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.

There is a range of illicit drug problems, and of pharmacotherapies as treatment for these problems. For the illicit drugs which feature as problems in the Northern Territory [amphetamine, cannabis, and opioid use] the level of evidence of the effectiveness of the treatments varies markedly. The effectiveness of pharmacotherapies for amphetamine dependence is not well established, with some evidence for amphetamine substitution which is limited (Shearer, Sherman, Wodak, & Van Beek, 2002), and little evidence for selective serotonin reuptake inhibitors. No pharmacotherapy is currently registered in Australia for the treatment of amphetamine dependence. There is no relevant pharmacotherapy for cannabis use currently. There are a number of pharmacotherapies registered for the management of opioid dependence in Australia.

The Northern Territory has not had a methadone 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.

NATURE OF OPIATE DEPENDENCE

Before considering the effectiveness of pharmacotherapies for opioid dependence, it is important to note dependent opiate users are those who continue to use opiates in the face of difficulties they know or believe to be caused by its use such as health, legal, and interpersonal difficulties. According to the DSM-IV opioid dependent individuals typically use opiates daily, develop tolerance to its effects, and experience withdrawal symptoms on abrupt cessation of use (Task Force on DSM-IV, 2000). Of the US adult population, 0.4 - 0.7% will develop opiate dependence at some time in their lives (Anthony & Helzer, 1995). About one quarter of people who have ever used opiates develop dependence (Anthony & Helzer, 1995).

Dependent opiate users who seek treatment may have used opiates for decades (Goldstein & Herrera, 1995; Hser et al, 1993). Daily opiate use is usually punctuated by cycles of detoxification treatment, and even incarceration. A proportion of people achieve enduring abstinence from opioid drugs after treatment but the absolute number from any single treatment may be small, though the number gradually increases with age and with cumulative exposure to treatment (Gerstein & Harwood, 1990).

With over 20 years or more of dependence, the chances of treated dependent opiate users becoming and remaining abstinent are roughly equal to their chances of dying prematurely [about a third in each case] (Goldstein & Herrera, 1995; Hser et al, 1993). The remaining third move through a cycle of imprisonment, drug treatment, and active opiate use into their 40s and 50s (Goldstein & Herrera, 1995; Hser et al, 1993). These people are daily opiate users for 40 - 60% of the time that they spend outside prison or treatment (Ball et al, 1983; Maddux & Desmond, 1992).

HISTORY OF OPIOID PHARMACOTHERAPIES IN AUSTRALIA

Methadone was introduced for pain relief when the supply of morphine was reduced at the end of World War II. In the early 1960s, methadone was used as a drug-substitution treatment for opioid dependence (Dole & Nyswander, 1965). Methadone treatment was first introduced into Australian in 1969. By the early 1980s there was controversy over the benefit of methadone treatment as a 'cure' for opiate dependence (Ward et al, 1992; Byrne & Newman, 1999). In the mid-1980s Australia was faced with a HIV epidemic, increased crime and demand for treatment and methadone treatment regained status (Ward et al, 1992; Byrne & Newman, 1999). Since 1985, the number of people receiving methadone treatment increased (Ward et al, 1992) to nearly 32,000 in 2001 [data provided by State and Territory Health Departments].

In 1935, the then Northern Territory Chief Medical Officer, Dr Cook, expressed concern about increasing opium smoking in the Territory. It appeared that a group of Chinese who were opium dependent were financing their habit by introducing and selling smuggled opium to Aboriginal labourers on the railway and in agriculture. Dr Cook proposed a system whereby the government would purchase opium and supply it to 'registered addicts'. The Commonwealth firmly rejected the proposal after consultation with the Leagues of Nations, which at the time reinforced Australia's commitment to the 1912 Hague International Convention on the Prohibition of Opium.

During the 1970s, a methadone program was established in Darwin. The program is not well described in documentation but it appears that oral methadone in tablet form was dispensed and in some cases doses could be taken away. The program was run under the supervision of the Psychiatric Service at Darwin Hospital and catered for some 45 individuals in 1977. It appears that the aim of the program was withdrawal rather than maintenance. There were apparently problems associated with the program, including methadone being diverted to the 'black market'. As program criteria became stricter and methadone was dispensed in liquid rather than tablet form, use of the program diminished and it was disbanded in 1978. At this time, the Forster Foundation was established and funding for treatment for opioid dependency was vested in a Therapeutic Community, Banyan House. This has been the mainstay of treatment for illicit drugs in the Territory since that time.

In 1993, a National Methadone Policy was developed based on the 1987 National Methadone Guidelines outlining the role of methadone and core operational procedures (Commonwealth Department of Human Services and Health, 1995).

In the mid-1990s, naltrexone became the focus of opioid treatment throughout the world and was considered to be the new 'wonder drug' or 'cure' for opiate dependence. Naltrexone acts as an opioid antagonist, blocking the effects of opioids. In Australia and other parts of the world, clinical trials used naltrexone for rapid opioid detoxification procedures and maintenance treatment. However, the promises of naltrexone being a 'cure' for opiate dependence diminished (Bell et al, 2000). Naltrexone has been registered for use in Australia since January 1999 for the treatment of opiate and alcohol dependence.

Until recently, methadone was the only available maintenance treatment for opiate users. Buprenorphine, an analgesic for clinical use in Australia, was researched as an alternative to methadone, and during the 1990s, clinical trials using buprenorphine for opioid dependence were conducted in Australia (NDARC NEPOD project staff, 2001). In October 2000, buprenorphine was registered for the treatment of opioid dependence including maintenance and detoxification.

DETOXIFICATION AND NON-PHARMACOLOGICAL TREATMENTS

Detoxification is the first step in the treatment of opiate dependence that aims at abstinence (Gerstein & Harwood, 1990). To maintain abstinence is harder, than it is to complete withdrawal; those who complete withdrawal are likely to return to opiate use without support to prevent relapse (Gerstein & Harwood, 1990). Relapse prevention may involve attendance at self-help groups, residence in a therapeutic community, or the taking of a maintenance opioid drug that prevents withdrawal symptoms and enables opiate users to rehabilitate themselves (Gerstein & Harwood, 1990).

Residential community and other residential treatments are alternative treatments for opioid dependence for those who wish to enter them. They are usually marked by relatively poor retention in treatment, relapse and poor patient acceptance (Ward et al, 1992).

METHADONE MAINTENANCE TREATMENT (MMT)

MMT is the most extensively researched form of maintenance treatment for opioid dependence (Ward et al, 1998). MMT involves the substitution of the opioid methadone, a long-acting orally administered drug, for the shorter-acting heroin that is usually injected (Dole & Nyswander, 1965). Methadone is taken once a day because its long duration eliminates opiate withdrawal symptoms for 24⁻36 hrs. It reduces craving for opiates and blocks the euphoric effects of injected opiates, thereby freeing the patient from the daily cycle of seeking out and using opiates.

Effectiveness of MMT

The effectiveness of treatments for opioid dependence would ideally be assessed through randomised controlled trials (RCTs). Only five such trials have ever taken place in the 35 years since MMT was introduced (Hall et al, 1998). All five trials involved small numbers of patients who were rarely followed for longer than one year (Dole et al, 1969; Gunne & Gronbladh, 1981). Nevertheless, all these trials produced positive results, despite small sample sizes that work against finding differences. Stronger support for the efficacy of MMT comes from the corroborative results of many observational studies in which statistical forms of control have addressed the major alternative explanations of apparent effectiveness that are dealt with by RCTs (Ward et al, 1998).

The major observational studies (Ball & Ross, 1991; Simpson & Sells, 1982) have generally supported the RCTs in showing that MMT reduces opiate use and criminal activity (Gerstein & Harwood, 1990; Hall et al, 1998). The studies have revealed substantial variation between different programs in treatment retention as well as in use of opiates and other illicit drugs (Ball & Ross, 1991). Studies in several countries have also shown that MMT is associated with a substantial reduction in mortality among heroin users (Ward et al, 1998; Gunne & Gronbladh, 1981).

MMT also prevents transmission of HIV among infected drug users by reducing needle sharing (Ball & Ross, 1991; Schoenbaum et al, 1989). MMT has protected patients from HIV infection in places where HIV has spread rapidly among injecting drug users who have not been in treatment (Schoenbaum et al, 1989; Metzger et al, 1993). Two large prospective cohort studies in the USA have also found that MMT protected against HIV infection (Metzger et al, 1993; Moss et al, 1994). For example, over 18 months, the odds of HIV infection were 5·4-times greater among those who were not in MMT compared with those who were (Metzger et al, 1993).

The effectiveness of MMT in observational studies of community treatment programs has not been as impressive as that in the RCTs, (Hall et al, 1998) indicating that methadone treatment in routine use is not a panacea for opioid dependence. About half of those who enter treatment leave within 12 months, and some of those who stay continue to use opiates and other illicit drugs, though much less frequently than before they entered treatment (Ward et al, 1998). The effects of MMT are modest, if judged by the unrealistic expectations that all patients will achieve enduring abstinence from all opioid drugs. However, MMT nevertheless attracts and retains more patients than alternative treatments and produces better outcomes among those who complete the treatment (Gerstein & Harwood, 1990; Hall et al, 1998).

The variability in program effectiveness shown in observational studies results from such factors as the types of participant in the programs, their use of other drugs [such as benzodiazepines and cocaine, the effects of which are not blocked by methadone], the dose of methadone given, the duration of treatment, the quality of the therapeutic relationships, and possibly the intensity of ancillary services (Hall et al, 1998). The most effective programs are those that provide higher doses of methadone as part of a comprehensive treatment program with maintenance rather than abstinence, from opioid use, as the treatment goal (Ward et al, 1998).

Risks of MMT

Although clear benefits have been shown from MMT, there are risks to the individual and the community that need to be kept to a minimum through control of the administration of methadone, in a manner that does not inconvenience patients. When suitable control measures are not used, patients may ingest more than their prescribed dosage, household members may accidentally drink the patient's methadone, and methadone may be sold or given to people who are not patients. These risks can be reduced by educating patients about the safe ingestion and storage of methadone [Table 1].

Table 1: Safe methadone use

Risks	Preventative measures
Overdose during induction	Initial doses in range 10-40mg Supervised ingestion of doses
Accidental poisoning of children	Take-home doses require a child-proof containers
Diversion	Take-home doses require a good response to treatment by patients

Because methadone may be fatal to non-tolerant individuals in the doses used in MMT, it is important to ensure that patients do not ingest more than their prescribed dosage, especially in the early weeks of treatment. Daily attendance at the dosing site and supervised ingestion of the methadone syrup may be used for this purpose. Once the patient starts to respond well to treatment, take-home doses of methadone are usually dispensed. Accidental poisoning of children can be prevented by the dispensing of take-home doses in childproof containers. Diverted methadone is usually bought by opiate users to manage withdrawal symptoms (Spunt et al, 1986). Ensuring that take-home doses are only dispensed to patients who respond well to treatment can reduce methadone diversion.

Deaths associated with accidental methadone poisoning have to be put in context of the raised risk of suicide and death from accidental opiate overdose among opiate users (Neeleman & Farrell, 1997). Concerns expressed recently in the UK about a dramatic increase in fatal methadone deaths are not supported by a recent study (Neeleman & Farrell, 1997) of fatal methadone and heroin overdoses in England and Wales. The value of supervised dosing to prevent methadone deaths was highlighted by a recent study (Williamson et al, 1997) of methadone-related deaths in South Australia that showed that deaths attributable to methadone syrup [as used in MMT] declined between 1984 and 1994, whereas deaths due to methadone tablets [physeptone] prescribed for chronic pain increased towards the end of this decade. Half of these deaths were due to physeptone tablets being diverted to non-patients.

Components of effective MMT

Assessment, induction, and methadone dosage

Entry to MMT has traditionally been made difficult for fear of creating iatrogenic dependence, or unnecessarily prolonging dependence. Evidence suggests that reducing barriers to entry increases participation in MMT, improves retention in treatment, and improves outcome while patients remain in treatment (Bell et al, 1994). Moreover, longitudinal studies indicate that there are no differences in the rates of long-term abstinence between patients who enter MMT and drug-free residential treatment, suggesting that MMT does not unduly extend opioid dependence (Maddux & Desmond, 1992).

Methadone has a long elimination half-life [24⁻36 hrs], with a lethal oral dose thought to be in excess of 40⁻60mg in non-opioid-dependent people (Drummer et al, 1992). However, because methadone accumulates in the body during stabilisation, an overdose can occur with a series of doses that individually may be within the individual's tolerance range (Ward et al, 1998) For safety reasons, most clinicians therefore recommend initial doses of 10⁻40mg, with split or serial dosing sometimes used for patient comfort (Payte & Khuri, 1993).

