do our utmost to accommodate them, but we are under pressure from the Department of Health. The Department of Health's perspective is that clients referred from the Corrections facilities have had a period of treatment within the Corrections facilities whilst voluntary clients have not had that opportunity. It has been clearly stated that we can accommodate

clients from Corrections IF the Department of Corrections funds those beds/places. We currently receive no funding / financial support from the Department of Corrections.

Mr CHAIR: We are talking about clients from the justice system with a court order saying they have to be at your facility?

Mr FRANCK: Yes, and we are not funded for that.

Mr CHAIR: You are taking on people like that?

Mr FRANCK: Yes, we are taking them on.

Mr CHAIR: It is not working. Is there a place for setting up a facility to take those clients which has a different approach?

Mr FRANCK: Yes, there is definitely room and we can accommodate that should it be appropriately and sufficiently funded. At a fairly low cost we can make rooms available and with limited staff we can provide focused rehabilitation programs for clients mandated by the Courts and Corrections. From a management perspective the centre (Banyan House) can manage, but with our current human resource pool we struggle. If we are appropriately funded we can do that, yes.

Mr MICHELL: To go on from Chris' statement, we are funded for a very specific purpose, which is residential rehabilitation for AMT, VSA and voluntary clients, although we try to provide other services as much as we can - aftercare, supporting parents and family/significant others, doing some youth diversion programs, etcetera. It is really around the capacity of a very small organisation trying to do a very big job. That is not just us, it is the case with other residential rehabilitation centres, including Indigenous-only focused services as well. I think everyone is struggling under the pressure on increased help seeking and Corrections mandated client base.

Mr CHAIR: We heard from the Health department today that residential rehab sees a number of people and it all seems to be hunky-dory, there does not seem to be a big waiting list, but they are not sure. Does that marry with your experience?

Mr GIBBS: Can I respond to that?

Mr CHAIR: Yes.

Mr GIBBS: The absence of a waiting list is not really indicative that the service is being used or that it is under stress. While it is technically correct it is a little misleading.

Mr CHAIR: You would say it is under stress?

Mr GIBBS: I would say that if a service is running at 85% to 90% with no scope to bring people who want treatment in - that is problematic. The ideal is you do not turn people away when they are ready to engage into rehabilitation. I am not saying that is consistently the case, but if the service is full that is what will happen. The longer people have to wait for a treatment, particularly in a voluntary context, the more problematic it becomes and the harder it is to engage.

Mr MICHELL: The conduit is withdrawal services. We provide a number of withdrawal beds and TADS, through the hospital, supply a number of beds. If people cannot access withdrawal beds that is a blocker for getting into our services because we need to ensure that people are medically supervised throughout their withdrawal**.**

Mr CHAIR: Is that sector under stress, withdrawal beds?

Mr MICHELL: I think it is limited in its resources. They do a great job, but once again, with our services, if we had added resources we could do a number of withdrawals as well. This is a bit of a blocker. It comes to a bottleneck and that sometimes slows down the system.

Mr FRANCK: The government services is perceived to struggle with resourcing and that has a flow-on effect on us because they buy the withdrawal beds from us – six withdrawal beds are dedicated to TADS and we cannot fill those beds from own referral base. If there is a blockage in the Department's assessment and allocation system/process, we sit with six empty beds. We have, over the past two

months, experienced five of the six beds being vacant for a six-week period – whilst we are aware of people in need and who could have been accommodated if we had access to the beds AND the medical staff to manage those clients.

Mr CHAIR: That is not because there were no people to use it, but because there was a blockage somewhere in the system?

Mr FRANCK: Yes. We are quite aware of people who need the service, but withdrawal client need to be supervised by medical staff, which I do not have.

Mr CHAIR: This is withdrawal beds?

Mr FRANCK: Yes, Withdrawal beds that 'belongs' to TADS. They allocate medical resources that come in and monitor them daily or as often as required. We monitor care them 24/7, but TADS medical staff (nurses) attend to their requirements from a medical perspective. We cannot take clients in for withdrawal without support from TADS AOD/Withdrawal nurses - because we do not have the medical staff. There is too much risk involved in withdrawals to admit clients without medical supervision and backing.

