

EXECUTIVE SUMMARY

Illicit drugs and the harms associated with their use continue to be major issues for Governments at all levels in Australia and throughout the rest of the world. In global terms the level of health-related harm caused by illicit drug use is relatively small compared to the harm associated with the socially accepted and regulated use of licit substances such as alcohol and tobacco. Only a small proportion of Territorians use illicit drugs other than cannabis. Those that do use these illicit drugs usually do so for a relatively short period of their lives. However, there can be substantial burdens of harm associated with the use of illicit drugs. These include involvement in crime, community and family disruption and distress, transmission of blood borne diseases such as HIV and Hepatitis C, and overdose related deaths. In comparison to the mortality attributed to alcohol and tobacco, the number of people dying from illicit drug misuse in the Territory is not high. However the impact of illicit drug-related morbidity and other problems is significant because generally it occurs at a much younger age and both the physical and social consequences can be serious.

Through reviewing the literature and hearing community views, the Taskforce has come to realise that the Northern Territory is in a unique situation. The illicit drug problems experienced in other States, such as the large numbers of heroin overdoses, public drug dealing and injecting and the level of drug-related crime, largely do not occur here. However there are people using illicit drugs, harming themselves and their families and coming into contact with the criminal justice system. Still there is an opportunity to prevent illicit drug problems from reaching the scale it has in other jurisdictions. For those using drugs and experiencing harm, there is an opportunity to intervene, engage them in treatment and reduce the harm. There is also a chance of assisting families of drug users, who may need information, access to services and support.

The Taskforce conducted wide-ranging consultations throughout the regional centres of the Territory. These included consultations with the general public and service providers in Alice Springs, Tennant Creek, Nhulunbuy, Katherine, Darwin and Palmerston. Overall, 67 people attended hearings for the general public, 105 attended meetings for service providers, 19 people came to drug user meetings and 12 young people attended youth meetings. In addition, the Taskforce received 79 submissions from a range of individuals and organisations. A summary of the community consultations has been provided at Appendix A and for the submissions at Appendix B.

There has been a particular focus on the needs of young people and families by the Taskforce. The issues pertaining to each of these population groups have been explored in detail and identified under the section titled 'Identified Priority Groups'.

Overall the Territorians who spoke or wrote to the Taskforce represented a mix of views and experiences relating to illicit drugs. Nevertheless, there were some broadly agreed themes:

- Alcohol is the major drug of concern in the Northern Territory.

- There is only limited established use of illicit drugs, other than cannabis, outside Alice Springs, Darwin and Palmerston.
- The apparent escalation in the use of cannabis has raised considerable alarm amongst the general public and service providers, including its use in remote communities (even though participants were reminded that the terms of reference did not include alcohol or cannabis specifically).
- Amphetamine availability and injecting use are reported in the main population centres and there are some anecdotal reports of its use in remote communities.
- Injection of prescription morphine, predominantly in Darwin, Alice Springs and Palmerston is causing concerns among a number of groups in the community including the police, medical practitioners and users.
- While less apparent, benzodiazepine injecting was also reported to be occurring, especially in urban areas.
- Mixed use of licit and illicit drugs is reported to be an increasing trend and service providers generally feel ill equipped to address it.

In the context of considering appropriate responses to illicit drugs in the Northern Territory, some broadly agreed themes emerged:

- The importance of acknowledging and building on existing strengths was emphasised in communities, in towns and across sectors.
- In response to the perceived trend for the use of illicit drugs by younger people, the general community response was often to propose earlier and 'better' education to prevent drug use problems, although this was often more in hope than expectations of success.
- General agreement that resilience skills, such as building on strengths, self esteem, and coping skills, should be part of the school curriculum as early as possible, to enhance their preventative value.
- A common theme at all levels of service provision was the question of who should provide drug information, education or advice. Some identified the importance of respect and credibility of the person providing the service.
- The significance of the family was emphasised in many contexts: prevention, early intervention and help for users. Support for families is often seen as the most efficient, effective and influential route to reach and assist the user.
- The need for holistic approaches to service delivery was emphasised many times. A general theme was that drug use should not be separated out from other aspects of a person's life.
- There is a need to improve communication between service providers, policy makers and users, to enhance policy and service planning.
- The value and potential efficiency of a strategic, integrated approach to drug use at every level, between organisations, sectors and all levels of government, was raised in many contexts.

- More work is needed to identify funding arrangements that recognise and support the special requirements for working with remote Indigenous communities.
- The media is a key source of opinion and apparent information, but there is general cynicism about it as a credible source of information or its ability to represent drug issues accurately.

The Taskforce has endeavoured, wherever possible, to seek evidence from research, Northern Territory data collections, and other sources to complement the information, experience and opinions expressed in the submissions and consultations. Obviously many issues and suggestions put to the Taskforce within the time limits allowed will require continuing and further examination and consideration.

New information is emerging all the time and it will be important for the Northern Territory Government to consider this report in the context of up to date information as it becomes available. A particular example is the data from the most recent National Household Survey of Drug Use which were not available for inclusion here.

RECOMMENDATIONS

It is important to highlight that the Taskforce's investigations and subsequent findings and recommendations provide a milestone in the development of a Northern Territory strategy to deal with illicit drug use. This report provides a significant contribution, and it is presented at a time of debate and change within the illicit drug arena in the Territory.

In presenting these recommendations, it is important to note that they are presented in the order that they appear in the text of the report; the numbers do not represent any order of priority.

1. INTRODUCTION

The Northern Territory Government has a vital role in creating an environment where the community can develop informed and effective solutions to the issues associated with illicit drug use. It is essential to recognise that the issues associated with illicit drug use can not effectively be dealt with in isolation. Given the complex issues underlying drug use and associated harms, a whole-of-government approach to the promotion of protective factors, the reduction of risk factors and prevention of harms is required.

The problems associated with drug use invariably raise a wide range of issues from education and prevention through treatment and rehabilitation to law enforcement.

It is necessary that a commitment be made at Ministerial, Cabinet and Chief Executive Officer level, to ensure that a cohesive and coordinated whole-of-government approach is achieved. This commitment will ensure that substance misuse issues, including illicit drug use, are handled in a more comprehensive manner.

As is the case in other jurisdictions, the Taskforce is recommending the establishment of a coordinating unit to provide a comprehensive focus on drug policy and strategy that involves law enforcement, education, health, housing, youth, welfare, business and the non-government sectors.

New South Wales provides an example of this type of approach, where the New South Wales Government has established The Office of Drug Policy to provide leadership, and to assist in the development and implementation of an integrated approach to drug programs and policies. A range of other jurisdictions also incorporate a whole-of-government approach including Queensland, Western Australia, Victoria, and South Australia, with differing structures that enable this to be effected.

It is recommended:

1.1 That a central coordinating unit be established to take responsibility for a comprehensive drug and alcohol strategy in the Northern Territory. This unit should:

- **Have the capacity to lead and strategically coordinate relevant government departments' drug related efforts.**
- **Be situated in the Department of the Chief Minister and be directly responsible to the Chief Minister, at least in the initial stages.**
- **Convene a high level interdepartmental committee, comprising the Departments of: the Chief Minister; Health and Community Services; Police, Fire and Emergency Services; Employment, Education and Training; Justice; Community Development, Sport and Cultural Affairs; and Treasury.**
- **Involve non-government and user group organisations.**

The deliberations of the Taskforce have raised a great deal of community and media interest. Substantial community input has been made to the process and a clear message was received by the Taskforce for the public to be informed of the Taskforce findings.

Therefore it is recommended:

1.2 That a summary version of this report be released to the public.

The Taskforce received information in both submissions and consultations regarding the role of the media in reporting on drug issues and shaping attitudes in the community. Drug use is covered in many different aspects of the media, such as news reporting, advertising and portrayal in television and radio programs. The media has an important role in the dissemination of accurate information around sensitive and emotive issues such as illicit drug use. The Taskforce believes that the local Territory media organisations should be actively engaged in the development of appropriate codes of practice to cover the issue of the portrayal, depiction and reporting of matters related to illicit drug use.

2. TRENDS

Sound policy and program development is highly dependent upon the availability of reliable and valid data. There are a number of factors that cause difficulty when it comes to reporting trends in illicit drug use and any associated issues. In particular illicit drug using behaviour is illegal and generally regarded as socially undesirable by a significant portion of the community. Given this, purchasing and consuming these drugs are hidden from public view and scrutiny. Usually it is when people experience harm from their drug use, seek treatment or are apprehended for criminal behaviour that data about who is using what drugs and the associated harms are collected. This lack of data is particularly noticeable when one compares illicit drug use to the use of the licit drugs, alcohol and tobacco, which have been well researched and whose use is generally considered socially acceptable.

Although the task of monitoring trends in illicit drug use and the associated harms is a difficult one, there are a variety of sources of information that are currently available at a Territory, National and international level. These data come from a range of sources such as surveys of the general population and specific subgroups to a wide variety of secondary data sets, particularly those collected by health and law enforcement agencies. When considering these data, it is important to recognise that it requires careful consideration regarding possible biases and inherent errors.

The Taskforce has received and reviewed data from many sources. It appears that the major drug problems in the Northern Territory remain alcohol and tobacco, both in terms of the economic costs and associated physical and social harms. These substances were outside the scope of this Taskforce but they are mentioned here since they are almost always used by those who use illicit drugs and because in community consultations participants were so adamant about alcohol being the number one issue. Cannabis was a close second in priority of community concern.

Illicit drugs other than cannabis are available in the main metropolitan centres and some rural communities. The Northern Territory has had an opiate problem that is largely made up of prescription medications. Like other places in Australia, change in drug using patterns and potential harms are occurring. Amphetamine type substances are being reported more frequently and occurring across the Territory.

Whilst the Taskforce had difficulty in obtaining specific Northern Territory data to indicate the local links between crime and illicit drug use, the research that has been undertaken, such as the IDRS studies, does establish that similarities are likely to exist with those that have been determined in other Australian jurisdictions and internationally. That is, there is a clear link between drug use and certain types of crime, such as property crime.

We are aware that there is limited clear, consistent and reliable information about the patterns of drug use and related harms in the Territory. If future policy and programs are to be soundly based, more effort is needed to maximise the usefulness of available data and support the collection and analysis of more consistent and reliable information. This needs to be done through a mix of extrapolation from National experience, where indicators suggest this is valid, and the extension of data collection in the Northern Territory where unique characteristics suggest some differences are likely. Efficiencies might be possible through adding resources to ensure larger samples in National population surveys for example.

The Taskforce therefore recommends:

- 2.1 That key indicators of drug use and associated harms need to be consistently collected, compiled, analysed and reported to Government and the community.
- 2.2 That some strategically selected national drug-related surveys be considered for additional funding to ensure appropriate numbers for Northern Territory specific analysis and comparisons.
- 2.3 That when major initiatives in such areas as mining, tourism and transport are planned a drug impact study be conducted as an aspect of planning and risk management strategies identified.
- 2.4 That the Illicit Drug Reporting System (IDRS) continue to be conducted in the Northern Territory.
- 2.5 That periodic assessments in 'sentinel' Aboriginal communities together with analysis of indicator data from Community Health Centres, Police and Correctional Services, be undertaken to identify emerging issues, determine the actual and perceived impact of drug use and guide possible constructive responses.

In a study by Collins and Lapsley (1992), *The social costs of drug abuse in Australia in 1988 and 1992*, estimated that the total economic cost of drug abuse to the Australian community in 1992 was \$18.844 billion. This included both tangible costs (eg hospitalisation, ambulance and emergency services) and intangible costs (eg prevention, treatment of drug-related illness, loss of productivity, property crime, theft, accidents and law enforcement). Of the total cost of \$18.844 billion, it was estimated that \$12.736 billion (67.3%) was due to tobacco smoking, \$4.494 billion (23.8%) was due to alcohol abuse and the remaining \$1.684 billion (8.9%) was due to the abuse of other drugs.

The third national study of social costs of drugs in Australia is currently being finalised by Collins and Lapsley. This study uses 1998-99 data and will update their previous work (1988 and 1992) and further refine the analysis of costs of drugs in our community. Previous State specific studies have allowed these economic researchers to produce State specific reports for Victoria and Western Australia. The Northern Territory would benefit from a specific analysis of the social costs of drugs given the particular characteristics of the Territory and the likely differences in the profile of drug use and patterns of harm. This work is feasible and every effort should be made to take advantage of any State specific analyses arising from the publication of the national report. This matter could be pursued in conjunction with other jurisdictions at a Commonwealth level.

It is recommended:

- 2.6 That economic research to determine the social cost of drug use in the Northern Territory is conducted building on comparable national studies.

3. PREVENTION

Harm minimisation, the key principle underpinning Australia's Drug Strategy since 1985, has been identified as one of the features contributing to the success of the National Drug Strategy. Harm minimisation, as a whole, refers to policies and programs aimed at reducing drug related harm: it aims to improve the health, social and economic outcomes for both individuals and the community as a whole. Harm minimisation encompasses a wide range of integrated approaches, including:

- Supply reduction strategies designed to disrupt the production of supply of illicit drugs;
- Demand reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; and
- A range of targeted harm-reduction strategies designed to reduce drug-related harm for particular individuals and the community as a whole.

Supply reduction refers to those interventions that are designed to reduce availability and supply of particular drugs using control measures such as prohibition and regulation. Predominantly these interventions are law enforcement and interdiction strategies. It must be emphasised that as with demand reduction and treatment strategies, traditional law enforcement and interdiction strategies have limited success when they are applied in isolation. Furthermore, there is evidence that sociocultural norms and informal social controls may be more important in determining the prevalence of drug use and how drugs are used than formal controls such as prohibition.

In an effort to prevent the harms associated with drug use and subsequent criminal activity and incarceration, law enforcement diversion programs are evolving throughout Australia. This includes the pre-court diversion program that is being implemented in the Northern Territory, with support from the Commonwealth Government. The aim of diversion is to interrupt drug use and divert people away from the criminal justice system and into services that provide information and treatment.

A number of other Australian jurisdictions are at present implementing drug court systems, as an alternative method of dealing with drug-related offending. A number of these programs are currently being evaluated. The Taskforce is aware that the Justice Department is currently investigating options regarding the introduction of a Drug Court system to the Territory. It would advise that close consideration be given to the experience and evaluation of these systems in the other jurisdictions, in guiding any future decision-making in the Territory. Cost-benefit considerations are likely to be most important.

In recognition of the role of illicit drug supply reduction measures, the Taskforce recommends:

3.1 Support for efforts to enhance evidence based, strategic use of law enforcement and criminal justice systems with regard to illicit drugs.

Demand reduction strategies aim to reduce the desire for and preparedness to obtain and use drugs with the purpose of preventing harmful drug use and preventing drug related harm. Preventing non-users from taking up drug use, delaying the up-take of drug use and reducing problems amongst substance users apply across the lifespan of individuals. These strategies can effectively be implemented in settings where people spend time and where the environment can support the strategies, for example, schools and workplaces as settings for drug education supported by policies on drug use.

Research indicates that strategies that are comprehensive (involving school, community, parents, community organisations and social policy) are more likely to be effective generally than single channel programs (for example, school based drug education programs or mass media advertising) on their own.

The community is supportive of efforts that might prevent the uptake, ongoing use of and harms associated with illicit drug use. Communities are concerned for individual drug users, their families and the overall communities in which drug use takes place.

There is a place for increasing the community knowledge about evidence for what might work. New evidence is emerging from national and international research to support initiatives that go beyond traditional drug education.

There are risk factors that increase the likelihood of drug trouble in individual, family, school and community domains. There is also a suite of protective factors in these domains that enable a person to rebound from negative life experiences and to cope with problems in a positive and healthy way. Two key themes emerging from risk and protective factor research are connectedness and resilience. Connectedness refers to a sense of belonging and having strong and meaningful connections to family, school, peers and the community. Resilience refers to the quality that makes a person able to deal with the problems and demands that may confront them in different social settings, and to respond well to a range of life events. Parental support has been identified as being important in the development of both of these factors.

The shielding effects of protective factors and the negative effects of risk factors often interact and are different for each individual. Caution should be exercised in causally linking risk factors to particular problem behaviours.

Evidence suggests that a key preventative step is to ensure that the early years are maximised to enable sound development. By intervening early it is theorised that these factors can be mediated thereby preventing escalation into later problem behaviours. A number of important transition periods or events, have been identified, along the pathway of development when interventions were most likely to be effective. These include: the birth of a child, preschool years, moving from primary to high school or graduating from high school and engaging in higher education, the workforce or possibly unemployment.

Specifically, it is recommended:

- 3.2 That pregnant women be recognised as a special group for focussed alcohol, tobacco and illicit drug education and support. This should include: provision of accurate and up-to-date educational materials; establishment of referral protocols to specialist alcohol and drug agencies; and training of relevant service providers.
- 3.3 That parenting support programs, particularly focussing on early parenting, be available and accessible to parents throughout the Northern Territory.
- 3.4 That the Northern Territory Government seeks opportunities to be a site in national and international research in the developmental prevention area.

Given the interrelatedness of prevention in these various areas and the extensive areas of possible targeted interventions, governments around the world are exploring new ways of funding programs that allow for coordinated contributions from the various areas or departments traditionally concerned with the impact 'downstream'. This is a mix of notions of 'joined-up-government' where the effort is to build the functional or departmental connections, and 'upstream' funding where resources are provided to address the very early antecedents contributing to a problem, rather than only reacting to problems when they have become obvious.

There is support for community strengthening initiatives. The identification of common antecedents to harmful drug use and other social and behavioural problems, including youth suicide and crime, suggest a multi-layered approach.

A comprehensive prevention program needs multiple elements. This can include strengthening and supporting communities through comprehensive programs such as 'Communities that Care' and ongoing support for evaluated local community initiatives such as 'Beat the Grog', alcohol restrictions in Tennant Creek focussing on the whole community. It also includes comprehensive drug education in schools that is embedded in the overall school program, early identification of those at risk and a willingness and ability to respond.

There is a need to provide information to the community about drugs and drug-related harm. Wide media strategies come at considerable cost. Synergies are however possible where other levels of government and non-government organisations are already active. The Northern Territory can add significant value to National efforts in this regard and identify Territory specific elements that build on the broad media base. This includes the ongoing phase of the National campaign targeting parents and the anticipated phase targeting young people. It is likely that one focus of the next National campaign will be on the problems associated with cannabis.

Therefore it is recommended:

- 3.5 That the Northern Territory take advantage of the ongoing National Illicit Drug Campaign and build in specific supporting measures with a Territory focus, to maximise the impacts of this National Campaign.

In relation to schools, the Taskforce believe that the most critical drug prevention measure needed is to ensure that all primary school children have access to quality education services and are encouraged and supported to fully participate. All other efforts are considered to be of a value adding type of approach, because unless the children are attending school they will not benefit from any programs or efforts the schools may be engaging in.

The whole-of-school intervention approach goes beyond the curricula to include the development and implementation of school policies, access to counselling and support services and involvement of the school community (such as parents and teachers). This type of model offers a systematic approach to reducing harmful behaviours of young people because it seeks to improve students' 'health literacy' (knowledge and attitudes towards health) as well as their 'health skills' (decision making, seeking help and problem solving).

An example of this type of approach in the Northern Territory is the Mind Matters Project being implemented as part of a National Mental Health Promoting Schools Strategy. A Victorian program, which has involved a whole-of-school intervention, is the Gatehouse Project. This is a school-based project aiming to reduce the rates of depression and self harm, two consistently identified risk factors for youth suicide. The project's overall aim is to build a healthy environment rather than concentrating on individuals. It emphasises the importance of positive connectedness between teachers and peers and has identified three priority areas for action:

1. Building a sense of security and trust;
2. Enhancing skills and opportunities for good communication; and
3. Building a sense of positive regard through valued participation in aspects of school life.

In acknowledgment of the importance of schools as settings for social learning:

3.6 That the health promoting schools model be supported, implemented and monitored in all Northern Territory schools.

Research is now available about which types of drug education programs are the most effective. School based drug programs which emphasise fear of drugs and their consequences and promote peer resistance strategies as a deterrent to experimentation are ineffective. Evidence suggests that approaches based on the 'social influence model' that take into account the social pressures to use drugs and the information and skills necessary to resist using them can prevent uptake of some drugs. More recently developed 'social inoculation-based education programs' such as the Life Skill Training Program have been shown to reduce alcohol, tobacco and cannabis use into young adulthood. A number of evaluation studies have shown that Drug Abuse Resistance Education (DARE) and the Life Education Program are ineffective in reducing alcohol or other drug use among students.

In the time available, the Taskforce was unable to determine the content and extent of alcohol and other drug education being offered in schools. Concurrently with this Taskforce's enquiries, there are two other review processes taking place that include a review of alcohol and other drug education, one by the Department of Employment, Education and Training (DEET) and one by DEET and the Northern Territory Police. It is expected that the outcomes of these reviews will be useful in guiding decision making in this area.

Taking into account the available research the Taskforce recommends:

3.7 That a broad and comprehensive approach to drug education, based on evidence and best practice is developed and implemented in Northern Territory schools. It will need to take account of the most effective models of drug education including consideration of who delivers the educational component, how parents and the wider community can be involved, what policies are needed to support the educational aims, how students are supported who are having problems in general and problems with drugs in particular.

The professionals who are currently involved in vital support roles in schools are in an excellent position to be providing interventions and guidance in the development of alcohol and other drug strategies in schools. These professionals include school nurses, counsellors, school-based police, liaison officers and others in the school environment currently playing a social welfare role.

The Taskforce recommends:

3.8 That those who already have a vital support role in schools receive training in alcohol and other drugs strategies and approaches, specifically in brief interventions.

Reducing Harms Associated with Injecting

There are injecting drug users in the Northern Territory. There are important policies and programs that reduce harm associated with some level of ongoing use of drugs. These are vital in preventing health problems among people who inject drugs (PWID) as well as in addressing concern about public nuisance and matters of public amenity associated with some drug use.

Needle and Syringe Programs (NSPs), as a public health measure, continue to be a key strategy for reducing the harms associated with injecting drugs. Issues of availability and disposal are essential elements to be considered and require strategies to be put into place, as they can and do often raise debate in the general community.

Primary NSPs currently operate in Darwin and Alice Springs, funded by the Commonwealth. This service is about to be expanded by the establishment of the Palmerston NSP. The NSPs are operated by The NT AIDS Council (NTAC) in Darwin (and Palmerston) and by Life Choices in Alice Springs. Currently approximately 500,000 needles and syringes are distributed by the NSPs. The primary NSPs are supported by secondary outlets operated by either NT Government sexual health clinics, district Communicable Disease Centres (CDCs) or by hospital Accident and Emergency departments. Fifteen pharmacies out of approximately 30 in the NT also distribute FITKITS on a commercial basis. At this stage there are no peer based NSP outlets in the Northern Territory.

A mixture of paid employees and volunteers currently staff the NSPs. NTAC has the equivalent of one full time NSP worker and Life Choices a half time worker. Other staff of these agencies are often called upon to operate the NSP as required. Some DHCS staff who work in either the sexual health clinics, CDCs or Accident and Emergency can distribute injecting equipment; this is an additional task that they take on and DHCS does not currently fund dedicated NSP positions.

Access to NSPs has been identified as an issue. At present most only operate during regular business hours, with additional Commonwealth funding recently becoming available to increase the hours of both the Darwin and Alice Springs NSPs, by five hours each.

It has been reported that there is virtually no access to new injecting equipment for people who reside outside the major population centres and no NSPs currently operate in Aboriginal communities. Anecdotal evidence suggests that injecting does occur in Aboriginal communities and other remote locations such as mining camps and pastoral stations.

The role of pharmacy based NSP outlets needs to be enhanced. This would include increasing the number of pharmacy based outlets as well as providing additional services with the provision of FITKITS such as providing information about safe injecting practices, safe disposal and services available for PWID.

A common theme raised in consultations was the need to be able to collect injecting equipment from non-stigmatising places, with the example given of pharmacies as a good place if staff training was put in place. It was made apparent to Taskforce members that different users have very different definitions of what is non-stigmatising, therefore it is important that there is diversity in the provision of NSPs to include primary, secondary, pharmacy and peer based services.

The Taskforce recommends:

3.9 That the current Needle and Syringe Programs (NSPs) be supported and expanded, to ensure that all the major population centres, Alice Springs, Darwin and Palmerston, have NSPs that are geographically and culturally accessible.

3.10 That the role of pharmacy based Needle and Syringe Programs (NSPs) needs to be enhanced.

The AIDS/STD Program of DHCS maintains quarterly reports on improperly discarded injecting equipment. Though the rates of improperly discarded equipment are low, the trauma that can arise from a needle-stick incident is significant and, as has been stated, “one dirty needle in the playground is one too many”. Due to this, it is essential that the community as a whole recognise the clear evidence that there have been no cases of HIV or hepatitis transmission as a result of a needle stick incident from improperly discarded injecting equipment.

It is also essential that appropriate strategies are introduced to ensure that people who use injecting equipment (for both legal and illegal substances) are informed about appropriate, safe and legal disposal methods and that the community as a whole is informed of what to do if improperly discarded injecting equipment is located. This will assist in dealing with an emotive and sensitive issue that causes considerable fear and concern in the general community.

It is recommended:

- 3.11 That a safe injecting equipment disposal program be implemented across the Northern Territory targeting:
- i) the broader community;
 - ii) people who inject illicit substances.

The Taskforce recognises the important place of user groups and harm reduction services throughout Australia over the past 15 years in informing policy and program development that has ensured relatively low rates of HIV infection and containment of the spread of other blood borne viruses such as Hepatitis C. These groups and services have an important role in the education of PWID about their drug use and methods of reducing risk and harm as well as providing a vehicle for assistance including access to treatment.

The Northern Territory Government has not previously explicitly supported or resourced any peer-based drug user groups. Experience elsewhere suggests that support of these groups benefits policy and program development and implementation. Peer based groups are an important source of information about new treatments as well as specific harm reduction measures. They can also have an important role in the provision of NSPs.

In recognition of the key role played by user groups it is recommend:

- 3.12 That peer-based services for people who inject drugs be supported and implemented in the major urban centres.

4. TREATMENT

The National Drug Strategic Framework 1998 - 2003 recognises treatment as an effective strategy for reducing the demand for drugs by stabilising the lives of drug dependent persons, and preventing drug use and crime. As outlined in the Framework, there is an expectation in the community, and among drug users and their families, that a range of treatment services will be accessible, regardless of age, race, gender, sexual preference and location. The range of services available must be comprehensive and recognise and respond to the individual nature and different stages of people's drug use.