After stabilisation, the daily dose of methadone should be adjusted individually to each patient, with no arbitrary ceiling dose. Restriction of the dosing range to below 50mg increases patient dropout. Higher doses [>60mg] are associated with longer stays in treatment and greater reductions in opiate use [Ling et al 1996]. Adopting a flexible dosing policy results in patients feeling more positive about their treatment [Maddux et al 1995] and produces better retention rates (Brown et al, 1982) [Table 2].

Table 2: Components of effective methadone treatment

- Flexible but adequate dose of methadone after stabilisation (usual range 50-150mg)
- Adequate duration of treatment
- Goal of maintenance
- Rapid and client-centred assessment and induction
- Psychosocial services to deal with social disadvantage, psychiatric co-occurring disorders and other psychosocial issues
- Trained staff with positive attitudes towards MMT and opioid-dependent patients
- Affordable -cost of treatment should not exceed ability to pay
- Engagement with clients rather than punishment of continuing illicit drug use

Duration and withdrawal from MMT

The Dole and Nyswander model of long-term maintenance on methadone has been supported by research over the past 30 years (Ward et al, 1998). This research suggests a linear relation between the time spent in MMT and reductions in opiate use and crime in the long-term. Patients who leave treatment prematurely (ie. are deemed by clinical staff as still at risk) are at a high risk of relapsing to opiate use (Ward et al, 1998).

Abrupt cessation of methadone results in a characteristic withdrawal syndrome, which, because of its long elimination half-life, is more protracted though less intense than that of shorter-acting opioids such as morphine and heroin. Detoxification from MMT is most effectively achieved by a slow reduction in the dose of methadone administered [Table 3]. The rate of reduction is best negotiated with the patient to maximise his or her involvement (Ward et al, 1998). Successful detoxification is more likely when supportive counselling is made available (Milby, 1988).

Table 3: Withdrawal from MMT: recommended dose reductions*

Maintenance dosage range	Recommended reduction rate
[greater than]80 mg per day	10 mg per week
40-80 mg per day	5 mg per week
10 00 mg per day	5 mg per week

^{*}Source: Bell and O'Connor (1994) in Methadone maintenance treatment process.

Most MMT patients are mildly anxious about the withdrawal symptoms they may experience. To provide them with clear and accurate information about what is likely to happen improves the chances of withdrawal being completed (Green & Gossop 1988). About one quarter of MMT patients report a phobic-like fear of detoxification which may complicate withdrawal from MMT (Milby et al, 1986).

Many former MMT patients undergo a "post-methadone syndrome", a protracted mild withdrawal syndrome that may make it difficult to remain opioid-free. Continuation of supportive counselling after cessation of methadone is often recommended but rarely received, despite evidence that patients are less likely to relapse if they participate in an aftercare program (McAuliffe, 1990).

ALTERNATIVE FORMS OF OPIOID MAINTENANCE TREATMENT

For 30 years, methadone has remained the primary drug for opioid maintenance treatment, but several alternative agents have recently been tested in controlled trials. These alternative agents could provide greater patient choice and avoid some of the disadvantages of methadone, such as the long withdrawal syndrome, the need for daily dosing and for takeaway doses, and the risk of overdosing during treatment induction.

The longer-acting agonist levo-alpha-acetylmethadol (LAAM) and the mixed agonist/ antagonist buprenorphine are equivalent in their effects to methadone in reducing illicit opioid use, (Mattick et al, 1998) with the advantage of dosing every second day rather than daily. This reduced dosing lowers treatment costs, is less onerous for patients, and cuts down take-away doses and risks of diversion. LAAM has the disadvantage that its longer half-life makes stabilisation of patients more difficult, which may increase the risk of overdosing during induction. Buprenorphine greatly reduces the risk of overdose, and has a shorter and less severe withdrawal syndrome than methadone and LAAM. Experience with buprenorphine in France suggests that it can be accepted as readily as methadone (Mattick et al, 1998).

BUPRENORPHINE MAINTENANCE TREATMENT (BMT)

In October 2000, buprenorphine was registered in Australia as a treatment option for opioid dependence. Buprenorphine is a partial agonist at the _ opioid receptor, giving a mild opiate effect yet blocking the effects of additional opioid use (Lintzeris et al, 2001). BMT involves taking buprenorphine sublingually either daily or on alternate days under supervision (Lintzeris et al, 2001).

Buprenorphine clinical trials undertaken in Australia provided an opportunity to explore alternative maintenance treatments for opioid dependence besides methadone. The goals of BMT are to reduce illicit opioid use, reduce the risk of overdose, reduce the spread of blood borne viral infections and improve the general health and social functioning of the patient (Ali et al, 2001).

Effectiveness of BMT

Buprenorphine maintenance treatment through RCTs has proven to be as effective as methadone treatment in terms of retention in treatment and reduction in illicit opiate use (Bickel et al 1988, Strain et al 1994, Johnson et al 1995). However, other studies (Kosten et al 1993, Ling et al 1996) have found that retention and reduction in opiate use were lower in the buprenorphine groups. The authors concluded that the fixed doses of buprenorphine used in the studies were inadequate and that future research needs to use higher buprenorphine doses. The earlier studies of buprenorphine maintenance used buprenorphine as an ethanol-based solution, which has a slightly higher bioavailability than the tablet preparation that is available in Australia.

Studies that are more recent have used sublingual buprenorphine tablets. One study compared buprenorphine [maximum 8mg] with methadone ['no upper limit' on dose] and found that the buprenorphine group had significantly less opiate positive urine. However, the retention rate was significantly lower than the methadone group. This may be due to the maximum buprenorphine dose having been set too low (Fischer et al, 1999). Other studies have found similar results where retention was lower in the buprenorphine group and many drop outs occurred in the induction phase (Gessa et al, 1998; Uehlinger et al, 1998).

A recently published double blind randomised trial of short-term [six week] buprenorphine and methadone maintenance found that the retention rate was better in the methadone group then the buprenorphine group (Petitjean et al, 2001). This may be due to inadequate induction doses. However, the study did find that both buprenorphine and methadone were effective in reducing opiate use (Petitjean et al, 2001).

A meta-analysis recently published found equivalent efficacy of buprenorphine and methadone in terms of illicit drug use (West et al, 2000). Other studies have shown that daily and alternate-day buprenorphine dosing have equivalent effects on opioid withdrawal symptoms (Fudala et al, 1990; Amass et al, 1994; Johnson et al, 1995) and illicit opioid use (Johnson et al, 1995).

Limited literature is available on buprenorphine and blood borne viral infections. However, like methadone, buprenorphine may be protective again blood borne viral infections due to a reduction in injecting drug use and the shared use of injecting paraphernalia.

Risks of BMT

While BMT has clearly shown to have benefits for the individual and the community, limitations do exist. Like MMT, BMT requires suitable control measures to avoid unnecessary risks. Such control measures include, supervised dosing, restricted take away doses and childproof containers. Without these control measures, patients may ingest more buprenorphine then prescribed, strangers or household members may accidentally ingest the buprenorphine dose or buprenorphine tablets may be sold illegally on the streets. Educating the patients about safety measures and the safe storage of buprenorphine may also reduce these risks.

While overdose with buprenorphine alone is unlikely in an opioid-tolerant individual, overdose can still occur in an individual with no tolerance to opioids (Lintzeris et al, 2001). However, the poor bioavailablity of buprenorphine when taken orally reduces the risk of accidental overdoses (Lintzeris et al, 2001). The risk of overdose is great when combined with other sedative drugs such as alcohol, benzodiazepines, barbiturates, tricyclic antidepressants and major tranquillisers (Lintzeris et al, 2001).

Components of effective BMT

Assessment, induction and buprenorphine dosage

Buprenorphine is administered sublingually and is typically prescribed as a daily dose. However, alternate day dosing is possible due to its long half-life [mean 35hrs]. The dose of buprenorphine is usually doubled when taken on alternate days.

The National Buprenorphine Clinical Guidelines outline that the first dose of buprenorphine should be administered at least 24hrs after the last methadone dose and at least 6hrs after the last heroin dose. The initial dose of buprenorphine should be between 2 to 8mg on the first day depending on the severity of dependence and no greater than 8mg. Buprenorphine maintenance doses usually range from 12 to 24mg per day, with a maximum of 32mg if alternate day dosing is involved (Lintzeris et al, 2001). Buprenorphine sublingual tablet preparations include 0.4, 2 and 8mg strengths.

Individuals should be closely monitored by an experienced clinician for signs of intoxication when considering buprenorphine dose increases. Buprenorphine dose increases can be achieved quite quickly without toxicity and some evidence has found that a slow induction may cause patients to leave treatment due to a low maintenance dose (Fischer et al, 1999; Ali et al, 2001).

Research has found that patients receiving a daily dose of 12 - 24mg are less likely to use illicit opioids and are more likely to remain in treatment (Ali et al, 2001). Access to a range of comprehensive psychological treatments and support should be made available to the patient.

Duration and withdrawal from BMT

Withdrawal from buprenorphine is said to be not as prolonged or severe as methadone withdrawal, however the research is limited (Bickel et al, 1988). Buprenorphine withdrawal is similar to other opioid withdrawals. The onset of withdrawal symptoms is usually around 24-72hrs after the last 24hr dose. Symptoms usually peak around 3-5 days after short-

term maintenance courses and 5-14 days for long-term [weeks/months] maintenance treatment (Lintzeris et al, 2001). Limited research is available on the duration of buprenorphine withdrawals, however mild to moderate withdrawal symptoms are likely to persist for weeks (Lintzeris et al, 2001).

NALTREXONE TREATMENT (NTX)

Maintenance with pure opioid antagonists, such as naltrexone, has been shown to be effective in opioid-dependent people for whom failure to comply with treatment has major personal consequences [eg, opioid-dependent health professionals]. But pure opioid antagonists have not proven popular with the wider population of opioid-dependent people, in whom low rates of compliance have been a major difficulty (Mattick et al, 1998).

Naltrexone was first used in the 1970s, however disappointing results from trials diminished the use of naltrexone for the treatment of opioid dependence (Heather et al, 1989; Bell et al, 2000). Recently in the 1990s, some entrepreneurs have promoted naltrexone-accelerated withdrawal under a general anaesthetic followed by naltrexone maintenance as a 'cure' for opiate addiction. This promotion has taken place in the absence of evidence for naltrexone's safety and efficacy, and after at least one death in the UK (Mattick et al, 1998). Naltrexone is registered in Australia as a treatment option for opioid dependence however, unlike buprenorphine and methadone, naltrexone has no drug effect to help patients adjust to being opiate free.

Effectiveness of NTX

Naltrexone has a limited but potentially valuable role in the treatment of opioid dependence. Although naltrexone has been found to be a safe and effective opioid antagonist, the research literature points to poor treatment patient acceptance and poor retention in NTX (Tucker & Ritter, 1997). A lack of rigor in the naltrexone literature was identified in a recent Cochrane review (Kirchmayer et al, 2001), which concluded that naltrexone could not be considered a treatment that has been scientifically proven superior to other treatments.

The average retention rate in NTX ranges from about six weeks (Lewis et al, 1978) to eight months (Ling & Wesson, 1984). The retention range appeared to depend on the type of patient studied and if additional adjunctive therapies were used. In a recent review, the average retention across reviewed studies was approximately three months (Tucker & Ritter, 1987). Early attrition from NTX is also common, with reports of 40-50% dropping out within the first week of treatment (Tucker & Ritter, 1997).

The highest retention rates have been reported for patients who are highly motivated to remain abstinent, such as business executives, physicians facing job loss (Washton et al 1984) and participants in prisoner work release programs (Brahen et al 1984). In studies comparing retention in naltrexone to retention in methadone maintenance, retention in methadone is greater (Grey et al., 1986; Osborn et al, 1986). The probability of a positive outcome in NTX, as for other treatments for drug dependence, is increased by stable social contacts [eg. spouse, family, and friends] and employment.

Although retention in NTX is poor, it works best for opioid users who are committed to long-term abstinence. The majority of studies suggest that those patients who remained in treatment had lower levels of craving, higher abstinence rates and longer periods of abstinence than patients who were treated with placebo or standard treatments (Tucker & Ritter, 1997).

Risks of NTX

While, naltrexone may benefit motivated patients, the risk of death is increased after NTX (Miotto et al, 1997). This may be due to a loss of tolerance to opioids. Another factor contributing to the risk of death is depression and the lack of education. Depression is common among opioid users (Regier et al, 1990) and the risk of deliberate suicide after discontinuing opiates is possible (Bell et al, 2000). For these reasons patients treated with naltrexone are at an increased risk of death compared to patients treated with other pharmacotherapies.