Mr CHAIR: You are more once they have finished that process they come to you for an extended period and …

Mr FRANCK: We accommodate clients for withdrawal if it they are assessed to be in the mild to moderate category. Mild to moderate implies they do not have complicated withdrawal, they are not susceptible to seizures, or they do not have complex mental health conditions/challenges that are not stabilised. If they are at a higher risk or a co-morbid medical condition – such as a major heart problem that elevates their risk profile. Due to our inability related to the absence of 24/7 medical staff we cannot monitor the higher level of withdrawals. Once again, that is a resourcing and funding issue.

Ms MOSS: I am sure I am not alone in being really concerned about the number of times we have heard today of ice being used as a commodity in exchange for sexual favours, and that has been mentioned in your submission as well. I understand a lot of this evidence is likely to be anecdotal, but what would you see as the commonality of that story from the clients you are seeing?

Mr FRANCK: Richard, can you respond?

Mr MICHELL: Once again, this is from the clients themselves quite often - I am not sure how prevalent that is, but as we heard from the NT AIDS and Hepatitis people, they would have a far better idea because they have direct contact with people who are still using. We hear stories of it being used to pay for sexual services and other services. You just have to go back to a lot of the discussions around the economics of methamphetamine in the Northern Territory - it is a lot more expensive. If you become dependent on methamphetamine in the Northern Territory you will have to find sources of funding, which will usually be involved in criminality unless you have a high paying job.

The Chair mentioned before the level of non-problematic users. It is possibly fairly high, especially if you look at some of the industry and high paying jobs in the Territory. There is probably a high prevalence there that is not gauged. Some people can support it, some people cannot. The particular worry is Indigenous communities. We have already heard today a number of stories about the price and what people will have to do to obtain the drug. It is the whole supply and demand issue.

Mr FRANCK: We have seen in our data that there is a definite shift in demographics such as age of people seeking help. The shift is towards younger females. In the past we probably would have had 90% males with 10% females. At this point of time we are about 60% to 40% and we cannot accommodate more women due to the nature and lay-out of our facility whereby we do afford gender-specific privacy. Yes, the increase in females seeking help relates to that specific problem as mentioned. Female clients often report getting paid for services with crystal methamphetamine – there is evidence of a high prevalence of that. We see also in the research, and anecdotally from younger people, they use ice for the effect of the drug. Contrary to other drugs that have the depressant, 'chill out' effect, ice gives users the 'superman/superwoman effect', Anecdotally young people report that one hit on ice, from a sexual perceptive, can equals experiencing 1000 orgasms….. Significantly enhance their sexual experiences. It is a very attractive drug for the young person seeking that kind of stimulation. That is where, unfortunately, a lot of young people are drawn into using the drug.

Mr GIBBS: It is somewhat of a misnomer to consider they are buying the drug. We have heard a lot of evidence today about the sophistication of the business operations. These people are very good at creating the market and holding on to the market. When you are supplying drugs on tick that money has to be paid back somehow and a lot of pressure is applied. It is not an even swap, and people are placed under significant stress to make decisions they would not normally make. They do that because of the pressure applied. Once that debt is established it is almost impossible to pay back.

Mr FRANCK: The reality is - the supply chain is very well funded while the demand management is grossly under or unfunded.

Ms MOSS: You also recommend a comprehensive work health and safety strategy, and I was interested in what would need to be included in such a strategy?

Mr FRANCK: From experience, we train our staff to be aware of unpredictable behaviour because the challenge with ice use *per se*. There is no set standard protocol workers can/should follow as yet. They have to be vigilant and observant of their surroundings specifically related to client and own safety when dealing with users – more-so when psychosis has set in.

From a personal and client safety perspective, it is very important that the capacity and facilities are geared and organised to deal with the unpredictable nature of drug-induced presentations. As I said, the management of clients presenting with traditional drug use effects - which more-often have the depressant effect - poses a different challenge than when dealing with people bouncing off the walls due to the energising effect of crystal methamphetamine.