Provision of treatment for those affected by their illicit drug use is an important element of government activity. There are many components to think about when planning treatment programs. These include:

- The community expectations of drug treatment;
- The appropriate profile of available treatment;
- Specific services within the drug treatment menu;
- The spread and quality of drug treatment services;
- Service capacity (including workforce issues);
- Treatment for those who access generic services (non specialist drug treatment services);
- Specialist treatments including pharmacotherapies; and
- Supporting measures and access, including a 24-hour telephone service.

Community Expectations of Treatment

The community has diverse expectations of treatment. These range between unrealistic hopes for 'instant cures' to pessimism and a belief that no treatment can work. Both extremes are unjustified. Treatment can be successful and generally has better outcomes than equivalent treatment of other chronic relapsing conditions, such as diabetes, hypertension and asthma. There is considerable misunderstanding about what to expect from treatment and when and how specialist drug treatment is indicated.

It is recommended:

- 4.1 That an information strategy or community education campaign is developed focussing on the value of treatment for drug users, and those affected by drug use, including what treatment is available and how to access it.

Profile of Available Treatment - service spread and quality:

The Taskforce has not been able to establish a comprehensive understanding of the adequacy or effectiveness of treatment services available across the Territory. This will require a specific review. While there is a listing of apparently available services, it has not been possible in the time provided to determine the willingness, capacity and expertise available in each of these services to address and successfully attend to people who are using illicit drugs. We are aware that there is a lot of good work being done, and there are experienced and committed staff in many locations.

We understand that most treatment services in receipt of Northern Territory Government funds are now expected to accept and treat people with a range of drug dependencies and problems. Many have historically focussed only on alcohol. The phenomenon of polydrug use is now common but some informants suggested that not all services are available to those whose primary problem is with illicit drugs.

There are important new elements needed to ensure an adequate menu of treatment options. A high priority is to enable the Northern Territory to offer the broad spectrum of treatment approaches that have been shown to be effective for opiate dependent people. This means that a priority should be the addition of a system for the provision of pharmacotherapies for treatment of opiate dependence (discussed further in section 5).

The Taskforce recommends:

4.2 That a mapping project of all current alcohol and drug related services be undertaken to establish an accurate picture of current service delivery.

(Refer also to Recommendation 6.1).

This project should provide information to determine any areas where redirection of funding and major redevelopment is required. In order for this to occur, a profile of desirable services needs to be generated. This overall project should be completed within a maximum of 12 months.

In conducting this mapping project, a consultative approach is important to facilitate a process where agencies, over time, strive to achieve best practice in program content and delivery and identify opportunities for minor service development. It is also important to enhance service quality and consistency both in the short and long term. The Taskforce recognises that this type of quality assurance is likely to have future resource implications, to meet standards, develop appropriate documentation and provide staff training where required. A separate study of the effectiveness of services is not considered necessary given that it would be a costly and time consuming. Rather published studies of what constitutes effective treatment services should be used to establish best practice and Northern Territory standards.

To enhance service quality and consistency, it is recommended:

4.3 That a system of accreditation for service providers be developed and implemented following the initial mapping and support exercise.

This is likely to require some future resourcing to support services to meet standards, improve infrastructure, develop appropriate documentation and train staff in some instances.

The Taskforce sees value in the retention of a mix of government and non-government services with an emphasis on provision of direct services by the non-government sector. Some specialist alcohol and drug services might best be retained within government services at this time of development; particularly to provide services to clients with complex needs, and to ensure a backdrop of support, expertise and consultancy for other agencies to access. The appropriate mix could be examined in the future to assess the capacity of the service system and appropriateness of this mix.

In the situation where Northern Territory Government is the source of most funding for drug treatment services, it is appropriate to ensure a reasonable spread and quality service system through administrative and monitoring systems.

It is recommended:

4.4 That service agreements are used as a mechanism for ensuring systematic coverage and evidenced based quality services.

More broadly, it is important to recognise and maximise the capacity of existing services while working with them to ensure appropriate, good quality service provision. This should be the starting point for enhancement of the treatment service system. This requires examination of resourcing levels and some possible reorientation of some services to be able to deal with illicit drug issues.

Adequate resourcing refers to the consideration of a number of factors, not the least of which are:

- the adequacy and safety of the physical facilities;
- allocation of resources to enable best practice standards to be implemented; and
- the calculation of an appropriate unit cost for each of the different service types being offered to ensure that appropriate funding is provided and expended in the allocated areas.

Any consideration of additional services should note the following priorities:

- A spectrum of services is needed in all major urban centres including assessment, withdrawal and counselling. These would not necessarily or ordinarily be residential. In addition, access to some long-term rehabilitation is important.
- A strategy to actively engage general medical practitioners is needed to encourage active participation in alcohol and other drug-related interventions (discussed specifically under pharmacotherapies).
- For prisoners, development of alcohol and other drug treatment and support services, providing a full spectrum of care and aftercare as they move between prison and the community is important, especially to break the cycle of re-offending.

Generic and parallel services:

Most drug users access a range of other services including general health, mental health, community, housing, employment and family services long before they seek or are urged to attend specialist drug treatment. It is important to recognise this dynamic in planning treatment options and to enhance the likelihood that they will be identified and interventions offered in these generic and other specialist services.

It is recognised that many people with a drug problem do not participate in drug specific treatment. It is also known that many have co-occurring health and social problems. It is necessary to de-mystify drug specific interventions and encourage those working in other services to engage with drug users, and to identify and offer drug specific interventions to them.

To support this focus, it is recommended:

4.5 That a two year project be funded for the development of protocols, support and training, and a standardised assessment tool; in order to strengthen the alcohol and other drug capacity of generic services and improve the linkages between generic services and alcohol and other drug agencies. This project could be linked to the mapping project to assist in investigating the responses and resources available currently.

As a minimum, one project worker should be employed, in the Top End and Central regions. An example of a similar process is the current Team Health project occurring between Mental Health and Supported Accommodation Assistance Programs (SAAP) agencies.

There is evidence of significant co-occurrence of substance misuse and mental health problems in some individuals. This needs to be addressed specifically. It is important that clients with co-occurring alcohol and drug and mental health problems receive a rapid, accessible, accountable and culturally appropriate service that enables continuity of care. A strategy would need to involve:

- Ready access for clients of alcohol and drug agencies and general practitioners to psychiatric assessment and emergency treatment if required;
- Protocols and policies that ensure co-management issues be considered and planned in an appropriate manner.
- Continuing professional development of alcohol and other drug workers in mental health issues and mental health workers in alcohol and other drug issues.

It is recommended:

4.6 That senior officials within mental health and alcohol and other drugs be directed to formulate a strategy to appropriately deal with clients with co-occurring disorders.

Specialist drug treatment services:

A well recognised and publicised point of access is important for people seeking help regarding alcohol and drug problems. While some find their way to appropriate treatment, many are uncertain of what is available and how to access it. Alcohol and other drug telephone services are available in all other jurisdictions in Australia. They are an important link and access point for the general community as well as for service providers seeking assistance, support, and referral information. It is essential for them to be available 24 hours per day and 7 days per week, and provide accurate and up to date information for those contacting them. In addition a strategy for informing people of the establishment of such a service needs to be targeted at both service providers and the general community.

The Taskforce recommends:

4.7 That an alcohol and other drug information service based on a 24-hour telephone service be established and widely advertised, to provide information, support and referral information.

Withdrawal from drugs is seen as a preliminary step to treatment for those who are dependent. This can occur in a variety of settings. An adequate range will include hospital, home, outpatient and residential settings, providing medicated and non-medicated withdrawal, and social support.

Withdrawal services provide respite from a drug-taking environment, manage symptoms of withdrawal and provide an entry point to longer-term treatment or rehabilitation. They are therefore an integral component in a range of core alcohol and other drug treatment services. It is important that withdrawal be seen as a gateway to further intervention and treatment. However it is important that commitment to ongoing intervention beyond the withdrawal episode is not a pre requisite for admission to a withdrawal program.

It is recommended:

4.8 That the ongoing development of a range of withdrawal options takes place to ensure access and quality of service provision.

A new model for the provision of withdrawal services in Darwin has recently been approved and the implementation phase is currently underway, with a number of working parties dealing with the specifics of implementation. The new model is being designed to cater for a much broader section of the community, who were identified as being poorly serviced by the current model. These particularly include young people, women, drug using parents and those in full time employment. The existing service will cease to operate in its current form as of the 30 June 2002.

The key features of the new model include:

- An enhanced Alcohol and Drug Services (ADS) with a capacity to provide a central assessment function, expert advice and client management by a specialist Alcohol and Other Drug Medical Officer;
- Home-Based Withdrawal Service medically supervised by General Practitioners with support by DHCS (Shared-Care Model);
- Out-patient Withdrawal and Counselling Service provided by ADS;
- Residential Social Support with outreach support provided by DHCS.

From the information provided in both consultations and submissions the Taskforce recognises that the proposed model for Withdrawal Services in the Top End has potential. It is, however, essential that an ongoing monitoring and evaluation process accompany the implementation. This would enable any necessary adjustments to be made during implementation, and would assist in determining the efficacy of the new approach.

Therefore, it is recommended:

4.9 That thorough ongoing monitoring and evaluation of the proposed model for Withdrawal Services in the Top End and its implementation take place.

With regard to current residential rehabilitation services, consultation and development are needed to enhance their capacity to respond to people with a primary illicit drug problem in addition to recent changes in service agreements incorporating these expectations.

Residential rehabilitation services should be used selectively. The Taskforce is aware that they are not the treatment of first choice in most instances. The costs of providing this type of service are significant and it is not practical to have one in every location.

There is already a range of residential services in all major urban centres in the Northern Territory. In this context no completely new service appears to be required, rather an assessment of what each residential service requires to fulfil their contractual agreement is necessary. This should include some review of physical facilities as well as program needs. It is expected that this activity would be part of negotiating service agreements.

In addition, the Taskforce is aware that a number of current illicit drug initiatives in the Territory are receiving funding through Commonwealth National Illicit Drug Strategy (NIDS) funding, which is time limited. A number of agencies have indicated that they would be unable to continue to operate should the NIDS funding not be continued.

It is the opinion of the Taskforce that Recommendation 4.2; 4.3; and 4.4 will be instrumental in guiding future decision making regarding the range of treatment services, including residential, to receive funding.

Service capacity - workforce development:

The Taskforce acknowledges a general need to increase the capacity of current services through furthering the development of knowledge and skills of the workforce in this area. The enhancement of skills should include government and non-government agencies, particularly in the Alcohol and Other Drug sector, Mental Health Services, Youth sector, Family and Children's Services and Correctional Services.

This will provide one vehicle for extending the responses that young people and families receive. Each sector might have somewhat different emphases and this needs to be determined with a training needs analysis in each case. For example some main areas for consideration for those working with youth and children's services might include :

- Risk and Protective factors
- Engaging Young people
- Cross cultural training
- Brief Intervention Techniques.

The Taskforce recommends:

- 4.10 That there is ongoing and further development of the Northern Territory's alcohol and drug training and development strategy to ensure it encompasses all frontline workers in both generic and specialist drug treatment sectors.**

For workers and services to take advantage of training opportunities, some resourcing for 'back-filling' the positions will be needed. Services appear to be already operating at capacity and therefore are often unable to release people to attend training. The level of funding needed would be determined as part of the project identified at Recommendation 4.2.

It is recommended:

- 4.11 That enhanced funding is made available for existing services to enable access to workforce development opportunities.**

5. TREATMENT - THE ROLE AND PRACTICAL APPLICATION OF PHARMACOTHERAPIES

Pharmacotherapies are medications used in the treatment of drug dependence. For opioid dependence these include buprenorphine, methadone and naltrexone. There has been considerable research, nationally and internationally, into the use and effectiveness of this type of treatment.

The Northern Territory has not had a methadone maintenance program since the 1970s and so is able to look objectively at the range of pharmacotherapies now available and learn from the experiences of other jurisdictions with regard to implementing programs. There is also the opportunity to integrate a pharmacotherapy program into both primary care services and established treatment services where it can have a place as a treatment option.

Evidence for the efficacy of pharmacotherapy replacement treatment is compelling with respect to:

- attracting and retaining opioid dependent persons in treatment, more so than any other intervention;
- reducing injecting drug use;
- reducing the spread of HIV and other infectious diseases;
- improving health and social functioning;
- significantly reducing mortality related to opioid use; and
- reducing crime, particularly property crime.

The probability of a positive outcome in pharmacotherapy treatment as with other treatment for drug dependence, is increased by stable social contacts [eg. spouse, family, and friends] and employment.

Opioid treatment using buprenorphine or methadone is endorsed by the Ministerial Council on Drug Strategy (MCDS) and all other Australian jurisdictions, as a key National strategy in addressing the harms associated with illegal opioid use.

Whilst there is a need to provide patients with a range of options, there are a number of attributes of buprenorphine treatment that make it a more attractive and preferred option. These include: a lower overdose risk, can be dispensed on alternate days, and offers easier withdrawal for most patients.

The Taskforce strongly endorses the availability of pharmacotherapies for the treatment of opioid dependence, for both maintenance and withdrawal, in the Northern Territory. The provision of pharmacotherapy treatment for illicit opioid dependence will undoubtedly be a significant step in improving treatment of opiate dependent persons in the Northern Territory. However, for such a treatment program to operate in a safe and effective way, and to minimise the risks of any adverse events and publicity, which may be detrimental to this program, it is essential that such treatment is offered within a comprehensive legislative and policy framework.

The Taskforce recommends:

- 5.1 That the necessary amendments be made to the *NT Poisons and Dangerous Drugs Act* to enable pharmacotherapies for the treatment of opioid dependence for both maintenance and withdrawal.**

A review of the *NT Poisons and Dangerous Drugs Act* is required to remove and/or revise the current sections that prohibit the use of Schedule 8 medications for the purposes of addiction. The DHCS is well placed to coordinate this review with input from the key stakeholders who may include: Divisions of General Practice; Northern Territory Pharmacy Guild, Australian Medical Association, Top End Users Forum.

Given the lengthy process involved in legislative change the Taskforce recommends, as an interim measure:

- 5.2 That Ministerial Guidelines under Section 31A of the *NT Poisons and Dangerous Drugs Act*, be drafted and endorsed by Cabinet, to allow for the immediate use of buprenorphine and methadone for maintenance and withdrawal treatment.**

There has been a range of different service models implemented in other jurisdictions. The most applicable to the Northern Territory context is a mix of public and private services. Other jurisdictions with a highly dispersed and decentralised population like the Territory have found that public programs are insufficient to meet all of the need that arises.

It is therefore recommended:

- 5.3 That the Territory's pharmacotherapy program be provided in both the public sector, and in the private sector through the use of accredited general practitioners.**

A specialist service is required for those patients who cannot be managed in the community. The service would need to have the capability of prescribing and dispensing medications, given that some clients are unable to be suitably placed with community pharmacies in the short term. Specialised treatment is also recommended for those patients with particular issues such as pregnancy, significant physical illness, severe psychiatric co-occurring disorders and aggression. The current government alcohol and other drug treatment services in Darwin and Alice Springs, ADS and CAAODS are operating as specialist services, with a clear mandate to provide services for difficult clients and support for other service providers.

The Taskforce recommends:

- 5.4 That the public sector component be established as a specialist service, located in Alice Springs and Darwin, with outreach services to Palmerston.**

Providing legislative and clinical safeguards are adhered to, increasing the number of GPs capable of treating drug dependence is a cost effective way to improve treatment options and promote alcohol and other drug issues to practitioners.

It is therefore, recommended:

- 5.5 That a system of general practitioner involvement in illicit drug treatment be adopted, as used in other jurisdictions, to provide general practitioners in the community access to specialist advice and support and thereby improve treatment availability across the Northern Territory.**

In all other jurisdictions a permit/notification system is mandatory. Doctors have an obligation under the state's legislation to notify or apply to the State Health Authority for a permit to prescribe certain medications (S8s and some S4s usually) to an individual after a certain amount of time has elapsed or immediately if the patient is drug dependent. The Northern Territory currently only has a voluntary contract system in place, and whilst this has been effective there are still problems which would be rectified by a mandatory contract or permit system for the use of Schedule 8 drugs.

The notification scheme is an administrative mechanism to reduce multiple prescriptions and improve the management of individuals with a long term need for Schedule 8 drugs by ensuring that each patient is contracted with a single doctor or practice, and can be prescribed restricted drugs only by those nominated doctor/s.

A number of the submissions received by the Taskforce from medical practitioners, pharmacists and other stakeholders emphasised the need for a comprehensive approach. The use of an advisory panel was emphasised to allow for a system of monitoring and, where required, formal advice. In addition the current prescription monitoring system is seen as ineffective because of the time delays in information being able to be compiled and disseminated.

It is therefore recommended:

- 5.6 That a mandatory notification or permit system be introduced in the Territory, for patient authorisation of prescribed Schedule 8 drugs, to be administered by Poisons Control, DHCS.**
- 5.7 That an up-to-date prescription monitoring system be established at Poisons Control, DHCS.**
- 5.8 That a panel be established to oversight policy and guidelines, deal with difficult patient issues, and audit practice in relation to the monitoring of Schedule 8 prescribing.**

With the introduction of maintenance options, it will be necessary for clear Northern Territory guidelines to be developed and endorsed that will include a range of issues.

It would be expected that guidelines would apply to both public and private sectors and would detail all aspects of service delivery including: legal considerations and procedures related to the prescribing of pharmacotherapies; requirements for initial assessment and stabilisation on treatment; ongoing management of patients including such issues as appropriate dosage and take-away dose policy; limits on the numbers of patients that GPs can manage.

The Taskforce recommends:

5.9 That Northern Territory pharmacotherapy policy and guidelines be established, in keeping with the National framework.

Numerous studies have shown that medical practitioners feel that their knowledge and skills in dealing with illicit drug issues are relatively low. Consequently few practitioners feel comfortable treating people who use illicit drugs. There are requirements in treating opioid dependent patients, not the least of which are the legislative requirements. For these reasons all other jurisdictions within Australia limit the treatment of opioid dependent persons to those practitioners who are trained and authorised to treat these patients.

There is a need for the development of a local training strategy to enable greater access and availability to training throughout the Territory. This should be developed in consultation with stakeholders such as the Divisions of General Practice, College of General Practice, Australian Medical Association and the Pharmacy Guild.

It is recommended:

5.10 That a Northern Territory accredited training program for the treatment of opioid dependence be established for medical practitioners and pharmacists.

There is currently no multidisciplinary pain service operating in the Northern Territory. It would be a useful adjunct to the establishment of a pharmacotherapy program to have appropriate assessment and management options for chronic pain. There is a need for a fully resourced multidisciplinary pain service to be able to cover the whole of the Territory, and to particularly look at alternative treatment options to pain management other than Schedule 8 medications.

The Taskforce recommends:

5.11 That the establishment of a multidisciplinary pain service be explored.

6. PRIORITY GROUPS

Youth

Young people are experimenting with a wider range of drugs, generally at a younger age, than has previously been documented. The Taskforce members have heard throughout the Territory of the concerns of a range of people regarding this, particularly in relation to the use of cannabis in combination with other substances, both licit and illicit.

The reasons why young people use drugs are complex and varied. An effective community response to illicit drug use by young people requires a holistic approach, as complex and varied as the needs it seeks to address. The complex causes involved, and the range of settings in which problematic drug use can arise, necessitate integrated and inclusive responses. These involve young people in the context of their families, peer groups, schools and communities, and not in isolation of these social groups and settings.

Young people have particular needs, and placing them in a specialist drug treatment service targeted at adults can have a detrimental effect, and can ultimately have the effect of deterring young people from seeking further assistance. There is also the added danger of exposing young people to those with more entrenched drug use if they are directed to these specialist agencies.

Many young people find youth services their first point of contact to access information and support in relation to a range of issues in their lives, not only drug use. Youth workers are particularly well placed to reach young people who use drugs, due to the informal approaches that foster a trusting relationship and commitment to young people. Additionally young people indicate that if they need support, they want it from people and agencies that are 'youth friendly'.

A united, committed and strategic response was identified as the only feasible way to reduce the impact and burden of harmful drug use on young people, their families and the general community. An integral aspect of this approach is the promotion of young people's overall emotional health and wellbeing.

Throughout the Territory there is a general lack of capacity among youth specific and generic services to deal with alcohol and drug issues. Youth services acknowledge that treatment and support are processes requiring continuity of care as well as support for specific interventions and aftercare.

It is therefore recommended, in combination with Recommendation 4.2:

6.1 That those services identified as providing assistance and treatment to young people under 18 are resourced to be able to provide adequate care planning, assessment, treatment and after care for those with drug related problems.

It appears that at present it is predominantly crisis accommodation youth services that are attempting to provide these services. Some young people are in danger of being excluded from services and slipping through the system due to limited resources. The current level of need should be identified and would essentially be part of the mapping exercise identified in Recommendation 4.2.

Outreach breaks down barriers to accessing services and allows for continuity of care. In essence it works with young people in their own environment rather than expecting them to come to a particular building and/or service.

It is recommended:

6.2 That youth outreach workers be established in each urban centre to be responsible for assisting young people in need by providing advocacy and support to access established services.

The focus of these positions would be the provision of outreach support to young people and, where appropriate, their families. It is envisaged that workers would be located in Darwin, Nhulunbuy, Katherine, Tennant Creek, Palmerston and Alice Springs. The service would include early intervention and prevention principles being applied, as well the provision of advocacy, support and, where appropriate, referral. It is anticipated that outreach workers would maintain flexible hours and would work in partnership with schools and community night patrols. The approach should be a priority of whole-of-government funding to ensure adequate development and maintenance across the Northern Territory. It is important to emphasise the need for an integrated approach between the government and non-government sectors. These positions need to be grounded within already existing services, such as with an already existing youth specific service. To be effective it is important that they are not sole operators and that support and supervision are present within a team environment.

There is strong evidence of the importance of early identification and intervention through agencies and schools to connect young people and families with assistance, as discussed at length in the Prevention section.

It is therefore recommended:

6.3 That family support workers, attached to appropriate youth services and schools, be established in the major urban centres to work in coordination with the outreach workers.

These workers will have a significant role in involving appropriate family members in the treatment process and would have a role in the education and support of family members.

Boredom and disconnection from the educational system were factors mentioned throughout community consultations. Alternative education and activity programs that specifically engage young people who are recognised as being at risk were identified as areas for further development. Examples of programs currently available are the Alice Springs Youth Drop In Centre Development Group, T.C. Raiders Tennant Creek, and Bushmob in Alice Springs. Alternative activities are also discussed in the Prevention section.

The Taskforce recommends:

6.4 That a coordinated system be developed to adequately resource community development programs that provide young people with drug and alcohol free activities, after hours.

Families

All family members including parents, siblings, grandparents, and children are potentially affected by the illicit drug use of another family member. The needs of all of these are only just beginning to be recognised. A significant unaddressed area of need is that of young children, under the age of 12, of drug abusing parents.

The definition of family is important in that it can have different meanings for different cultural and social groups. For example Indigenous families have a much wider and more inclusive definition of family which includes a much wider involvement of what is referred to as extended family.

Family involvement in treatment can occur at two levels: working with the family or family members as clients in their own right or, working with them as part of an individual's treatment. Quite different issues are likely to arise in these two scenarios.

Comprehensive drug treatment needs to consider the role of families, particularly given that it is often families that initially seek treatment for the drug user. Families have a vital role in supporting drug users to access treatment and sustain their involvement, as well as supporting them beyond the treatment episode.

The Taskforce heard very strongly from families, in particular, that they often feel isolated and alone when confronted with issues related to a drug using family member.

It is recommended:

6.5 That support networks for parents and families be established.

These networks are particularly important in terms of the families' role in supporting drug using family members through treatment as well as providing support and aftercare beyond treatment. The Taskforce identified a current vacuum throughout the Territory and recommends that a range of possible support networks are explored in terms of their applicability to the local context. Examples of programs implemented elsewhere include: volunteer and self help groups being established; provision of telephone information service targeted specifically at families; and specific funding being made available to agencies to provide a dedicated response to family members.

It was a consistently identified need in all of the consultations that families did not know where to go and what was available, and that many families do not feel comfortable accessing mainstream services. Also if access was required after hours, there were limited options available.

As per recommendation 4.7, an alcohol and drug telephone information service is recommended. This type of service can provide accurate, immediate and accessible information to families who require it, and would need to be marketed as providing specific assistance to families as well as others.

It is recommended:

- 6.6 That the proposed alcohol and other drug information service (Recommendation 4.7) be readily available to families and adopt a particular focus on families.
- 6.7 That consideration should be given to funding a 2 year pilot project to investigate user-friendly, confidential family support and referral centres to assist families, in particular, with an initial contact point, assessment, support, counselling, advocacy, referral and information.

It is proposed that the pilot be conducted in two sites to investigate the most feasible model of service delivery. The project would be expected to provide an initial contact point for those families in need. It would be essential for the project to have an action research component and that it be reviewed and evaluated. The proposed two year time period is to allow time for the pilot to be adequately established and evaluated.

In acknowledging the importance of family and kinship systems there is a need to explore financial assistance and initiatives to enable parents wishing to access residential rehabilitation programs to keep their children with them throughout treatment. It would be advantageous to link into other projects that are investigating these issues on a National basis such as a project investigating child care needs for people wanting to access alcohol and drug treatment currently being conducted in Victoria.

Therefore it is recommended:

- 6.8 That an investigation takes place to identify strategies that will improve access to treatment for drug-using parents.

Issues of particular concern would include:

- financial assistance to enable parents to access child care services; and
- respite care needs.

Indigenous

The Taskforce is concerned that the views and experiences of Indigenous Territorians might not be adequately represented in this report and have thus recommended some further consultation in this regard. For reasons that lie outside the terms of reference of this Taskforce, some of these Indigenous communities are especially vulnerable to the harm associated with illicit drug use. Increasing levels of cannabis use was a common theme reported throughout all areas of the Territory.

The Taskforce recommends:

- 6.9 That further consultation takes place regarding an appropriate response to illicit drug issues for Indigenous Territorians.

The Taskforce is aware that the current deliberations of the Select Committee on Substance Abuse in the Community will go towards rectifying this current lack of consultation and information, particularly in relation to the issues associated with cannabis.

CONCLUDING COMMENTS

Alcohol misuse and tobacco use remain the major cause of drug related harm in the Northern Territory. These were outside the scope of this Taskforce but they are mentioned here since they are almost always used by those who use illicit drugs and because community consultations were so adamant about alcohol being the number one issue. Cannabis is a close second priority of community concern.