Before commencing NTX patients should have an opioid free interval and be made aware of the possible dangers involved. Due to the possible dangers, it is advised that patients treated with naltrexone should carry at all times a card or medical alert bracelet stating that they are on naltrexone and will not respond to opioid analgesia. Naltrexone should not be given to any other person and precautions should be taken to safe guard naltrexone tablets.

Components of effective NTX

Assessment, induction and naltrexone dosage

Before a patient commences NTX, a comprehensive assessment procedure should be completed with the risks and benefits of NTX explained to the patient.

According to the National Interim Naltrexone Clinical Guidelines, to avoid precipitated opioid withdrawals, patients should have an opioid free interval [7 days since last opiate use and 14 days since last methadone use] before commencing on naltrexone (Bell et al, 1999). However, because many patients are unable to remain abstinent for the required opioid free period, a naloxone [Narcan (c)] challenge test is recommended before the first dose of naltrexone (Bell et al, 1999).

The guidelines recommend delaying the induction onto naltrexone if the patient is 'positive' to the naloxone challenge. If the patient has a mild response to the naloxone challenge, 12.5mg of naltrexone may be given to the patient, however the patient may experience discomfort for 24hrs. If a 'negative' result from the naloxone challenge is observed then 25mg of naltrexone may be administered. If there are no signs of withdrawal after 2 hrs, the patient can take 25mgs the next day and then continue to take 50mgs daily (Bell et al, 1999).

The patient should be reviewed at least once during the first week of naltrexone treatment. Symptomatic medications [clonidine, octreotide, metoclopramide, buscopan, quinine sulphate] may be used during the induction onto naltrexone to alleviate withdrawal symptoms (Bell et al, 1999). Unlike buprenorphine and methadone, naltrexone dosing is not supervised after the initial induction phase.

Some patients continue to use opiates while still taking naltrexone, using opiates intermittently and resuming naltrexone. The occasional pattern of opiate use is problematic and patients are at risk of a fatal opiate overdose because the tolerance level to opioids is reduced. It is recommended to give repeated warnings to a naltrexone patient on the risks of a fatal overdose (Bell et al, 1999).

Duration of NTX

Limited research is available on the optimal duration of NTX. Research has shown that the risk of relapse is high for at least 12 months and possibly up to three years (Bell et al, 2000). However, for stable, abstinent patients who have made significant changes it may be reasonable to discontinue NTX after 6-12 months (Bell et al, 2000).

NATIONAL EVALUATION OF PHARMACOTHERAPIES FOR OPIOID DEPENDENCE

The Australian National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) Project was a three-year National project evaluating a range of opioid detoxification and maintenance treatments involving methadone, naltrexone, buprenorphine, and LAAM, with associated psychosocial and medical interventions from 13 different trials. The costs and cost-effectiveness of detoxification and maintenance treatments were also reported.

The research program involved a total project funding of approximately \$7 million. More than 250 clinical and research staff provided treatment and collected the data on 1,425 patients.

Findings from the NEPOD project

The treatments examined in the NEPOD project were methadone maintenance, buprenorphine maintenance, LAAM maintenance, and naltrexone treatment. The trials of methadone, buprenorphine and LAAM maintenance with opiate users produced similar results, although LAAM was superior to methadone. Opiate users who remained in treatment substantially reduced their opiate use and the number of opiate-free days increased.

Naltrexone treatment was provided to a group of opiate users who were either, already detoxified and abstinent when they entered treatment, had received rapid detoxification or had received conventional inpatient detoxification. The results found that very few patients achieved complete abstinence. However, for those patients who remained in naltrexone treatment, opiate use reduced. Overall, the pharmacotherapies produced substantial reductions in opiate use while patients remained in treatment, but retention in NTX treatment was very poor.

NEPOD project, costs and cost-effectiveness

Overall, the daily costs of providing maintenance treatments were similar for methadone and LAAM, followed by buprenorphine, with naltrexone treatment being most expensive.

Buprenorphine maintenance was more expensive to provide, per day abstinent from opiates than methadone, but reductions in the price of buprenorphine and increased efficiency in the administration of buprenorphine may reduce its total cost and increase its cost-effectiveness. The recent listing of buprenorphine on the PBS will significantly reduce costs to states and territories. In Australia, methadone maintenance is the most cost-effective treatment currently available for the management of opioid dependence. Methadone maintenance also achieved one of the highest rates of retention among the four pharmacotherapies examined.

LAAM is not registered for use in Australia however; it was more cost-effective than methadone maintenance due to a better retention rate and slightly better ability to suppress opiate use. Although this is a promising result, it is based on a small sample of patients, and the superiority of LAAM over methadone has not been observed in other studies. This result therefore needs to be interpreted cautiously.

ANCILLARY SERVICES

Monitoring illicit drug use

In the USA, urinalysis [and sometimes hair analysis] is used to monitor patients' illicit drug use and ensure that they are taking their prescribed methadone or LAAM. The monitoring of drug use in itself does not reliably reduce illicit drug use (Havassy & Hall, 1981). To reward reductions in drug use with privileges, such as take-home methadone doses, has been shown to be effective, but there is no evidence that the loss of privileges for illicit drug use is effective (Stitzer et al, 1993). There are also disadvantages with the monitoring of illicit drug use in this way, it sends a message to patients that they cannot be trusted, and it may be humiliating for patients to be observed urinating [and for staff to observe it]. The latter difficulty can be minimised by the use of temperature-sensitive containers for collection of urine samples.

Counselling

The traditional role of counselling in MMT as delivered in special-purpose clinics has been case management and crisis assistance to help patients resolve difficulties associated with their opioid dependence. Co-occurring psychiatric disorders are not usually dealt with by counsellors in such clinics unless the counsellors are qualified to do so (Mattick et al, 1998). When MMT, BMT or NTX are managed by a general practitioner, the general practitioner usually provides this routine counselling.

The model of MMT that has been effective in most studies has usually been clinic-based and has included counselling, even though MMT without formal counselling has become increasingly common throughout the world. Recent studies with randomised designs have failed to show consistently that the provision of additional services, including

counselling, achieves better outcomes (Mattick et al, 1998). Intensive services, when set up as separate services, seem to render treatment more expensive with only marginal improvements in effectiveness (Kraft et al, 1997).

Although there is no well-tested model of drug counselling in MMT, counselling should be based on reflective listening to develop an empathetic alliance, whether the counselling is provided by a specialist or a general practitioner (Mattick et al, 1998). Mandatory psychotherapy or counselling is unlikely to be beneficial, and may even have a negative impact on patients' attitudes to treatment (Mattick et al, 1998). Supportive counselling is particularly important when patients are detoxifying from buprenorphine or methadone.

SPECIAL POPULATIONS

Pregnant women

Illicit opiate use exposes both pregnant women and her foetus to dangerous fluctuations in blood morphine, unknown drugs and contaminants, and infections such as hepatitis B, hepatitis C, and HIV (Finnegan, 1991). Pregnant women who continue to use opiates are more likely to give birth prematurely to opiate-dependent neonates (Finnegan, 1991).

Limited research is available on the use of buprenorphine and naltrexone while pregnant and during breastfeeding. Methadone maintenance treatment is usually the preferred treatment option for opiate dependent pregnant women. MMT serves multiple purposes such as, the removal from the drug-seeking environment, reduces any necessary illicit behaviour, and prevents the ups and downs in the maternal opiate level that may occur throughout the day (Finnegan, 1991). Buprenorphine is contraindicated in pregnancy (MIMS Australia, 2001). However, if the patient becomes pregnant while taking buprenorphine they can either transfer onto methadone under close observation or continue with buprenorphine treatment aware of the dangers involved [neonatal respiratory depression and withdrawal symptoms] (Lintzeris et al, 2001). There are no adequate or well-controlled studies on naltrexone during pregnancy and precautions should be taken when prescribing naltrexone to a pregnant woman. The decision to continue naltrexone treatment in pregnancy involves evaluating the risks to the foetus and the possibility of relapse to opiate use (Bell et al, 2000).

To provide a pregnant woman with a daily dose of methadone protects her foetus from the peaks and troughs of morphine blood concentrations, illicit opiates of unknown composition, and injection-related viral infections (Finnegan, 1991). Provision of a daily dose of methadone also facilitates antenatal care (Finnegan, 1991). Pregnant women in MMT programs have longer pregnancies, fewer complications at birth, and give birth to infants who are larger for their gestational age than those of opiate-dependent women not in treatment (Giles et al, 1989). An adequate methadone dose also reduces the chances of a relapse to opiates.

Many infants born to methadone-maintained women have an abstinence syndrome within 72hrs of birth (Finnegan, 1991). The onset, severity, and duration of the syndrome is influenced by many factors, but tends to be longer after exposure to methadone than after exposure to opiates. Such infants need comprehensive monitoring with an abstinence scoring system and will require, in most cases, pharmacotherapies to suppress withdrawal symptoms and to achieve detoxification safely. Breastfeeding is not contraindicated in the 6 months after birth for women in MMT (Geraghty et al, 1997). Precautions should be taken when naltrexone is administered to a breastfeeding woman (MIMS Australia, 2001). Buprenorphine treatment is contra-indicted for breastfeeding women (Lintzeris et al, 2001; MIMS Australia, 2001).

Co-occurring psychiatric disorders

Opioid dependent individuals have much higher rates of depressive disorders, antisocial personality disorders, and alcohol misuse and dependence than occur in the general population (Regier et al, 1990). But these disorders are not contraindications for MMT (Woody et al, 1984). Some depressive disorders remit in response to MMT, but patients who remain depressed after stabilisation on methadone require specialist assessment and treatment with psychotherapy [cognitive-behavioural or psychodynamic] or anti-depressant medication, or both (Woody et al, 1984). Buprenorphine and naltrexone treatment are not contraindicated for co-occurring psychiatric disorders, however particular cautions should be taken when assessing the suitability for these treatments (MIMS Australia, 2001).

Current Situation

Pharmacological interventions are endorsed under point two of the Government's Three Point Drug Plan. This includes the clear statement that "Under Labor, doctors will be able to treat addicts with any pharmacological intervention approved by the Commonwealth." (Building A Safer Community: Tough On Drugs. Position Paper - March 2001.)

Methadone

Since 1996, the NT Poisons and Dangerous Drugs Act has made provision for methadone to be prescribed for opiate dependent injecting drug users under certain conditions:

- infected with Human Immunodeficiency Virus (HIV) to prevent transmission of Acquired Immune Deficiency Syndrome (AIDS);
- women who are pregnant and for up to six months following delivery to protect the foetus:
- individual needs hospitalisation for serious medical illness which may or may not be related to intravenous drug use; and
- for three months, on a planned reduction schedule, to assist withdrawal for people who are assessed as suitable and needing this particular kind of assistance to cease their injecting opiate drug use.

Buprenorphine

In July 2001, Ministerial Guidelines for the use of buprenorphine were endorsed in the Northern Territory, to assist withdrawal from opiate dependency over a 6 to 12 month period.

Naltrexone

A number of General Practitioners in the Northern Territory are prescribing naltrexone for alcohol treatment under the Pharmaceutical Benefits Scheme. A number are also using it to treat the maintenance of opioid cessation, to enable patients to remain opiate free. Patients on this program currently pay approximately \$7 per day, as REVIA is priced at around \$150 for 30 (50mg) tablets, throughout Australia.

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.

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.

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 opioid dependence will undoubtedly be a significant step in enhancing 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.

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 an attractive preferred option. These include: a lower overdose risk, can be dispensed on alternate days, and offers easier withdrawal for most patients.

It is recommended:

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.

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.

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. 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.

The Taskforce has found through its investigations that opiate use and dependence are currently prominent in only Darwin, Palmerston and Alice Springs. It is likely that opiate use and misuse is also happening in other areas of the Territory, however it was found to be at very limited levels. The opiate most frequently used in the Territory was reported to be prescription morphine. As reported in one consultation:

"It's not at all unusual for opiate users to come up to [the Territory] because they believe there are no opiates here. They come to leave the heroin behind but they find morphine, and it's cheaper and better quality."

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.