The work health and safety engagement and de-escalation capacity is very important - it is essential our staff are properly trained in WHS aspects when working with ice-affected clients. Personal space / safety / potential harm reduction is important when managing clients with a largely unpredictable presentation. Drug-induced aggression can escalate in an instant. One staff member should e.g. not be left alone with an ice-affected individual – impact – more resources would be required to manage safely.

Mr WOOD: In relation to funding, you say just before your recommendations the ever-increasing lack of commitment to renew funding by the Commonwealth government brings job insecurity amongst staff leading to a higher staff turnover. Last time I visited your facility you were telling me there was a risk that the Commonwealth would cut funding. Has that happened?

Mr FRANCK: The Commonwealth has just reconfirmed the funding at the same level for another year. It generally works in three-year contracts, but they only reconfirmed the funding for another 12 months. The confirmation came through yesterday – 10 days before the end of the financial year. This kind of instability has a destabilising effect on staffing levels. Staff on contracts – all our staff are on contracts only – has to know well in advance if their positions are to be cancelled so they can start looking for alternative employment. From an employer perspective - if you have to reduce staff, you have to give them at least six weeks or two months' notice. Yesterday was 18 June. If I had to reduce staff, to inform them in this point of time that their positions were to be defunded, I would have been compelled to pay redundancies – unfunded. We are grateful to have received confirmation of another year's funding, but staff are nervous regarding their future employment. Finding alternative gainful employment in the NT is problematic – so we have to think of exceptional strategies to retain staff. 25% of our funding is thus insecure. It will have a devastating effect on our operation if we are to lose that quantum of our funding. I will have to close down 25% of our accommodation and rehabilitation capacity – against a 145% increase in people seeking help.

Mr WOOD: Did you put in a submission in to the Commonwealth inquiry?

Mr FRANCK: Yes.

Mr WOOD: Did you talk to them about this?

Mr FRANCK: Yes, I did.

Mr WOOD: Did you get some positive feedback? If they are serious about the ice epidemic …

Mr FRANCK: I have not received any feedback. We had the privilege of the National Ice Task Force visiting Banyan House recently during their visit to the Northern Territory. We thus had a good opportunity to demonstrate what we do with the limited funding we receive. We experienced Prof Murray and his team

to be open-minded and inquisitive of the impact the drug use has on people and how we currently respond to the increase in presentations.

Mr CHAIR: You are very lucky, they did not talk to us.

Mr FRANCK: The awareness is there; they know about the impact. The reality is – from a funding perspective - the national review of all mental health services will undoubtedly affect what and how the Federal Government will approach support and funding. The information around the national review is pretty scarce. We do not really know what the impact the review will have on funding and capacity to deliver services. That is a big challenge and a threat for us - from a funding and service capacity perspective.

Mr WOOD: Two people today have spoken about the SMART court drug court. You have that as one of your recommendations. Can you tell us if people coming out of the SMART court would cause you the same problems as the people you are getting through the courts at the present time? Is the SMART court system a lot better than the way you are getting people …

Mr FRANCK: From my research it facilitates more streamlined process where people do not go to gaol first for an extended period of time – potentially getting institutionalised then being released with a criminal devastating record. The presentation and impact on services would probably be the same, the challenges will be the same, but if there is an efficient system in place with appropriate funding attached, (our) services can be delivered more cost effective and efficient. The current court and corrections systems are too disjointed, time and resource demanding. We have to provide one staff member to visit the corrections facility 1.5 days per week – unfunded – just to do assessments. 2.5 hours travelling for 2 assessments – IF the incarcerated person turns up / can be located to attend assessment. Too often does our resource drive 2.5 hours return and has to return without one assessment being done. I use health funding for that …. Problematic.

Mr MICHELL: Resourcing is the issue around that. If you have more people going through who have been diverted from the justice system into a diversion system as in other states and territories such as in Victoria there is drug diversion from courts and drug diversion from police. Most of those have been reasonably effective over the years, but I think that does draw on resources. The more you identify need and the more you push a system then the system becomes overwhelmed. We can only work with what we have, and to provide services does require resourcing.