Illicit drugs other than cannabis are available in the main metropolitan centres and some rural communities. The Northern Territory has had an opiate problem that is largely prescription medication diverted to the black market. Like other places in Australia, change in drug using patterns and potential harms are occurring. Amphetamine type substances are being reported more frequently and throughout the Territory.

We have, wherever possible, returned to the information and evidence available in considering our recommendations. It was not always possible to explore all issues to our satisfaction in order to make definitive recommendations. The ongoing monitoring of drug use trends and related harms is necessary to ensure soundly based policy and program development in the future. While research from elsewhere is valuable, there are unique characteristics of drug use in the Territory, which suggest attention to the research agenda is important.

Given the size of the Territory budget, it is important to build on programs that are resourced at a national level rather than initiate everything from scratch. This is especially so for information campaigns.

The prevention arena offers an opportunity for some innovative thinking and development; especially in supporting very young children's development and in strengthening communities. This should not be left to the drug area alone. Instead coordinated government action is required across many areas. Schools are important social settings and better drug education is only one part of their role in preventing drug problems.

Prevention initiatives should not be developed at the cost of treatment, which has a vital role as well. Getting a comprehensive map of available services and then working with them to enhance their capacity and quality are priorities.

The introduction of pharmacotherapy treatments is necessary to bring the Northern Territory into line with the rest of Australia. It will benefit drug users and the whole community but requires some careful planning and development of mechanisms to ensure it is introduced in a comprehensive and safe manner. Communities need to be brought on this journey so that there is a good understanding and realistic expectations of new treatments whenever they are introduced.

Community members need a point of contact for information, advice and referral when they need drug related help. A service is needed to link those seeking help with the treatment and support providers. There are some special groups that warrant attention in responding to drugs. These include young people and families. The Indigenous community needs to be considered further.

The Taskforce has been pleased to have had an opportunity to focus on illicit drugs and related harms in the Northern Territory. It has been allowed a privileged window into community matters of great concern. We have seen troubled people and some troubled communities. We have also seen capacity and commitment to attend to drugs in the Territory. It will be important to ensure that, whenever possible, the Territory community participates in future developments. Communities need to be involved in ongoing discussions about drugs, including alcohol and tobacco, since they are a part of everyday life for so many people in the Territory.

We commend this report to the Minister and remain willing to provide further explanation if necessary and appropriate.

1. INTRODUCTION

OVERVIEW

Illicit drug use is a complex social problem with no simple solutions. It is not an isolated behaviour, but is closely associated with broader social issues. There is a need for a multi-faceted, multi-layered approach that calls on a range of resources across sectors of government, non-government agencies and communities, and users, their families, and their friends.

Through reviewing the literature and hearing community views, the Taskforce has come to realise that the Northern Territory is in a unique situation. The illicit drug problems experienced in other States, such as the large numbers of heroin overdoses, public drug dealing and injecting and the level of drug-related crime, largely do not occur here. However there are people using illicit drugs, harming themselves and their families and coming into contact with the criminal justice system. Still there is an opportunity to prevent illicit drug problems from reaching the scale it has in other States. For those using drugs and experiencing harm, there is an opportunity to intervene, engage them in treatment and reduce the harm. There is also a chance of assisting families of drug users, who may need information, access to services and support.

Several important general observations can be made about the nature, level and context of illicit drug use and related harms:

- Increasing numbers of people are using a wider range of illicit drugs throughout Australia.
- Initiation appears to be occurring at a younger age.
- Multiple drug use has become an established norm among people using illicit drugs.
- Generational differences are apparent in the types and patterns of use.
- Excluding cannabis, only a small minority of people may use illicit drugs today, however, numbers are increasing, many are young, and there are significant impacts on their lives and their futures, on their families, and for our society.
- Risk and protective factors for illicit drug use are common to an array of growing social concerns that include a range of mental health problems and suicidal behaviour, problem behaviours, juvenile offending and later criminal involvement, and their effects on the next generation of children.

The drugs under consideration by the Taskforce are those defined as illicit. Licit drugs are available but are subject to varying levels of regulation and restriction. The differing legal response to drugs is a result of complex social and political forces not a statement about the intrinsic physical harm that can be attributed to these drugs. The community is increasingly aware of the risks of harmful drug use and has accepted greater regulation when dangers are clear. Even so, it is worth reiterating the significant health and social issues related to alcohol and tobacco in particular.

The illicit drugs under investigation by the Taskforce include opioids, amphetamines, anabolic steroids and designer drugs (such as ecstasy) which are legislated as illegal through the *NT Misuse of Drugs Act*. Prescription medication can also be (and is) diverted for 'street use' and misused; in this context prescription medication is also considered illegal or illicit. Cannabis, while not specifically included in the Taskforce's brief, was considered in relationship to the other illicit drugs.

The Taskforce has had a particular focus on the needs of young people and families. The issues pertaining to each of these population groups have been explored in depth in the chapter titled, Identified Priority Groups.

THE NORTHERN TERRITORY CONTEXT

There are a number of features that distinguish the Northern Territory environment. Condon et al (2001) highlight the following:

- The age structure is very different from that of the rest of Australia, with 38% of the Aboriginal population and 22% of the non-Aboriginal population being aged under 15 years, and only 3% being aged over 65 years;
- Aboriginal people comprise 28% of the population, with 70% of Aboriginal people living in remote communities, compared to only 35% of non-Aboriginal people;
- The population is growing at approximately twice the rate of Australia overall;
- The Northern Territory covers approximately one sixth of the land mass of Australia, but includes only one percent of the Australian population;
- There are only five urban centres, all of which are remote from the rest of Australia, and only two of which have populations of greater than 10,000 people; and
- Thirty percent of the Northern Territory population lives outside of these centres;

Additionally, there are particular attributes that characterise the use of substances in the Northern Territory. These include:

- the historically entrenched role of alcohol, its widespread use as currency and for relaxation and socialising and the highest per capita consumption in Australia;
- the highest prevalence of tobacco smoking in Australia and to date, the poorest regulation of tobacco;
- the spread of the population across vast distances, giving rise to feelings of isolation and remoteness and adding to strong parochial attachment;
- the high proportion of single young people;
- the relatively high turnover of the non-Aboriginal population which can lessen the cumulative effects of any community based education programs and make personal involvement difficult. An example of this highly mobile group is the military population, as 'migrant workers' who are resident in the Northern Territory only for limited time periods. A migrant worker population is characterised by a population of younger adults with young children;

- the nature of the workforce and the high proportion of industries which are known to be associated with higher levels of substance use, and other factors, such as the high influx of tourists, and the mix of Aboriginal and non-Aboriginal cultures; and
- the relatively high amount of prescription drugs, morphine and benzodiazepines particularly, used in an illicit manner.

PROCESS

The significant information and facts about the current use and harms associated with illicit drugs in the Northern Territory that have informed the Taskforce's deliberations and findings are outlined in this report.

The Taskforce's terms of reference required it to provide the Minister for Health and Community Services with recommendations regarding:

1. The trends in the use of illicit drugs in the Northern Territory, particularly by young people and drug using parents of children up to 12 years of age.
2. What is available and what should be practically applied in the Northern Territory setting, with a focus on the above priority groups.
3. An adequate spectrum of durable approaches and interventions through developmental, prevention, early intervention, crisis management, and recovery programs.
4. The nature and level of support available and what should be available to families who have a drug-using member.
5. The particular role and practical application of pharmacotherapies within the range of interventions in the Northern Territory setting.

As a result of its investigations, the Taskforce has many significant concerns about illicit drug use in the Northern Territory. These concerns focus on the harmful effects that drugs can have on the users, their families, friends and the community. More broadly, the Taskforce is concerned that the general community currently has a poor understanding of the nature of these drugs, and the impact that they can and do have on society.

Reducing drug use, misuse and associated harms are critical in the light of the Taskforce's concerns about the impact of drugs. Prohibition can have a place by containing supply and reducing demand. However, a wide range of other strategies also prevents the uptake, use and associated problems, and these deserve greater attention. There are a range of risk and protective factors which can increase or decrease the likelihood of drug trouble in individuals. Early childhood has increasingly been recognised as a critical time for prevention efforts to be applied. Options include education and information strategies, underpinned by policy and structural changes such as legislative reform and support for local community action. In this area the Northern Territory is well placed because of its history of developing and implementing successful public health programs, for example the Living With Alcohol Program.

Providing support and treatment to people with serious drug use problems may prevent the development of further problems and will, in some instances, reduce use. Effective support and treatment must be flexible to respond to the diverse needs and situations of drug users. Treatment services need to focus on those with serious problems, and to respond to the harms produced and the context in which misuse occurs.

Since 1985, and particularly since effective responses were developed to HIV/AIDS, Australia has pursued a drug policy goal of harm minimisation. The Taskforce believes available evidence lends strong support to continuing to follow a harm minimisation approach. None of the evidence reviewed by the Taskforce has argued that there is a set of policies or strategies capable of eliminating drug use completely from our society in the foreseeable future. On the contrary, considerable concern has been expressed about the social causes of drug use and the likelihood that future trends will be towards increased rather than decreased use.

The Territory's response to illicit drugs requires clear objectives that will enable evaluation of existing activity and assessment of the likely impact of alternative approaches. The objectives need to be framed in the knowledge that the health consequences of problematic drug use are substantial and that any law enforcement, prevention and treatment approach can have both positive and unintended negative consequences.

The Taskforce believes the objectives for the Territory's future response to illicit drugs need to be:

- Framed within a context of high levels of use of licit substances, particularly alcohol, tobacco and petrol.
- Focused on minimising the harms caused by the misuse of illicit drugs; and
- Focused upon minimising the supply, demand and use of illicit drugs.

The National Drug Strategic Framework 1998-99 to 2002-03 sets out a range of broad principles, policies and priority areas for reducing the harm caused by drugs in the Australian community. The National Action Plan on Illicit Drugs has been drafted to offer guidance in setting priorities for action under the Framework, within seven key strategy areas:

1. Demand reduction: promotion of opportunities, settings and values that promote resilience and reduce the uptake and use of drugs and the risks of drug use.
2. Supply reduction: interventions to reduce availability and supply.
3. Treatment
4. Harm reduction.
5. Workforce development.
6. Research
7. Performance measurement.

The Taskforce has explored a range of evidence from research and evidenced based practice. In particular, the before mentioned National Framework and Action Plan on Illicit Drugs have provided a clear starting point, as the Northern Territory Government has endorsed these documents at a National level.

The Taskforce has had four months to conduct its investigations. It has had the benefit of input from written submissions, public consultations, experts from throughout Australia and a broad review of the evidenced based literature in the area. The findings of the Taskforce have been informed by all these contributions. A summary of the community consultations has been provided at Appendix A and for the submissions at Appendix B.

The material and subsequent recommendations presented in this report raise a range of policy and operational issues. While the Taskforce has attempted to provide some clear directions for the future it acknowledges that many matters require further consideration, including informed public debate and careful planning for any reform measures.

In addition, the Taskforce would like to acknowledge that there have been a number of other processes that have been occurring in parallel with its deliberations. These are likely to have had an impact, both positive and negative at times, to the information provided to the Taskforce and to its overall deliberations. Where possible, cross-referencing to these has been made in our analysis to encourage future consideration and possible coordination of effort. Those that the Taskforce has been made aware of are:

- The Select Committee on Substance Abuse in the Community;
- Drafting and debate regarding the proposed 'drug house' legislation;
- Joint review committee from the Departments of Education and Police investigating School Based Policing; and
- The project being conducted by the Department of Education, Employment and Training, Strategic Directions for Health and Drug Education.

The Taskforce is concerned that the views and experience of Indigenous Territorians might not be adequately represented in this report and have thus recommended some further consideration in this regard. For reasons that lie outside the terms of reference of this Taskforce, some of these Indigenous communities are especially vulnerable to the harm associated with illicit drug use.

CURRENT SITUATION

Illicit drugs and their effect on individual, families and the community, and especially on young people, are highly emotive topics and seem to promote views that are not always well grounded in factual information. During its investigations and deliberations, the Taskforce heard many inaccurate, false, and misleading assertions. The Taskforce is concerned that a number of service providers in the area of alcohol and other drugs are not always as well informed about illicit drugs as one would expect. Examples included the lack of information regarding strength and availability of different types of cannabis; and the appropriate clinical management of amphetamine withdrawal and polydrug use.

It is likely that the lack of well informed public debate about illicit drugs is in part due to their low prevalence relative to other drugs such as alcohol and tobacco, a lack of concerted public education and the fear they evoke in the community, unfortunately fuelled by some sensational media reporting.

Community understanding of the consequences of problematic alcohol and tobacco use is relatively high. This level of understanding is most probably a result of the extensive public health efforts over the years to prevent harms associated with the sanctioned use of these legal substances. The same effort to educate the public about illicit drugs has not occurred as Government policy is prohibition and the major response has been supply reduction.

Currently it is the reality that the use of illicit drugs, other than cannabis, is not widespread in the community. Consequently, there is a real opportunity to prevent further escalation of illicit drug use and its associated harms. On the basis of evidence available to it, the Taskforce has concluded that greater emphasis should be placed on measures to reduce demand for illicit drugs, such as health promotion strategies and treatment. It is important to reduce the harm associated with their use while maintaining law enforcement as an important means to control the supply.

In taking this approach the Taskforce does not seek to condone drug use. Nevertheless, it recognises that there will be those who will experience harms and/or have problems associated with their drug use. The major goals of a comprehensive drug policy need to be preventing the uptake and preventing harms associated with drug use.

The Northern Territory has not had a methadone maintenance program since the 1970s and so is able to look objectively at the range of pharmacotherapies now available and learn from the experiences of other jurisdictions with regard to implementing programs. There is also the opportunity to integrate a pharmacotherapy program into both primary care services and established treatment services where it can have a place as a treatment option.

Importantly, the Northern Territory has a young population. Investing in the health and well-being of the Territory's children, promoting their competence, building their resilience and increasing their coping skills, will be the key to preventing a range of later mental health problems, troubles with the law and harmful drug use (National Action Plan on Illicit Drugs, 2001).

WHOLE-OF-GOVERNMENT APPROACH

Since self-government, the Northern Territory Government has been listening to community concerns about substance misuse and working with the community on solutions. In 1979 when responsibility for health and welfare, liquor licensing and community development in Aboriginal communities was transferred to the newly formed Northern Territory Government, the need to tackle the harm attributed to alcohol misuse as a matter of urgency was brought to the Government's attention. A conference was held in February 1980 that served as a forum for interested people from community and government organisations to meet, discuss the issues and present specific recommendations to Government. One of the recommendations was about establishing a Drug and Alcohol Authority, which would then have responsibility for implementing and overseeing the other recommendations as well as other functions.

In 1981 the Drug and Alcohol Advisory Committee (DAAC) was established. DAAC was chaired by the Secretary for Health and had a total membership of ten. Five of these members were ex-officio and were the heads of departments involved in drug and alcohol issues: Departments of Health, Community Development and Education, and the Liquor Commission and Police Force of the NT. The Minister for Health appointed the other five members and these represented community drug and alcohol groups from the five regions of the Territory. The operational arm of DAAC was the Drug and Alcohol Bureau, situated in the Department of Health. This structure provided the means for community to have a voice at the highest government level, for coordination of activities across government and non-government sectors and for implementation of policies through a funding mechanism (Fleming, 1985).

Ten years later, alcohol misuse continued to cause community concern. A public inquiry by the Sessional Committee on Use and Abuse of Alcohol by the Community took place during 1990, leading to 41 recommendations. In late 1991, the Alcohol Policy Unit (APU) was established, initially in the Office of the Chief Minister, to implement the recommendations. To place the APU in the Office of the Chief Minister was a strategic decision, to give the message that the issue was a Government priority, requiring a whole-of-government strategy. The Northern Territory Government embarked upon an innovative program to address the prevalence of alcohol related problems. Called the Living With Alcohol Program (LWAP), it was resourced from a levy imposed on alcohol with alcohol content greater than three per cent.

The LWAP was a whole-of-government approach and was the predominant substance misuse program for its 10-year duration. The Alcohol and Other Drugs Program (AODP), continued during this time administered by the Department of Health, and carried out activities linked to National Drug Strategy and the Tobacco Action Project. The LWAP ceased to be a separate entity as of June 2000, and has become incorporated into the broader AODP.

The Northern Territory Government has a vital role in creating an environment where the community can develop informed and effective solutions to the issues associated with illicit drug use. It is essential to recognise that the issues associated with illicit drug use can not effectively be dealt with in isolation, rather what is required is a coordinated whole-of-government and community response.

The problems associated with drug use invariably raise a wide range of issues from education and prevention through treatment and rehabilitation to law enforcement.

It is necessary that a commitment be made at Ministerial, Cabinet and Chief Executive Officer level, to ensure that a cohesive and coordinated whole-of-government approach is achieved. This commitment will ensure that substance misuse issues, including illicit drug use, are handled in a more comprehensive manner.

As is the case in other jurisdictions, the Taskforce is recommending the establishment of a coordinating unit to provide a comprehensive focus on drug policy and strategy that involves law enforcement, education, health, housing, youth, welfare, business and the non-government sectors.

New South Wales provides an example of this type of approach, where the New South Wales Government has established The Office of Drug Policy to provide leadership, and to assist in the development and implementation of an integrated approach to drug programs and policies. A range of other jurisdictions also incorporate a whole-of-government approach including Queensland, Western Australia, Victoria, and South Australia, with differing structures that enable this to be effected.

The Taskforce recommends:

1.1 That a central coordinating unit be established to take responsibility for a comprehensive drug and alcohol strategy in the Northern Territory. This unit should:

- Have the capacity to lead and strategically coordinate relevant government departments' drug related efforts.
- Be situated in the Department of the Chief Minister and be directly responsible to the Chief Minister, at least initially.
- Convene a high level interdepartmental committee, comprising the Departments of: the Chief Minister; Health and Community Services; Police, Fire and Emergency Services; Employment, Education and Training; Justice; Community Development, Sport and Cultural Affairs; and Treasury.
- Involve non-government and user group organisations.

The deliberations of the Taskforce have raised a great deal of community and media interest. Substantial community input has been made to the process and a clear message was received by the Taskforce for the public to be informed of the Taskforce findings.

Therefore it is recommended:

1.2 That a summary version of this report be released to the public.

The Taskforce received information in both submissions and consultations regarding the role of the media in reporting on drug issues and shaping attitudes in the community. Drug use is covered in many different aspects of the media, such as news reporting, advertising and portrayal in television and radio programs. The media has an important role in the dissemination of accurate information around sensitive and emotive issues such as illicit drug use. The Taskforce believes that the local Territory media organisations should be actively engaged in the development of appropriate codes of practice to cover the issue of the portrayal, depiction and reporting of matters related to illicit drug use.

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2. TRENDS IN THE USE OF ILLICIT DRUGS IN THE NORTHERN TERRITORY

OVERVIEW

Sound policy and program development is highly dependent upon the availability of reliable and valid data. There are a number of factors that cause difficulty when it comes to reporting trends in illicit drug use and any associated issues. In particular illicit drug using behaviour is illegal and generally regarded as socially undesirable by a significant portion of the community. Given this, purchasing and consuming these drugs are hidden from public view and scrutiny. Usually it is when people experience harm from their drug use, seek treatment or are apprehended for criminal behaviour that data about who is using what drugs and the associated harms are collected. This lack of data is particularly noticeable when one compares illicit drug use to the use of the licit drugs, alcohol and tobacco, which have been well researched and whose use is generally considered socially acceptable.

Although the task of monitoring trends in illicit drug use and the associated harms is a difficult one, there are a variety of sources of information that are currently available at a Territory, National and international level. These data come from a range of sources such as surveys of the general population and specific subgroups to a wide variety of secondary data sets, particularly those collected by health and law enforcement agencies. When considering these data, it is important to recognise that it requires careful consideration regarding possible biases and inherent errors.

An understanding of trends in drug related harms within a population requires some knowledge of the characteristics of the use of the drugs in the population (ie. who is using and how are they using), and characteristics of the drug market (ie. indicators such as price, purity and availability). Research has demonstrated that changes in the levels of harm associated with a particular drug within a community may be influenced by changes in the prevalence of the use of the drug, changes in the manner in which it is used, and changes in the characteristics of the drug market such as its availability, purity or the price of the drug (Department of Health Services, Victoria, 2000).

Research conducted locally, nationally and internationally has demonstrated that illicit drug use is associated with a wide range of harmful consequences including health, legal, social, and economic problems.

PREVALENCE AND OTHER INDICATORS

General Population

The National Drug Strategy Household Survey (NDSHS) has been conducted on seven occasions since 1985. In the NDSHS respondents are asked about their knowledge of drugs, their attitudes towards drugs, their drug consumption histories and related behaviours.

First results from the 2001 National Drug Strategy Household Survey (NDSHS) were released on May 23. Northern Territory results will be available later in the year. In this survey illicit drugs were defined as illegal drugs (such as cannabis), prescription drugs when used for illicit purposes (such as tranquillisers/sleeping pills) and other substances used inappropriately (such as naturally occurring hallucinogens and inhalants).

Almost two in every five Australians had used an illicit drug at some time in their lives and almost one in six had used illicit drugs in the previous 12 months. The most accessible illicit drugs were pain killers/analgesics and cannabis-38.4% and 21.0% of the population respectively, were offered or had the opportunity to use these drugs. One in every three Australians aged 14 years or older had used cannabis at some time in their lives.

The proportions of Australians aged 14 years or older who had recently used or used heroin in their lifetime were low (1.6%). Approximately 3% of the population aged 14 years or older have ever used or recently used amphetamines. Similar proportions of the population aged 14 years or older had ever used or recently used ecstasy. It is estimated that a low proportion of the population aged 14 years or older had ever injected or recently injected drugs (0.6% recent use).

In 1998, 10,030 Australians aged 14 years and older participated in the NDSHS, 703 participants were from the Northern Territory. Interpretation of the Northern Territory data of people who inject drugs, needs to be treated with great caution because of the small sample size. Given these small numbers the results may not be reliable and should not be generalised across the population of the Northern Territory.

The survey showed that the Northern Territory, of all the jurisdictions, had the highest proportion of people who had ever used any illicit drug at 62%. The survey includes persons over the age of 14 years and the category 'ever used' includes those who have tried something only once as well as those who may be more regular users. Illicit drugs were defined in this survey as illegal drugs, drugs and volatile substances used illicitly and pharmaceutical's used for non-medical purposes.

Recent use of any drug (defined as use within the preceding 12 months prior to the survey) in the Northern Territory had increased from 24% in 1995 to 38% in 1998, with the 1998 figure reported to be the highest percentage across the Australian jurisdictions.

Figure 1 - Recency of use (%) of illicit drugs by persons aged 14 years and over, 1998

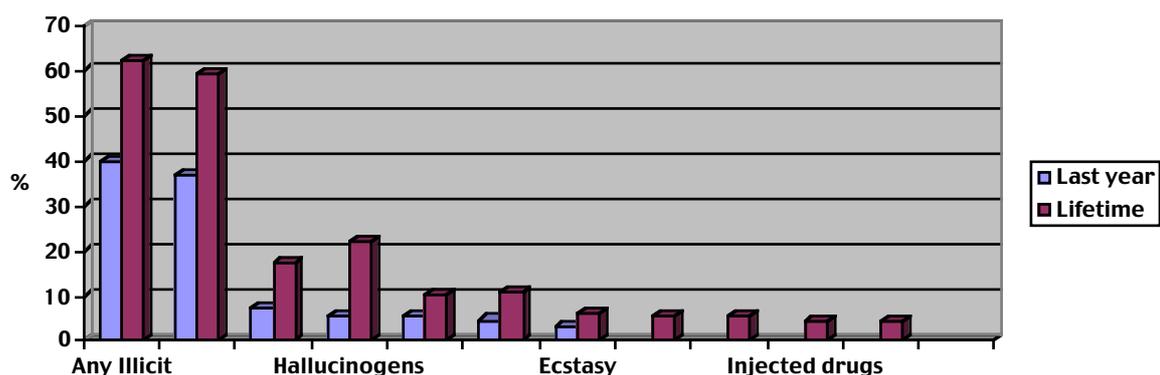


Figure 1 indicates the most prevalent drug ever used and used in the previous year by Northern Territorian adults and young people is cannabis with 59.1%, followed by hallucinogens (21.8%), amphetamines (17.6%), tranquillisers (10.8%), pain killers (10.8%), ecstasy (5.9%), inhalants (5.8%), cocaine (5.6%) and heroin (4.5%). Overall, 4.3% of Northern Territorians surveyed reported having ever injected an illegal drug.

The pattern of use indicates that three in five Territorians surveyed had tried an illicit drug in their lifetime, one in ten, of those ever using an illicit drug, stated that cannabis was their first choice and less than one in every ten had one of the other illicit drugs in the survey as their preferred drug.

Young People

The 1999 Australian School Students Alcohol and Drugs (ASSAD) national survey has the most recent prevalence data for Northern Territory school students aged 12 to 17. In this survey illicit drugs are defined as cannabis, tranquillisers, steroids, inhalants, amphetamines, ecstasy, cocaine, heroin and LSD/hallucinogens. These data were collected for the first time in the 1996 survey (Bertram and O'Reilly, 1998).

Of those surveyed older students were more likely to have used cannabis sometime during their lifetime, with at least half of 15 to 17 year olds having used cannabis. In comparison less than 25% of 12 and 13 year olds had ever used cannabis. Of the 15 to 17 year olds that reported use, between 15 and 35 percent had used it on 20 or more occasions. Of those students who reported having used cannabis, 80% reported that they had used it in conjunction with another substance, most notably alcohol and /or tobacco. Table 1 shows the proportion of students who reported ever trying other illicit drugs such as steroids, amphetamines, ecstasy, cocaine, opiates and hallucinogens, over the last two surveys in 1996 and 1999. There are some increases amongst some of the age groups, however overall marked increases have not been indicated.

The 1999 survey indicates that in general less than one in twenty students reported to have used any of the drugs listed. There was, however, a higher prevalence of reported use of hallucinogens and amphetamines, with 10 to 24 per cent of 14 to 17 year olds reporting use at some time in their lives.