A range of issues were raised regarding the provision of pharmacotherapies, particularly in terms of offering a centralised unit, a community-based approach, or a mixture of both. The consensus tended to be that a community based approach would offer greater access and availability to clients, however there needed to be the back up of a specialised clinic, especially for complex and difficult clients. In addition, it was acknowledged there were likely to be a number of barriers to this occurring in isolation. During the consultations in Darwin and Alice Springs doubts were voiced about whether enough GPs and pharmacists would be willing and available, especially for more complex clients, and it was pointed out that provision through a centralised service would be easier. Discussions in each location were inconclusive, but the most commonly agreed solution amongst service providers appeared to be a mixture of individual providers in a community-based model with the support and back up of a centralised DHCS operated service.

The Taskforce recommends:

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

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.

A Darwin GP based drug clinic was established in 1999 through Alcohol and Other Drugs Services on the RDH campus. Visiting specialists from South Australia trained a number of GPs, three of whom then conducted regular sessions at ADS, mainly focusing upon the opiate withdrawal and management program.

DHCS recognises the need to provide an expert referral and support service to the primary care sector in the alcohol and drugs field, and has recently recruited a medical officer who will be commencing at ADS in July 2002.

The involvement of general practitioners in the service delivery model is essential for the success of this program. This will improve access and availability of this treatment type throughout the Territory. For any strategy to be effective with GPs, it is essential that it is developed in consultation and not imposed. The Taskforce recognises that GPs are well placed to be effective providers of a range of interventions for illicit drug users, and in particular the provision of pharmacotherapies. For a GP focused strategy to be effective, there is a need to have ready access to a range of information, advice, support and referral options from a specialist unit or practitioner. A successful model that can be further explored in terms of its applicability to the Northern Territory is one that has been successfully implemented in New South Wales by Dr Tony Gill.

Providing legislative and clinical safeguards are adhered to, increasing the numbers of GPs to treat 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.

IMPLEMENTING AND MAINTAINING PHARMACOTHERAPIES FOR OPIOID DEPENDENCE.

Process issues

Methadone and buprenorphine are funded by the Commonwealth through the Opiate Dependence Treatment Program under Section 100 of the National Health Act 1953. Naltrexone is available under an authority prescription through the Pharmaceutical Benefits Scheme (PBS) for use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence. There is no subsidy under PBS for the treatment of opioid dependence.

The usual process by which buprenorphine and methadone can be available to patients is through an approved medical practitioner or in some cases a specialist doctor. The doctor reviews a patient's condition and if they are assessed as appropriate for the program, a permit [or the relevant authority] will be sought for the patient. Once administration arrangements are in place and buprenorphine or methadone is prescribed, the patient takes the prescription to an approved pharmacy for dispensing. The patient then attends the pharmacy daily, or as required, to receive their dose with regular review by the medical practitioner.

Current Situation

In all other jurisdictions a permit/notification system is mandatory. Doctors have an obligation under the jurisdiction's legislation to notify or apply to the local Health Authority for a permit to prescribe a 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 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 Voluntary Notification Scheme has been in place in the Territory since February 1999. Under the Notification scheme, doctors can choose to have a signed written agreement with their patient that s/he will see only that doctor, and attend only one pharmacy [two could be agreed]. Poisons Control Branch are notified of the contract details negotiated between the GP and the patient as soon as practical. The POISONS CONTROL Branch maintains a database of 'contract' patients and immediately notify a doctor if a patient has recently 'contracted' with another doctor to obtain S8s. Doctors can phone the Poisons Control Branch when entering into a contract. Pharmacists can also call for verification.

Amendments to the *NT Poisons and Dangerous Drugs Act* are in train to make the scheme mandatory. To date, 530 contracts have been issued with 234 current contracts in place. The scheme has been shown to assist in reducing 'doctor shopping', particularly in the Darwin region.

Contracts have been identified as the most useful way of 'notifying' DHCS because;

- 1. they are a record of patient details and prescribing practices,
- 2. they provide a means of gaining patient consent for these details to be shared with Poisons Control, doctors and pharmacists, and
- 3. most importantly, contracts are recognised as a therapeutic tool for the prescribing doctor and the patient. Contracts outline mutual obligations and reinforce the involvement of the patient in his/her own care.

DHCS have indicated that regardless of the introduction of a mandatory system, contracts will continue to be recommended as a therapeutic devise because they are good treatment practice. Contracts clarify the rights and responsibilities of both parties and research has found that although contracts are not legally binding they do influence retention rates and participation in treatment.

A number of the submissions received by the Taskforce from medical practitioners, pharmacists and other stakeholders emphasised the need for a comprehensive approach to the use of pharmacotherapies to enhance the existing treatment options. The use of advisory panel is highly recommended to allow for a system of monitoring and, where required, formalised 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 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.

Authorisation to prescribe pharmacotherapies for opioid dependence

Methadone and buprenorphine prescribing is usually restricted to those medical practitioners who have the knowledge and skills to assess and treat opioid dependent patients. Each authorised medical practitioner will have approval to prescribe to a limited number of patients. This number is determined by; the expertise and experience of the doctor, accessibility and availability of the doctor, whether the doctor is working full-time or part-time, the type of patients and the type of setting provided by the doctor [availability of other clinicians and ancillary services] (Lintzeris et al, 2001; National Drug Strategy, 1998).

Current Situation

Medical practitioners in the Northern Territory must obtain authorisation from the Chief Health Officer to be approved to treat opioid dependent patients. There are no current limits applied to the number of patients that doctors can manage, given the small numbers of people who have been treated for the purposes of withdrawal to date. With the introduction of maintenance options it will be necessary for clear Territory guidelines to be developed and endorsed that will include issues of this type.

The Taskforce recommends:

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

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.

Accredited training program

In Australia, medical practitioners are required to undertake an accredited pharmacotherapy-training program in order to prescribe buprenorphine and methadone for opioid dependence. Each jurisdiction has a formal accredited training mechanism. The accredited training course will usually entail a training manual that gives an overview of opioids, treatment approaches and the medical treatments available i.e. methadone, buprenorphine and naltrexone. Also included in the accreditation process is a one day training program, a clinical placement, and possibly an interactive website (Bell et al, 2000).

A written examination based on the information provided in the manual is then undertaken either at the workshop or on the interactive website. Performance by the trainees at the workshop, the exam and the clinical placement are assessed with the outcome for trainees being either 'satisfactory' or 'not satisfactory' (Bell et al, 2000). This accreditation process is required Australia wide and should be available to all jurisdictions. Some of the training process may differ in each jurisdiction.

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, above those with which medical practitioners usually have to deal with, not the least of which are the legislative requirements. For these reasons it is necessary to continue to limit the treatment of opioid dependent persons to those practitioners who are trained and authorised to treat these patients, as is the case in all jurisdictions within Australia.

Current Situation

Prescribing and monitoring have been in line with National methadone guidelines, including the requirement for the prescribing doctor to be appropriately trained and skilled. In the Northern Territory, the doctor must contact the Chief Health Officer to have a client endorsed as meeting the criteria.

In partnership with the Divisions of General Practice, the Department has provided training opportunities conducted by visiting interstate experts. The training has focused upon methadone, buprenorphine and naltrexone and has involved theory, practical sessions and an exam.

There are currently a small number of general practitioners in the Northern Territory who are accredited to prescribe buprenorphine and methadone, for the purposes of addiction.

A number of informal training sessions have also been conducted for community pharmacists, which have proven to be well attended.

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.

Supply arrangements

The Commonwealth Government provides funding to the States and Territories for the bulk of methadone purchases and subsidises the supply of buprenorphine.

Monitoring and Regulation

Each jurisdiction is responsible for the central monitoring and regulation of buprenorphine and methadone. The Commonwealth is responsible for collating and maintaining National buprenorphine and methadone treatment data collected and provided by the jurisdictions (Lintzeris et al 2001, National Drug Strategy 1998). The data collected include; the number of patients registered in the treatment, the number of patients entering treatment for the first time and readmissions, retention in treatment, dosage and death rates in treatment.

Current Situation

There is no current data collection system for clients currently receiving pharmacotherapies in the Northern Territory. In establishing the previously recommended legislative and policy framework such a system will provide the ability for this information to be collected, monitored and evaluated.

CHALLENGES IN OPIOID MAINTENANCE TREATMENT

The major challenge in reducing the public-health burden of opioid dependence is to deliver safe and effective maintenance treatment to as many people as can benefit from it. The principal obstacles to achieving this goal are: restricted government funding for treatment (in the face of a limited patient capacity to pay for it); prejudices against maintenance treatment on the part of medical staff, patients, the general public and politicians; and difficulties in ensuring treatment quality and safety by achieving a balance between over-regulation and *laissez-faire* provision (Ward et al 1998).

The ability to increase the availability of opioid maintenance treatment is limited by the capacity of governments to fund treatment places. Funding shortages require more efficient and less expensive ways of delivering treatment, some of which may prove more attractive to patients than the current models. One alternative is to have general practitioners as prescribers and community pharmacies as dispensers of methadone, as in the UK. The expensive multi-disciplinary US-style MMT clinics could then deal only with the more difficult patients. A community-based approach to opioid maintenance treatment fits well with the longer-acting opioid drugs, such as buprenorphine and LAAM. A potential disadvantage of this approach is poorer monitoring of treatment quality and safety. Treatment availability may also be increased through provision of support services for detoxification and aftercare to assist stable patients to withdraw successfully from treatment, thereby making treatment places available for new patients. However, new models for delivering pharmacotherapies must be properly assessed to ensure that the demonstrated effectiveness of the traditional treatment model is retained.

There may be limits to public tolerance of new strategies to deliver opioid maintenance treatments. A fall in clinical demands to reduce illicit opioid drug use may be seen as a blurring of the distinction between drug substitution for therapeutic purposes and the provision of socially sanctioned opioids under medical supervision. The adoption of takeaway policies that are too liberal may lead to increased diversion of prescribed opioids to finance treatment or opiate use; this, in turn, may lead to overdose deaths among opiate users who are not enrolled in treatment. Informed training programs for staff who deliver the treatment are essential, since the effectiveness of maintenance treatment can be seriously compromised by inadequate service provision (Ward et al 1998).

General Community Views

The community and service providers in each location were invited to discuss the introduction of pharmacotherapies for those who are opiate dependent. It was only in Alice Springs, Darwin and Palmerston that this treatment option was seen as being an urgent requirement.

There was general agreement that pharmacotherapies need to be available for dependent users, but that they should be seen only as part of a range of treatment options.

"The same things don't work for everybody - must tailor it to the individual. Treat the client not as an addict, or a junkie - as a person. Recognise they have money problems, housing problems, all sorts of other problems... You need methadone, naltrexone, buprenorphine - as many solutions as possible, it's how they interact with their lives."

The Northern Territory is in a somewhat unique situation where methadone has not been available for the purposes of maintenance for a considerable period of time. Consideration is thus required as to the role of the different pharmacotherapies within the Territory setting.

A number of problems were identified with the current situation in the Northern Territory, with regards to the availability of pharmacotherapies. These included:

- The need for the legislation to be changed to allow maintenance pharmacotherapies rather than only withdrawal regime options.
- Difficulty in attracting medical practitioners to work in the drug and alcohol area at both the specialist services and in General Practice. This was put down to a range of reasons, however the main theme was that medical practitioners have avoided getting into a field where the most effective treatment method they could offer (maintenance pharmacotherapies) has been illegal.

This is evidenced by the following comment:

"General Practitioners remain very reluctant to take on new opiate dependent patients and it is clear that much support and reassurance as well as legislative change is necessary for them to be comfortable taking this population group on again."

- A range of the service providers and users consulted were emphatic that pharmacotherapies be available however they cannot be seen as a stand-alone treatment but rather as part of a range of options. It was particularly emphasised that supporting services should be accessible.
 - "... we must make sure that there's choice available. Looking at someone's lifestyle, we've got to remember that not everybody who uses drugs can stop their life. A lot of people who use drugs are professionals, and work, and have a life, they just also happen to use drugs and wish to address that, so we have to make sure there are choices available for people, because not one treatment option is going to work for all people".

OTHER ISSUES

Pain

The trend of the misuse of prescription medication, particularly that of prescription morphine, has been widespread in the Northern Territory. It appears that there are several different groups using morphine at present. These include a significant group of patients suffering from genuine medical conditions, generally pain, for whom this treatment is appropriate. In addition there are those patients who have developed dependency problems because of overuse of their pain medication. Another group consists of those who are presenting with perceived pain conditions in order to obtain a prescription for morphine based medications as an ad-hoc treatment for their opioid dependence. These people would be better managed on drugs such as buprenorphine and methadone as part of a formal treatment program. The other significant group consists of those persons who are using prescription morphine recreationally and may not yet be dependent. Many of these persons may not be at the stage of their drug using careers where they are ready to accept or require opioid maintenance.