In some other states they have clinicians within the courts from agencies so they can make the assessment about what is the most appropriate treatment modality for that individual at the time. It is also done in tandem with mental health services – dual diagnosis being very big on that agenda because we know that a number of people with mental health issues will often use substances to counteract the symptoms of their mental illness.

Mr GIBBS: There are some other parts to that which I think would help you. The assessment process required to present someone to court for a consideration from the magistrate that they go into a program requires an in depth assessment. The second part of that is the monitoring of compliance so people know they have to participate in the treatment otherwise they are returned to court. The process is to see that they do not go straight to treatment, but the treatment and their compliance and engagement with treatment is monitored and is fed back to the court.

Mr WOOD: Did you get clients from the SMART court when it was operating?

Mr MICHELL: Before our time.

Mr FRANCK: All three of us only started this year in the changing of the guard. To speak with authority on that one it is not possible from our perspective, but staff who have been there for some time did report the previous system to be more effective than the current arrangement.

Mr WOOD: To be honest with you, I felt there was a certain element of politics in its dissolution because it had been set up by a magistrate. Unfortunately, if my memory is right, she left because of what was happening. It is just interesting hearing three groups say we should look at it. One of our pillars is rehabilitation. Obviously, from my point of view, if we can keep some people out of prison, especially those who are at a point where they cannot help themselves so what is the point in putting them in a prison – I am interested in revisiting this area if it would make a difference.

Mr MICHELL: Hearing from the police today, the law enforcement fraternity does a great job but the point of them stressing the fact that just policing this will not end it. The other thing, as far as an economy - look at the economy of the Northern Territory. If we start arresting everyone who uses drugs and then has criminal convictions - how does that work economically, your workforce, and a whole lot of other things? That diversion has been proven effective in a lot of states and territories in Australia as well as overseas.

Giving people an option on their first off or small amounts and things like that is much more cost effective than imprisoning them.

Ms MOSS: I was interested in what you said at the beginning of the session. Were you comfortable hearing some of the things you did today that you do not see and you do not agree with? If you are comfortable answering the question do so in whichever way you want. What are the differences are between what people are seeing.

Mr FRANCK: I would say you do not bite the hand that feeds you.

Mr MICHELL: I am happy to talk about the community level, mental health, and drug and alcohol services working together. I thought part of the conversation put forward today was that everything was working very well, and I guess in the hospital system that it works fairly well. Having come from another state where I have seen it work a bit more effectively, there is still quite a siloed mentality in some community organisations. Some of that is because of resourcing, and some is may be skill levels, but working more collaboratively, especially around mental health, drug and alcohol, families, housing and youth needs to occur. I think there are opportunities to work more closely together.

Mr FRANCK: Another example that was mentioned this morning is that there is sufficient rehabilitation facilities for young people - I am not aware of such services. I do not know where they are because I do not believe they exist. I am not aware of effective/sufficient number of programs available for young people in Darwin, let alone the rest of the Territory.

Mr CHAIR: That was my question.

Mr MICHELL: With regard to youth, specifically when you look at rehab, most were set up for probably 30- or 40-year old heroin and alcohol users initially. The demographics have changed; the culture of drug use has changed. We see a lot of young women and we now see a lot of young people at the stage they want to enter residential rehabs. A system of putting someone into residential rehab at 18, in an adult system, is probably completely different to how you would deal with the younger person, say 16 or 17. There is a different way in which residential rehabs are run across Australia, especially for young people. This is because the focus for young people is often on building resilience and looking at the broader issues relating to youth rather than what we have traditionally done in Adult residential rehabilitation centres. Adult rehabs are much more structured on adult program. There needs to be some diversity in how we approach the issue of youth drug use as compared to adult drug use.

Mr CHAIR: You spoke about youth diversion too. What programs were you thinking of when you wrote that? Diversionary programs for youth as part of your recommendations, and I wonder what exactly you are going to?

Mr MICHELL: It is about developing programs. I will let Chris talk about it. They do not exist at the moment as far as we are aware. As you said, DAISY is one program we were aware of and maybe a couple of Indigenous focused ones, but there are no specific ones we are aware of.

