LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

12th Assembly

'Ice' Select Committee

Public Hearing Transcript

1.45 pm – 2.30 pm, Monday 7 September 2015

Litchfield Room, Parliament House

Members:

Mr Nathan Barrett, MLA, Chair, Member for Blain

Ms Lauren Moss, MLA, Deputy Chair, Member for Casuarina

Mr Francis Kurrupuwu, MLA, Member for Arafura

Mr Gerry Wood, MLA, Member for Nelson

Witnesses:

Amity Community Services Inc.

Bernard Dwyer: Chief Executive Officer

Nicola Coalter: Deputy Executive Officer

Rian Rombouts: Coordinator Counselling Service

Mr CHAIR: On behalf of the committee, I welcome everyone to this public hearing into the prevalence, impacts and government responses to the illicit use of ice in the Northern Territory. I welcome to the table to give evidence to the committee from Amity Community Services Inc., Bernard Dwyer, CEO, Nicola Coalter, Deputy Executive Officer and Rian Rombouts, Coordinator Counselling Service.

Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today. This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask that the committee go into a closed session and take your evidence in private. I will ask you to each state your name for the record and the capacity in which you appear. I will then ask you to make a brief opening statement before proceeding to the committee's questions.

Could you please state your names and the capacity in which you are appearing?

Mr DWYER: Bernard Dwyer, CEO of Amity Community Services,

Ms COALTER: Nicola Coalter, deputy of Amity.

Mr ROMBOUTS: My name is Rian Rombouts and I am coordinator for counselling services.

Mr CHAIR: Would you like to make an opening statement Mr Dwyer?

Mr DWYER: Yes. Thank you for the opportunity to speak to the committee. Firstly, if it is okay with the committee I would like to briefly outline Amity and our own experience, then Nicola will talk about the concerns and issues we are seeing around methamphetamine and some of our statistics. Rian will discuss treatment, options and the evidence in that area.

Amity was established about 40 years ago. We provide education, intervention and prevention services around alcohol, other drugs, gambling and co-occurring mental health issues. Amity works in a number of Indigenous town communities as well. We are working with the people there to decrease the harms around alcohol, drugs and volatile substances. We also work in the area of gambling, and provide Territory-wide public health information, a 24-hour helpline and intervention and deliver gambling venue training. The counselling service is located in Parap and Amity's counselling building was constructed six years ago with a grant from the federal government to assist addressing amphetamine-type substance use, and is specifically designed for people who may be using stimulants and attending for counselling. Among the features are double exits for every counselling office, wide corridors and duress alarms. It is also insulated for a cool and quiet low-stimulus environment.

Rian, Nicola and I have mental health backgrounds and qualifications. Rian and I are registered psychiatric nurses, each with more than 40 years working experience in the area, including more than 20 years in drug and alcohol specifically. Rian has worked in detoxification, methadone clinics, counselling, court diversion, as well as general mental health. I have worked in forensic mental health, rehabilitation, detoxification, counselling and outreach, as well as general mental health. Nicola is a registered psychologist and has worked for eight years providing counselling, education, intervention prevention services around alcohol, other drugs and gambling, and co-occurring mental health issues. She has also had extensive work experience in the hospitality industry, which is very helpful in some areas.

The approach in Australia to address drug issues over the past decades has been around supply, demand and harm reduction. There has been a strong reliance on supply reduction, but evidence and experience shows that while it is important it has had limited impact by itself and can increase the harms in some areas. Portugal and Switzerland have tried slightly different approaches with a strong focus on drug use as a health issue while still addressing supply, and have had significant positive outcomes.

I will hand over to Nicola now to give a brief overview of the concerns and issues arising, and also what we are seeing at Amity at the moment.

Ms COALTER: I would like to kick off, as Weil and Rosen said in their book *From Chocolate to Morphine:*

> *People have always and will always seek ways to change how they think, feel and behave. In our quick fix society that is often drugs.*

Why do people use drugs? For experimental use, curiosity, for recreational use, enjoyment, because of their environment, intensive or bingeing use, dependent use - meaning that we are dependent on a substance and we need it to feel normal - or therapeutic use, whether that is prescribed or not. An example is it helps us with avoiding negative feelings, also to ease pain of trauma and abuse in our life, past or present, challenging living environments and unhappy home lives.

Recently the National Cannabis Prevention and Information Centre conducted an online survey about experiences and perceptions of ice use. Over 11 000 people participated in this survey. These people reported they use ice because:

- I like feeling high
- to party and socialise
- to escape reality
- because I have issues and thoughts I do not want to deal with
- I feel like I can think more clearly
- all my friends use it
- to help me focus at work.