Medical practitioners have been unable to treat opioid drug dependent persons with pharmacotherapies such as buprenorphine and methadone and this has placed many practitioners in a situation where they may have prescribed morphine as a maintenance treatment for drug dependent persons due to the lack of maintenance pharmacotherapy.

"The lack of a comprehensive clinic with a range of therapeutic options addressing addiction in the Northern Territory has meant that many patients have not been honest about their addiction issues when attending GPs and hospital clinics."

There is no multidisciplinary pain service operational 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 for 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.

Pharmacy Issues

There was strong support for the use of community pharmacies in the dispensing of pharmacotherapies, with the emphasis being upon having a larger number of pharmacies each with a small number of clients, rather than having a few pharmacies each with large client bases.

During the consultations with users in Darwin and Palmerston very clear views were expressed that they would not want to collect their medication from a central location, and certainly not from the hospital. In particular it was raised that a centralised collection point would only increase stigmatisation, as well problems around congregation, which would not be beneficial for users who are trying to, establish new networks. Users want to be able to collect medication from places that are part of normal life: the pharmacy or GP.

Issues raised by pharmacists included:

- Need for ongoing training and support
- Pharmacists should be permitted to retain the right to refuse the supply if the patient is deemed unsuitable for the community setting. Therefore there needs to be dispensing facilities in the centralised unit for a small number of patients.
- Issues around appropriate remuneration for efforts by pharmacists, both in terms of dispensing fees but the issue of retainer funding was also raised.
- Development of appropriate information systems, to enable streamline reporting systems between all relevant parties.

REFERENCES

Ali R, Biggs L, Dorlego B, Gill T, Larkins K, Moyle K, Murray T, Perrin J, Quigley A, Rysavy P, Sunjic S, Wilson C, and Richards I. (2001). National Buprenorphine Policy. National Drug Strategy, Department of Health and Aged Care, Canberra.

Amass L, Bickel WK, Higgins ST, and Badger GJ. (1994). Alternate-day dosing during buprenorphine treatment of opioid dependence. Life Sciences. 54: 1215-1228.

Anthony JC, Helzer JE. (1995). Epidemiology of drug independence. In: Tsuang MT, Tohen M, Zahner GE, eds. Textbook in psychiatric epidemiology. New York: Wiley-Liss, 1995: 361-406.

Auriacomb M and Tignol J. (1997). Buprenorphine in France: quality of life and conditions for treatment success. Res Clin Forums 19, pp. 25⁻32.

Ball JC, Ross A. (1991). The effectiveness of methadone maintenance treatment: patients, programs, services, and outcomes. New York: Springer-Verlag.

Ball JC, Shaffer JW and Nurco DW, (1983). The day-to-day criminality of heroin addicts in Baltimore - a study in the continuity of offence rates. Drug Alcohol Depend 12, pp. 119-142.

Bell J, Caplehorn JRM and McNeil DR. (1994). The effect of intake procedures of performance in methadone maintenance. Addiction 89, pp. 463⁻471.

Bell J, Kimber J, Mattick RP, Ali R, Lintzeris N, Monheit B, Quigley A, Ritter A, and White J. (2001). Interim Clinical Guidelines - use of Naltrexone in relapse prevention for opioid dependence (abbreviated version). National Drug Strategy, Department of Health and Aged Care, Canberra.

Bell J. (2000). Pharmacotherapies Accreditation Course: A Training Manual for Participants. Centre for Education and Information on Drugs and Alcohol (CEIDA), Sydney.

Bickel WK, Stitzer ML, Bigelow GE, Liebson IA, Jasinski DR, and Jhnson RE. (1988). A clinical trial of buprenorphine: Comparison with methadone in the detoxification of heroin addicts. Clinical Pharmacology and Therapeutics 43: 72-78.

Brahen LS, Henderson RK, Capone T, and Kordal N. (1984). Naltrexone treatment in a jail work-release program. Journal of Clinical Psychiatry. 45: 49-52.

Brown BS, Watters JK, Iglehart AS. (1983). Methadone maintenance dosage levels and program retention. Am J Drug Alcohol Abuse 1982-83; 8: 129-39.

Byrne A, and Newman R. (1999). Methadone - many myths, but little mystery. In: Heroin Crisis. Bookman Press Pty Ltd., Melbourne, Victoria.

Commonwealth Department of Human Services and Health. (1995). Review of Methadone Treatment in Australia. Commonwealth Department of Human Services and Health, Canberra.

Dole VP and Nyswander M, (1965). A medical treatment for diacetylmorphine (heroin) addiction: a clinical trial with methadone hydrochloride. JAMA 193, pp. 80⁻84.

Dole VP, Robinson JW, Orraca J et al., (1969). Methadone treatment of randomly selected criminal addicts. N Engl J Med 280 pp. 1372⁻1375.

Drummer H, Opeskin K, Syrjanen M et al., (1992). Methadone toxicity causing death in ten subjects starting on a methadone maintenance program. Am J Forensic Med Pathol 13, pp. 346-350.

EMEA. (2001). EMEA Public statement on the recommendation to suspend the marketing authorisation for Orlaam (Levacetylmethadol) in the European union. The European Agency for the Evaluation of Medicinal Products.

English DR, Holman CDJ, Milne E, et al. (1995). The quantification of drug caused morbidity and mortality in Australia, 1995 edition. Canberra: Commonwealth Department of Human Services and Health.

Finnegan LP, (1991). Treatment issues for opioid-dependent women during the perinatal period. J Psychoactive Drugs 23, pp. 191-201.

Fischer G, Gombas W, Eder H, Jagsch R, Peternell A, Stuhlinger G, Pezawas L, Aschauer HN, and Kasper S. (1999). Buprenorphine versus methadone maintenance for the treatment of opioid dependence. Addiction 94: 1337-1347.

Fudala PJ, Jaffe JH, Dax EM, and Johnson RE. (1990). Use of buprenorphine in the treatment of opioid addiction. II. Physiology and behavioural effects of daily and alternate-day administration and abrupt withdrawal. Clincial Pharmacology and Therapeutics. 47: 525-534.

Geraghty B, Graham EA, Logan B et al., (1997). Methadone levels in human breast milk. J Hum Lactation 13, pp. 227-230.

Gerstein DR, Harwood HJ, eds. (1990). Treating drug problems, vol I: a study of the evolution, effectiveness, and financing of public and private drug treatment systems. Washington: National Academy Press.

Gessa DR, and H. H. (Eds). (1990). Treating drug problems. Volume 1. A Study of the evolution, effectiveness and financing o public and private drug treatment systems. (Vol 1). National Academy Press. Wahington DC.

Giles W, Patterson T, Sanders F et al., (1989). Outpatient methadone programme for pregnant heroin using women. Aust N Z J Obstet Gynaecol 29, pp. 225-229.

Goldstein A and Herrera J. (1995). Heroin addicts and methadone treatment in Albuquerque: a 22-year follow-up. Drug Alcohol Depend 40, pp. 139⁻150.

Green L and Gossop M. (1988). Effects of information on the opiate withdrawal syndrome. Br J Addiction 83, pp. 305-309.

Grey CC, Osborn E, and Reznikoff M. (1986). Psychosocial factors in outcome in two opiate addiction treatments. Journal of Clinical Psychiatry. 42: 185-189.

Gunne L-M and Grönbladh L. (1981). The Swedish methadone maintenance program: a controlled study. Drug Alcohol Depend 7, pp. 249⁻256.

Hall W, Ward J, Mattick RP. (1998). Introduction. In: Ward J, Mattrick RP, Hall W, eds. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic, 1998: 1-14.

Hall W, Ward J, Mattick RP. (1998). The effectiveness of methadone maintenance treatment: heroin use and other crime. In: Ward J, Mattick RP, Hall W, eds. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic, 1998: 17⁻58.

Hall W. (1995). The demand for methadone maintenance treatment in Australia: technical report no 28. Sydney: National Drug and Alcohol Research Centre.

Havassy B and Hall S. (1981). Efficacy of urine monitoring in methadone maintenance. Am J Psychiatry 138, pp. 1497⁻1500.

Heather N, B. R, Saunders JB, and Wodak AD. (1989). The Effectiveness of Treatment for Dug and Alcohol Problems: An Overview. National Campaign Against Drug Abuse, Commonwealth Department of Community Services and Health, Canberra.

Hser Y, Anglin MD and Powers K. (1993). A 24-year follow-up of California narcotics addicts. Arch Gen Psychiatry 50, pp. 577⁻584.

Johnson RE, Eissenberg T, Stitzer ML, Strain EC, Leibson IA, and Bigelow GE. (1995). Buprenorphine treatment of opioid dependence: Clinical trial of daily versus alternateday dosing. Drug and Alcohol Dependence 40: 27-35.

Johnson RE, Chutuape MA, et al. (2000). A comparison of Levomethadyl Acetate, Buprenorphine and Methadone for Opioid Dependence. The New England Journal of Medicine. 343(18): 1290-1297.

Kirchmayer U, Davoli M, and Verster A. (2001). Naltrexone maintenance treatment for opioid dependence (Cochrane Review). In: The Cochrane Library., Oxford: Update software. (1).

Kosten TR, Schottenfeld R, Ziedonis D, and Falcioni J. (1993). Buprenorphine versus methadone maintenance for opioid dependence. Journal of Nervous and Mental Disease 181: 358-364.

Kraft MK, Rothbard AB, Hadley TR et al., (1997). Are supplementary services provided during methadone maintenance really cost-effective? Am J Psychiatry 154, pp. 1195⁻1197.

Lewis DC, Mayer J, Hersch RG, and Black R. (1978). Narcotic antagonist treatment: Clinical experience with naltrexone. International Journal of the Addictions. 13: 961-973.

Ling W, and Wesson DR. (1984). Naltrexone treatment for addicted health professionals: A collaborative practice experience. Journal of Clinical Psychiatry. 45: 46-48.

Ling W, Wesson DR, Charuvastra C et al., (1996). A controlled trial comparing maintenance in opioid dependence. Arch Gen Psychiatry 53, pp. 401⁻407.

Ling W, Wesson DR, Charuvastra C, and Klett CJ. (1996). A controlled trial comparing buprenorphine and methadone maintenance in opioid dependence. Archives of General Psychiatry 53: 401-407.

Lintzeris N, Clark N, Muhleisen P, Ritter A, Ali R, Bell J, Gowing L, Hawkin L, Henry Edwards S, Mattick RP, Monheit B, Newton I, Quigley A, Whicker S, and White J. (2001). National Clinical Guidelines and Procedures for the use of Buprenorphine in the Treatment of heroin Dependence. National Drug Strategy, Department of Health and Aged Care, Canberra.

Maddux JF and Desmond DP. (1992). Methadone maintenance and recovery from opioid dependence. Am Drug Alcohol Abuse 18, pp. 63⁻74.

Maddux JF, Desmond DP and Vogtsberger KN. (1995). Patient-regulated methadone dose and optional counseling in methadone maintenance. Am J Addict 4, pp. 18⁻32.

Marks J. (1987). Management of drug addicts: hostility, humanism, and pragmatism. Lancet i, pp. 1068-1069.

Mattick RP, Bell J, Daws LC, et al. (1998). Review of the evidence on the effectiveness of antagonists in managing opioid dependence. NDARC monograph 34. Sydney: National Drug and Alcohol Research Centre.

Mattick RP, Oliphant D, Ward J, et al. (1998). The effectiveness of other opioid replacement therapies: LAAM, heroin, buprenorphine naltrexone, and injectable maintenance. In: Ward J, Mattick RP, Hall W, eds. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic, pp: 123-57.

Mattick RP, Ward J, Hall W. (1998). The role of counselling and psychological therapy. In: Ward J, Mattick RP, Hall W, eds. Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic, pp. 265⁻304.

McAuliffe WE. (1990). A randomized controlled trial of recovery training and self-help for opioid addicts in New England and Hong Kong. J Psychoactive Drugs 22, pp. 197⁻209.

Metzger DS, Woody GE, McLellan AT et al., (1993). Human immunodeficiency virus seroconversion among intravenous drug users in and out of treatment: an 18-month prospective follow-up. J Acquir Immune Defic Syndr 6, pp. 1049⁻1055.

Milby JB, Gurwitch RH, Wiebe DJ et al., (1986). Prevalence and diagnostic reliability of methadone maintenance detoxification fear. Am J Psychiatry 143, pp. 739-743.

Milby JB. (1988). Methadone maintenance to abstinence: how many make it? J Nerv Ment Dis 176, pp. 409⁻422.

MIMS Australia. (2001). MIMS Annual, Twenty-fifth Edition. Vivendi Universal Publishing Company, Sydney.