Mr FRANCK: Asking what programs we could talk about, with all three of us having worked in Queensland, Tasmania and Victoria, we are aware of great programs that have been developed, researched and evaluated. Not having the same level of funding and development of programs in the NT, we are now starting to develop similar interventions / solutions based on our experiences. The challenge is - it will take two or three years to get to a point where these are developed, implemented and evaluated – validated. Instead of re-inventing the wheel, we try to purchase them from other states, but it has been proved to be very expensive – we cannot fund that from our current operational funding sources.

One program - we recently partnered with St Vincent's Hospital in Melbourne. And although we do it in the spirit of Partnering, those organisations aim to protect their intellectual property and charge huge fees for the rights to use their programs. The fact is to buy the rights to use their program costs nearly $30 000 and then there are ongoing royalties and copyrighted resources. We want to bring that in but it costs too much money, and the dollar only buys so much.

Diversion programs in Ballarat – for instance – from my experience added significant value. I am aware of a great program facilitated by the Ballarat City Council where various service organisations participated and schools committed to involve students of certain age groups to educate and safe-guard the youth. I am also aware of programs funded by the Victoria Government such as the Reducing Risky Drinking program to develop and trial creative ways to engage people with problematic drug use (alcohol at the time), and develop and to deliver effective brief interventions to reduce harm and potential risk - thus reducing the overall burden on the health system. I managed a program called Reduce2Two for the Victorian government, where we partnered with the Ballarat Council and other service providers (including Police, St John's Ambulance and the regional hospital's emergency department), engaged young people at risk of substance misuse delivering preventative/early interventions. The schools signed up, brought learners to a pub in town where we created a safe space and educated in the specific environment about what they can expect when visiting such an establishment, their safety, what to be alert for and how to manage. St John Ambulance was involved in doing first aid and 'Save a Mate' training. That was a very comprehensive program to alert young people to the risk and danger as part of the diversion. There are various programs available on the market that we can quite easily duplicate or adapt in the Northern Territory to make sure people are aware what the drug is and how we can intervene early and reduce harm.

Mr GIBBS: We have heard a lot today about the evidence and lack of evidence in the extent of use. We have also heard of a fairly large opportunity - consistent urine screens. What I heard today is it is self-reporting. It is really easy to do a screen. It is not invasive at all, and I would highly recommend that we screen everybody routinely. By that I mean people going into prison ….

Mr CHAIR: I thought you meant just run around and screen everyone.

Mr GIBBS: I did not mean us.

Mr WOOD: You said watch the hand that feeds you, but the Territory funds you as well?

Mr FRANCK: Appreciatively, yes.

Mr WOOD: Through the Department of Health?

Mr FRANCK: Seventy five percent of my funding comes from the Northern Territory Department of Health.

Mr WOOD: Do you need more funding and do you need to expand?

Mr FRANCK: Emphatically yes, we need more funding. When the Committee visits Banyan House, you will be surprised to see the facility we have and what is being delivered on a very tight budget. You would think it is impossible, but we do deliver – what I believe is a great service to all Territorians. Yet we can only do so much with what we receive. We are acutely aware of all the opportunities of what can be done, but we do not have the financial capacity to do that. We have a 26-bed facility and we operate 24/7. I have eight clinical staff (6.8FTE) to do that, which includes the manager, to run the entire service. It is virtually impossible to – similar services interstate often advise that they would not be able to do that. Yes, we need more funding. We could do so much more if we have more and appropriate funding.

Mr WOOD: Do you also need to expand?

Mr GIBBS: Absolutely.

Mr WOOD: I know you are limited for room.

Mr GIBBS: Absolutely.

Mr FRANCK: We have land available, and could probably triple the centre. We need to expand to provide e.g. services to younger people, we can accommodate expansion if funded.

Mr WOOD: You could have a youth facility there as well.

Mr FRANCK: We could have a youth facility on site.