Table 1: Ever Used Listed Drugs: Percentage of Students by Age, Sex and Year of Survey

Age	Sex	Tranquillisers		Amphetamines		Hallucinogens		Heroin/Other Opiates	
		1996	1999	1996	1999	1996	1999	1996	1999
12	Male	23	9	2	5	6	4	-	4
	Female	4	10	6	2	-	1	2	4
13	Male	22	9	3	4	7	6	-	2
	Female	19	16	4	1	7	3	4	3
14	Male	18	20	4	10	7	13	1	6
	Female	13	18	8	7	9	11	5	5
15	Male	13	17	8	4	8	9	-	5
	Female	17	19	3	8	6	14	8	6
16	Male	15	23	5	10	13	13	2	3
	Female	21	12	11	6	9	9	4	2
17	Male	22	17	11	6	14	15	14	3
	Female	11	27	5	8	24	24	2	4

Source: 1999 ASSAD Survey – Summary of Northern Territory Results (not yet published)

Street intercept surveys were conducted in the Northern Territory in 1994 and 1998 in the urban centres of Darwin, Alice Springs, Katherine and Tennant Creek to determine drinking behaviour, related attitudes and other drug use of youth aged 16 to 24 years and no longer at school. In 1998 half of those surveyed had used cannabis in the six months prior to the survey and slightly more males than females had used the drug. Just over one in ten respondents (12.4% of respondents) had used stimulants. Very few (3.8%) had used opiates in the preceding six months, and those aged 18 - 20 had higher use (7.1%) than the 16-17 (2.3%) or 21-24 (1.9%) age groups. Use of illicit drugs had changed little since the 1994 survey (Crundall and Weir, 1994; O'Reilly and Townsend, 1999).

In the Northern Territory Youth Survey Report published in February 2001 and conducted in May and June 2000 by the Office of Youth Affairs, Department of the Chief Minister, eight out of 845 respondents indicated that they had injected themselves with an illegal drug in the previous 12 months. This figure is in line with the estimated 1% of the Australian population who have injected in the previous 12 months (Cavenagh, 2001).

Some 270 individuals 20 years and under presented at the Northern Territory alcohol and drug treatment services in 2000/2001; this represented 9% of the total clients (DHCS, AODP Database). The majority of these presentations were in Darwin and Alice Springs with only small numbers being reported in the other regional centres.

Families

It is difficult to estimate how many families in the Northern Territory are affected by a member's drug use. Data available on individual drug use from the National Drug Strategy Household Survey 1998 have been previously presented. This survey estimated that 53,630 persons 14 years and older had used an illicit drug in the 12 months preceding the 1998 survey. Of these 35,990 were males and 24,340 were less than 30 years old. The predominant illicit drug reported was cannabis (approximately 93%) with only small numbers (not statistically significant) of individuals reporting other illicit drug use making it difficult to accurately interpret these figures.

Research indicates that one in five Australians used an illicit drug in the past 12 months (Gowing et al., 2001). However, it is evident that there are at least the same number of families as there are individuals who are potentially affected by drug use.

The AODP Database statistics indicated that in 2000/01, 545 people presented to Northern Territory alcohol and drug services to seek assistance for the alcohol and drug problem of someone else. Predominantly this was for alcohol (330), cannabis (100) and amphetamines (59). These figures are highly likely to be an underestimate of the numbers of families and significant others affected by the alcohol and drug using behaviour of a family member.

Parental neglect due to drug use is a growing concern within the community. There is an increasing number of Northern Territory children being taken into care. There has been reports of the coexistence of the misuse of drugs and alcohol, particularly alcohol, by parents and incidents of serious child abuse (Family and Children's Services, DHCS). Anecdotal evidence provided by DHCS Family and Children's Services field staff indicates that substance misuse (predominantly alcohol) is an issue in approximately 70% of child protection cases. While no published figures are available; it is the view of Family and Children's Services that there has been an increase over the last 10 years.

Research has recently been completed, as part of an innovative international 'Family Coping' research project with Aboriginal people, highlighting the impact of substance misuse upon children, family and culture. The research has also been conducted in the United States and Mexico, and aims to identify how family members are affected by excessive substance use, how they cope with this and manage what is often an untenable situation (Orford et al., 2001).

Indigenous People

The estimated resident population for the Northern Territory in June 1996 was 181,900 of which the Indigenous population comprises 27.2%. While most of the Northern Territory population live in the major centres of Darwin, Katherine, Nhulunbuy, Tennant Creek, and Alice Springs, the reverse is true for the Indigenous population, with 63% living in remote communities, outstations and cattle stations (ABS, 1996).

People living in remote Indigenous communities are affected by a range of issues that may impact on their health and contribute to harmful use of alcohol, tobacco and other drugs. Communities have consistently identified excessive alcohol consumption as an issue of significant concern and have advocated the need for alcohol intervention and treatment services to be available in remote and rural communities. In line with these directions the Northern Territory Government's LWAP had the stated aim of increasing the capacity of Indigenous communities to provide support and care services for people experiencing alcohol or drug problems.

Information regarding contemporary patterns of substance use in the Northern Territory Indigenous communities is inadequate; it is either limited to National surveys (ABS NATSIS Survey, 1994; NDS 1994) or to outdated Northern Territory data (Watson et al, 1988). At the local community level the evidence is largely anecdotal. The main substances of concern reported in the Northern Territory include alcohol, tobacco, cannabis, inhalants, and kava.

Amongst Indigenous people, two national surveys have been conducted, both in 1994: The National Drug Strategy's Household Survey, Urban Aboriginal and Torres Strait Islander People's Supplement, (NDS, 1994); and the National Aboriginal and Torres Strait Islander Survey (NATSIS, 1994), carried out by the Australian Bureau of Statistics. Both surveys provide different levels of information. The NATSIS survey reports both National and Northern Territory data and gives evidence for regional variation across the Northern Territory. It does however fail to provide information on consumption patterns including quantity or frequency (ABS 1996).

The more detailed NDS (1994) survey provides a more comprehensive report about consumption patterns amongst Indigenous people but is limited to the urban setting and does not contain detailed Northern Territory findings.

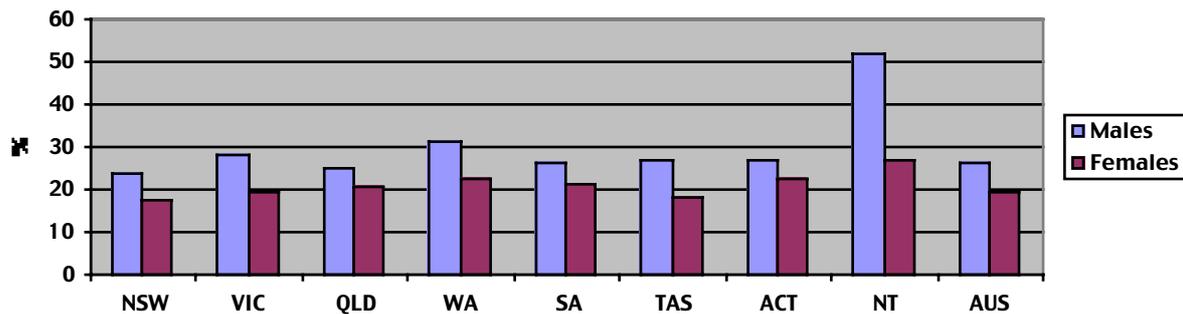
The 1994 NDSHS Indigenous supplement, involving 635 urban Indigenous people from the Northern Territory, reported 48% had tried cannabis; 22% identified as current users (30% males and 15% females) (NDS, 1994). According to this survey, use of cannabis is more widespread among the urban Indigenous community with nearly double the proportion of current users than in the general urban population.

A more recent cross-sectional study (Clough et al, 2000), involving 101 East Arnhem Indigenous people conducted by Menzies School of Health Research in one remote community reported 43% used cannabis. This was a two and a-half fold increase from an earlier case-control group (n=689). The 2000 study also found the mean duration of cannabis use was four years and matched Health Worker reports of cannabis now becoming available for sale in remote areas during the last three to five years.

NORTHERN TERRITORY WHEN COMPARED TO OTHER AUSTRALIAN JURISDICTIONS

The 1998 NDSHS indicates that the Northern Territory has the highest overall rate of recent use (ie. over the previous 12 months) of any illicit drug. Recent use of illicit drugs is greater for males than females in the Northern Territory, as it is in all Australian jurisdictions [Figure 2].

Figure 2 - Recent drug use (%) of persons aged 14 years and over by gender and jurisdiction, any illicit drug, 1998.



Source: 1998 National Drug Strategy Household Survey

Male rates above the National average of 26.2% were reported in the Northern Territory (51.9%), Western Australia (31.3%), Victoria (28.0%), Tasmania (26.9%), Australian Capital Territory (26.8%) and South Australia (26.4%). Female rates above the National average of 19.5% were reported in the Northern Territory (27.1%), Western Australia (22.7%), Australian Capital Territory (22.6%), South Australia (21.5%) and Queensland (20.4%). There was a National average of 11% of recent use of any illicit drug excluding cannabis, with higher than the National rates reported in the Northern Territory (14.6%), Western Australia (13.6%), South Australia (12.8%) and Victoria (12.5%) [Table 2]. The Australian Institute of Health and Welfare do caution that the Northern Territory data needs to be treated with caution because of the small sample size and high standard error. Given this the results may not be reliable and caution should be exercised in drawing firm conclusions. Table 3 provides an estimate of the number in each jurisdiction using the substances listed based on population data and the results of the NDSHS from 1998.

Table 2: Recent drug use (%) of persons aged 14 yrs and over by jurisdiction, 1998

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUS
Any illicit drug									
14-19	39.4	41.1	33.2	35.8	47.8	39.2	36.9	41.1	38.9
20-29	37.5	42.3	43.7	52.9	43.1	43.9	40.0	49.4	42.1
30-39	22.8	27.8	23.0	26.7	23.9	21.9	29.2	59.2	25.1
40+	9.5	10.8	11.5	13.5	12.3	12.3	11.8	19.1	11.0
Males	23.5	28.0	24.7	31.3	26.4	26.9	26.8	51.9	26.2
Females	17.6	19.2	20.4	22.7	21.5	18.4	22.6	27.1	19.5
Persons	20.5	23.5	22.5	26.9	23.9	22.6	24.7	39.9	22.8
Any illicit drug excluding cannabis									
14-19	17.0	15.5	15.2	17.3	18.9	15.1	17.0	16.5	16.4
20-29	20.9	25.0	19.6	32.5	24.0	13.8	21.0	23.0	23.0
30-39	7.4	11.4	9.9	10.3	8.3	6.5	7.8	16.3	9.3
40+	4.1	7.6	5.0	5.7	9.4	9.1	5.8	5.8	5.9
Males	11.2	14.3	9.8	17.6	14.1	12.1	12.7	21.1	12.7
Females	7.4	10.9	10.2	9.7	11.6	8.2	9.3	7.7	9.4
Persons	9.3	12.5	10.0	13.6	12.8	10.1	11.0	14.6	11.0

Source: 1998 National Drug Strategy Household Survey

All States and Territories showed large populations of current smokers, hazardous/harmful drinkers and marijuana/cannabis users that vastly outnumber other recent illicit drug use.

Table 3: Recent drug user estimates:(a) selected substances/behaviours, States and Territories, Australia, 1998

Substance/ behaviour	NSW (’000)	Vic	Qld	WA	SA	Tas	ACT	NT	Aus
Tobacco	1,296	1,028	794	401	269	107	65	51	4,012
Alcohol	260	193	187	93	70	19	14	15	850
Cannabis	851	669	484	325	213	60	50	52	2,702
Heroin	32	37	18	22	6	2	<1	<1	118
Injected illegal drugs	17	33	28	27	5	2	<1	1	114
Recent use of any illicit	1,047	885	621	393	289	85	61	57	3,437

(a) Estimates were based on 10,030 respondents in the 1998 National Drug Survey. The number of tobacco users reflects the sum of daily and occasional smokers. The estimate of alcohol relates to the ‘conservative’ analysis of the number of people that reported hazardous or harmful alcohol use.

(b) Caution needs to be exercised for Northern Territory data due to small sample size, high standard error and the subsequent dangers of drawing firm conclusions.

Source: ABS Population estimates June 1998 and 1998 National Drug Strategy Household Survey.

AUSTRALIAN ILLICIT DRUG USE TRENDS IN COMPARISON WITH OTHER COUNTRIES

It is difficult to compare research between different countries because of variations in methodology, sample size, age groups and the year in which surveys have been conducted. Therefore, caution needs to be exercised in the interpretation of the data presented in this section.

The Australian rate of 17.9% of cannabis use is reported to be approximately twice the rate of the United Kingdom (9.0%), the United States (8.6%) and Spain (7.6%). The Australian rate of 3.6% of amphetamines is slightly higher than for the United Kingdom (3.0%), and more than three times higher than Spain (0.9%) and the United States (0.8%). For ecstasy the Australian rate of 2.4% was more than twice the rate for the United Kingdom (1.0%), Spain (0.9%), Germany (0.9%) and Netherlands (0.8%). Compared to other Western countries Australia had the third highest overall rate (1.4%) of the annual use of cocaine compared to the United States (1.7%) and Spain (1.6%), with lower rates reported for the United Kingdom (1.0%) and the Netherlands (0.7%) (WA Community Drug Summit, 2001).

OTHER INDICATORS

Treatment Agency Data (for NTG funded agencies)

Opiates and cannabis were most often the reason for clients being admitted to treatment for drug use in the five-year period indicated, shown in Table 4, 2001 data is incomplete and has not been included. Almost as common was polydrug use, (the use of more than one drug) followed by amphetamines. Of interest is that the number of clients presenting with illicit drug problems almost tripled over the period with 372 in 1996 and 1074 in 2000. This needs to be interpreted within the context of an increasing Northern Territory population, however it would not account for the entire increase by any measure.

Table 4: Drug Admissions to Treatment Agencies 1996-2000

Substance	1996	1997	1998	1999	2000
Amphetamines	26	41	62	97	194
Barbiturates	1	2	2	0	1
Benzodiazepines	25	18	32	14	7
Tranquillisers	3	1	3	0	5
Cannabis	117	159	194	141	260
Cocaine	2	2	1	2	3
Hallucinogens	1	4	3	1	7
Opiates	110	148	257	326	340
Antidepressants	6	4	4	1	20
Ecstasy	0	1	0	1	3
Minor Analgesics	0	1	2	0	4
Polydrug use	81	129	178	362*	230*
TOTAL	372	510	728	945	1074

Source: Alcohol and Other Drugs Client Database

* Coding for polydrug use different as categories redefined.

Overall, demand for illicit drug treatment through alcohol and other drug agencies has increased but remains relatively low, when compared with the demand for alcohol treatment. This reflects not only an increasing trend but also potentially highlights the historical focus of the majority of the treatment agencies in the Territory. In 2000/01, 1249 people sought treatment for alcohol misuse across the Northern Territory, compared to 208 for opiate misuse, 206 for cannabis misuse, and 162 for amphetamine misuse. Table 5 indicates the majority of admissions were in the Top End, (predominantly in Darwin: 166 for opiates; 137 for cannabis; and 135 for amphetamines), accounting for 34.6% of all admissions in the Top End compared with 21.3% in Alice Springs. When cannabis is removed from the figures the differences between regions remain similar, with treatment for cannabis accounting for a significant portion of those presenting to existing treatment services.

Table 5: Drug Admissions to Treatment Agencies 2000/2001 by Region

	Top End Service Network	Central Australian Service Network
Cannabis	153	53
Amphetamines	137	25
Morphine	129	4
Heroin	48	14
Other Opiates	13	0
Benzodiazepines	6	0
Hallucinogens	5	0
Tranquillisers	4	0
Cocaine	2	0
Ecstasy	2	0
Other	1	0
Barbiturates	1	2
Total*	501	98
Total without Cannabis	348	45
Total all admissions	1448	460
% of illicit drugs (Incl. cannabis)	34.6%	21.3%
% of illicit drugs (Excl. cannabis)	24%	9.8%

Source: Alcohol and Other Drugs Client Database

* - Total number of admissions including licit substances such as alcohol and tobacco.

Illicit Drug Reporting System (IDRS)

In 1997, Commonwealth Health and Aged Care commissioned the National Drug & Alcohol Research Centre to trial the Illicit Drug Reporting System in three states. In 1998 the Northern Territory was invited to participate and conducted the key informant survey component for inclusion in the 1999 study. In 2000 and 2001 all jurisdictions have conducted the full study following a standard procedure manual.

The stated purpose of the research is to act as an early warning system, detect trends, indicate areas that may require further research and contribute to policy decisions. The three components are:

- A quantitative survey of current injecting drug users. Inclusion criteria focused on participants who had been injecting at least monthly for the past six months and with Darwin as the principal place of residence in the preceding 12 months.
- Qualitative interviews with key informants recruited from professional settings. Inclusion criteria of at least weekly contact with illicit drug users in the six months preceding the study or contact with at least ten illicit drug users in the previous six months.

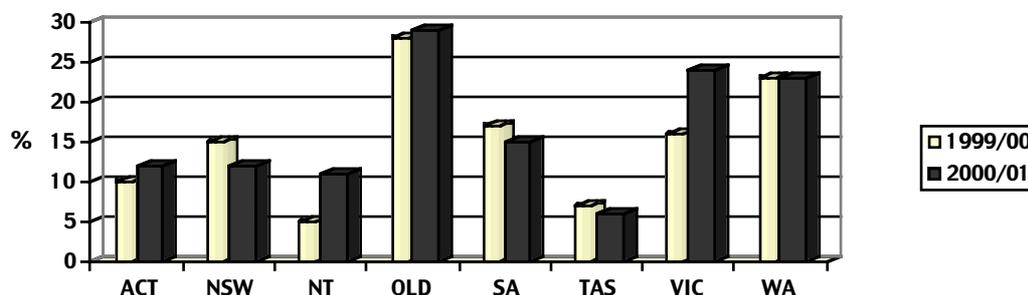
- Analysis of secondary indicator data on illicit drug use or associated harm.

The Northern Territory 2000 survey found that the average age of first intravenous age was 19 years and amphetamines was the drug most likely to be the first drug injected. Heroin was the drug reported to be preferred by most intravenous drug users, however morphine was the drug most likely to have been last injected. This is a different pattern of use to most other Australian jurisdictions. In addition, polydrug use was prevalent with non-fatal drug overdose reported as common amongst injecting drug users (O'Reilly and Rysavy, 2001).

The 2001 study found that within the survey of people who inject drugs the participants were predominantly male, of non-Indigenous origin, mean age of 34.3 years, unemployed and not currently in drug treatment. Ten percent of the sample identified as Indigenous and this proportion is similar to that reported in 2000. Half of the sample had a prison history and one in three had been arrested in the previous year. The mean age of first injection was 20 years and amphetamine was most likely to be the first drug injected. Heroin was the preferred drug of most people who inject drugs (PWID), but morphine was the drug most likely to be last injected. Polydrug use was prevalent, with nine drugs being the median number ever used.

The 2001 study reported an increase in the average purity level of amphetamine seizures in the Northern Territory across 1999/00 and 2000/01, as shown in Figure 3.

Figure 3: Average purity level of amphetamine seizures, 1999/00 and 2000/01



Source: O'Reilly, 2002

O'Reilly (2002) also provided data regarding the number of seizures for a number of drugs across all jurisdictions in 2000/2001 (Table 6). These data indicate that the Territory had few seizures, and those they did have were for cannabis and drugs other than cocaine, heroin and MDMA.

Table 6: Drug seizures by jurisdiction, 2000/2001

Jurisdiction	Cannabis	Cocaine	MDMA	Heroin	Other*	Total
No. seizures						
NSW	385	30	65	15	1675	2170
VIC	191	10	41	6	1022	1270
QLD	195	9	15	3	348	570
SA	33	3	12	2	212	262
WA	85	8	12	1	241	347
TAS	1	0	0	0	1	2
ACT	2	0	0	0	5	7
NT	33	0	2	1	41	77
Total	925	60	147	28	3545	4705
Weight (kg)						
NSW	6.12	15.67	285.36	212.26		
VIC	11.79	0.53	24.47	1.48		
QLD	1.96	93.70	11.12	0.04		
SA	0.54	317.01	1.55	0.48		
WA	49.87	0.53	15.92	0.99		
TAS	0.11	0	0	0		
ACT	0.01	0	0	0		
NT	0.41	0	0	0.34		
Total	70.80	427.44	338.42	215.60		

* Other is stimulants other than cocaine, narcotics/analgesics other than heroin, psychotropics/hallucinogenics other than MDMA (ecstasy) or cannabis products, steroids and all depressants and sedatives.

Source: O'Reilly (2002)

Comparison of the IDRS studies from 1999 to 2001 indicate that there is a continuing trend toward an increasing number of users, particularly amongst youth and Indigenous people, with the prevalence of polydrug use increasing among youth and Indigenous people. The 2001 study in particular indicated an emerging trend of increased polydrug use, increased availability and use of crystal methamphetamine, benzodiazepines and ecstasy and greater criminal activity, as reported by the PWID survey component. Morphine and amphetamine continue to dominate the drug scene; the use of cocaine is low among the drug using population. Overall cannabis was found to be consistently the most widely used drug in the Northern Territory, excluding tobacco and alcohol.

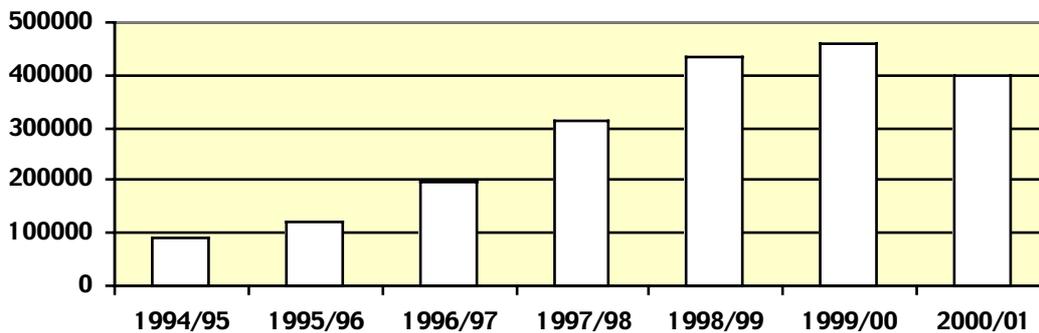
Needle and Syringe Programs

Needle and Syringe Programs distribute injecting equipment in all districts throughout the Territory, including Alice Springs, Tennant Creek, Katherine, Nhulunbuy and Darwin, indicating that injecting drug use is occurring throughout all of the regional centres (Roberts and Grant, 2001).

Snapshot surveys conducted at the Needle and Syringe Program (NSP) in Darwin have indicated that the most commonly injected drug continues to be morphine, with the preferred drugs of choice reported to be heroin and amphetamine (Gee, 2001). In Alice Springs the drug use patterns are reported to be much closer in alignment with other parts of Australia, where the most commonly injected drug in Australia is heroin (Roberts and Croft, 2000). Amphetamines make up a large proportion of drugs used by clients accessing the NSP at Life Choices (Savage et al., 2000).

The Northern Territory AIDS Council (NTAC) in Darwin collects data on the number of needles and syringes distributed and these are presented in Figure 4. There has been a steady increase from 89,475 in 1994/95 to 459,619 in 1999/00; however a decrease has been evident in distribution in 2000/2001, to 397,286. This decrease may be accounted for by the increase in pharmacies purchasing 'FITKITS' from alternative sources to NTAC. It has not been possible to obtain the pharmacy figures at this time.

Figure 4: Number of needles and syringes distributed, 1994/95 to 2000/2001



Source: Needle/Syringe Program figures (Northern Territory AIDS Council)

The Australian Needle and Syringe Program (ANSP), commonly known as the 'fingerprick' study is conducted annually. It collates survey information on the prevalence of the last drug injected; the 2000 data are presented in Table 7.

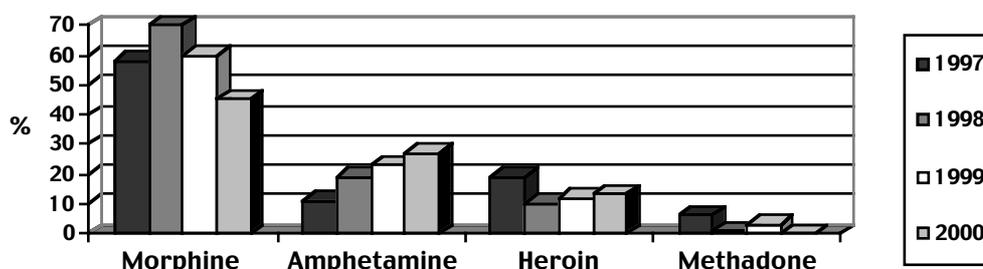
Table 7: Prevalence of last drug injected by jurisdiction, 2000

DRUG	ACT	NSW	VIC	QLD	SA	TAS	WA	NT
Cocaine	0 0%	45 5%	0 0%	3 <1%	3 1%	0 0%	1 1%	1 0%
Heroin	130 80%	533 59%	254 87%	366 45%	175 56%	3 11%	71 50%	12 13%
Methadone	3 2%	65 7%	0 0%	11 1%	7 2%	4 15%	3 2%	0 0%
Morphine	3 2%	5 1%	5 2%	18 2%	10 3%	6 22%	7 5%	43 45%
Other	0 0%	8 1%	0 0%	6 1%	1 <1%	0 0%	1 1%	0 0%
Amphet- amine	10 6%	91 10%	19 6%	283 38%	93 30%	6 22%	33 23%	26 27%
> One drug	14 8%	141 15%	12 4%	62 8%	18 6%	7 26%	16 11%	9 10%
Not reported	1 1%	11 1%	2 1%	10 1%	3 1%	0 0%	10 7%	3 3%

Source: National Centre in HIV Epidemiology and Clinical Research for the Collaboration of Australian Needle and Syringe Programs.

The Northern Territory has the third highest rate of amphetamine injection (27%), South Australia was second at 30% and Queensland reported the highest rate (38%). The ANSP survey data highlights a unique pattern of opiate injection in the Northern Territory, where morphine is reported as the most frequently injected drug among the people who inject drugs.

Figure 5: Prevalence of last drug injected among PWID in the Northern Territory, 1997 to 2000.



Source: National Centre in HIV Epidemiology and Clinical Research for the Collaboration of Australian Needle and Syringe Programs.

Figure 5 indicates the reported prevalence of the last drug injected from 1997 to 2000. A decrease in the prevalence of people who have injected morphine is evident from 1998, although this has been accompanied by a steady increase in the percentage of those last injecting amphetamine. At the same time, the proportion that last injected heroin decreased from 20% in 1995 to 13% in 2000.

Schedule 8 Prescription Drugs

In August 1999, the Health Insurance Commission (HIC) visited a number of doctors in the Darwin area in response to concerns about the high prescribing rate for MS Contin. This inquiry followed increasing concerns raised in the community about the diversion of Schedule 8 drugs for illicit use.