Miotto K, McCann MJ, Rawson RA, Frosch D, and Ling W. (1997). Overdose, Suicide Attempts and Death Among a Cohort of Nlatrexone-Treated Opioid Addicts. Drug and Alcohol Dependence 45: 131-134.

Moss AR, Vranizan K, Gorter R et al., (1994). HIV seroconversion in intravenous drug users in San Francisco 1985⁻1990. AIDS 8, pp. 223⁻231.

National Drug Strategy. (1998). National Policy on Methadone Treatment. Publications and Design Section, Public Affairs, Parliamantary and Access Branch, Commonwealth Department of Health and Aged Care. Canberra.

NDARC NEPOD Project Staff. (2001). National Evaluation of Pharmacotherapies for Opioid Dependence. National Drug and Alcohol Research Centre. Sydney.

Neeleman J and Farrell M. (1997). Fatal methadone and heroin overdoses: time trends in England and Wales. J Epidemiol Community Health 51, pp. 435-437.

Osborn E, Grey C, and Reznikoff M. (1986). Psychosocial adjustment, modality choice, and outcome in naltrexone versus methadone treatment. American Journal of Drug and Alcohol Abuse. 12: 383-388.

Payte JT, Khuri ET. (1993). Principles of methadone dose determination. In: Parrino MW, ed. State methadone treatment guidelines. USA: US Department of Health and Human Services, 1993: 47⁻58.

Petitjean S, Stohler R, Deglon JJ, Livoti S, Waldvogel D, Uehlinger C, and Ladewig D. (2001). Double-blind randomised trial of buprenorphine and methadone in opiate dependence. Drug and Alcohol Dependence 62: 97-104.

Regier DA, Farmer ME, Rae DS et al., (1990). Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) study. JAMA 264, pp. 2511⁻2518.

Schoenbaum EE, Hartel D, Selwyn PA et al. (1989). Risk factors for human immunodeficiency virus infection in intravenous drug users. N Engl J Med 321, pp. 874⁻879.

Shearer, J., Sherman, J., Wodak, A. Van Beek, I. (2002). Substitution therapy for amphetamine users. Drug and Alcohol Review, 21, 179-185

Simpson DD and Sells SB. (1982). Effectiveness of treatment for drug abuse: an overview of the DARP research program. Adv Alcohol Subst Abuse 2, pp. 7-29.

Spunt B, Hunt DE, Lipton DS et al. (1986). Methadone diversion: a new look. Drug Issues 16, pp. 569-583.

Stitzer ML, Iguchi MY, Kidorf M, et al. (1993). Contingency management in methadone treatment: the case for positive incentives. In: Onken LS, Blaine JD, Boren JJ, eds. Behavioural treatments for drug abuse and dependence: NIDA research monograph 137. USA: National Institute on Drug Abuse, 1993: 19⁻35.

Strain EC, Stitzer ML, Liebson IA, and Bigelow GE. (1994). Comparison of buprenorphine and methadone in the treatment of opioid dependence. American Journal of Psychiatry 151: 1025-1030.

Task Force on DSM-IV. (2000). Diagnosite and Statistical Manual of Mental Disorders. Fourth Edition. American Psychiatric Association, Washington DC.

Tucker T, and Ritter A. (1997). Naltrexone: A literature review. in Ritter A, Kutin J, Lintzeris N, and Bammer G, eds. In: Expanding treatment options for heroin dependence in Victoria: buprenorphine, LAAM, naltrexone and slow release oral morphine. New Pharmacotherapies Project - Feasibility Report. Turning Point Alcohol and Drug Centre Inc., Fitzroy, Victoria.

Uchtenhagen A, Butzwiller F, Dobler-Mikola A et al., (1997). Programme for a medical prescription of narcotics: a synthesis of results. Eur Addict Res 3, pp. 160⁻163.

Uehlinger C, Deglon JJ, Livoti S, Petitjean S, Waldvogel D, and Ladewig D. (1998). Comparison of buprenorphine and methadone in the treatment of opioid dependence: Swiss multicentre trial. European Addiction Research 4: 13-18.

Ward J, Mattick R, and Hall W. (1992). Key issues in Methadone Maintenance Treatment. National Drug and Alcohol Research Centre, University of New South Wales Press Ltd., New South Wales.

Ward J, Mattick RP, Hall W, eds. (1998). Methadone maintenance treatment and other opioid replacement therapies. Amsterdam: Harwood Academic.

Washton AM, Pottash AC, and Gold MS. (1984). Naltrexone in addicted business executives and physicians. Journal of Clinical Psychiatry. 45: 4-6.

West SL, O'Neal KK, and Graham CW. (2000). A meta-analysis comparing the effectiveness of buprenorphine and methadone. Journal of substance abuse, 12: 405-414.

Williamson PA, Foreman KJ, White JM et al.(1997), Methadone-related overdose deaths in South Australia, 1984⁻1994. Med J Aust 166, pp. 302⁻305.

Woody GE, McLellan AT and Luborsky L, et al. (1984) Severity of psychiatric symptoms as a predictor of benefits from psychotherapy: the Veterans Administration-Penn study. Am J Psychiatry 141, pp. 1172⁻1177.

6. PRIORITY GROUPS

YOUNG PEOPLE

Overview

Young people for the purposes of this investigation have been identified as those between the ages of 12 and 24 years. It is important to recognise that between these ages young people are undergoing significant physical, social and emotional change as they move from social and economic dependence on family and the community to autonomy as adults. There can be a tendency to consider this age range as one group under the title of 'youth', however it is important to recognise that there is a great deal of diversity within it.

Drug use is not something that is specific to young people. Most people within the community will have used drugs of some sort and in this respect young people are no different. There are a variety of reasons why young people report using drugs and, in a drug taking society, it is not surprising that drugs are typically perceived as a response to needs and desires. A marked difference between young people and adults who use drugs is that young people generally exhibit less physical dependence, however they do often experience increased negative social consequences as a result of their use.

Young people often experiment with drug use, licit and illicit and for a small number, use is chaotic and at problematic levels. In general, young people have different patterns of drug use to adults, and often require specific prevention and treatment frameworks and service models designed around their specific needs and issues. The issues surrounding young people and drug use need to be considered within the context of family, peer group, school and community, and not in isolation from these factors.

Determining the patterns and prevalence of youth drug use is difficult and compounded by the illicit nature of use. In considering levels of use, it is equally important to differentiate between experimentation and trial of drugs, occasional use and problematic drug use. Information about levels of use are largely informed by data from drug treatment services and from agencies targeting at risk youth, both of whom are more likely to report severe and complex drug problems amongst young people.

There are differing views in the general community, as to what level and type of drug use by young people is acceptable. It is therefore useful to clearly distinguish typical patterns of drug use, which are identified with young people. These include:

- Experimental drug use in early adolescence it is common for individuals to begin to experiment with using various drugs. The Department of Human Services, Victoria (1998) has found evidence that such experimentation is beginning at earlier ages, particularly in relation to cannabis.
- Occasional or 'Recreational' use generally in the later years of secondary school, experimental drug use continues to become more 'recreational' in its use for relaxation and socialisation.

- *Binge use* involves episodic 'binges' of a variety of substances at hazardous and harmful levels, and is generally a feature of those in their older teenage years. This type of use can be, but is not necessarily, associated with developing dependency issues.
- Continuing use this involves regular use and continuing binge use, which can indicate that dependency is becoming part of the use pattern. Where this use is continued by young people into their twenties, it may become an entrenched part of life.

The risk of young people developing serious problems with drug use is more likely if other areas of their lives have been disrupted. Disordered family relationships, social disadvantage and early and prolonged periods of homelessness are predictive of serious problems with substance abuse as a young person and in later adult life (Spooner et al., 1996). The levels of drug use can clearly reflect the degree of marginalisation experienced by young people. At the same time, it is also the case that higher levels of drug use can also occur among secondary school students from families in the higher income brackets (Zubrick et al, 1997).

Polydrug use, particularly amphetamines, alcohol, ecstasy, inhalants and abuse of prescription drugs, is also a feature of problematic adolescent drug use (Spooner et al., 1996).

While surveys of school students and out of school youth suggest that drug use in young people has remained relatively constant over the last six years and that alcohol use has decreased, there is evidence of harmful and heavy illicit drug use by homeless and otherwise disadvantaged youth. Anecdotal evidence received through the Taskforce has provided evidence that there is an increase in the use of illicit drugs by young people.

A proportion of young people who present to SAAP (Supported Assistance Accommodation Program) and family support services are using substances harmfully, or are affected by other people's drug use (usually other family members or partners). Concerns about young people using illicit drugs have been documented by youth services in both Alice Springs and Darwin and the Supported Accommodation Assistance Program Territory Advisory Committee. Services report difficulty in responding appropriately to drug affected clients for a number of reasons, predominantly around funding/resource levels and skills to manage complex drug problems.

Although youth services are accessible and appropriate for young people under 18 who are experimenting or using illicit drugs and requesting support or information, resource levels need to reflect this. Youth agencies need to be resourced to be able to provide services for drug affected young people as often these young people are excluded by services that are "alcohol and drug free".

Programs designed for people with established drug use are inappropriate for young people early in the pathway to drug use. Specifically, adolescents in drug treatment programs are not just younger versions of adults in drug treatment. Some of the specific issues that need consideration are:

■ Intoxicated young people are at risk of respiratory depression, self harm, high-risk behaviour and may be aggressive and uncooperative. Crisis services are unable to provide care or supervision for an intoxicated young person as they have a duty of care for other clients and staff. Intoxicated clients may therefore be excluded from the services and slip through the system.

- Sobering up services are *not* appropriate for under 18s. Young people intoxicated in public may be returned to the care of family by police or taken into police custody for their own protection. Currently, this does not allow for professional intervention or referral to an appropriate professional service.
- Prevention and early intervention activities need to identify young people at risk of drug use and those beginning to experiment with drugs, with an aim to divert these young people from progressing to harmful drug use. Professional youth and family friendly services need to work within the harm minimisation principle underpinning Australia's Drug Strategy since 1985.
- The extent to which genetic, environmental, cultural and learned behaviours interact to determine substance misuse is the subject of considerable research (Spooner et al., 2001). Drug misuse is usually only one of a number of issues to be addressed with young people and may be a result of or contribute to family conflict, financial problems, difficulties at school including early school leaving, work disruption or contact with the criminal justice system.

Indigenous Young People

Keys Young (1998) in their report on Homelessness in the Aboriginal and Torres Strait Islander context found that the particular affiliation of Indigenous people to their land and 'country' is imbued with a religious, spiritual, physical and cultural significance that is unique to Indigenous Australians. Similarly, the ties to the family are particularly marked in Indigenous communities. Kinship networks comprise a complex web of mutual rights, obligations and responsibilities and constitute a central organisational plank of traditional Indigenous society. Despite the overwhelming pressures on Aboriginal and Torres Strait Islander families over the last 200 years, this sense of kinship and mutual support is still very important today.

Financial pressures, substance misuse, family breakdown, severe overcrowding due to 'hidden homelessness' are all taking their toll on Indigenous people and their families.

A large proportion of Indigenous young people and their families do not access mainstream health and welfare agencies. Indigenous young people have stated that there are issues of confidentiality for them accessing Indigenous specific services because family members are employed by such services. In mainstream services, processes, assessments and boundaries in these agencies are often intimidating and culturally insensitive. Due to the importance of family and kinship structures in the Indigenous context and the severe strains under which these are placed, agencies and schools need to take a holistic approach to working with young Indigenous clients to identify appropriate family members, who can provide the necessary care and support.

Workers working with Indigenous drug users quite often confuse poverty with poor parenting or neglect. Families where there is a drug using member more often find they have limited ways or means of approaching the problem when day to day survival takes precedence. Appropriate assistance can include income supplement, food, legal and other forms of assistance, though not necessarily assistance focussed on the drug user. Providing other 'basic needs' and support is a way of strengthening the pathway to assisting the young drug user and his or her family.

Youth Treatment

In terms of youth treatment services a number of approaches have been identified as more successful (Howard, 1998). These are generally more effective than general counselling, particularly if they include addressing school, work and family issues as well as family and/or significant others. The objective for treatment services should not just be on abstinence or the focus on substance misuse. Rather it is generally agreed that the focus should be working with young people to develop coping skills and support networks to engage them in education and training, and to 'reintegrate' them back into the family and community. The majority of young people will not require specialist treatment, benefiting instead from brief case management (one to six sessions) that is often appropriately provided as part of comprehensive general health or social care rather than specialist alcohol and other drug services (NSW, 2000).