A number of researchers recently have identified particular industry groups and people who have higher than average use: hospitality, construction, media, mining, people who are lesbian, gay, bisexual or transgender and also sex workers. You may have already heard from some of these groups.

We know that most people most of the time - and the evidence backs up this statement - about 80% of people, manage their drug use and their change process by themselves. Most people take their own hand out of the fire. Therefore, providing reliable information and brief and early intervention about drug use - the effects and change - is very important to a population level.

Social determinants of health: according to research your health outcomes can be predicted by your postcode. Research tells us this. What are the social determinants of the environmental and societal factors that influence the health outcomes of people and populations? They include the economic, physical and sociocultural environment. If we, for a moment, think back to the reasons I presented as to why people use drugs and the social determinants of health, and think of some environments that people live in, you might better understand why I may choose to use substances.

We see methamphetamine use as a growing and emerging concern throughout our community. A quick snapshot of Australia and then I will talk a little about what we see at Amity.

The National Drug Strategy Household Survey 2010-13 provides this snapshot in regard to meth particularly: recent and lifetime population use rates of methamphetamines are stable; recent use of crystal methamphetamine – ice - has more than doubled; recent of powder – speed - has almost halved; recent use of base has dropped significantly; overall methamphetamine use is becoming more frequent; and weekly and monthly ice use has increased.

I brought along some graphs. May I pass them to the front? What we see at Amity- it is apparent from the research and our experience that methamphetamine use heightens the risk of negative health and psychological and social outcomes. People attending Amity have disclosed a range of negative impacts associated with alcohol and other drug use. These are not exclusive to people who use methamphetamines, but are commonly experienced by people with methamphetamine issues.

People report problems with relationships, relationship breakdown, domestic and family violence, increased aggression, mental health concerns, anxiety, paranoia, depression, physical health issues, employment issues or unemployment, child welfare and protection problems, housing, financial and legal issues.

While methamphetamine is causing significant problems for individuals, families and our community, it needs to be viewed in the context of harms associated with drug use across the Territory. The focus must remain on the various drugs causing health, legal and social problems, as well as major cost to the

community. Even if the scourge of methamphetamines is addressed, the majority of drug harms will remain.

As can be seen from those graphs, 2015 is predicted on our current stats. Alcohol continues to rise. Cannabis is all over the place, and the change from amphetamines to methamphetamines is indicative of what we know from research.

Ms ROMBOUTS: We are looking at evidence-based treatment, at prevention and awareness of the drug, early intervention, brief intervention, counselling, detox, drug substitution and rehabilitation. We need a wide range of services.

We now know there is less evidence that scare tactics, gaols and forced treatment works. As Bernie mentioned already, we are looking at Portugal where they legalised drugs and put that money to other use. Again, why do people use drugs? Nicola already mentioned that. The reality is that people have been using drugs forever because they have heaps of positive benefits. It feels nice, makes you feel good, opens up the mind and gives the mind a break from reality. This, then, makes the drug a health issue.

Amity looks at evidence-based practices, and there are different forms of users we need to look at because certain users need this and other users need this. There is a big need and we should look at the broad field. At Amity most people we see already use regularly and intermittently. The treatment is counselling with motivational interviewing, explanation of drugs and the effects on the brain, cognitive behaviour therapy, relapse prevention, and some people are referred by Corrections and the motivation to change is different than people who self-refer.

When the Credit Court was in place people using amphetamines were referred to Amity. The good thing was this court diversion gave people a chance to change their use and that was then reflected in their sentencing.

Between 1 July 2014 to 30 June 2015 a total of 253 clients were seen and 60 identified ice as their problem. Interestingly, - that is 24% - 130 people saw alcohol as their problem, so alcohol is a bigger problem than ice. Other people might need detox, but it is well documented that detox, by itself, does not work. Most people who are drug users have detoxed by themselves many times. I have known people who have booked themselves into a hotel room with a 'Do not disturb' sign and detox there. Most ice users have detoxed by themselves. That is where the problem starts; they only fall back into the habit because it is so hard to keep on going because motivation is really tested.

Detox for ice can work. There is some evidence that a chemical substitute such as Ritalin and other forms of dexamphetamine have some success. However, there needs to be more ongoing research.

Clients need follow-up for a long period of time. In the area of residential rehab, a special rehabilitation for meth users is needed. The rehab used for alcohol and heroin is quite a different picture. Ice users need a low-stimuli environment to detox - no harsh lights, no loud music or voices. So straightaway accident and emergency is not suitable.