Mr MICHELL: When you talk about ice specifically and look to diversion programs, we can develop or pick up and run diversion programs specifically for methamphetamine clients. Although it is sometimes better to

on a drug is a drug is a drug and not specifically one substance. Sometimes it is about dealing directly with methamphetamine because that is the issue they have been diverted for although a comprehensive drug program could be more effective

Development of these programs is usually quite easy in that they are usually based around the same parameters. It is just about looking at what the drug is, how it operates and how we support people, however it is a separate resourcing issue from what we do at the moment on a daily basis.

Mr GIBBS: We know there are definite treatments that work, particularly not just with the user but with families as well, and they have been demonstrated around the world to work. We can deliver them here, it is just the issue of funding.

Mr CHAIR: Thank you very much, gentlemen, for talking to us today.

Copy of Opening Statement: Select Committee on 'Ice'

Thank you Mr Chairman for the invitation and opportunity to inform the Select Committee on the prevalence, impacts and government responses to illicit use of the drug Crystal Methamphetamine in the NT from a rehabilitation perspective.

I will shortly highlight a few observations tabled and not tabled today – I will not reiterate what has been raised in our submission to the Select Committee.

In the first instance – in the context of ICE use, I don't believe Australia is dealing with an epidemic as at times sensationalised in the media but it is a matter of significant social concern. We are dealing with a different type of presentation, as Crystal Methamphetamine as a STIMULANT involves a different neurobiological context than the traditional drugs, including alcohol. Crystal methamphetamine affects different parts of the human brain – the limbic system (easier arousal with more difficult de-escalation) and the prefrontal cortex (unpredictable emotional responses and profound personality changes). This highlights a more complex approach to a significantly more complex higher-end psychiatric series of conditions.

The mainstream and NGO services predominantly are positioned and geared to deal with suppressant type drugs and not stimulant type drugs. Most services predominantly use staff with lower end qualifications (Cert IV in AOD) whilst the complexity of this drug requires a far more complex and different treatment approach, most probably with a different skill set. Most services currently funded are being funded only to employ very operationally qualified staff.

The Forster Foundation currently has one operating unit – Banyan House that provides residential rehabilitation services to clients residing across the NT who can access the residential facilities in Berrimah. This facility enjoys very low level of funding and has very limited resources to manage the current need, and does not have the capacity (human resources and residential facilities) to deliver services outside the current realm. The Forster Foundation does have the forensic and mental health/AOD expertise to engage in the delivery of other services if adequately funded – we do not have the resources at this stage under the current funding arrangements.

It needs to be emphasised that The Forster Foundation is currently funded by the Department of Health as a health facility to provide services to AMT/VSA and voluntary clients ONLY. They explicitly advises us on a regular basis that the funding provided by the

Dept of Health is not to be used to deliver services to Corrections mandated clients – we currently to our utmost to accommodate a certain number of mandated clients.

The Forster Foundation does not have accommodation and human resources available to accommodate forensic clients. We have land available to develop such capacity if adequately funded.

Regarding the space related to YOUTH, I cannot comment with authority as we focus our services on clients 18 y/o and older. Internal data informs us that there is a significant shift in gender and age regarding ICE use and clients accessing our services for treatment. The shift leans towards younger females, which adds complexity to our capacity to accommodate residents and deliver appropriate services. It was highlighted today that there is a need for more non-urban related services, and there is scope where The Forster Foundation can engage in delivering appropriate services on an outreach/in-reach basis if adequately funded.

Regarding WITHDRAWAL services – if the current trend of increased use continues, the current capacity to manage longer term and more complex withdrawals will run out of steam. Current services are geared to manage depressant type of withdrawals which operates on a 10-14 day turnaround. Evidence indicates that ICE withdrawal can take much longer and a different approach, and that will require a different capacity and resource mix – we believe we cope with current demand, but forecast problems in the near future.

It is important for us to continue to seek out and formulate relationships with other stakeholders as we believe a multi- faceted approach will be the most effective. This is especially relevant for services such as those who work in the areas of mental health, youth, housing and supporting families. We are continuing to develop new programs to address specific support needs however it is difficult to develop and operate new programs on existing funding.