Improving access to youth treatment does not require the development of specialist youth services and adult services are not appropriate for this age group (Spooner et al. 1996). Youth services and program staff members who have already developed rapport could provide or source drug intervention as part of their case planning. Godley et al (1994) propose the use of a case management approach to adolescents with substance misuse problems and emphasise the importance of ensuring that aftercare strategies are in place. Case management is not dependant on specialist youth drug agencies and allows for including family and the necessary support structures, tracking relapses, connecting youth with school, work and community resources and helping young people to fulfil legal obligations.

Service development and the enhancement of current youth and family services that offer innovation and flexibility in their delivery to young people who use illicit drugs or are affected by a drug using family member should be viewed as a priority area. Anecdotal evidence received through community consultations and submissions shows that there is an increase in demand on existing youth services to provide assistance to under 18 illicit drug users.

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'.

Outreach workers are seen to be accessible and able to identify young people with a range of problems. They play an important referral and linkage role for young people and are involved in prevention and early intervention activities as well as being there when young people are experiencing problems.

Current Situation

On the basis of its investigations the Taskforce is concerned about the current capacity of services to respond to young people with drug problems. Service gaps have been identified in the specialist and generic sectors. Further information will be obtained through the implementation of Recommendation 4.2.

The Taskforce received a great deal of information about the lack of options for 'detox', meaning a safe place for respite for youth. There are also few other services able to deal with young people whose health and wellbeing are seriously affected by drug misuse. It was found that there are gaps in the network of services able to support young people, particularly those with serious drug misuse and related problems. Some of the gaps and issues identified are:

- Services to prevent drug-related harm and to reduce known contributors to harmful drug use receive the least funding and are the first programs to be cut. Social institutions, particularly schools, and economic policies may marginalise young people and contribute to a sense of alienation from the community.
- Most professionals working with young people have limited training in responding to drug related harm. When services are able to respond they have limited resources to be able to do so. Workers in the alcohol and other drug sector and Family and Children's services, particularly, have limited training in engaging and working with young people or families with a drug-using member.
- Alcohol and other drug services are rarely accessed by under 18s because they are stigmatising, and have rigorous compliance regimes and because young people themselves may not identify themself as needing treatment. Community facilities with already stretched resources are attempting to provide adequate care to drug affected young people presenting, with little demonstrated effectiveness.
- Young people may have to move from service to service in order to have a range of personal and social issues addressed, such as housing, health, financial, family breakdown, school, and in this process give up and exit the system.
- Many services exclude or are under resourced to work with family or significant others. Currently many services exclude family and kinship ties and are less inclined to acknowledge the impact of the day to day living situation on these families. Holistic care is an important way of supporting, caring and motivating young people for change.
- Boredom and disconnection from the educational system were identified as risk factors throughout community consultations. Alternative education programs such as Alice Outcomes and activity programs like Bushmob in Alice Springs have been developed and specifically engage young people who are identified at risk.
- There is a lack of coordination between service delivery points, and protocols and referral procedures are needed.

Community Views

A number of youth services and organisations made representations to the Taskforce at both the consultations and through submissions. In addition, a specific youth consultation session was conducted in Alice Springs. Of note was that a significant proportion of young people under 24 years were represented in the user group consultations in Alice Springs, Darwin and Palmerston.

There was a clear message to the Taskforce from a number of sectors of the community, as well as service providers, of concern about increasing illicit drug use among young people. The drugs of highest concern were cannabis, alcohol, inhalants, prescription drugs and amphetamines.

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

Clear and specific service gaps were identified in terms of youth specific services throughout the Territory. In Alice Springs and Darwin there was definite agreement about the need for respite and safe places for youth affected by drugs to access. Another proposal on which there was much agreement in Darwin and Palmerston, and some overlap of ideas in Katherine, was the need for a multi purpose drop in centre where young people can access information.

"... a safe place that is drug free where the child can become lucid again, start eating again. They need somewhere where they can get 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 is."

Outreach workers for youth were a major focus, to have a focus on both prevention and treatment needs. Rehabilitation services for youth were also identified as a gap, but there was less clarity about how this need should be met.

"... a lot of young people don't like coming in to formal counselling and there's no capacity to go out and do outreach work in my role Having the ability or the capacity for a worker to become more involved with young people's programs..."

The need for alternate activities, particularly in the evenings, for youth was also voiced in a number of locations, and had particular emphasis in remote communities.

"In a remote community environment, one of the major issues is boredom, and peer pressure which stems from boredom. So the kids in particular have got nothing to do when school is over for the day, ... There's no organised activities for the kids, or if there are, it's dependent on a non Aboriginal person who'll run it till 5 oclock, or 6 o'clock when they knock off for the day. And then the rest of the evening it's just left to the kids to amuse themselves."

Conclusions

The current capacity of youth specific and generic services to deal with alcohol and drug issues was identified as lacking throughout the Territory. Youth services acknowledge that treatment and support are processes and therefore there needs to be a continuity of care as well as support staff available for intervention 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 adequately provide 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 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 as 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 risk factors overwhelming mentioned throughout community consultations. Alternative education and activity programs that specifically engage young people who are identified 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

Overview

All family members including parents, siblings, grandparents, and children are potentially affected by the taking of illicit drugs by another family member. The needs of all of these people 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 misusing parents.

When any one person in a family has problems associated with illicit drug use, this use can affect everyone in the family. Family members may become caught up in the issues, have trust violated or become enmeshed in a web of guilt and fear. Roles in the family may change, such that children can become the caretakers of drug using parents; partners can take on a parental type role with their spouses; parents of adult children can find themselves in relationships in which their adult children do not develop or 'grow up'; grandparents become the parental figures in their grandchildren's lives (Duncan, 1998; Department of Human Services Victoria, 2000).

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 extended family members.

Not all drug use is a serious problem. It has been estimated that 90% of drug takers do not become problematic users (Family Drug Support, 1998). However, any amount of drug use can have a profound impact upon families. This can vary from general fear and anxiety that someone may be using an illicit drug such as cannabis, to shock at the discovery of injecting drug use to the horror associated with the death of a family member from a drug overdose. The fear which families experience is not unrealistic; the impact of drug dependence can be debilitating and traumatic (WA Community Drug Summit, 2001).

Although drug dependent parents are not necessarily incompetent, there is strong evidence that alcohol and drug misuse can significantly increase the potential for negative family processes which are harmful to children in the short and long term (Barnard, 1999).

Families who are affected by the use of illicit drugs are often adversely affected by the negative view of drug use often portrayed by the media and perpetuated in the wider community. These negative attitudes not only stigmatise the users but also the families of the users. The combined effects of having to live with someone who has issues related to their illicit drug use and the negative community attitude to drug users, often result in families generally feeling overwhelmed and isolated.

Families of users often believe they suffer the brunt of the drug misuse and difficulties that arise from a family member's drug consumption, and are often the ones holding things together. They suffer significant physical, psychological and social stresses that often result in higher physical and psychological morbidity (Orford et al, 1998; Velleman, 1996). These findings have also been identified amongst Aboriginal people in the Northern Territory. Research findings also point to the fact that family members have higher rates of primary care consultations and that, despite receiving treatment for their physical or psychological symptoms, the cause often remains undetected or unexplored (Copello et al., 2000).

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. Anecdotal reports provided by DH&CS Family and Children's Services field staff indicate that substance misuse, predominantly alcohol, is an issue in approximately 70% of child protection cases. This is reported to be an increase on the level reported 10 years ago.

Family approaches

Generally, workers in the alcohol and drug field focus on addressing drug misuse problems through the users - getting them to change their behaviour or providing environments in which harm is minimised. Support for families is limited and is provided at the specialist end of the drug treatment continuum. This leaves a gap in services for family members, particularly at the primary health care level where contact with family members is greatest.

General practitioners are often the first point of contact for families and users, but they are often too busy to deal with them in an appropriate manner. In the event a family member does receive treatment for drug use, immediate and extended family are usually not included in the recovery process. Client confidentiality is often cited as the reason for this exclusion by treating professionals. Client confidentiality was raised during the Taskforce consultations as an issue that can be frustrating for both families and service providers.

There is a need, therefore, to enable practitioners within primary care settings to improve their skills of detection and intervention with relatives of people who misuse substances in order to enable them to respond more effectively. Not only would this reduce the burden on both the relatives and the health care system, but it may also impact on the drug user. Evidence exists to support the fact that working with relatives can act as an indirect intervention with a drug user both in terms of engaging the user into treatment (Barber and Crisp, 1995; Meyers et al, 1996) and in improving outcomes (Copello et al 2000).

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 the drug user to access treatment and sustain their involvement, as well as supporting them beyond the treatment episode.

The experience of families is that they have to 'shop around' (Department of Human Services, Victoria, 2000). In Victoria, some of the problems families identified with services included:

- The greatest fear among most parents is that their child will ultimately become an intravenous drug user. Merely dismissing anxiety about cannabis because it is not heroin, does not allay their fears;
- Unhelpful initial contact can be a barrier to drug users and their families in pursuing further help;
- In a crisis families need immediate and tangible help;

- Fragmentation of services, exacerbated by poor interagency coordination impedes access to help;
- Families get caught between agencies with differing philosophical approaches and subsequent competition for funds;
- Waiting lists remain very long even though families are led to believe that there is room for all;
- There are too few residential programs;
- Home withdrawal is an important option for families, but lack the necessary long-term support structures. Sometimes also families just want time out or respite; and
- A common complaint from families interviewed is that talk does not convert to tangible assistance.

The Taskforce heard these same issues raised repeatedly during the consultations held for both service providers and the general public.

Role of the Family

The role of the family in the origins of drug use is far from simple. A recent National Health Medical Research Council (NHMRC) review indicated that:

- 1. Drug use behaviours are not caused by any single factor. However, the family is the single most important risk or protective factor for drug misuse.
- 2. The risk and protective factors relating to drug misuse relate to a range of other problem behaviours, such as delinquency.
- 3. Influences on drug use begin very early in life and are cumulative.
- 4. Family influences are not equally significant.
- 5. Parents are not the only significant family members (Mitchell et al., 2001).

Family functioning, parental management and role modelling are strong predictors of drug use and possible escalation to harmful use. Families that use alcohol and other drugs in a way that is uncontrolled and antisocial are unlikely to contribute to responsible attitudes and behaviours in relation to alcohol and other drug in their children. (Norman, 1997). Equally, strong parental attachment, effective parenting skills and positive role modelling have consistently been identified as protective factors against drug misuse (Spooner et al, 1996). Roche (1999) argues that a strong relationship with a caring, capable adult (usually a parent) is the single most important protective influence on normal psychosocial development. This argument supports a focus on parents but also suggests that mentoring and extended family involvement should be fostered where parental involvement is not possible.

The effect of family factors on drug use is greatest early in life prior to initiation or at the experimental stage. Once drug use is initiated, peers become a more dominant influence (Mitchell et al., 2001), suggesting that parenting strategies aimed at preventing use and minimising use need to be available in late childhood prior to uptake or in very early adolescents when most young people are likely to be experimenting with both licit drugs and illicit drugs.

Indigenous young people in remote communities were more influenced by family attitudes and modelling (to alcohol use) than peer influence, a finding that is contrary to findings for non-Indigenous adolescents (Jesson, 1999). Programs that support family and cultural obligations to children in the community may be effective as a prevention strategy.

In addition to support for parents specific to drug misuse, strategies need to be in place to promote parenting skills and family connectedness through family support services from infancy through childhood and adolescence (National Crime Prevention, 1999). Children and youth who are emotionally connected to their families, schools and community are less likely than other students to suffer emotional distress, have suicidal thoughts and behaviours, be violent, drunk, smoke cigarettes or use cannabis (Roche 1999). Interventions focusing on creating supportive family and school environments have been shown to be effective. Social connectedness has a major impact on the health and wellbeing of young people (Resnick et al, 1997)

Community Views

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.

There was widespread agreement that more emphasis should be placed on actively supporting families as an important prevention strategy. Families were recognised as a 'prime site of social learning' and having the potential to be either a positive or negative influence with regard to the uptake of drugs and harmful use of drugs.

"Role modelling is the greatest dictator of a person's adult behaviour. And so you do need to look at educating the kids, but if the adults are using drugs, alcohol, whatever, there's the greatest chance that with those kids they're going to grow up to mimic their parents. So you've got take that holistic approach or we're going to get nowhere."

"More active support for families in their educative role about drugs included the availability of factual information and skills development for talking to their children about drugs. Schools could be an important source of drug information for parents and could provide forums for parent discussion groups about drugs, their effects and strategies for dealing with drug issues with children and youth."