Figures collated through the Poisons and Pharmacy Branch of DHCS indicate that morphine usage in the Northern Territory makes up 3.8% of the total Australian prescription of morphine. In 1998, MS Contin 100mg prescriptions in the Northern Territory made up 11% of the National MS Contin 100mg consumption. These figures are based on wholesale supply to jurisdictions and include all injections, tablets, capsules and mixtures used in hospital and community health practice. The bulk of this supply was being used in the Darwin area. It must be remembered when considering the Northern Territory that the jurisdictional population is significantly smaller than other capital centres which can skew overall statistics and that the numbers of visitors from other states/territories can affect the apparent impact.

Between 1991/92 and 1996/97 the number of S8 prescriptions increased from around 6,000 to 21,718. Prescriptions alone may give an incomplete story because some General Practitioners (GPs) provide daily prescriptions to minimise misuse. However, it is quite clear that actual tablet numbers of MS Contin 100mg, the most commonly prescribed form of morphine, increased substantially until 1999.

This increase in the Northern Territory could be due to an increase in prescribing by 1 or 2 practitioners, which again, in a relatively small system skews the figures. Another factor could be that a major increase in early discharge from hospitals, with a shift to tablets rather than injections, occurred earlier in other parts of Australia. This is speculative only and regardless of these factors it is well known from anecdotal sources that prescription morphine has been readily available on the 'black market', particularly in Darwin. Other drug use in the Northern Territory could be considered in this context. Illegal opiate use is not as high in the Northern Territory as other jurisdictions and may be a result of morphine substitution.

A number of factors have occurred since the peak prescribing period in 1999, such as the introduction of the Voluntary Notification Scheme, scrutiny by the HIC, and training opportunities for GPs. These and other factors are likely to have contributed towards a fall in MS Contin supply. Table 8 shows the annual figures for the prescription rates of MS Contin, as recorded by the Northern Territory Prescription Register. By the end of 2000, a fall of 73% in prescriptions written for MS Contin 100mg since the 2nd quarter 1999 (the peak prescribing period) has been achieved, with a corresponding reduction of 58% in the number of tablets of MS Contin 100mg. An increase is apparent for the past two quarters in terms of both prescriptions and tablets.

Table 8: Scripts Dispensed for Ms Contin 100mg in 1999 - 2002

		1 st quarter	2 nd quarter	3 rd quarter	4 th quarter	Totals
1998	Scripts	1397	2017	2330	2773	8517
	Tablets	38,191	54,166	70,317	80,114	242,788
1999	Scripts	2532	2844	2654	1846	9876
	Tablets	75,238	90,756	83,901	68,334	318,229
2000	Scripts	1538	1242	1159	776	4715
	Tablets	63,777	54,670	47,808	39,587	205,842
2001	Scripts	639	665	656	871	2831
	Tablets	33,956	33,395	31,451	34,580	133,382
2002	Scripts	957				
	Tablets	37,339				

Source: Poisons and Pharmacy Branch, DHCS, Northern Territory Prescription Register

Prison Data

The Corrections Medical Services (CMS) operates primary medical care services to the Northern Territory prison system. The prison service as elsewhere in Australia deals with a significant number of alcohol and drug problems amongst inmates. CMS has reported significant increases in the rates of prisoners being admitted who have drug and alcohol problems. The CMS database records “*a snapshot of the situation at prison entry.*”

All prisoners are given a drug and alcohol assessment by the prison medical service as part of their reception into the prisons. Table 9 shows the reported levels of use of illicit drugs by the inmates for cannabis, opioids, amphetamines and injecting drug use for 2001. A steady increase is evident with significantly higher use of cannabis reported in the Top End in comparison to Central Australia. These data also indicate higher levels of injecting being reported, with amphetamine use considerably higher in the Darwin prison. It is important to note that illicit drug use (excluding cannabis use) is only a small percentage of the total prison receptions in both Alice Springs and Darwin.

Table 9: Number (and %) of Receptions Reporting ‘Ever Used’ Drugs or Injected Drugs in 2001 by Prison Location and Aboriginality

Location	Alice Springs Total Receptions=808		Darwin Total Receptions=1436	
	Drug	Total	Aboriginal	Total
Cannabis	80 (0.9%)	62 (7.7%)	339 (23.6%)	215 (15%)
Opioids	18 (2.2%)	3 (0.4%)	51 (3.6%)	16 (1.1%)
Amphetamines	16 (2%)	6 (0.7%)	56 (3.9%)	15 (1%)
Injected Drugs	15 (1.9%)	5 (0.6%)	64 (4.5%)	20 (1.4%)

Source: compiled by Dr C Wake, Corrections Medical Services

MORTALITY AND MORBIDITY DATA

Mortality caused by drugs

The Australian Bureau of Statistics (ABS) maintains a database on the number of opioid related deaths as coded by the International Classification of Death [ICD-9 1988-1998; and ICD-10 from 1999 onwards]. According to this database the Northern Territory recorded 8 deaths in 1999 coded to have involved a drug overdose. Of these deaths 4 were opiate related, with the majority involving a cocktail of drugs. In 1998, ten opiate related deaths were recorded in the Northern Territory as compared with two in 1996 and one in 1997. In Australia in 2000 there were 725 opiate related deaths, 960 in 1999, 737 in 1998, 600 in 1997 and 526 in 1996 (Table 10).

There has been until recently an Australia wide increase in opioid overdose deaths at a National level, which has shown a nearly fourfold increased rate, from a rate of 30.1 per million (population aged 15 to 44 years) in 1991 to a rate of 112.5 in 1999 (Table 11). The Northern Territory has experienced fluctuations during this time but the common theme has been relatively low rates of opioid overdose related deaths.

Table 10: Number of opioid overdose deaths among those aged 15 - 44 years by jurisdiction, 1988 - 2000.

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
1988	201	99	15	12	18	0	0	2	347
1989	154	98	19	8	18	1	2	2	302
1990	193	78	8	18	14	5	0	0	316
1991	142	63	9	12	12	3	0	2	243
1992	178	77	18	28	21	0	1	4	327
1993	177	84	22	40	23	4	2	5	357
1994	201	91	34	32	38	4	5	1	406
1995	251	136	42	34	68	6	0	13	550
1996	244	142	27	30	61	5	2	15	526
1997	292	168	26	36	70	1	1	6	600
1998	358	210	38	45	59	7	10	10	737
1999	401	347	70	52	73	3	4	8	960
2000	249	263	113	40	43	5	2	10	725

Source: O'Reilly (2002)

Table 11: Rates per million population aged 15 - 44 years of opioid overdose deaths by jurisdiction, 1998 - 2000

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
1988	75.1	48.5	11.4	18.1	23.8	-	-	13.7	45.3
1989	56.6	47.2	14.0	12.0	23.2	4.7	22.2	13.5	38.3
1990	70.4	37.1	5.8	26.8	17.7	23.4	-	-	39.9
1991	51.5	29.8	6.4	17.8	15.1	14.0	-	13.0	30.1
1992	64.3	36.5	12.6	41.6	26.3	-	10.9	25.7	40.6
1993	64.2	40.1	15.1	59.9	28.8	18.8	21.9	31.9	43.6
1994	72.8	43.8	22.8	48.2	47.3	19.0	55.2	6.4	49.6
1995	90.5	65.7	27.7	51.6	83.7	28.7	-	82.8	67.0
1996	87.3	68.4	17.5	45.8	74.2	24.1	21.9	95.3	62.9
1997	103.8	80.3	16.7	55.6	83.6	4.9	10.0	38.7	71.5
1998	126.4	99.6	24.2	69.7	69.4	34.6	99.8	65.8	87.1
1999	141.6	163.4	44.2	80.9	85.0	15.1	39.6	52.9	112.8
2000	87.1	122.9	70.8	62.6	49.8	25.4	19.7	66.5	84.8

Source: O'Reilly (2002)

Morbidity caused by drugs

Drug problems and disorders

The Australian 1997 National Survey of Mental Health found that 8% of all persons aged 18 years and older had a substance abuse disorder (11% of males, 5% of females), out of which 6.5% had an alcohol related problem, that is harmful use or alcohol dependence. No jurisdictional breakdowns are available because of the small numbers involved.

Admissions to hospitals

Information regarding hospital admissions has been provided by the Corporate Information Services section of the Department of Health and Community Services. Diagnoses are coded according to the ICD coding systems [ICD-9 1988-1998; and ICD-10 from 1999 onwards].

Whilst these figures provide an indication of the number of inpatient admissions in Territory Hospitals that may be attributed to various types of illicit drugs, it is of limited utility for monitoring trends in illicit drug morbidity within the community. This is likely to be because the vast majority of cases of illicit drug morbidity are treated within the accident and emergency departments and do not require an admission. Consequently, these data are likely to underestimate total hospital treatment associated with these conditions. Table 12 shows the numbers of inpatient admissions for some selected illicit drug related primary diagnoses in the Territory over the period 1996/97 to 2000/01. This table shows that illicit-drug-related admissions are relatively infrequent events, and overall there has been an increase in the number of episodes in these categories, fluctuating within the specified time period.

Table 12: Numbers of inpatient admissions for Northern Territory Public Hospitals for selected illicit drug diagnoses, 1996/97 - 2000/01

Diagnosis Group	96/97	97/98	98/99	99/00	00/01
Cannabis dependence	2	14	21	16	19
Opioid overdose	-	4	-	18	14
Drug Psychoses	33	106	136	87	96
Opiate Dependence	5	26	28	40	35

Source: Corporate Information Services, DHCS.

Blood Borne Virus Notifications

Blood borne viruses, in particular HIV and hepatitis B and C, represent a major health hazard for individuals who inject drugs. The sharing of equipment for injecting illicit drugs has infrequently resulted in HIV transmission throughout Australia. However throughout Australia, the transmission of the hepatitis C virus (HCV) continues to occur at very high rates in people who inject. In Australia, approximately 210,000 people are infected with HCV, and the costs, both human and economic, are acknowledged as immense.

HCV and HIV are notifiable conditions under the Northern Territory Notifiable Disease Act. Table 13 shows the notified cases for HIV and HCV for the period 1991 to 2001. The HIV rates are relatively small in the Northern Territory and therefore accurate interpretation of the data is difficult.

Table 13: Northern Territory HIV and Hepatitis C rates by year

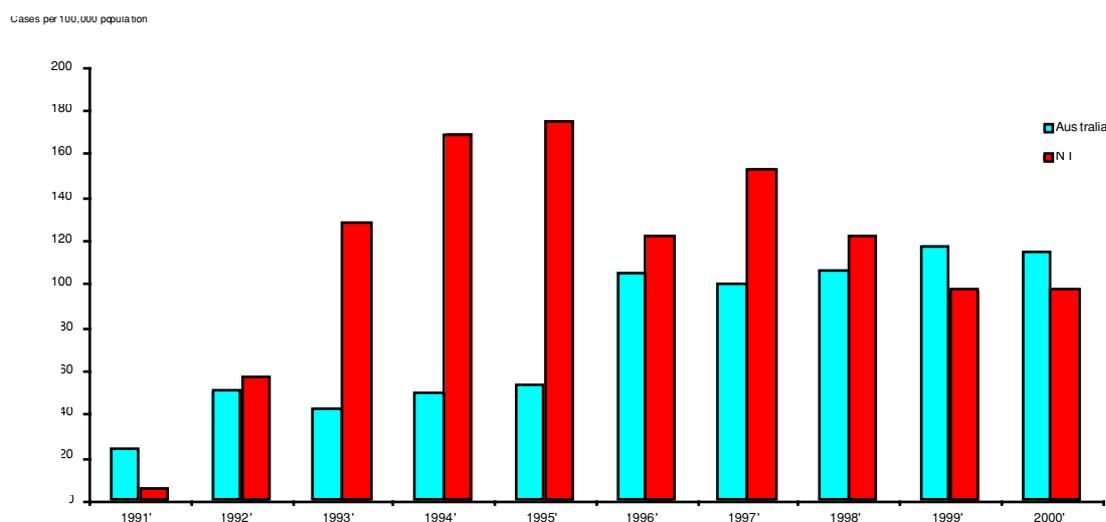
Year	HIV		Hepatitis C	
	Cases	Rate ¹	Cases	Rate ¹
1991	6	3.6	10	6.0
1992	6	3.6	95	56.5
1993	10	5.9	218	127.7
1994	5	2.9	293	169.0
1995	1	0.6	311	175.2
1996	6	3.3	222	122.1
1997	11	5.9	286	153.0
1998	12	6.3	232	122.1
1999	5	2.6	187	97.0
2000	3	1.5	191	97.7
2001	4	2	212	106.6

¹ cases per 100 000 population

Source: CDC Unit, DHCS

Epidemiological data are not entirely accurate for a variety of reasons, these include: a lack of population prevalence studies, current tests which do not differentiate between a new infection and a long-standing or chronic infection, and blood donors who may have HCV tending to self select out of donating. In addition there are also variations in data collection methods used throughout Australia. In the Territory there are at least 2,154 Territorians infected with HCV and there are some 200 infections diagnosed each year (Roberts and Grant, 2001). Figure 5 compares the National and Northern Territory HCV rates across the period 1991 to 2000 and indicate that the Northern Territory rates are decreasing from peak in 1995.

Figure 6: Northern Territory and National Hepatitis C rates by year



Source: CDC Unit, DHCS

HCV rates in Northern Territory prisons

In the Northern Territory the rates of HCV are low (Alice Springs, 2.3% and Darwin, 4.6% estimated rates for 2002) and the rate of positive tests amongst Aboriginal people is only one third that of the remainder which is almost entirely non-Indigenous. This is in sharp contrast to the reported rates in major prisons in other Australian jurisdictions, which have HCV positive rates of approximately 50% among inmates (data provided by the Corrections Medical Service).

LAW ENFORCEMENT

Alcohol and other drug related crime requires an extensive and unified effort by police, correctional services and associated bodies to address problems such as violent crime, including domestic crime, public disorder, road trauma, property crime and organised crime associated with the supply of illicit drugs.

Drug offender and offence statistics have been provided by the Office of Crime Prevention derived from information held within the Integrated Justice Information System (IJIS). IJIS is the information system used by Police, Courts and Correctional Services to record information about people, offences, court cases and correctional services episodes. These statistics provide only a measure of those matters that come before the court and result in a finding of guilt and those instances where the police issue a Drug Infringement Notice (DIN); they do not provide an accurate measure of overall drug offending within the Territory. DINs are issued for types of offences that relate to personal use, where these will only result in court action if there is a failure to pay fines issued.

In 2000 /01 the number of individuals found guilty of a drug offence dropped by over 30% from the previous year's level. This decrease has largely been attributed to the non-enforcement of DINs occurring since a Supreme Court finding in December 1999. A flow on effect has been that DINs have not been enforced since May 2000; enforcement is expected to resume in May 2002.

Individuals falling into the age group of 20 to 34 account for over 50% of those drug offenders found guilty. Overall, offenders aged 30 plus tend to be convicted of the more serious offences, involving commercial quantities or drug import / export. In 2000-01 the numbers of those convicted aged 17 and under fell from 40 the previous year to 10. Several factors have been put forward to account for this decrease:

- From 1 June 2000 persons aged 17 ceased to be treated as adults;
- In September 2000 the juvenile pre court diversion program was introduced and included those who came to the notice of police for possession and/or use of an illicit drug; and
- The non-enforcement of DINs has a significant effect on the numbers of younger offenders, as they are predominantly involved in personal use offences.

Over the three-year period 1998 to 2001, 45% of known offences related to cannabis; less than 4% related to cocaine, heroin, kava, LSD and amphetamines; 15% related to prescription drugs; and 30% were not specified.

Other than those offences related to obtaining, manufacturing, dealing and using which can be quantified, it is difficult to ascertain the actual levels of crime associated with illicit drug use. The single most important difficulty is that in collecting data about drug use, most users are prepared to indicate what type and at what level of drug use they are involved with. However, they can be reticent to provide information about criminal activities related to obtaining the money to buy drugs.

Within Australia, the Drug Use Monitoring in Australia (DUMA) program has been operating in three States, the Southport watchhouse (Queensland), the East Perth lockup (Western Australia) and Bankstown and Parramatta police stations (New South Wales). DUMA is a project that seeks to measure drug use among those people who have been recently apprehended by police. Data from DUMA are used to examine issues such as the relationship between drugs and property and violent crime, monitor patterns of drug use across time, and help assess the need for drug treatment amongst the offender population.

The DUMA 2000 Annual Report clearly indicates a link between crime and drug use, as shown in Table 14. This indicates that considerable income had been derived from illegal activities in the 30 days prior to arrest. In addition, the DUMA reports that averaging across the four sites, half of all adult detainees self-reported that they had been arrested on a prior occasion in the previous 12 months. Consistently across all sites, adult male detainees tested positive to a range of drugs regardless of the charge. Thus, males detained for minor offences up to the most violent offences tested positive.

Table 14: Sources of illegal income in the past 30 days among those who obtained income illegally (n=191)

	% respondents	% responses
Other illegal activities	74.9	60.9
Drug dealing	35.6	28.9
Prostitution	12.6	10.2

Source: Australian Institute of Criminology, DUMA Collection 2000

In particular the DUMA 2000 data confirm the links between opiate use and property offending. It is reported that of those detainees whose most serious charge was property offending:

- 25 percent tested positive to amphetamines;
- 27 percent to benzodiazepines;
- 57 percent to cannabis;
- 45 percent to opiates
- 82 percent to any drug; and
- 66 percent to any drug excluding cannabis.

Similarly, the Northern Territory findings of the 2000 IDRS survey also indicate that there is a direct correlation between drug use and crime. For example Table 15 shows the levels of criminal activity self reported by people who inject drugs (PWID).

Table 15: PWID criminal activity in the previous month (n=96)

Type of crime	%
Property crime	8
Dealing	30
Fraud	12
Violent Crime	2

Source: Northern Territory Police Submission, 2002

In addition, almost half of those surveyed (46%) had been in prison at some stage with 28% arrested in the previous 12 months. It is important to note that these results are likely to be under estimates as some of the PWID refused to answer questions relating to crime and others were reported to be hesitant in their responses.

Whilst the Taskforce had difficulty in obtaining specific Northern Territory data to indicate the local links between crime and illicit drug use, the research that has been undertaken, such as the IDRS studies, does establish that similarities are likely to exist with those that have been determined in other Australian jurisdictions and internationally. That is, there is a clear link between drug use and certain types of crime, such as property crime.

EXPENDITURE

Economic costs of drug abuse

In a study by Collins and Lapsley (1992), The social costs of drug abuse in Australia in 1988 and 1992, estimated that the total economic cost of drug abuse to the Australian community in 1992 was \$18.844 billion. This included both tangible costs (eg hospitalisation, ambulance and emergency services) and intangible costs (eg prevention, treatment of drug-related illness, loss of productivity, property crime, theft, accidents and law enforcement). Of the total cost of \$18.844 billion, it was estimated that \$12.736 billion (67.3%) was due to tobacco smoking, \$4.494 billion (23.8%) was due to alcohol abuse and the remaining \$1.684 billion (8.9%) was due to the abuse of other drugs.

The third National study of social costs of drugs in Australia is currently being finalised by Collins and Lapsley. This study uses 1998-99 data and will update their previous work (1988 and 1992) and further refine the analysis of costs of drugs in our community. Previous state specific studies have allowed these economic researchers to produce state specific reports for Victoria and Western Australia. (Eg: Collins, D and Lapsley, H (1999) The social costs of tobacco in Victoria and the Social Benefits of Quit Victoria, Quit Victoria. Melbourne). The Northern Territory would benefit from a specific analysis of the social costs of drugs given the particular characteristics of the Territory and the likely differences in profile of drug use and patterns of harm. This work is feasible and every effort should be made to take advantage of any state specific analyses arising from the publication of the National report. This matter could be pursued in conjunction with other jurisdictions at a Commonwealth level.

Direct expenditure on alcohol and drug strategy

According to the DHCS Annual Report published in 2001, the actual expenditure for the Alcohol and Other Drugs Program (AODP) was \$10.341 million in 2000/2001. This amount included \$670,000 of Commonwealth funds from the National Drug Strategy.

The Commonwealth provides funding of \$2.25 million to agencies and organisations throughout the Northern Territory to support alcohol and other drug initiatives. The Commonwealth Department of Health and Ageing administers these funds.

An additional \$1.7 million dollars has been allocated to the Territory by the Commonwealth for the Prime Minister's Pre Court Diversion initiative.

It is clear DHCS policy that service delivery should be conducted by Non-Government organisations, wherever possible. It is the Department's role to provide specialist services, back up support and training. At present the majority of alcohol and other drug treatment services in the Northern Territory are provided by the Non-Government sector. All service agreements for 2001/02 are now specifying that agencies need to deal with alcohol and other drugs, rather than just alcohol, as had historically been the case.

COMMUNITY VIEWS

There was general agreement across all regions of the Territory that the largest substance use issue was alcohol. In terms of illicit drugs cannabis was the first and most frequently raised issue at the consultations. Concerns were raised about the widespread use of cannabis in both the urban and remote areas, across a range of age groups. A particular concern was the problems arising from the use of cannabis in conjunction with other substances, both licit and illicit.

Other illicit drugs were far less widely used, however amphetamine use was reported to have been increasing, particularly amongst young people less than 24 years of age. Widespread use of opiates was only reported in Darwin, Palmerston and Alice Springs, with morphine being named as the most available. It was also in these centres that a broad range of other drugs such as ecstasy, cocaine, and heroin were noted.

"There is a rising trend in the use of amphetamines, especially during the past two years with the heroin drought."

"Young people are mostly smoking gunja: when speed comes into town they get it, but there is ongoing use of gunja."

During the consultations a number of individuals discussed problems associated with illicit drug use, on the whole these related to the use of cannabis in combination with other drugs.

"... about 70% of the people presenting for some problem other than cannabis also use cannabis as well. Its such a common polydrug use and induces so many other psychiatric or mental health issues that can occur, not due to the primary drug of concern ... and that's why I think, and is why education for dual diagnosis is so important in the future....They don't see cannabis as an issue, its just something that they do - its just like drinking water or having a cigarette, its just not the issue."

"We've been to national conferences where we've had recognised leaders in alcohol and other drugs telling us how safe cannabis is, yet we're dealing with the people for whom, it wasn't safe for them."

"[It is] complicated too by introducing things that by themselves seem relatively mild, but then with mixing you get much more extreme reactions."

RECOMMENDATIONS

The Taskforce has brought forward data from many sources. In doing so, we are aware that there is limited clear, consistent and reliable information about the patterns of drug use and related harms in the Northern Territory. If future policy and programs are to be soundly based, more effort is needed to maximise available data and support the collection and analysis of more consistent and reliable information. This needs to be done through a mix of extrapolation from National experience, where indicators suggest this is valid, and the extension of data collection in the Northern Territory where unique characteristics suggest some differences are likely. Efficiencies might be possible through adding resources to ensure larger samples in National population surveys for example.

It is recommended that:

- 2.1 That key indicators of drug use and associated harms need to be consistently collected, compiled, analysed and reported to Government and the community.
- 2.2 That some strategically selected National drug-related surveys be considered for additional funding to ensure appropriate numbers for Northern Territory specific analysis and comparisons.
- 2.3 That when major initiatives in such areas as mining, tourism and transport are planned a drug impact study be conducted as an aspect of planning and risk management strategies identified.
- 2.4 That the Illicit Drug Reporting System (IDRS) continue to be conducted in the Northern Territory.
- 2.5 That periodic assessments in 'sentinel' Aboriginal communities together with analysis of indicator data from Community Health Centres, Police and Correctional Services, be undertaken to identify emerging issues, determine the actual and perceived impact of drug use and guide possible constructive responses.
- 2.6 That economic research to determine the social cost of drug use in the Northern Territory is conducted building on comparable National studies.

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3. PREVENTION

OVERVIEW

Harm minimisation, the key principle underpinning Australia's Drug Strategy since 1985, has been identified as one of the features contributing to the success of the National Drug Strategy (Single and Rohl, 2001). Harm minimisation, as a whole, refers to policies and programs aimed at reducing drug related harm: it aims to improve the health, social and economic outcomes for both individuals and the community as a whole. Harm minimisation encompasses a wide range of integrated approaches, including:

- Supply reduction strategies designed to disrupt the production of supply of illicit drugs;
- Demand reduction strategies designed to prevent the uptake of harmful drug use, including abstinence-oriented strategies to reduce drug use; and
- A range of targeted harm-reduction strategies designed to reduce drug-related harm for particular individuals and the community as a whole.

SUPPLY REDUCTION

Supply reduction refers to those interventions that are designed to reduce availability and supply of particular drugs using control measures such as prohibition and regulation. Predominantly these interventions are law enforcement and interdiction strategies. It must be emphasised that as with demand reduction and treatment strategies, traditional law enforcement and interdiction strategies have limited success when they are applied in isolation.

Furthermore, there is evidence that sociocultural norms and informal social controls may be more important in determining the prevalence of drug use and how drugs are used than formal controls such as prohibition (MCDS, 2001). The influence of social norms was taken into account in the development of the Living with Alcohol Program. There were specific strategies identified to influence the social acceptance of heavy drinking and drunkenness.

The National Action Plan on Illicit Drugs informs that historically, law enforcement and interdiction have formed the basis of drug control effort, based on the following premises:

- They reduce the physical availability of illicit drugs;
- They reduce drug use through the deterrent effects of a perceived high risk of being caught and punished;
- They stem, suppress and disrupt the flow of trafficked drugs, sending a deterrent message to drug traffickers, making it difficult for them to engage in their business, and to a lesser extent unpleasant for users on the street;
- They reduce the demand by driving up the price of drugs;
- They reflect what is acceptable as a social norm and send a message to the community about it; and

- They punish those who offend against the law and against prevailing social moral values in the community.

While research into the most effective means of controlling the supply of drugs has not been able to provide definite answers at this time, the National Action Plan on Illicit Drugs supports the continuation of research to explore the relative cost-effectiveness of different strategies. As pointed out in the National Action plan, the challenge is “in predicting the full range of benefits and harms that might arise from the current set of policy options” (p25).

Current situation

A number of other Australian jurisdictions are currently implementing drug court systems as an alternative method of dealing with drug-related offending. A number of these programs are currently being evaluated. The Taskforce is aware that the Justice Department is currently investigating options regarding the introduction of a Drug Court system to the Territory. It would advise that close consideration be given to the experience and evaluation of these systems which is being undertaken in other jurisdictions (such as in New South Wales, Victoria, South Australia and Western Australia), in guiding any future decision making in the Territory.

In addition the Taskforce is aware that substantial reform is currently taking place to legislation related to supply of drugs.