Detox for alcohol and heroin takes about five to seven days, while for ice users this is 10 to 14 days. What happens for ice users is they crash for the first three days, then they often have no capacity to engage or even reach a simple goal of having a shower. This is related to chemicals in the brain - and I am not going to talk about that because I do not know too much about it.

The treatment needs to be done in plain English, with explanation how meth affects all aspects in a person's life. When people first stop using there is a big gap and nothing is enjoyable. This will take a long time to get back as the body and brain repairs themselves, and is done by physical activity, a healthy lifestyle and a change of environment.

The thing with ice is that it takes about 12 to 18 months to get the chemicals in the brain back. That is a long period for rehabilitation. There is evidence that there is a need for staff training and for emergency staff and police to learn how to de-escalate situations. They already know how to do that but the situations they face are quite often challenging.

There is a need for all treatment agencies to work together so referral pathways are established, especially in the cases of domestic violence and children. One shoe does not fit all. A nit-pick study in 2015 showed that young people around the ages of 14 are interested in trying this drug, so more effective education is needed to start it schools - not scare tactics as to what is happening.

Information from clients I spoke to stated that ice is easy to obtain and purity is stable. This is confirmed by the EDRS which also shows that ice is readily available in the Northern Territory. Price has been relatively stable in 2014-15, with some people reporting that they get it cheaper if they are regular users. You are looking at $150 for 0.1 gm, $350 for 0.25 gm and $600 to $1000 for 1 gm.

When people are coming down, they crash, they are exhausted, irritable, paranoid and aggressive. A few things need to happen, but also there is a role of support groups for users. There is a role for employment programs. Friends and family need to be educated and there needs to be some financial support - perhaps support groups of friends and family. And there need to be some community forums where they dispel the myth, and we need to build support in the community. Thank you.

Mr CHAIR: Thank you very much. You talk in your submission that your numbers for people accessing your services, specifically related to ice, are up from 23% to 39%. What are those numbers? Are we talking hundreds of people or 20 people?

Mr DWYER: There were 46 last year and it looks like 70 this year.

Mr CHAIR: Can I also get a read on exactly what you guys do. Do you have detox beds?

Ms COALTER: No, we provide face to face counselling which is a very …

Mr CHAIR: Just counselling?

Mr DWYER: We work with GPs or other services either in the community, specialist mental health or whatever to provide …

Mr CHAIR: Your referral networks are basically GPs.

Mr DWYER: We have good connections with the GP services, but word of mouth is quite high as well.

Mr CHAIR: Your success rates - if you are working through not necessarily a full rehab program, but rehab counselling, are you linking with people who do rehab?

Ms COALTER: On the continuum of care rehab is different to counselling. It motivates people and teaches them skills to manage their behaviour and choices when they are back in the community.

Often in rehab it may be around detoxification and learning how to manage again without the substance, but when we put people back into their real life environments they need a whole range of skills and that is where the face to face counselling can …

Mr CHAIR: You are picking up after that set rehab time frame?

Mr DWYER: No, not everybody needs to go to rehab. Traditionally it has been one of the methods of dealing with any drug use, but it is only one area and does not suit everybody. It also depends on the individual and the environment they are in. If people are homeless, have poor social connections, financially difficult issues then rehab may be appropriate. For others they may be in work.

Ms COALTER: When we were at the meth symposium in Melbourne recently they said the time from first use to time of problematic use can be 10 years. If we think back to the industries where people are working, and usually shift workers, people can manage their drug use and manage their employment. It might be an indication that they do not need rehab and certainly do not need detox, but might want to change over a period of time. That is where we come into play on that continuum of care.

Mr CHAIR: Right.

Mr DWYER: Also there is a lot of information of the effectiveness of different services. If you are looking at effective and cheaper, quite often there is a group that will suit the counselling mode and then you have a group that will need residential rehabilitation and detox within that environment. It is not that all needs to go to one and then back through, it depends on their circumstances.

Most people who change their drug use, whether it is tobacco, alcohol or amphetamine - very few people are using the same at 17, 18, 19 or 20 as they are at 70. We may all have experienced various things in

our life and at different times are more vulnerable to drug use or a particular behaviour, but quite often if we are given the resources and support we make our own changes or make changes in the environment we are in. Not everybody needs to go to residential rehab.

We work quite closely with Banyan, and do not have a problem working in an environment where some people need that environment and others …

Mr CHAIR: You are not seen as competitors; you just have a different clientele?

Mr DWYER: No, we see it as a continuum.

Ms COALTER: It is a continuum of care. As Rian mentioned, not all shoes fit all people. It depends on what I might need because of what is going on. For example, if I am a construction employee and can hold down a job but want to change, coming to somewhere like Amity might be really useful for me. However, if I do not have a job or a home I may choose residential rehab to support me through those processes.

Mr CHAIR: Are you seeing a link between the demographic of people accessing your services, or a change in the demographic trending?

Ms ROMBOUTS: Not really. Having said that, there is a shift towards Palmerston, Virginia and Coolalinga, but statistically. But statistically I have no evidence of that; I have not searched for it.

Mr CHAIR: Ages?

Mr DWYER: Aged 25 to 35. That would be the bell curve - some younger, some older, but …

Mr CHAIR: Generally 25 to 35?

Mr DWYER: Yes. It would cover most of …

Mr CHAIR: Industries?

Ms COALTER: We do not identify. We identify employed or not employed. Most people, most of the time over the history of Amity, indicate that they are employed ...

Mr DWYER: To some degree.

Ms COALTER: Most people, most of the time, are self-referred.

Mr WOOD: Any correlation between FIFOs and the increase?

Ms COALTER: The evidence suggests that all shift workers are more susceptible. The high-risk industries are construction, transport and mining.

At the meth symposium in Melbourne they also talked about drive in/drive outers as the same as fly in/fly outers for maintaining the schedule, and also for partying and socialising on time off ...

Mr CHAIR: On your week off, yes. Why do you believe you are seeing the shift to methamphetamine, away from particularly just amphetamines or possibly other drugs, depending on which set of data you look at?

Ms ROMBOUTS: It is money.

Mr CHAIR: It is cheaper to take …

Ms ROMBOUTS: Yes, it is cheaper to take ice than it is amphetamine. The other thing too is because it is not available anymore. Amphetamines have been around since the early 1920s but it is not available anymore. People still prefer that, but because it is not available, they go to ice, then ice becomes cheaper, in fact.

Mr DWYER: It is probably price and availability are the thing, yes.

Ms COALTER: The key indicators of drug use.

Mr CHAIR: Regarding that demographic that you see, I am interested in your demographic because you are probably – we hear a lot of information about the down and outers, addict-type people. Are you guys seeing ...

Ms COALTER: That is not our client group.

Mr CHAIR: … a different clientele, a more employed, middle-class-type people who are having issues?

Mr DWYER: Tradies, yes. People in some sort of employment, not necessarily full-time employment but some working extreme hours as well so they may use it for …

Mr CHAIR: Functional reasons.

Mr DWYER: Functional reasons. That is right, yes.

Ms COALTER: There is a story about a bricklayer who can lay more bricks when he has a few pipes than when he does not engage in substance use. If you are being paid by the bricks that you lay, that seems to be a bit of a motivation.

Mr CHAIR: Yes. That is good because a lot of the information we hear from people is not the information that you have access to. So I am very interested to look at what you think needs to be done to assist in that space. We are receiving lots of recommendations on how to help one end. But in dealing with this issue there is not much that has been said about people who are taking it either for functional reasons or for fun. How can we stop the people who are taking this for fun? How do you get them? How do you get onto them? How do you get them to realise they need your services?

Ms ROMBOUTS: One of the things we have is an assertive follow-up. People come to us, then if they, for instance, do not come again we will follow them up. We will phone them and invite them to come back. They quite often talk to their colleagues and they say, 'Okay, go to Amity'.

Ms COALTER: When you talk about people who may not even access a treatment agency, in the three pillars of the national drug strategy that is demand reduction, having a public health approach where we have a campaign that is based in evidence, not the current one that is on our TV screens, and teaches people about the effects and the potential harms.

For example, Bernie will hold up a poster 'Treatment Works'. We have …

Mr DWYER: If we are aiming at construction industry and fly in/fly outs, this is at the airports now. It indicates that treatment works as well, for a start. We know from Nicole Lee's work – it is mentioned in our submission - that treatment returns seven for every dollar.

Ms COALTER: She talks about how you will get a return on investment of 2:1 in policing and a return on investment of 7:1 on treatment.

Mr CHAIR: To do what?

Mr DWYER: We encourage people to engage in treatment, but also if they are going to use, not to do it in the most dangerous way. We want them to think …

Ms COALTER: The strategies are all evidence based from research. They talk about, 'take a break with your drugs, take a break from your drugs, avoid daily use, take care of self-control, eat, sleep and drink water, avoid using alone' - that is one of the biggest indicators of potential harm when we start using our substances alone; true for gambling as well - … test before you use'.