The Northern Territory Police in their submission to the Taskforce informed that they are involved in a number of programs, which impact on reducing harm to the community. This aspect of addressing drug issues is clearly outlined in the Northern Territory Police, Fire and Emergency Services Strategic Plan 2001 - 2005 where it outlines as part of its Strategic Priority area the following priority.

“Identify and target those who produce, finance, traffic and deal in drugs”

This strategic priority, written in the way it is, also alludes to the Northern Territory Police partnership in the National Drug Strategy and its underlying principle of harm minimisation and the supply reduction thrust of the National Illicit Drug Action Plan.

The Drug Enforcement Unit (DEU) is obviously the primary arm of the Northern Territory Police drug law enforcement, being a dedicated unit, which focuses totally on drug law enforcement. The unit has a number of current priorities that include the following:

- Identifying and targeting offenders by using intelligence and information systems in line with standard intelligence-led policing practices with a view to minimising illicit drug activity across the Northern Territory.
- Support drug awareness and education programs that reflect the agreed principle of ‘Harm Minimisation’.
- Apply a ‘taskforce’ approach to investigations where the extent of criminality extends beyond issues involving illicit drugs alone or requires inter-jurisdictional cooperation.
- Utilise current legislation to the fullest. Continue to initiate and be involved in the development of new legislation and/or improvement of existing legislation to maximise drug enforcement effectiveness.

- Target the manufacture, cultivation and supply of illicit drugs with a view towards minimising illicit drug activity.
- Monitor and enhance existing strategies relating to the availability of illicit drugs in remote communities.
- Maximise efficiency of resources through better management practices and further investment in that resource by utilising available training resources and experience gained here, interstate and overseas.
- Maintain the ability to prioritise drug investigations.

Other units within Northern Territory Police also have duties that specifically impact in one way or another in regard to drug law enforcement issues. For example, Officers In Charge (OICs) of Bush Stations and areas within General Duties and the Criminal Investigation Branch frequently address drug offences and will continue to do so.

Other areas of the Strategic Plan indicate the Northern Territory Police's commitment to addressing drug issues and the effects of substance use on and within the community. Within this framework, police activity spans across a variety of areas, a number of which touch on or have links to drug issues. Some programs are undertaken in partnership with other departments, such as the School Based Policing Scheme with the Education Department and others engage the community, such as the Neighbourhood Watch Program. It is important to note that whilst most are addressing particular policing issues to do with upholding the drugs laws they also impact preventively on illicit drug issues. An example of this would be the police patrols of public areas as a deterrent to street dealing and public use of drugs.

In an effort to prevent the harm associated with the drugs and crime connection, law enforcement diversion programs are evolving throughout Australia. This includes the diversion program that is being implemented in the Northern Territory with support from the Commonwealth Government. The aim of diversion is to interrupt drug use and divert people away from the criminal justice system and into services that provide information and treatment.

A number of other Australian jurisdictions are currently implementing drug court systems as an alternative method of dealing with drug-related offending. A number of these programs are currently being evaluated, in particular in New South Wales and Victoria. The Taskforce is aware that the Justice Department is currently investigating options regarding the introduction of a Drug Court system to the Territory. It would advise that close consideration be given to the experience and evaluation of these systems in the other jurisdictions, in guiding any future decision-making in the Territory. Cost-benefit considerations are likely to be most important.

In recognition of the role of illicit drug supply reduction measures the Taskforce recommends:

3.1 Support for efforts to enhance evidence based, strategic use of law enforcement and criminal justice systems with regard to illicit drugs.

DEMAND REDUCTION

Demand reduction strategies aim to reduce the desire for and preparedness to obtain and use drugs with the purpose of preventing harmful drug use and preventing drug related harm. Preventing non-users from taking up drug use, delaying the up-take of drug use and reducing problems amongst substance users apply across the lifespan of individuals. These strategies can effectively be implemented in settings where people spend time and where the environment can support the strategies, for example schools and workplaces as a settings for drug education supported by policies on drug use.

Research indicates that strategies that are comprehensive (involving school, community, parents, community organisations and social policy) are more likely to be effective generally than single channel programs (for example, school based drug education programs or mass media advertising) on their own.

It has been recognised that whether an individual decides to use drugs and then whether the person's use causes harm to the person and to his or her family and community is influenced by a number of complex and interlinking factors. These factors include the properties of the drug itself and its accessibility; the genetics, beliefs and life experiences of the individual and the culture and environment in which the person lives. It has also been recognised that as a person develops, different factors are more or less influential and, at particular times, interventions can modify a potentially harmful course of events.

The National Action Plan on Illicit Drugs points out that recent research suggests that comprehensive demand reduction strategies need to:

- seek to strengthen resilience among young people, whether in or out of school by fostering stable relationships with family and adults, especially in the early years, enhancing their sense of belonging to family or social group or locality, and increasing their education and training opportunities and employment prospects;
- productively influence youth culture;
- seek to increase the community's understanding of the antecedents of drug use and effective interventions to reduce harm;
- link drug-specific interventions with interventions in related areas such as youth crime prevention and mental health promotion strategies, employment and educational strategies; and
- maximise the effectiveness of school-based programs through efforts to keep young people engaged in school as long as is appropriate, and the identification and provision of support for at-risk children, management of drug-related incidents, and a broad-based quality curriculum.

The Taskforce is aware that there are a number of Government initiatives that focus on children and families underway. For example, Learning Lessons: an independent review into Indigenous education in the Northern Territory (1999) is being implemented and it highlights the importance of providing Indigenous children with the ways and means to engage in the wider community by improving their educational outcomes through a "system-wide, cross-government partnership approach".

The community is supportive of efforts that might prevent the uptake, ongoing use and harms associated with illicit drug use. Communities are concerned for individual drug users, their families and the overall community in which drug use takes place. There is a place for increasing the community's knowledge about evidence about what might work. New evidence is emerging to support initiatives that go beyond traditional drug education.

There are risk factors that increase the likelihood of drug trouble in individual, family, school and community domains. There is also a suite of protective factors in these domains that enable a person to rebound from negative life experiences and to cope with problems in a positive and healthy way. Two key themes emerging from risk and protective factor research (Resnick et al, 1997) are connectedness and resilience. Connectedness refers to a sense of belonging and having strong and meaningful connections to family, school, peers and the community. Resilience refers to the quality that makes a person able to deal with the problems and demands that may confront them in different social settings, and to respond well to a range of life events. Parental support has been identified as being important in the development of both of these factors.

In recent years there has been an increasing focus on a risk and protective factor approach, in Australia; for example, the work of the National Crime Prevention Strategy and the Centre for Adolescent Health in Victoria.

The shielding effects of protective factors and the negative effects of risk factors often interact and are different for each individual. Caution should be exercised in causally linking risk factors to particular problem behaviours.

Regardless of whether they act as a marker or a cause, risk factors function to tell us that there may be a problem in an area of a young person's life. For example, failure in school is consistently identified as a risk factor for a range of problem adolescent behaviour. However, it is clear that this may not necessarily be a reflection of academic ability alone. Rather there is a need to look further afield to identify ways to enable that student to learn and thrive in an environment appropriate to their needs.

Early childhood is increasingly recognised as a vital focus for prevention efforts. Given the interrelatedness of prevention in these various areas and the extensive domains of possible targeted interventions, governments around the world are exploring new ways of funding programs that allow for coordinated contributions from the various areas or departments traditionally concerned with the impact 'downstream'. This is a mix of notions of 'joined up government' where the effort is to build the functional or departmental connections and 'upstream' funding where resources are provided to address the very early antecedents contributing to a problem rather than only reacting to problems when they have become obvious.

A comprehensive prevention program therefore needs multiple elements. This can include strengthening and supporting communities through comprehensive programs such as 'Communities that Care' and ongoing support for evaluated local community initiatives such as the alcohol restrictions in Tennant Creek focussing on the whole community. It also includes comprehensive drug education in schools that is embedded in the overall school program, early identification of those at risk and a willingness and ability to respond.

The value of developmental prevention

Evidence suggests that a key preventative step is to ensure that the early years are maximised to enable sound development. There is a growing interest in the impact of identified risk factors in childhood on later health outcomes and as predictors of problems behaviours such as criminal involvement, drug use and mental health problems (Spooner, Hall and Lynsky, 2001). The risk of developing certain health conditions or health compromising behaviours is now understood to be associated with the interactive and cumulative impact of social and biological factors across the life course (National Public Health Partnership, 2001). Factors associated with substance use and harmful use include: certain parenting styles, family conflict and poor attachment, poor school orientation and low academic achievement, social and behavioural problems in pre school and primary school, peer rejection, a deviant peer group and poor social skills (O'Leary, 2001).

By intervening early it is theorised that these factors can be mediated thereby preventing escalation into later problem behaviours. National Crime Prevention study in 1999 identified a number of important transition periods or events along the pathway of development when interventions were most likely to be effective. Transition phases include the birth of a child, preschool years, moving from primary to high school or graduating from high school and engaging in higher education, entering the workforce or possibly being unemployed, providing guidance on when interventions should be targeted.

The Victorian Expert Committee on Drugs (2000) has identified a number of key transition points and possible interventions to address drug use from infancy to adulthood; these have been detailed in Table 1.

The influence of risk and protective factors is greatest in very early childhood and at key transition periods across the lifespan, with early childhood interventions being identified as the most cost effective. It should be noted that developmental prevention is still in its infancy, the model is yet to be thoroughly tested and interventions are still developing (O'Leary, 2001).

Current situation

The Taskforce found Table 1 on Developmental Prevention Strategies to be useful when seeking community views on young people and families especially. In general it was not possible to determine the level or quality of activity taking place across the life stages in the Northern Territory. From the public consultations, the Taskforce was able to ascertain that those attending the consultations recognised the importance of providing families with the means to raise capable and resilient children and that an investment in families and children is a sound one.

Table 1 - Developmental Prevention Strategies

When	Involving	Example of Program / Initiative
Antenatal	Parents, hospital, maternal and child health nurses	Information about impacts of parental smoking, drinking and other substance misuse on the newborn and child. Preparation for parenthood
	Child and maternal health nurses	Structured additional support for those mothers with substance misuse and mental health problems
Postnatal	Parents, child and maternal health nurses	Access to parenting advice Family strengthening programs
0 – 5	Parents, childcare and preschool	Programs aimed at improved learning and emotional development in those at risk Information for parents about modelling moderate substance use Programs to integrate isolated mothers into parent networks
5 – 11	Teachers, school counsellors, parents	Early years of schooling: Transition programs to support social skills development Mechanisms for teachers to access additional support for children displaying aggressive and poor socialisation skills Programs to prepare children for transition to high school Links to community groups, sport and activities Mechanisms to support parents
11 – 18	Secondary school, other pathways to employment, media	A focus on social and emotional development Development of mechanisms to involve and support parents Clear information about drug use in the community Development of a capacity to monitor truancy and school leaving Programs to reintegrate those who have ‘dropped out’ into a learning environment
14 – 21	Workplaces, universities and TAFE institutions	Targeted information about substance use for those entering the workforce, taking up further study Support for young people entering the workforce, particularly early school leavers Recreation and public space projects Early detection of mental illness and psychosis
21 +	Professionals such as GPs, peers and workplace	Clear information about safe levels of drug use Support for GPs to provide advice – including referral and brief interventions Information about drugs at work, including work social functions

Source: Victorian Drug Policy Expert Committee (2000).

Community Views

At community consultations, the importance of sound start to life and a stable and safe family environment in which to grow up were acknowledged as key prevention measures. In particular the role of families, schools and the wider community were highlighted as areas for focussed attention. There was a strong message that families need support, that schools are a place where children can be educated about drugs and that attitudes and attributes present in wider community can do much to ensure that prevention strategies are effective.

"We must get to the 0-5 year olds to avoid the generational effects of drug abuse."

More broadly, the Taskforce recognised that the Northern Territory by virtue of its unique population profile, by its geography and by its relative isolation may be disadvantaged with regard to being in touch with the latest findings in the developmental prevention field. On the other hand, these same features may provide opportunities; for example, the Northern Territory was involved in an innovative international 'Family Coping' research project, initially under the auspices of the World Health Organisation (Orford, et al, 2001).

Specifically, it is recommended:

- 3.2 That pregnant women are recognised as a special group for focussed alcohol, tobacco and illicit drug education and support. This should include: provision of accurate and up-to-date educational materials; establishment of referral protocols to specialist alcohol and drug agencies; and training of relevant service providers.**
- 3.3 That parenting support programs, particularly focussing on early parenting, are available and accessible to parents throughout the Northern Territory.**
- 3.4 That the Northern Territory Government seek opportunities to be a site in national and international research in the developmental prevention area.**

COMMUNITY EDUCATION

Community education is critical to maintaining substance use issues on the public agenda, for engaging the community in issues, and for delivering specific messages aimed at changing attitudes and behaviours in a sustainable manner.

It includes social marketing, targeted information sessions and skills development, and is essential for creating a climate in which healthy public policy and legislative reform are possible. It is well documented that a public health development policy is much more likely to be embraced at the community level if it is preceded by an effective community education campaign (WHO, 1986). Population based community education strategies necessarily focus on a mainstream audience making the message inapplicable to those already misusing substances (Victorian Drug Policy Expert Committee, 2000). It does have a role in agenda setting, promoting either negative or positive perceptions of a certain behaviour; reinforcing and being reinforced by targeted drug education and community development strategies as well as stimulating learning, interest and debate in drug issues.

Community education has a role to increase personal knowledge and skills, and mobilise communities to address harmful substance misuse or encourage safe use. For this to happen, individuals and communities need to be aware of the costs that can arise from substance misuse, and be encouraged to take individual and collective responsibility (Green and Kreuter, 1991). Education strategies need to engage the community in discussion about issues, and in the development of solutions or actions to address those issues (WHO, 1986).

Best practice in community education must be targeted to the needs of the audience, and be meaningful, accurate and consistent. It is an area of continuous effort, requiring ongoing creativity to promote information in an engaging way, and which reinforces gains made. This is fundamental to ensuring that the final result is one of increasing knowledge and skills, and facilitating attitudinal change (Wass, 1994).

Long-term behavioural change is more likely when the target groups are engaged in identifying and addressing their particular substance misuse issues. In this way community development becomes an integral part of the community education process (WHO, 1986).

The Taskforce identified there is a need to provide information to the community about drugs and drug-related harm. Population wide media strategies come at considerable cost. Synergies are however possible where other levels of government and non-government are already active. There are sound structures to facilitate coordination of resources such that the Northern Territory can add significant value to National campaign and education efforts in this regard and identify Territory specific elements that build on the broad media base.

Community Views

In all locations, people voiced the opinion that the general public or community should be better informed about drugs. People expressed varied opinions about the effectiveness of recent drug education campaigns, but there was general agreement that ongoing public education campaigns over the past ten years have begun to reduce the stigma and defensiveness attached to drug use.

“All those campaigns help to break the silence, the parents and the community has to be more informed, so that we are more able to talk about the issues as a community.”

It was emphasised that campaigns must avoid blaming users or parents: *“take the blame out so they can hear the message”*.

Service providers emphasised the importance of coordinated, strategic approaches to public education campaigns. National campaigns need to be supported by local activities and services, so that when short term Commonwealth funding stops something sustainable remains. This requires advance warning and collaborative planning involving Federal and Territory governments, and local service providers across health, education and possibly other sectors.

“We must use existing networks, ... keep GPs more informed, pull in the collaboration, keep campaigns going and use them with existing networks.”

The need for general education about illicit drugs, particularly cannabis, but also the effects of polydrug use, was raised in many locations, but the demand was said to be especially strong in remote communities. Some of those requiring information are service providers and families of users. It was reported that community members, especially elders and women, require information to help them determine appropriate responses for their communities.

“Communities elders particularly want to be aware of the information so they can be forewarned, they want to be aware before it happens, they want to be the ones who control things - keep people in line.”

“They need to know how to identify what people are using, how to deal with it, and to cut the supply.”

Current situation

AODP has previously used National community education campaigns as an opportunity for developing local strategies to reinforce the educational messages of the campaign. It has found that when planners for National campaigns have engaged the various jurisdictions from the beginning of the process, there has been the willingness and opportunity to commit resources and develop local strategies to ensure maximum impact. For example during the National Alcohol Strategy campaign focussing on what parents can do, a series of workshops for parents were organised in each of the urban centres. However, some National media campaigns have not been considered appropriate as the subject matter was not an issue for Territorians at that time; for example the recent heroin overdose campaign consisting of resources for peer education about what do in the case of an overdose and training for frontline workers on how to manage overdose.

The Northern Territory cannabis flipchart and dissemination strategy were developed in response to concerns raised about the impact that cannabis was having in communities.

The Taskforce recommends:

3.5 That the Northern Territory take advantage of the ongoing National Illicit Drug Campaign and build in specific supporting measures with a Territory focus, to maximise the impacts of this National Campaign.

Mobilising Community Action on Illicit Drugs

Community action has been identified as a process which can positively effect drug prevention strategies (Allamani et al, 2000) and is an approach which is increasingly being used to prevent illicit drug uptake, develop community amenity and cohesion, and address illicit drug related harm (National Illicit Drug Strategy). The Victorian Drug Policy Expert Committee (2000) proposed expanding the role of local communities in addressing drug related harm because:

- Many actions can only be undertaken at a community level;
- Local effort is able to mobilise community resources;
- Different communities can tailor responses according to need and
- Communities that act on their own behalf are healthier (page vii).

Community action is contingent on broad support in the form of public policies and legislation in which drug use occurs and is reliant on a process to disburse funds in a timely and efficient way. One local example of this is the 'Beat the Drum' project convened by and for people affected by illicit drug misuse (ADCA, 2002).

Community grants are an effective means of supporting local action and funding localised strategies to support the community to represent their own needs through social and public action. Community grants should be provided with an emphasis on community development and as a partnership between government and the community (with appropriate levels of support provided).

Current situation

AODP has a history of utilising small grants programs to stimulate and support community action around a particular drug issue. Community grants are reliant on a balance between accountability and quick disbursement. Delays in the money being allocated can seriously undermine the benefits of community action.

Alternative Activities

Promoting alternative activities to substance misuse can be effective as part of a broader approach and is used mainly with young people. Alternative activities include recreation programs, appropriate schooling and training and employment programs and are most effective in regions and communities where opportunities that are interesting and engaging are limited (d'Abbs and Maclean, 2000). Conditions for effective activities include involving staff that are sensitive to the needs of young people and activities that interest the target group and provide opportunities for risk taking. Projects developed using a community development process and which include the target group in planning and implementation are likely to be better received and more sustainable.

The value in alternative activities may not be the activity as such, but in the mentoring relationship with caring adults, the development of new (non using) peer relationships and the hope offered by work or educational opportunities.

Current situation

School Based Police (SBP) run a number of alternative activities such as blue light discos, a junior police ranger scheme and Police & Citizen's Youth Club, all of which aim to provide safe supervised activities in a drug free environment.

The Taskforce also heard from a number of organisations providing programs to engage Indigenous youth in alternative activities, notably the Bush Mob in Alice Springs and TC Raiders in Tennant Creek.

Community Views

There was recognition that a whole of community effort is needed to address drug use and misuse.

The case for creating alternative activities to occupy young people in towns and remote communities was put forth during some consultations. It was also suggested that better facilities should be provided for young people to meet either formally or informally.

“But just for the other kids who aren't interested in drugs or alcohol or petrol, they've got nothing better to do, they hang out with their mates and they eventually take on their behaviours. Things for kids who aren't actually participating in illicit drug use is one of the best methods of prevention, particularly on communities. Things that are relevant and interesting to them, which may be different to what kids in town want to do.”

School Based Drug Education

As important 'sites of social learning', schools are an obvious place for providing information, education and skills to reduce drug related harm. However, drug education (whether provided in schools or other settings) alone does not necessarily change behaviour. It is, however, an integral part of any drug prevention program.

An underlying principle of the National School Based Drug Education Strategy (1999) states that drug education should be provided as part of a developmentally appropriate curricula to allow for learning about drugs within a broader context of health literacy and for cross over with other health issues relevant to young people. At present, high school students in the Territory are not required to have health education beyond Year 8. Given that trends indicate that drug use increases throughout high school (Bertram and O'Reilly, 1998), age appropriate education could address real experiences and changing norms as students' age.

Research is now available about which types of drug education programs are the most effective. School based drug programs which emphasise fear of drugs and their consequences and promotes peer resistance strategies as a deterrent to experimentation are ineffective (Roche, 1999). Evidence suggests that approaches based on the 'social influence model' that takes into account the social pressures to use drugs and the information and skills necessary to resist using them (Midford, 2000) can prevent uptake of some drugs. More recently developed 'social inoculation-based education programs' such as the Life Skill Training Program have been shown to reduce alcohol, tobacco and cannabis use into young adulthood.

A number of evaluation studies have shown that Drug Abuse Resistance Education (DARE) and the Life Education Program are ineffective in reducing alcohol or other drug use among students (Midford, 2000).

The whole-of-school intervention approach goes beyond the curricula to include the development and implementation of school policies, access to counselling and support services and involvement of the school community (such as parents and teachers). This type of model offers a systematic approach to reducing harmful behaviours of young people because it seeks to improve students 'health literacy' (knowledge and attitudes towards health) as well as their 'health skills' (decision making, seeking help and problem solving). The process builds capacity within the school to address a multitude of issues over time. The goal of health literacy over drug information and skills training appears to be not only preferable but more realistic (Deilman, 1997). It also takes into account the environment in which drug education is taught with the aim of having school policies on drugs support educational endeavours.

The 'health promoting schools' model or framework is underpinned by a holistic view of health and by the principles of equity and empowerment. It is a comprehensive, systematic and intersectoral approach to promoting health in the school setting and has as key components the formal health education curriculum, the school ethos, the physical environment, the policies and practices of the school, the health service and the school-home-community nexus (Booth and Sambal, 1997). By providing a supportive physical and social environment conducive to making healthy choices, the school can promote the health of individual students and through interactions with families and the wider community can extend the health enhancing conditions and benefits beyond the school setting (Parsons, et al 1996).

An example of this type of approach in the Northern Territory is the Mind Matters Project being implemented as part of a National mental health promoting schools strategy. A Victorian program, which has involved a whole-of-school intervention, is the Gatehouse Project. This is a school based project aiming to reduce the rates of depression and self harm, two consistently identified risk factors for youth suicide. The project's overall aim is to build a healthy environment rather than concentrating on individuals. It emphasises the importance of positive connectedness between teachers and peers and has identified three priority areas for action:

1. Building a sense of security and trust;
2. Enhancing skills and opportunities for good communication; and
3. Building a sense of positive regard through valued participation in aspects of school life.

Current situation

In the time available, the Taskforce was unable to determine the content and extent of alcohol and other drug education being offered in schools. Concurrently with this Taskforce's enquiries, there are two other review processes taking place that include a review of alcohol and other drug education, one by the Department of Employment, Education and Training (DEET) and one by Northern Territory Police.

Since September 2001, DEET has been undertaking a project titled 'Strategic Directions for Health and Drug Education'. The purpose of the project is to develop a plan outlining options for provision of health and drug education in the DEET environment.

Currently there are a range of health and drug education functions and resources spread across the Department. It also funds other health and drug education programs such as Life Education, delivered by non-government organisations. The driving forces behind the review are the high priority the Northern Territory Government is placing on effective drug education programs in relation to crime prevention and its commitment to improving learning outcomes for Indigenous students.

The project was required to:

- identify and evaluate existing health and drug education program delivery and associated resourcing, with particular emphasis on financial and personnel resources, and
- develop strategic options for future program delivery and resourcing.

The report is nearly finalised and expected to be considered by the DEET Executive in June 2002.

The School Based Police (SBP) and its major prevention program the Drug Abuse Resistance Education Program (DARE NT) specifically target crime and drug use prevention. These programs have been run in the Northern Territory since 1988 and are currently the subject of a review to ascertain, among other things, the most appropriate means of delivering drug education in schools.

SBP are stationed at all major high and secondary schools throughout the Northern Territory. Each officer is stationed full time at the local high or secondary school and covers the surrounding feeder primary school area. SBP have a variety of duties which, dependent on the school community, do vary slightly depending on community needs.

As part of the services offered, SBP deliver the DARE program to all primary schools within their feeder area. SBP undergo a three week intensive training course associated with teaching the DARE program. The program covers all 7 years of primary school with a series of lessons each year which build up to the final year (Year 7). The Police state that the program reaches 81 per cent of all primary aged children.

DARE has been written to complement the NTDE Health Curriculum. A Links Document compiled by the police and education integrate Life Education, DARE and the K-10 Health Curriculum. Currently a new Northern Territory Curriculum Framework is being developed and there will be a need for the DARE Links Document to be redeveloped to complement the Health Curriculum, pending the review.

The review began in April 2002 and is due for completion in the near future.

Community Views

All agreed that some drug education should be provided through schools, but views varied about the content, and about who should present it. The general consensus was for schools to start early by supporting children in primary school to develop resilience by focussing on strengths and providing decision making or self-esteem training during early years. While there remained considerable support for factual information and harm minimisation strategies, there was no consensus about the age at which this approach should be introduced. Nevertheless, training in coping skills was keenly supported for all age groups. This is supported by the literature in this area.

"We must recognise that kids experiment to be together, it is a culture that exists. It's here to stay and they need skills to survive within this culture, and to help them reduce the risks. ... We need more research to know better what they need to help them come out the other side unscathed."

With regard to who should provide school based drug education, there were mixed views presented. While the SBP program was acknowledged as being important, whether constables were the best people to do drug education was debated. Most people supported ongoing encouragement and training for teachers to address drug related issues in an integrated way throughout their lessons and/or as a specific drug education component, despite some limitations.

Furthermore, unanticipated impacts of school policies and the value to be gained from providing schools with support as they develop drug-related policies were discussed.

"It really depends on school policy as to what actually happens in the school. So sometimes the policy structures are set up that unintentionally reinforce drug use within the school, and sometimes they're not aware of how to structure sanctions and opportunities for learning and rehabilitation even within the school system. You have a lot of kids who tend to use together, if you're thrown out of school together it's a good opportunity to go bonging on together in someone's backyard. So those sorts of issues aren't really addressed very clearly, and I don't think there's a lot of information for people who are making decisions about those issues."

A view put forth about the wider school environment and its role in drug education, reinforced in the literature, was the potential effect of the school environment on psychosocial development and negative health outcomes (including drug use).