Unfortunately, in Australia we do not have the capacity to help people and test their drugs to ensure they are okay and do not inject. Injection is a significant harm for people.

If we are looking at a population level, this is about to go on the back of one of our buses to educate the whole population that if they use - because people do use drugs - these are really good strategies.

Mr DWYER: Again, there are different segments of the community you are trying to aim a different message at. This one will be on the back of buses – that is on doors. In some areas it has additional information about avoid injecting, avoid using the …

Ms COALTER: These are in GP clinics, and we have had feedback from doctors where finally we have some evidence-based strategies for people.

Mr DWYER: It is encouraging people to access treatment as well. It is not downplaying the negatives that this can lead to. We know that if people stay alive they are more likely to change than if they are engaging in behaviours that are really high-risk and likely to increase HIV, Hep C and all those ancillary issues.

Ms MOSS: Something else in your submission was on workforce development, something we have spoken about quite a lot as a committee. Also, people have spoken about preparedness and how you deal with aggressive behaviours and those things. Could you elaborate more on what you see as the needs in workforce development across the sector to deal with this issue and what you do at Amity to protect your frontline workers?

Ms COALTER: Again, referring to the national symposium on methamphetamine this year, they talked about the AOD sector having these skills. The confidence to use these skills is often lacking for agencies. For workforce development we are suggesting a diverse range of workers, not just people in counselling, who may be responding to methamphetamine use in our community - police, paramedics, emergency department staff as well as AOD. In particular in our environment it was the infrastructure, the purpose-built counselling building that is low stimulus, cool and does not have a lot of stuff hanging around the walls; it is quiet and can be very calming. I do not think in the years - I have been at Amity for seven years and in those seven years we have not had an incident with violence or aggression, but you guys have been around a lot longer than me.

Ms ROMBOUTS: They would not dare.

Mr DWYER: We have had people who have been quite psychotic and we have encouraged them to come with us to mental health services etcetera. I remember a family violence incident happening on the footpath and coming into work rather than in direct relation to our service. Working on not increasing the issues relating to drug use or whatever is probably one of the keys, but also the way people interact with the person who may be experiencing quite significant difficulties in understanding or rational thinking. We look at keeping sessions shorter rather than longer because the inability to concentrate may be an issue, so having short, sharp information rather than …

Ms COALTER: Also take home information. Again, evidence coming out of the research is suggesting shorter sessions because of people's concentration and ability to maintain engagement, and also written information to take home that is quite simple and about strategies for change.

Mr DWYER: I know the question is about staff training so a good understanding of what the drug is, what the expected behaviours would be, what methods or activities you have to engage with the person in through - de-escalating issues and having good referrals so that if people are experiencing major issues in relation to psychosis or mental health issues you have good connections with other services.

Having worked in the area for many years, we accept that at times people are not in a position to make rational, informed decisions and are a danger to themselves or others. In those cases, there may be a need for other services that can contain them, so we may work with the police, Mental Health Services or ambos.

Ms ROMBOUTS: I would like to add to that. When there is a person who is rather psychotic, you do not argue with them; you agree with them. Having worked in acute psychiatry for a long time you learn that sort of skill. Lots of people do not want to agree with that. If people say, 'I missed my plane. I need to go now.' You say, 'Okay, hop in, I will take you to the airport' - via Cowdy Ward, of course. But you do not argue with them because that only increases the stress and the anxiety, and that then causes aggression.

Ms COALTER: When you use stimulants you are already highly reactive. Being in an environment, for example, an emergency department or a police lock-up cell, is not going to calm your stimulus and your anxiety at all; it is going to increase it. That is why things escalate out of control.

Ms ROMBOUTS: Quite often the client will escalate because they see a person in uniform.

Mr WOOD: A question related to one of your statements in your report. You mentioned it in the summary at the beginning:

Amity supports the reinvestment into a specialist Alcohol and Other Drug court for the Territory.

You mentioned also we had a SMART Court. Do you believe that is something that we should reinvest in?

Ms ROMBOUTS: Definitely. I worked in the CREDIT court which came before the SMART Court. People had a chance before they went to gaol to change their life. That is where they come in for counselling, you do the motivational interviewing, you start doing a balance from what is good, what is not so good about your drug use. People then might get motivated to alter their lifestyle. With the help from urine samples they can prove to the court they have stopped using. Then the magistrate – it was a magistrate court –then quite often lightened the sentence or kept it going for a while for persons to start to find the benefits of not using and all of a sudden having a job and getting some money in the bank. So they get motivated to change. I loved the CREDIT court.

Mr WOOD: Did you see it work?

Ms ROMBOUTS: Yes, definitely.

Ms COALTER: Rian worked in it.

Mr DWYER: For a couple of years, yes.

Ms ROMBOUTS: Yes, I did see it work, but there are always people who do not want to change.

Mr WOOD: It is a carrot-and-stick approach, is it not?

Ms ROMBOUTS: Yes.

Ms COALTER: The benefit of the court system diverted people into treatment and treatment needs to be a significant part of the solution.

Mr DWYER: But it definitely does not need to be a very loose, good-intentioned court, it needs to be structured. There are definite processes involved. Like you say, there is a carrot and stick, if you like. If people do not want to go to treatment and address issues through that, then there are other options which may be the criminal justice system. Also the reporting mechanisms or the need to be not using or whatever the requirement is, is transparent and verifiable.

Mr KURRUPUWU: Is there a service in remote communities?

Mr DWYER: From Amity? No, we work in town communities here, so we are aware that there are sometimes people from remote communities come into the town communities. It is questionable whether – the information is that some people engage in using methamphetamine and then go back to their community, so there is always the potential of developing strong links between the town and the remote communities. But we are predominately Darwin for the drug service.

Mr CHAIR: Can I ask a question about how you are funded?

Ms COALTER: Sure.

Mr CHAIR: How are you funded?

Ms COALTER: Our counselling service is funded by the Northern Territory Department of Health, our gambling service is funded by the Northern Territory Department of Business and our illicit drug counselling and referral project, which is a very small project, is funded by the federal Department of Health, as is our AOD Indigenous town communities work.

Mr DWYER: It is a mixture of Territory and Commonwealth.

Mr CHAIR: I heard there were some federal funding issues.

Mr DWYER: There was definitely uncertainty of funding about May this year. There was still no clarity then that funding had been extended for 12 months. After that 12 months there may again be uncertainty about funding for the town communities and the illicit drugs project- 30 June. .

Mr CHAIR: That is your illicit drug work?

Ms COALTER: It is our illicit drug counselling and referral work. Although we have face to face counselling around alcohol and other drugs from the Territory Department of Health, the work that we do in building referral networks with GPs and throughout the communities is funded federally.

Mr DWYER: And developing community education as well as half a position for face to face counselling.

Mr CHAIR: How much of that is your business?

Ms COALTER: It is half a position in our counselling - our illicit drugs federal money.

Mr CHAIR: A percentage of your whole business? Is it a big part? How much are we talking? Are we talking about $1m?

Mr DWYER: No, illicit drugs is something like …

Ms COALTER: No, $117 000 per annum.

Mr WOOD: Is that not one of our problems? If you are looking at long-term change you need long-term funding.

Ms COALTER: Absolutely.

Mr CHAIR: Am I allowed to say this without sounding like I am bashing the feds? Are we not in a big campaign against ice?

Mr WOOD: Yes, that is right. You cannot run a program if everyone is stressed about whether they will have a job next year.

Ms COALTER: Sometimes you cannot staff a program if you have no certainty in your workforce.

Mr DWYER: It is certainly something we are aware of because this year we had to work through that issue and try to maintain staff and programs without any predictability so people have to start looking. People have mortgages to pay and all the rest of it so they have to move on. The problem is they have a lot of experience, and also we have spent a lot of money on developing the skills staff need.

Mr CHAIR: Is the NT government money more firmed up?

Mr DWYER: The NT government now ...

Mr CHAIR: Service agreements and things?

Mr DWYER: Yes, we have until June 2017. It was three-year funding this time, and also with the Department of Business and gambling it is three years. That has not always been the case. It has been one-year funding quite often, but I think there was - we have had a fairly good relationship with the departments. We have known whether funding is likely. One thing this year was there was no information and no way of predicting which way things would go.

Mr CHAIR: From the feds?

Mr DWYER: It was not because their mechanisms were grinding away and going to happen. With the federals it was quite difficult to predict the outcome.

Ms MOSS: Are there any other issues you would like to raise with us or for us to consider?

Mr DWYER: No. In the submission there are four points we have highlighted as significant. We will leave it at that.

Ms COALTER: Thank you.

Ms ROMBOUTS: Thank you.

Mr CHAIR: Thank you for sharing with us today.