"... Primary prevention needs to focus on sites of social learning, which is the family, but also the education system itself. ... While particular drug programs can have a protective effect, the behaviours and the environment in which we are allowing our children and our young people to undergo a substantial part of their social development really needs to come under scrutiny, and it comes down to things like, whether those systems are modelling the sorts of behaviours and beliefs and attitudes that we are assuming that this particular health education is going to achieve."

In relation to schools, the Taskforce believe that the most critical drug prevention measure needed is to ensure that all primary school children have access to quality education services and are encouraged and supported to fully participate. All other efforts are considered to be of a value adding type of approach, because unless the children are attending school they will not benefit from any programs or efforts the schools may be engaging in.

In acknowledgment of the importance of school settings for social learning, it is recommended:

3.6 That the health promoting schools model be supported, implemented and monitored in all Northern Territory schools.

In addition,

- 3.7 That a broad and comprehensive approach to drug education, based on evidence and best practice is developed and implemented in Northern Territory schools. It will need to take account of the most effective models of drug education including consideration of who delivers the educational component, how parents and the wider community can be involved, what policies are needed to support the educational aims, how students are supported who are having problems in general and problems with drugs in particular.

The professionals who are currently involved in vital support roles in schools are in an excellent position to be providing interventions and guidance in the development of alcohol and other drug strategies in schools. These professionals include school nurses, counsellors, school-based police, liaison officers and others in the school environment currently playing a social welfare role.

The Taskforce recommends:

- 3.8 That those who already have a vital support role in schools receive training in alcohol and other drugs strategies and approaches, specifically in brief interventions.

REDUCING HARMS ASSOCIATED WITH INJECTING

As previously highlighted there are injecting drug users in the Northern Territory. There are important policies and programs that reduce harm associated with some level of ongoing use of drugs. These are vital in preventing health problems among drug users as well as in addressing concern about public nuisance and matters of public amenity associated with some drug use.

Governments do not condone illegal behaviours such as injecting drug use or the consumption of cannabis, though they do acknowledge, however, that these behaviours occur. Government has a responsibility to continue the development and implementation of public health and law-enforcement measures designed to reduce the harm that such behaviours can cause, both to individuals and the community as whole.

Within the context of this Taskforce and its report, Harm Reduction fits under the banner of 'Prevention'. "With the term 'prevention' becoming embedded in our language, it is important for us to be clear about what we are aiming to prevent. Policies and services developed and funded under the banner of prevention should encompass the full range of responses to alcohol and drug-related problems, including those traditionally thought of as harm reduction initiatives."(Hamilton, 2002).

Drug related harms

Drug related harm(s) can arise from a range of patterns of drug use including:

- intoxication - single session use, examples of possible harm include: unsafe sex, not using clean injecting equipment, unfamiliarity with safe injecting techniques due to infrequency of use; and overdose;
- regular use - frequent though not dependent use, examples of possible harm include poor work performance, and financial difficulties;
- dependent use - obtaining and using a drug dominates aspects of the users life, examples of possible harm include loss of employment and relationships, and health problems.

Drug related harms can occur across a broad spectrum and may include areas such as: health, social, economic, work/study/leisure activities, relationships, and legal, to name a few. They affect not only the user but can also impact upon their friends and families as well as the general community.

Given the broad range of harms that can occur, and the variations between people who use drugs, a variety of responses to drug related problems is needed. One aspect of an overall response is to provide a range of harm reduction strategies that are accessible and acceptable to those people who use illicit drugs.

Harm Reduction, then, is policies and programs designed to reduce the harm that arises from both licit and illicit drugs, including preventing anticipated harm as well as reducing the actual harm. It is fundamentally pragmatic, aiming to be both realistic and socially effective (Roberts and Grant, 2001). Approaches vary across populations, places and timeframes. For example, strategies to reduce tobacco consumption for young people in remote areas of the Northern Territory will be different than strategies for safe needle disposal for homeless People Who Inject Drugs (PWID) in the Darwin central business district.

Two core components of Harm Reduction for people who use illicit drugs are the Needle and Syringe Program (NSP) and peer education.

Needle and Syringe Programs

The Needle and Syringe Program is a public health measure designed to reduce the spread of blood borne viral infections such as hepatitis C (HCV) and HIV amongst PWID (Hurley et al, 2001). Since their introduction in Australia in 1987, NSP has made a significant contribution to the prevention of the spread of HIV and HCV. In particular, the role of NSP in minimising the incidence of rates of HIV and HCV infection in Australia is well documented and acknowledged around the world. NSP outlets also provide an important point of contact for PWID in terms of provision of information, education and referral to drug treatment programs (ANCD, 2002). NSP outlets can be the only point of contact for health issues that PWID access, where they are able to discuss issues relating to injecting drug use. Research suggests that one-third of the client group accessing NSP outlets are regular drug injectors who do not generally have access to other services (NHCECR, 2000).

There are various types of NSP outlets: Primary NSP outlets are stand-alone agencies that have the provision of injecting equipment as a primary role of the agency (eg. Northern Territory AIDS Council (NTAC) and Life Choices (LC)). Secondary NSP outlets offer NSP as an adjunct to other health services (eg. Sexual Health Clinics, Emergency Departments). Pharmacy NSP outlets are operations in commercial pharmacies that sell either FITKITS (pre-packaged injecting equipment) or single needles/syringes. In addition to the three types of outlets identified above, some areas of Australia have mobile services, outreach services and vending machines (Roberts and Grant, 2001).

NSP outlets are in a unique position as being able to act as a conduit to treatment and counselling. Primary NSP outlets currently offer a range of important services to PWID along with the provision of new injecting equipment, swabs, sterile water and appropriate 'sharps' disposal containers for the safe disposal of used injecting equipment. Services available at primary NSP outlets, in addition to the equipment detailed above are the referral to treatment, health, social, legal and welfare services and education and distribution of educational material. Whilst Secondary NSP outlets may not be able to provide the level of service that Primary NSP outlets can it is essential that all workers in NSP outlets are trained to a level that enables them to provide basic health and referral information to clients as appropriate.

Current Situation

Primary NSPs currently operate in Darwin and Alice Springs, funded by the Commonwealth. This service is about to be expanded by the establishment of the Palmerston NSP. The NT AIDS Council (NTAC) operates the NSPs in Darwin (and Palmerston) and by Life Choices in Alice Springs. Currently approximately 500,000 needles and syringes are distributed by the NSPs. The primary NSPs are supported by secondary outlets operated by either NT Government sexual health clinics, district Communicable Disease Centres (CDCs) or by hospital Accident and Emergency departments. Fifteen pharmacies out of approximately 30 in the NT also distribute FITKITS on a commercial basis. At this stage there are no peer based NSP outlets in the Northern Territory.

Access to NSPs has been identified as an issue. At present most only operate during regular business hours, with additional Commonwealth funding recently becoming available to increase the hours of both the Darwin and Alice Springs NSPs, by five hours each.

It has been reported that there is virtually no access to new injecting equipment for people who reside outside the major population centres and no NSPs currently operate in Aboriginal communities. Anecdotal evidence suggests that injecting does occur in Aboriginal communities and other remote locations such as mining camps and pastoral stations.

A mixture of paid employees and volunteers currently staff the NSPs. NTAC has the equivalent of one full time NSP worker and Life Choices a half time worker. Other staff of these agencies are often called upon to operate the NSP as required. Some DHCS staff who work in either the sexual health clinics, CDCs or Accident and Emergency can distribute injecting equipment, this is an additional task that they take on and the Department does not currently fund dedicated NSP positions.

Commonwealth funding has recently been made available to the Territory to provide community education and some pharmacy education. This work will be undertaken by Amity Community Services over the next year.

Commonwealth funding has also been provided for a Policy Officer, for one year, to be based with the AIDS/STD program to develop policy and offer advice on NSP/IDU and HCV issues. This position will also be expected to provide some professional education for those working in the field. Funds will also be available to community organisations for small projects on NSP/IDU/HCV issues, these may include direct service delivery as well as education and training of staff and target groups.

The role of pharmacy based NSP outlets needs to be enhanced. This would include increasing the number of pharmacy based outlets as well as providing additional services with the provision of FITKITS such as providing information about safe injecting practices, safe disposal and services available for PWID. Though this report discusses disposal issues further on, it is important to note that it is not possible to return used injecting equipment to pharmacy based NSP outlets at this stage.

The Taskforce recommends:

- 3.9 That the current Needle and Syringe Programs (NSPs) be supported and expanded to ensure that all the major population centres, Alice Springs, Darwin and Palmerston, have NSPs that are geographically and culturally accessible.**
- 3.10 That the role of pharmacy based Needle and Syringe Programs (NSPs) needs to be enhanced.**

A common theme raised in consultations and was the need to be able to collect injecting equipment from non-stigmatising places, with the example given of pharmacies as a good place if staff training was put in place. It was made apparent to Taskforce members that different users have very different definitions of what is non-stigmatising, therefore it is important that there is diversity in the provision of NSPs to include primary, secondary, pharmacy and peer based services.

“...you need to be able to get these things from places that are a part of your life”.

It is therefore important that NSPs are provided from a diverse range of organisations, agencies and where possible peer based organisations.

Safe Disposal of Injecting Equipment

With regard to the safe disposal of used injecting equipment, there are approximately 20 publicly accessible disposal units in the Northern Territory (Roberts and Grant, 2001). Under Section 3 of the *Misuse of Drugs Regulations (NT)* it is specified that a “hypodermic syringe or needle that has been used in the unlawful administration of a dangerous drug shall be disposed of (a) by depositing it in a rigid walled and puncture resistant container that is sealed or securely closed in such a manner that the contents are incapable of causing injury to any person; and (b) by either - (i) placing the container with its contents in a household or other refuse bin; or (ii) handing it or causing it to be handed to a person referred to section 12(2) of the Act.”

NTAC currently work closely with Darwin City Council (DCC) in ensuring that safe disposal units are located at known ‘hotspots’ within the DCC area. NTAC also provide education about NSP and safe disposal to a variety of businesses and agencies with the Darwin Metropolitan area. NTAC will extend its service to the Palmerston area in the near future.

Life Choices in Alice Springs are similarly committed to promoting responsible disposal, through the distribution of appropriate disposal equipment and education. They are looking for opportunities to work with the Alice Springs Council and other agencies with regard to the provision of strategically placed disposal containers in the community.

Some work with local councils is conducted in the various Territory districts outside of Alice Springs and Darwin. For example the work of CDC staff in Nhulunbuy with local authorities in their area.

Current Situation

The AIDS/STD Program of the DHCS maintains quarterly reports on improperly discarded injecting equipment. Though the rates of improperly discarded equipment are low, the trauma that can arise from a needle-stick incident is significant and, as has been stated, “one dirty needle in the playground is one too many” (Roberts and Grant, 2001). Due to this, it is essential that the community as a whole recognise the clear evidence that there have been no cases of HIV or hepatitis transmission as a result of a needle stick incident from improperly discarded injecting equipment (Dolan et al, 2000). In 2000 approximately 0.5 million needle and syringes were distributed through Northern Territory NSPs. There is no documented evidence about how many are distributed through pharmacies. In that year there were 132 discarded syringes reported across the Northern Territory (0.003% of those known to be distributed).

It is also essential that appropriate strategies are introduced to ensure that people who use injecting equipment (for both legal and illegal substances) are informed about appropriate, safe and legal disposal methods and that the community as a whole is informed of what to do if improperly discarded injecting equipment is located. This will assist in dealing with an emotive and sensitive issue that causes considerable fear and concern in the general community.

It is recommended:

3.11 That a safe injecting equipment disposal program be implemented across the Northern Territory targeting:

- i) the broader community;
- ii) people who inject illicit substances.

Peer education

The importance of involving affected communities is enshrined in the National Hepatitis C Strategy and the National HIV/AIDS Strategy. Peer education and support are two ways of effecting this. Peer education has been used to effectively educate people about a wide range of health issues. One of the most successful examples of peer education is the education that has taken place amongst PWID and homosexually active men and with regard to HIV/AIDS. Australia's success to date at containing the wider spread of HIV has been underpinned by the success of peer support and education.

The following is a quote obtained during consultations by Roberts and Grant (2001):

"Peer driven education models that empower casual users to become educators among their peer groups. A dual service of outreach and office work where necessary. Outreach on the streets where the users are."

Although peer education occurs whenever and wherever there are groups of people, funded peer education programs in the Northern Territory have had a chequered past. In the Northern Territory, funded peer education initiatives for PWID have been few and far between.

In the early 1990s AIVL (Australian Injecting & Illicit Drug Users' League) was funded by the Commonwealth to undertake a peer education campaign for PWID in the Northern Territory. This project, though successful at the time, was not able to continue due to the ending of funding period.

Current Situation

The Top End Users' Forum (TUF) is a peer based support network for people who inject drugs. TUF has recently been funded for one year to undertake the production of a quarterly peer based magazine for PWID with regard to the prevention of blood borne viruses and other issues relating to injecting drug use. This will be an important mechanism to articulate the authentic voice of peer experience and knowledge. Additional Commonwealth funds have been allocated to fund a part time peer support worker to be based with TUF to act as focal points for information and referral for the drug using community. These projects are funded for one year and there is no ongoing commitment from the Commonwealth to continue supporting the projects after 2003/4.

Whilst TUF is currently a strong and vibrant entity, its resources are likely to be stretched in providing the organisational resources to support an Editor and a Support Worker. These projects do not provide any funding to build the capacity of the organisation to enable it to set up effective management structures. As a result TUF's current success is based on the goodwill and work of a number of key volunteers rather than on any additional capacity of the organisation to undertake any additional projects without core funding.

The value of peer education was raised in a number of consultations:

"One of the best forms of education is peer based education. It doesn't cost a lot, it can be run by volunteers. ... along with other programs that are already in use, I'm not saying it should be stand alone. Other programs are already working around Australia that we could pick up on.

The Taskforce recognises the important place of user groups and harm reduction services throughout Australia over the past 15 years in informing policy and program development that has ensured relatively low rates of HIV infection and containment of the spread of other blood borne viruses such as Hepatitis C. These groups and services have an important role in the education of drug users about their drug use and methods of reducing risk and harm as well as providing a vehicle for assistance including access to treatment.

The Northern Territory Government has not previously explicitly supported or resourced any peer-based drug user groups. Experience elsewhere suggests that support of these groups benefits policy and program development and implementation. User groups are an important source of information about new treatments as well as specific harm reduction measures.

In recognition of the key role played by user groups, it is recommended:

3.12 That peer-based services for people who inject drugs be supported and implemented in the major urban centres.

Whilst NSP and Peer Education are the more noted aspects of Harm Reduction, there are also a variety of other methods of Harm Reduction, both as specific examples of harm reduction initiatives and types of harm reduction initiatives:

- Types of Harm Reduction Activities
 - Brief Interventions
 - Education for families and partners of drug users
- Specific examples of Harm Reduction Activities
 - Less harmful ways of smoking Cannabis
 - Not sharing snorting implements
 - Non Injectable Routes of Administration (NIROA)

In conclusion, Harm Reduction is a vital component of any strategy designed to improve the health, social and economic outcomes for both individuals and the community as a whole. The importance of NSP and peer education as essential aspects of Harm Reduction needs to be acknowledged by all concerned.

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4. DRUG TREATMENT IN THE NORTHERN TERRITORY

OVERVIEW

The National Drug Strategic Framework 1998 - 2003 recognises treatment as an effective strategy for reducing the demand for drugs by stabilising the lives of drug dependent persons, and preventing drug use and crime. As outlined in the Framework, there is an expectation in the community, and among drug users and their families, that a range of treatment services will be accessible, regardless of age, race, gender, sexual preference and location. The range of services available must be comprehensive and recognise and respond to the individual nature and different stages of people's drug use.

The World Health Organisation states that three of the following criteria must have been met in the preceding 12 months for an individual to be classified as drug dependent: withdrawal syndrome; tolerance; use of drug to avoid / relieve withdrawal syndrome; subjective compulsion to use; narrowing repertoire of behaviour; increasing importance associated with use of drug at the expense of other behaviours; and early relapse into drug use following cessation.

Treatment interventions for illicit drug use and dependence range from:

- withdrawal interventions, often considered a first step towards treatment rather than treatment in itself;
- pharmacological treatments such as buprenorphine and methadone substitution;
- psychosocial treatments such as outpatient counselling, cognitive behavioural interventions; therapeutic communities; self help groups; skills training and family therapy; and
- alternative treatments such as acupuncture and herbalism.

There is a substantial body of national and international literature as well as experience to inform on evidenced-based practice in the alcohol and drug field. In Australia a number of recent overviews have been published (Proudfoot and Teeson, 2000; Dale and Marsh, 2000; Gowing et al, 2001). A common theme throughout the literature is the need for comprehensive and integrated strategies. Strategies need to include within them the general population as well as specific target groups, including those considered most at risk (Hill et al, 1999).

It is important to recognise that there is no uniform entity that constitutes a drug problem. Issues that require or that would benefit from treatment will vary with the type of drug involved the intensity and duration of use and the personal and social circumstances of the individual. It follows that the nature of any intervention, and its setting and duration will vary in accordance with the issue being targeted.

In addition, the type of intervention will vary dependent upon the goals that are being pursued. Historically the goal of treatment for all drug problems was abstinence from all drugs. In more recent times the goals are generally more realistic and individually focused. For example, the goal of harm reduction strategies for intravenous drug users in terms of safe injecting practices and clean injecting equipment is more preferable than for unsafe drug use which can have huge consequences for both the user and the community. Recognition of the need for a variety of treatments reflecting the range of problems and client goals has significant consequences for the extent to which the community can make an impact on drug use problems. The following comparison is indicative of this, where in the United States where services are relatively narrow and largely abstinence focused, only 10 - 30% of illicit drug users are in contact with treatment services, whereas in the Netherlands where there is a broad range of flexible services that are client focused, some 60 - 80% are in contact (Wardlaw 1992, Bull 1992).

EFFECTIVENESS OF TREATMENT SERVICES

It needs to be emphasised that, overall, treatment is not a panacea for alcohol and drug problems. The problems addressed by treatment agencies are far from straightforward, rather they are affected by a range of attributes of the individuals presenting, as well as the social circumstances in which they occur. It is also important to note that in the consultations conducted by the Taskforce and in the submissions it received, it has been those service providers who see drug users in a range of health and welfare settings who are at the forefront of demand for more treatment services as well as concerned others, rather than drug users themselves. Drug users themselves were more concerned about being provided with quality options and services, which afforded them choice.

The Victorian Drug Policy Expert Committee, Stage 2 Report, 2000, formulated a number of objectives and propositions about drug treatment. These are also relevant to the Northern Territory context and provide a framework for assessing what needs to be done to develop an effective treatment system.

1. Drug treatment is as effective as treatments for most other similar chronic conditions, such as diabetes, hypertension and asthma.
2. Clients typically have multiple needs, including medical, psychological, social, vocational and legal. Effective treatment is able to respond to these multiple needs.
3. Drug withdrawal is an essential first step for many individuals but, as a 'stand-alone' intervention, it has little impact on long term use.
4. Lapses to drug use during treatment are common and do not indicate that treatment is ineffective. It is critical, however, that lapses can be monitored and addressed during the treatment process.
5. Recovery from dependence can be a lengthy process and frequently requires multiple and/or prolonged treatment episodes.
6. No single intervention is appropriate for all individuals. Treatment type must be matched to the individual's problems.
7. Treatment must be available and accessible promptly, typically, clients only present interest in treatment periodically.
8. Treatment should be planned and reviewed regularly as client's needs change.
9. Clients need to remain in treatment long enough for treatment to impact. For most clients, around three months is a significant threshold. Programs should include strategies for engaging and holding clients in treatment.
10. Counselling and behavioural therapies are critical components of effective programs.
11. Medication is a critical component for some clients.
12. Clients with coexisting drug dependence and mental health problems should be treated for both conditions in an integrated way. As coexistence is so frequent, clients presenting with one or other disorder should be assessed for the other.
13. Treatment does not have to be voluntary to be effective. Sanctions and rewards from family, the criminal justice system or employers can be effective in motivating a client to enter or remain in treatment.

The applicability of these objectives to the Northern Territory context was affirmed by the information obtained by the Taskforce during its consultations and through the submissions received.

The community has diverse expectations of treatment. These vary between unrealistic hopes for “instant cures” to pessimism and a belief that no treatment can work. Both are wrong. Treatment can be successful and generally has as good as, if not better, outcomes than equivalent treatment of other chronic relapsing conditions. Research undertaken (McLellan et al, 1998) has indicated that the relapse rates after one year for drug dependence are between 40% to 60%, as compared with Type 1 diabetes 30% to 50%; hypertension 50% to 70%; asthma 50 to 70%. In general there is considerable misunderstanding about what to expect of treatment and when and how specialist drug treatment is indicated.

Community Views

The Taskforce affirms the importance of recognising the community expectations in terms of what they consider to be treatment. A strong message received by the Taskforce has been the need for people to have a choice about the type of intervention that may assist them in changing drug using behaviours.

“... People wanting treatment should be given the choice of what they have first.... When you have ownership of it you have incentive not to fail.”

During the consultations many people emphasised the need for better access to information to what is available. There was a considerable amount of confusion and/or ignorance about what services and interventions were available, by both service providers and the general community.

It is recommended:

- 4.1 That an information strategy or community education campaign is developed focussing on the value of treatment for drug users, and those affected by drug use, including what treatment is available and how to access it.**

ACCESS TO TREATMENT

Clients often do not access treatment until some years into their harmful drug using career. By this time, their lifestyle has often been compromised and their dependence is having significant impacts on a number of aspects of their life. A US research study found that entry into treatment often occurs six to ten years after initiation into illicit drug use (Fletcher et al., 1997). Seeking treatment is then part of a client's crisis management strategy.

There are a number of advantages in attracting clients into treatment at a much earlier stage in terms of early intervention and the avoidance of problems related to chronicity. Early access points can occur at a number of different places such as Needle and Syringe Programs, and the primary health care system.

Drug users will often need and seek out support and interventions for problems related to their drug use, even when they are not seeking to change their overall drug using behaviour. When they do want to reduce or cease drug use they most often look to specialist drug treatment services in order to consider their options. The specialist drug agencies are therefore mostly operating in a reactive climate where they respond to the needs of those presenting. There may be greater opportunities for a more proactive approach to the initiation of drug treatment if individuals were identified at an earlier stage of their drug using career, via contact with the broader health and welfare systems.

Community Views

There was wide spread agreement that a more holistic approach to service delivery is needed, whereby an individual can address a range of issues rather than be 'bounced around' the different service structures dealing with each piece.

"Not many agencies are funded to sit down and problem solve with the person and work out what they want to do to get on with their own issues."

"... need services that help users during their period of usage as well as the time they want to stop."

"We could consider how existing services be adapted: not just those that are classically considered as alcohol and drug services. [For example] when looking at young people, there are opportunities to work with some of the youth services."

PROFILE OF AVAILABLE TREATMENT

The Northern Territory has a relatively young, dispersed and diverse population, living in relatively small and in some cases, isolated communities and consideration needs to be given as to the most appropriate types of service delivery. In particular, to factors such as the use of family connections, support services and the use of more generalist (primary health care) type services. Models that are designed to be effective in large city population settings do not necessarily translate into the particular environment of the Territory.

When identifying interventions for substance misuse a broad intersectoral approach is required, including strategies to control availability as well as preventative strategies focusing on promoting health, preventing harm and providing a range of interventions for those experiencing problems associated with use. In the short term at least, a greater emphasis on prevention and early intervention will result in an increase demand for intervention at all levels (Ali et al., 1992). In particular there is a strong relationship between problematic substance use, mental health, social services, and family services.

The provision of responses by a range of human services, in addition to specialist drug services, is fundamental in providing an integrated service to people affected by drug use. Drug use has relevance for antenatal care, dietary problems, financial problems, relationship breakdown, safety and shelter and legal concerns. Ignoring the effects and issues associated with drug use can compromise care. For example ignoring drug use in a client with mental health problems will reduce the effectiveness of mental health treatments. Overall, effective responses are those that attend to all the needs of the person presenting (Gowing et al, 2001).

A wide range of professions and organisations are already involved in responding to people affected by drug use. They are considered to be credible and effective agents of change by both users and the community. A good example is the high standing that general practitioners have in most communities. Others include human services such as health, justice, housing, welfare and the youth sector.

Determining the service type and mix is complicated by the capacity (or otherwise) of the Territory and Commonwealth alcohol and drug funded services and the preparedness of services that do not receive current dedicated drug funding support (such as general practitioners, nursing personnel, generalist and family counselling services and remote community government councils) to become involved in illicit drug interventions.

The impact of illicit drug use on other services systems such as the courts and welfare services suggests a broader range of services need to be equipped to manage drug problems and for improved links to specialist drug services.

Most of the current services that address drug problems are provided by specialist agencies. A very limited number of alcohol and drug services are provided by mainstream health and justice agencies. The mainstream agencies do however confront the issue of drug use and its associated problems in their general case management on a regular basis.

The system of service provision for illicit drugs in the Northern Territory needs to be able to meet a number of basic challenges if it is to maximise its effectiveness. These include:

- The Taskforce has found a variety and diversity of drug problems in the different regions of the Territory, therefore the range of services needs to be sufficiently broad to provide adequate coverage of the various treatment needs.
- The service system needs to be effectively linked to the community in which it operates so that it addresses identified needs and is able to adapt to changing circumstances and any emerging trends in a timely manner. This could be addressed by greater community and consumer involvement in decision making. As well as by greater flexibility in service agreements to allow greater adaptability and accountability.
- The individual services need to be able to maximise the number of persons engaged into treatment and retain them in treatment for the optimal period.
- The service system should require and support individual services to reflect evidenced based practice in the field.
- The Taskforce consultations and submissions received indicate a need for greater collaboration and cooperation between individual services to reduce unnecessary competition and duplication of services, in a climate of limited funds being available.
- The service system and individual organisations must be cost effective.

Current Situation

The current services and strategies that have come to the attention of the Taskforce are provided in Appendix C. This listing is extensive but not exhaustive, as it cannot reflect all the activities undertaken by community groups and relevant government agencies that do not form specific drug strategy policies and programs. The listing does not attempt to indicate a definitive assessment as to how effective the programs and services listed. This was considered beyond the scope of the Taskforce's timeframe and resources.

Community Views

The Taskforce's deliberations have confirmed that there is no single best treatment approach that will suit all individuals. Clients have a variety of needs and an effective treatment system needs to provide as many choices as possible to attract as many clients as possible to treatment.

The Taskforce has not been able to establish a comprehensive understanding of the adequacy of treatment services available across the Northern Territory. This will require a specific review. While there is a listing of apparent available services, it has not been possible in the time provided to determine the willingness, capacity and expertise available in each of these services to address and successfully attend to people who are using illicit drugs. The Taskforce is aware that a lot of good work is being done, and there are experienced and committed staff in many locations.

There are important new elements needed to ensure an adequate menu of treatment options. A high priority is to enable the Northern Territory to offer the broad spectrum of treatment approaches that have been shown to be effective for opiate dependent people. This means that a priority should be the addition of a system for the provision of pharmacotherapies for treatment of opiate dependence.

More broadly, it is important to recognise and maximise the capacity of existing services while working with them to ensure appropriate, good quality service provision. This should be the starting point for enhancement of the service system. This requires examination of resourcing levels and some possible reorientation of some services to be able to deal with illicit drug issues.

Adequate resourcing refers to the consideration of a number of factors, not the least of which are:

- the adequacy and safety of the physical facilities;
- allocation of resources to enable best practice standards to be implemented; and
- the calculation of an appropriate unit cost for each of the different service types being offered to ensure that appropriate funding is provided and expended in the allocated areas.

Any consideration of additional services should note the following priorities:

- A spectrum of services is needed in all major urban centres including assessment, withdrawal and counselling. These would not necessarily or ordinarily be residential. In addition access to some long-term rehabilitation is important.
- A strategy to actively engage general medical practitioners is needed to encourage active participation in alcohol and other drug-related interventions (discussed specifically under pharmacotherapies).
- For prisoners, development of alcohol and other drug treatment and support services providing a full spectrum of care and aftercare as they move between prison and the community is important, especially to break the cycle of re-offending.

The Taskforce recommends:

4.2 That a mapping project of all current alcohol and drug related services be undertaken to establish an accurate picture of current service delivery.

This project should provide information to determine any areas where redirection of funding and major redevelopment is required. In order for this to occur, a profile of desirable services needs to be generated. This overall project should be completed within a maximum of 12 months.

In conducting this mapping project, a consultative approach is important to facilitate a process where agencies, over time, strive to achieve best practice in program content and delivery and identify opportunities for minor service development. It is also important to enhance service quality and consistency both in the short and long term. The Taskforce recognises that this type of quality assurance is likely to have future resource implications, to meet standards, develop appropriate documentation and provide staff training where required. A separate study of the effectiveness of services is not considered necessary given that it would be a costly and time consuming. Rather published studies of what constitutes effective treatment services should be used to establish best practice and Northern Territory standards.

To enhance service quality and consistency, it is recommended:

4.3 That a system of accreditation for service providers be developed and implemented following the initial mapping and support exercise.

The Taskforce sees value in the retention of a mix of government and non-government services with an emphasis on provision of direct services by the non-government sector. Some specialist alcohol and drug services might best be retained within government services at this time of development; particularly to provide services to clients with complex needs, and to ensure a backdrop of support, expertise and consultancy for other agencies to access. The appropriate mix could be examined in the future to assess the capacity of the service system and appropriateness of this mix.

In the situation where government is the source of most funding for drug treatment services, it is appropriate to ensure an adequate spread and quality service system through administrative and monitoring systems.

It is recommended:

4.4 That service agreements are used as a mechanism for ensuring systematic coverage and evidenced based quality services.

Most drug users access a range of other services including general health, mental health, community, housing, employment and family services long before they seek or are urged to attend specialist drug treatment. It is important to recognise this dynamic in planning and to enhance the likelihood that they will be identified and interventions offered in these generic and other specialist services.

It is recognised that many people with a drug problem do not participate in drug specific treatment. It is also known that many have co-occurring health and social problems. It is necessary to de-mystify drug specific intervention and encourage those working in other intervention and support services to engage with drug users including attention to, and treatment of, their drug related issues.

To support this focus, it is recommended:

4.5 That a two year project be funded for the development of protocols, support and training, and a standardised assessment tool; in order to strengthen the alcohol and other drug capacity of generic services and improve the linkages between generic services and alcohol and other drug agencies. This project could be linked to the mapping project to assist in investigating the responses and resources available currently.

As a minimum, one project worker should be employed, in the Top End and Central regions. An example of a similar process is the current Team Health project occurring between Mental Health and Supported Accommodation Assistance Programs (SAAP) agencies.

There is evidence generally of significant co-occurrence of substance misuse and mental health problems in some individuals. The Taskforce considers it important that clients with co-occurring alcohol and drug and mental health problems receive rapid, accessible, accountable and culturally appropriate service that enables continuity of care. A strategy would need to involve at least the following:

- Ready access for clients of alcohol and drug agencies and general practitioners to psychiatric assessment and emergency treatment if required;
- Protocols and policies that ensure co-management issues be considered and planned in an appropriate manner.
- Continuing professional development of Alcohol and Other Drug workers in mental health issues and Mental Health workers in alcohol and other drug issues.

It is recommended:

4.6 That senior officials within mental health and alcohol and other drugs be directed to formulate a strategy to appropriately deal with clients with co-occurring disorders.

SPECIALIST DRUG TREATMENT

Information

Overall there was agreement that there is currently a lack of a well-recognised publicised point of access for people wanting to seek assistance regarding their alcohol and other drug problems. Telephone services are currently available such as that provided by Amity Community Services, and the government services. However, the major drawback reported was that the service is only available during business hours and that it was difficult to access the information that they exist in the first place.

Alcohol and other drug telephone services are available in all other jurisdictions in Australia. They are an important link and access point for the general community as well as for service providers seeking assistance, support, and referral information. It is essential for them to be available 24 hours per day and 7 days per week, and provide accurate and up to date information for those contacting. In addition a strategy for informing people of the establishment of such a service needs to be targeted at both service providers and the general community.

In addition, further dissemination of information regarding the Alcohol and Drug Information Network (ADIN) website needs to take place throughout the Northern Territory.

The Taskforce recommends:

4.7 That an alcohol and other drug information service based on a 24-hour telephone service be established and widely advertised, to provide information, support and referral information.

Assessment and Treatment matching

Ideally all clients would be assessed to form the basis for matching them to the most appropriate treatment regime and goals. This however does not take into account that some interventions are applied opportunistically, such as brief interventions, that clients will often self select treatment approaches, and that often only limited options can be offered because of the abilities of the clinician, the belief system of the client and the range of services available at that time.

In undertaking a comprehensive assessment, illicit drug users should be assessed for the consumption of illicit and other drugs (including alcohol) and the degree of dependence, HIV and Hepatitis B and C risk taking, general physical well-being, psychological adjustment, criminality, social adjustment and functioning, and their motivation for change. The outcome of the assessment should be a summary of the facts gathered and the formulation of clear treatment goals and plan, which are discussed with and acceptable to the user. With respect to treatment matching, in the absence of further research, it is recommended that clinicians guide clients on the basis of their expertise and by providing them with a comprehensive and clear listing of the treatment alternatives so that the client can make an informed decision from the choices available (Dale and Marsh, 2000).

Community Views

Information obtained from the user consultations in particular emphasised the need for interventions to be matched to the needs of the client not to what is available or preferred by a particular agency or professional. Respect for clients was a central theme, both in the way clients are treated and in the services they are offered. There was general agreement that clients:

“... need to keep some self respect...”

People wanting treatment should be given the choice of what they want first, it should be up to the client, not the doctor. When you have some ownership of it you have the incentive not to fail. You will fail, but you need to try again.”

Brief Interventions

There is a growing body of evidence that indicates brief interventions are more effective than no treatment and that they can be as effective as more intensive interventions, for certain client groups (Proudfoot and Teesson, 2000). They can occur in a range of settings including: schools, hospitals, needle and syringe programs, primary health services and by, for example, general practitioners, nurses and a range of other health professionals as well as in human service and work settings.

On the whole brief interventions are more suitable for those with low levels of dependence and for those individuals experiencing few problems related to their substance use. They are not recommended for those with complex needs such as co-morbidity, severe dependence, or cognitive impairment (Dale and Marsh, 2000).

The general principles for the application of brief interventions are:

- Establishing the readiness/motivation to change or consider changing using behaviour;
- Use of harm minimisation principles in applying interventions; and
- Know referral pathways to treatment/support options.

Current Situation

The two primary Needle and Syringe Programs, Northern Territory Aids Council (NTAC) in Darwin and Life Choices (LC) in Alice Springs, provide brief interventions to users who are picking up clean injecting equipment. It is also likely that some general practitioners are providing these types of interventions at present as well.

Screening and brief intervention services that detect drug problems prior to dependency and involve education, self-help materials and brief counselling are being promoted through the AODP, DHCS. In particular screening programs are currently conducted in Alice Springs and Royal Darwin Hospitals.

Community Views

A general theme that the Taskforce was made aware of was the lack of an integrated approach to service delivery in the illicit drug field. In addition there was a sense that service providers feel they are currently working well beyond capacity. In this type of climate it is difficult for service providers, whether they are in the specialist or generic sectors, to take on a more proactive rather than reactive model of service delivery.

Withdrawal

Withdrawal or detoxification is defined as “the process by which alcohol or drug dependent persons recover from intoxication in a supervised manner so that withdrawal symptoms are minimised” (Heather and Tebbutt, 1989: 47). It can occur in a range of settings including home, as an outpatient or in a residential or hospital setting. It may include the provision of medications to provide symptomatic relief or not. The form a withdrawal episode takes will depend upon a range of factors including: the drug or drugs of dependency, the severity of the dependence, previous withdrawal episodes, and the reason the client is undergoing withdrawal.

Withdrawal services provide respite from a drug-taking environment, manage symptoms of withdrawal and provide an entry point to longer-term treatment or rehabilitation. They are therefore an integral component in a range of core alcohol and other drug treatment services. It is important that withdrawal be seen as a gateway to further intervention and treatment. However it is important that commitment to ongoing intervention beyond the withdrawal episode is not a pre requisite for admission to a withdrawal program.

Current Situation

There are currently two residential withdrawal facilities in the Northern Territory. In Alice Springs the Drug and Alcohol Services Association (DASA) provides a four bed withdrawal program (non-medicated unless the client brings their own prescribed medications). Clients are encouraged to participate in a short treatment program of 10 days as part of the withdrawal intervention.

The Central Australian Alcohol and Other Drugs Services (CAAODS) provides a home withdrawal program, staffed by a part time medical practitioner and two nursing staff.

Medical withdrawal is also available through the hospitals in all the regions subject to bed availability. Reports have been made that it is extremely difficult to access this option.

The Darwin Detoxification Unit is a government service, which at present provides a medical residential withdrawal service, with ten beds. The Taskforce has been made aware of changes to the current withdrawal services in the Top End. Historically the Darwin Detoxification Unit was established at the Royal Darwin Hospital and provided a social support model for those wishing to withdraw from alcohol. Banyan House provided withdrawal services for those dependent upon drugs from 1978 to 1996. In 1996 the Lennings review recommended that a separate drug withdrawal service be established for drug users. Following the Lennings review Banyan House ceased providing withdrawal services to their clients, and the Darwin Detoxification Unit became a generic service accepting clients to detoxify from all substances.

The recent review of withdrawal services for the Top End identified a number of issues with the current service, these included:

1. consistently low bed occupancy of 53% and an average length of stay of 3 - 4 days;
2. 30% of clients having repeat admissions during the year;
3. client completion rates decreased annually from 54% in 1997/98 to 41% in 2000/01; and
4. unsuitability for young people, women, drug using parents and those in full time employment.

A new model for the provision of withdrawal services in Darwin has recently been approved and the implementation phase is currently underway, with a number of working parties dealing with the specifics of implementation. The new model is being designed to cater for a much broader section of the community, who were identified as being poorly serviced by the current model. These particularly include young people, women, drug using parents and those in full time employment. The existing service will cease to operate in its current form as of the 30 June 2002.

The key features of the new model include:

- An enhanced Alcohol and Drug Services (ADS) with a capacity to provide a central assessment function, expert advice and client management by a specialist Alcohol and Other Drug Medical Officer;
- Home-Based Withdrawal Service medically supervised by General Practitioners with support by DHCS (Shared-Care Model);
- Out-patient Withdrawal and Counselling Service provided by ADS;
- Residential Social Support with outreach support provided by DHCS.

Community Views

In Darwin and Palmerston a great deal of concern was expressed in all of the consultations about the forthcoming changes being made to withdrawal services in the Top End. In particular, numerous examples were provided of situations and people for whom home withdrawal will not be suitable and a general level of concern was expressed about how their needs will be met.

Concerns were also raised about the adequacy of the Alice Springs services. Users in particular believed that the current services were unable to meet their needs, feeling that they were more orientated towards the needs of people detoxifying from alcohol rather than from opiates and/or amphetamines.

A common theme raised was the need for a safe service staffed by experienced and credible staff.

"... somewhere safe to detox with people around who you trust - you need people with credibility."

A comment that was raised at numerous consultations was the lack of withdrawal options for users under the age of 18 years. On exploration however the issues appeared to be more related to issues around management of intoxicated youth and the need for a place of respite for both the young users and their families. These concerns are reflected in the following selection of quotes:

"... a safe place that is drug free where the child can become lucid again, start eating again. They need somewhere where they can get them away from use so that parents or others can talk to them again."

"What our young people mean by detox is a place where they can lie down and rest, and have respite from actual use. ... So the bottom line is a space to take that choice further and on top of that to have some sort of professional support should those young people require or request it, to help them overcome their addiction whatever it."

In addition, there was concern raised about a total reliance upon home withdrawal options without the necessary support and professional input, which is reflected in the following.

"...for parents who have a drug using child, its too scary to have your child detox at home."

Withdrawal from drugs is seen as a preliminary step to treatment. This can occur in a variety of settings. An adequate range will include hospital, home, outpatient and residential settings, medicated and non-medicated, that take into account any particular needs of specific groups such as young people, drug using parents, and indigenous.

The Taskforce recommends:

4.8 That the ongoing development of a range of withdrawal options takes place to ensure access and quality of service provision.

From the information provided in both consultations and submissions the Taskforce recognises that the proposed model for Withdrawal Services in the Top End has potential. It is, however, essential that an ongoing monitoring and evaluation process accompany the implementation. This would enable any necessary adjustments to be made during implementation, and would assist in determining the efficacy of the new approach.

Therefore, it is recommended:

4.9 That thorough ongoing monitoring and evaluation of the proposed model for Withdrawal Services in the Top End and its implementation take place.

Non-pharmacological illicit drug treatment

Non-medicated treatment can and does occur in both residential and non-residential community based settings. The counselling and therapeutic process described in Dale and Marsh (2000) applies to both residential and non-residential settings. The most appropriate treatments are described as those based in learning theory and include contingency management such as cognitive-behavioural interventions focusing on relapse prevention.

Generally, there needs to be more research into non-medical treatment options for illicit drugs.

Out Patient Community Based Treatment

Out patient community based treatment involves a client accessing a service on a regular basis as determined by a treatment plan. There is a range of settings where this can occur including a hospital out patient section, a government or non-government run agency, such as a specialist alcohol and drug service, or a community health centre.

Out patient treatment is suitable for those people who have mild to moderate dependencies and are assessed as suitable for this treatment setting. In addition to assessing the severity of dependence the following should also be taken into account; gender and cultural issues, cognitive factors, support networks and other problems the client is experiencing (Dale and Marsh, 2000).

Community based treatment is suitable for both those who require residential detoxification and those who do not. Clients with a higher degree of dependency are more likely to benefit from more intensive programs that assist in developing networks that are not supportive of drug use.

Current Situation

Outpatient treatment is currently provided in every regional centre, by both government and non-government services, throughout the Territory. Government services are provided in Darwin, Alice Springs and Nhulunbuy. Alcohol and Other Drug Services (ADS), in Darwin, and CAAODS, in Alice Springs, provide specialist drug and alcohol services, which provide outpatient treatment following assessment by a medical officer and/or counsellor. The Alcohol and Other Drug Program in Nhulunbuy, provides limited outpatient counselling.

A range of non-government agencies currently provide outpatient services and these include: Darwin - Amity Community Services, Alcohol Awareness and Family Recovery, Employee Assistance Service (EAS), and Council for Aboriginal Alcohol Program Services (CAAPS); Katherine - EAS; Tennant Creek - Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG), and Anyinginyi Alcohol Aftercare; and Alice Springs - Drug and Alcohol Services Association (DASA), and EAS.

Community Views

A common theme from the consultations received was the lack of information in most locations regarding what services are available for individuals wanting to address illicit drug problems. Most of the services available do not appear to be known to those needing to access the services.

Residential Rehabilitation

Residential rehabilitation as a form of drug treatment, is based on the principle that a structured drug free residential setting provides an appropriate context to address the underlying causes of drug dependency. Generally this form of treatment is suitable for those who have a high dependency or are unable to access a community-based agency, lack a supportive environment to reduce or cease their drug use or who are homeless (Proudfoot & Teesson, 2000; Brady, 1995).

In Australia there are a number of residential models that have evolved since the early 1970's, including therapeutic communities (TC's) and short and long term programs. The majority of the research around long-term residential programs has been on TC's (Berends et al., 1999 citing Ernst & Young, 1996) and indicates that for a small number of substance dependent people, most notably opioid dependent, this treatment model is appropriate.

Short-term programs are typically four to six weeks duration and are provided to people immediately after detoxification. The available literature suggests that this type of service should be targeted to people who have:

- Less entrenched histories of substance dependence;
- Previous histories of out patient treatment failure;
- No previous history of treatment failure in residential settings;

- No significant cognitive failure;
- Less severe co-morbidity (such as mild depression or anxiety, stable psychotic conditions); and
- Better psychosocial supports including employment opportunities (Ernst and Young, 1996).

Longer term programs, typically 60 - 100 days and 100 and above days, should be targeted to:

- People with severe drug use problems, in particular opioid dependence, where these problems pose a significant risk to the health and welfare of the person themselves and others;
- People for whom non residential or short term treatment options have failed to address their treatment needs in the past;
- People whose home setting or social circumstances are not supportive of non-residential treatment options, to the extent that such treatment options are unlikely to succeed; and
- People with significant co-morbid disorders, requiring longer stabilisation. (Ernst and Young, 1996).

Dale and Marsh (2000) suggest that evidence based practice for residential treatment program should be broad based and include:

- Facilitation of access to medical facilities
- Employment, education and skills training
- Life skills training (cooking, budgeting etc)
- Parent skills training
- Entry into non-drug using community groups and activities of interest, psychiatric facilities and legal services (where appropriate), and
- A re-integration program.

Current Situation

The following services are funded to provide residential rehabilitation services in the Territory.

Darwin

Banyan House - a residential treatment program for people dependent on drugs.

Council for Aboriginal Alcohol Program Services (CAAPS) - a residential and outpatient treatment service for Aboriginal people and their families.

FORWAARD - a residential rehabilitation program primarily catering for Aboriginal people with alcohol related issues.

Salvation Army Bridge Program - a 12-week residential program and a day program for persons with alcohol and other drugs misuse problems.

Katherine

Kalano Rockhole - a residential rehabilitation service primarily for Aboriginal people dependent on alcohol.

Tennant Creek

BRADAAG - an alcohol and other drug residential and day program for Aboriginal and non-Aboriginal clients.

Alice Springs

Central Australian Aboriginal Alcohol Programs Unit (CAAAPU) - coordinates residential, day and aftercare treatment programs catering primarily for Aboriginal clients with alcohol related issues.

Injartnama Village - is a residential outstation program for Aboriginal clients predominantly with petrol problems, approx 100kms out of Alice Springs.

It is noted that services have been historically funded to provide only services for alcohol, with the exception of Banyan House. Service Level Agreements are now being broadened to include a range of substances - it is not known what the capacity or capability of the sector is to take on these extra responsibilities.

The Taskforce believes that consultation and development is needed to enhance their capacity to respond to people with a primary illicit drug problem for the current residential facilities.

Residential rehabilitation services should be used selectively. ***They are generally not the treatment of first choice in most instances.*** The cost of provision of this type of service is significant, and it is not practical to have one in every location.

There is already a range of residential services in all major urban centres in the Northern Territory. In this context no completely new service appears to be required.

In addition, the Taskforce is aware that a number of current illicit drug initiatives in the Territory are receiving funding through Commonwealth National Illicit Drug Strategy (NIDS) funding, which is time limited. A number of agencies have indicated that they would be unable to continue to operate should the NIDS funding not be continued.

It is the opinion of the Taskforce that Recommendation 4.2; 4.3; and 4.4 will be instrumental in guiding future decision making regarding the range of treatment services, including residential, to receive funding.

Community Views

In Alice Springs users, service providers and members of the public all spoke about the need for local residential rehabilitation for illicit drug users. They stressed the inadequacy of current arrangements whereby those wanting to rehabilitate must travel interstate, breaking contact with their family and support networks. The following comment was made in relation to the availability of residential rehabilitation after someone has completed withdrawal:

“The situation is analogous to a doctor who has done the operation but is too busy to sew the person up and puts them in the corridor and they stay in the corridor.”

There were mixed views about whether residential facilities should include rehabilitation from alcohol as well as other drugs, and whether or not they should provide detoxification facilities. There was general agreement that women should be able to bring children to the service with them. In Darwin, in particular, users spoke about difficulties that women with children face in trying to undertake residential rehabilitation.

Alongside a need for locally based rehabilitation, users and some service providers stressed that the option to travel interstate for rehabilitation should be retained. This was felt to be important to allow some individuals to move out of their current social circles as well as to reunite with family members' interstate.

Pharmacotherapies

There are a number of pharmacotherapies now available in Australia, primarily for the treatment of opioid dependence. These include methadone, buprenorphine and naltrexone. To ensure an adequate menu of treatment options in the Northern Territory, the Taskforce considers it a priority that a system for the provision of pharmacotherapies for the treatment of opiate dependence be developed.

Chapter 5 provides a detailed description of pharmacotherapies, and their proposed application to the Northern Territory context.

Self-Help groups

Dale and Marsh (2000) have reviewed the literature on self-help groups and conclude: “irrespective of the theoretical orientation of the agency or its counsellors, AA/NA should be considered as a potential service that could be of benefit for some clients.”

Gowing et al (2001) indicate that self help groups can be successful for some individuals particularly in reducing the propensity for relapse but that it is important to differentiate between attendance and participation. Participation in this process is crucial for successful outcomes.

Current Situation

The Taskforce has been made aware that Narcotics Anonymous is only available in Darwin for those wishing to access it. In the smaller centres there are a number of issues related to privacy and confidentiality.

After-care / follow up

Treatment plans need to include exit planning from the treatment process including linking clients with appropriate support services and networks before the completion of treatment and negotiate after care/follow up. The literature supports the notion that there can be improved outcomes for clients when follow/after care is carried out (Gowing et al, 2001).

Follow up is often difficult due to the transient nature of the drug using population however, it can be very valuable both from creating an opportunity for brief relapse intervention, if it is indicated, and for the purpose of gaining information on treatment efficacy.

The ideal time to follow-up is within 1-3 months of the conclusion of treatment. Dale and Marsh (2000) recommend that follow up sessions “primarily consist of rapport re establishment, discussions of drug use and current issues facing the client, and the completion of the standardised assessment instruments that were used on entry to treatment”. Follow up/after care can either be individually or group based and when face to face contact is not possible telephone or written contact can be substituted.

In rural and remote locations follow up/after care needs to be carefully considered and planned. In circumstances where treatment has been provided away from the usual place of residence there needs to be close liaison between the treatment provider and those who will provide ongoing follow-up support. This includes both health workers and where appropriate family and community members.

Community Concerns

At a range of the consultations, the importance of aftercare and follow up was acknowledged. There was general agreement that treatment in itself is not likely to have a successful outcome, however service providers currently believe that they do not have the resources to provide support beyond the treatment episode.

“When are we supposed to provide aftercare? Aftercare - after hours?”

“...For people coming out of services from heavy drug use, they're really out on a limb.”

Drug users highlighted a tendency from their experience of both prison and rehabilitation services to “push people out the door, setting you up to fail.”

SERVICE CAPACITY - WORKFORCE DEVELOPMENT

In order for the treatment sector to deliver well targeted, evidenced-based interventions efficiently and effectively, a critical mass of well qualified, competent practitioners is required. Training is required for all frontline workers, both in the specialist and generic sectors.

The Taskforce acknowledges a general need to increase the capacity of current services through furthering the development of knowledge and skills of the workforce in this area. The upskilling should include government and non-government agencies, particularly in the Alcohol and Other Drug sector, Mental Health Services, Youth sector, Family and Children's Services and Correctional Services.

This will provide one vehicle for extending the responses that young people and families receive. Each sector might have somewhat different emphases and this needs to be determined with a training needs analysis in each case. An example of some main areas for consideration for those working with youth and children's services might include:

- Risk and Protective factors
- Engaging Young people
- Cross cultural training
- Brief Intervention Techniques.

Current Situation

AODP currently provide a range of continuing education and accredited training programs. Such programs serve important functions however they can be difficult for staff to attend (due to time, geographical or staffing constraints) and are often reliant upon staff self-selecting to participate.

The Taskforce recognise that alcohol and drug education and training needs to be available to a broad range of professionals within the Northern Territory who are currently struggling to deal with these issues.

Community Views

The Taskforce heard general agreement from the community, users and the service providers, both specialist and generic, that training and development was essential.

"support for agencies in terms of education and training and getting some skills to work with people with drug and alcohol issues...Because I think there's lots of agencies that are struggling to deal with this issue and some of them might be policy issues, in terms of the reality is that if you say, this is drug and alcohol free then all you do is take the problem underground, and perhaps you can take some information around these activities?"

The service providers from alcohol and other drug agencies named specific topics and skills for which they want further training. Examples of these are: information and skills to address polydrug use; issues relating to substance misuse and mental health; skills to work with a wider family group; and pharmacotherapy training.

There was also an identified need for existing services to work smarter and more collaboratively together to ensure that limited resources are used in an effective and evidenced based manner.

“Networking is critical, we’ve got to be careful that [we] don’t try to do everything ourselves. We really do need to be networking a lot better so we can really complement what each other’s trying to do. There’s good stuff happening there and we just need to, I guess, formalise it in a sense, so that there’s an understanding of what is going on and what needs to develop in future programs and to have the support of government in doing that”

It is recommended that:

4.10 That there is ongoing and further development of the Northern Territory’s alcohol and drug training and development strategy to ensure it encompasses all frontline workers in both generic and specialist drug treatment sectors.

For workers and services to take advantage of training opportunities, some resourcing for ‘back-filling’ of positions needs to be available. Services are already operating at capacity and therefore are often unable to release people to attend training. The level of funding needed would be determined as part of the project identified at Recommendation 4.2.

It is recommended:

4.11 That enhanced funding is made available for existing services to enable access to workforce development opportunities.

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