"Families feel so powerless because they don't have the information or education. We need to get the information to families, don't just put it on TV. Families don't get the skills from that, they don't know what to do."

There was also a strong view that families who are struggling for any reason need active support to minimise the potential negative impact on children. For example, Family Support Services could play a responsive, holistic, early intervention role with families in need.

"We need workers to go out to the people, not wait for people to come in to a centre somewhere. ... Family Support Services would take a preventive approach. Community services would identify certain families where it would be good to find someone to work with the family at that time, provide counselling, educative life skills relevant to the situation. A lot of people don't have the skills to deal with their lives."

A common theme was that the importance of families is often unrecognised and families often do not know where to get information, and are generally unaware of what is available to them. It was felt that families needed to be supported as a means of promoting prevention and to enable them to educate themselves and other family members regarding drug use.

Comments from both users and family members at the consultations highlight this. A user commented:

"My mother needed someone to take her aside and tell her that it wouldn't be like that for ever. People get through it. To cope, parents go into denial. ... When their kids start using parents feel like a failure."

One parent described the difficulty of finding support, reporting that it took two years until they were able to access counselling support for themselves.

"I actually did feel like we were the intruders. I wanted to be told by his caseworker, if there were things that we could be doing, and that would help for us too... We asked a few times for help, but the big problem that was brought back to us was confidentiality for our son. ... I actually felt that we needed treatment as well as our son."

"... very difficult to know which service to approach. I actually felt that we were being pushed from pillar to post, and in fact it was like we didn't really have any rights in what we were trying to do to support our child."

Other similar cases were reported, where family members tried to access their relative's service provider but were turned away because of confidentiality issues. There was a general call for more support for families of users.

Service providers in several locations discussed how they were trying to involve families more in service delivery. It was emphasised however that this often required specialist skills and was an aspect of service delivery that is not currently recognised in funding agreements.

"Most agencies do try to respond to families, but it hasn't been a policy of funding bodies before, it's a new initiative. We need to have more understanding of that, and need to have people trained in that area. Its difficult to know sometimes how you're going to see 7 or 8 family members together, we need some more skills in that area."

"Even if the parents only think their child is using drugs at 10,11,12, they are really quite concerned. And our aim is to maintain some relationship between the parent and the child, whatever threads there are with the parents, to build on that. That's what we would do, whether the child is using or not".

Current Situation

There are two agencies who have an explicit family focus and they are: Alcohol Awareness and Family Recovery in Darwin and Holyoake in Alice Springs. Both of these agencies provide a range of services for families with specific programs for parents, partners, siblings and children of drug users.

There is a diverse range of parent education courses and activities available in the Territory. The private program *How to Drug Proof Your Kids* is occurring in some regions. In addition the AODP, DH&CS, has produced as well as distributed, a range of local and National educational pamphlets, booklets and other material for parents.

In 1995 the Living With Alcohol (LWA) program and world-renowned experts, Professors Jim Orford and Richard Velleman undertook a collaborative *Family Coping* interview study in the Northern Territory. The project ultimately aims to equip workers, including 'frontline' and primary health workers, with the knowledge, skills and resources that are needed to effectively intervene with family members affected by the excessive drinking of other close relations. Similar research, already commenced in the United Kingdom and Mexico, had originally been seeded by the World Health Organisation. This project is currently being implemented in the Territory with a focus upon Indigenous communities.

It is recommended:

6.5 That support networks for parents and families be established.

These networks are particularly important in terms of the family's role in supporting a 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 highly 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 centre to assist families, in particular, with an initial contact point, assessment, support, counselling, advocacy, referral and information.

It is proposed that the pilot project be conducted in two sites, Alice Springs and Palmerston, 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 assess 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 (Success Works).

Therefore, it is recommended:

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

Of specific focus would be the issues around:

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

INDIGENOUS

As among members of the wider community, the increasing use of illicit drugs is of concern to Indigenous Territorians. Overall the use of illicit drugs, outside of the major urban centres is relatively small. The exception to this is the alarmingly rapid increase in cannabis use reported in remote and rural communities. The use of illicit drugs must be seen and addressed in the context of other drug use, most notably alcohol, tobacco, kava, petrol and other inhalants, and the common issues that underlie all drug use. Currently the use of licit substances such as alcohol, tobacco, petrol and other inhalants cause considerably more harm in the indigenous population than does the use of illicit drugs. However, the issues surrounding the rapid uptake of cannabis and the consequential impact upon communities, in a relatively short period of time, provide a timely reminder of the potential for an equally rapid uptake of other illicit substances and their potential harmful impacts. Focus needs to be strongly on strategies designed to prevent future harms. These include the range of supply, demand and harm reduction strategies.

One of the predominant difficulties for the Taskforce in trying to understand the current impact of illicit drug use on Indigenous Territorians is the limited statistical information available currently on its extent and associated impacts and harms.

Indigenous people living in the Northern Territory are a diverse group, particularly in regard to cultural practices. They live in a range of urban settings and remote communities, and move between the two, increasingly putting them in contact with people who may use and/or supply illicit drugs. Patterns of drug use in the Indigenous community are varied and there is concern about the widespread use of cannabis within the Indigenous community becoming normalised practice. It was noted that the use of amphetamines is still relatively rare in the regional areas but is apparent in some areas. Some have suggested that this use is related to the proximity of activities such as tourism and mining.

As with alcohol misuse, the impact of illicit drug use on Indigenous families is a source of multiple problems ranging from violence to mental illness. Of concern is the reported occurrence of inadequate child care by parents with substance misuse problems, and the extended roles being undertaken by grandparents and other family members.

The Taskforce was presented with evidence of increasing illicit drug use among Indigenous Territorians, with polydrug use being common, most particularly alcohol, cannabis, tobacco, petrol and other inhalants. This raises a range of issues including:

- The need to address the underlying causes of harmful substance use, such as housing, employment and mental well being, and for existing services both within and outside of the drug and alcohol field to respond to those causes.
- There are few treatment programs currently that target illicit drug use for Indigenous clients. Given the small numbers at present this is justified however there is a need to upskill the current services and programs, who work with Indigenous people, which have historically been alcohol abstinent-based, to cope with possible future demand.
- There are few illicit drug prevention programs specifically targeted for Indigenous people. In conjunction, there are limited opportunities for Indigenous youth to engage in alternative recreational and vocational activities.

- The reported high levels of non-attendance at school within the Indigenous population, particularly in remote communities, means that currently schools are probably not an effective site for drug education efforts.
- Given the high numbers of Indigenous people in detention, particularly men, harm minimisation strategies and treatment options need to be available to prisoners in a culturally appropriate manner.
- The families of people who use drugs are often subject to a range of harms, and few services currently exist that support Indigenous families affected by drug use.

Given the potential for illicit drug use to add to the burden of harm experienced by Indigenous people, the Taskforce recommends:

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

REFERENCES

Barber, J. & Chrisp, B. (1995). The 'Pressures to Change' Approach to working with the Partners of Heavy Drinkers. Addiction, 90, 268-276.

Barnard, M. (1999). Forbidden Questions: Drug-dependent Parents and the Welfare of their Children. Addictions, 94 (8), pp. 1109.

Copello, A., Orford, J., Velleman, R. Templeton, L., and Krishnan, M. (2000). Methods for reducing alcohol and drug related family harm in non-specialist settings. Journal of Mental Health 9, 329-343

Department of Human Services, Victoria. (1998). Young People and Drug Needs Analysis. Drug Treatment Services Unit, Department of Human Services: Melbourne.

Department of Human Services, Victoria. (2000). Involving Families in Alcohol and Drug Treatment [online]. Available http://www.dhs.vic.gov.au/phd/0006057.

Duncan, D. (1998). Prevention issues: Some Cautionary notes. In R. Hampton, V. Senatore, & T. Gullotta (eds.). Substance Abuse, family Violence & Child Welfare: Bridging Perspectives. Thousand Oaks, Ca: Sage Publications.

Family Drug Support (1998) Family Drug Support: A Guide to Coping. A Tribes Project by the NSW Users and AIDS Association Inc and members of Family Drug Support Tribe. NSW Department of Health: Sydney.

Godley, S.H, Godley, M.D, Pratt, A. & Wallace, J.L. (1994). Case Management Services for Adolescent Substance Abusers: A Program Description. Journal of Substance Abuse Treatment, Vol 11, No. 4, pp309-317.

Howard, J. (1998). Keynote presentation. First International Conference on Drugs and Young People. Melbourne, November 22-24.

Jesson, J. (1999). Underage Drinking amongst Indigenous Youth in the Northern Territory: Summary Paper. Living With Alcohol Program. Territory Health Services.

Keys Young (1998). Homelessness in the Aboriginal and Torres Strait Islander context and its possible implications for the Supported Accommodation Assistance Program (SAAP) prepared by Keys Young for Commonwealth Dept. of Health and Aged Care, Canberra.

Meyers, R., Dominguez, T. & Smith, J. (1996). Community Reinforcement Training with Concerned Others. In Van Hasselt VB & Hersen M (Ed) Sourcebook of Psychological treatment Manuals for Adult Disorders. New York: Plenum Press.

Mitchell P, Spooner C, Copeland J, Vimpani G, Toumbourou J, Howard J and Sanson A. The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems. NHMRC, 2001.

National Crime Prevention (1999). Pathways to Prevention: Developmental and early intervention approaches to crime in Australia. Canberra: Attorney General's Department.

Norman, E. et al. (1997). Prevention programs reviewed: What works? In Drug Free Youth: A compendium for prevention specialists. E Norman (ed.). New York: Garland Publishing.

NSW Health Department (2000). The NSW Drug Treatment Services Plan. NSW Health Department.

Orford J., Natera G., Davies, J., Nava, A., Mora J., Rigby, K., Bowie, N., Copello A. & Velleman R. (1998). Tolerate, Engage or Withdraw: A Study of the Structure of Families Coping with Alcohol and Drug Problems in South West England and Mexico City. Addiction, 93:12, 1799-1813.

Resnick, M., Bearman, P., Blum, R., Bauman, K., et al. (1997). Protecting adolescents from harm: findings from the national Longitudinal Study on Adolescent Health. Journal of the American Medical Association, Vol. 278, No. 10.

Roche, A. (1999). The story of research. What others can teach us. What's Working in Drug and Alcohol Interventions for Youth. In Queensland Drug Summit. Focus on Youth. Queensland Health, Brisbane 16-17 March, 1999.

Spooner C. J., Hall, W., and Lynskey, M. (2001). Structural Determinants of Youth Drug Use. ANCD Research Paper (2). Sydney: National Drug and Alcohol Research Centre.

Spooner C. J., R. Mattick and J. Howard (1996). The Nature and Treatment of Adolescent Substance Abuse (NDARC Monograph no. 26). Sydney. National Drug and Alcohol Research Centre.

Velleman, R. (1996). Alcohol and Drug Problems: An Overview of the Impact on Children and the Implications for Practice. In, Gopfert M, Webster J. and Seeman M. (Eds). Seriously Disturbed and Mentally Ill Parents and their Children. University Press: Cambridge, 233-243.

WA Community Drug Summit (2001). Community Drug Summit Report 13 - 17 August 2001. Community Drug Summit Office: Perth. [online] Available http://www.drugsummit.health.wa.gov.au

Zubrick, S.R., Silburn, S.R., Gurrin, L., Theo, H., Shepherd, C., Carlton, J., & Lawrence, D. (1997). Western Australian Child Health Survey: Education, Health and Competence 1997. Perth: Australian Bureau of Statistics and the TVW Telethon Institute for Child Health Research.

Appendix A CONSULTATIONS WITH THE GENERAL PUBLIC, SERVICE PROVIDERS, & DRUG USERS

BY DR ANTHEA DUQUEMIN

INDEX

Introduction and key points

- 1.1 Introduction
- 1.2 Process for the consultations
- 1.3 Format of the following pages
- 1.4 Summary of some key themes that emerged from the consultations

Reported trends in drug use and associated concerns

Summary Of Section 2

- 2.1 Trends in use of individual drugs and identified concerns
 - 2.1.1 Cannabis
 - 2.1.2 Amphetamines
 - 2.1.3 Prescription drugs
 - 2.1.4 Opiates
 - 2.1.5 Other drugs
- 2.2 General observations about drug trends and data collection
- 2.3 Perceived reasons for drug use
 - 2.3.1 Boredom
 - 2.3.2 Involvement, being part of a group
 - 2.3.3 Dealing with crisis and/or despair
 - 2.3.4 Role modelling: impact of the family
 - 2.3.5 Lack of information

Approaches to prevention

Summary Of Section 3

- 3.1 Prevention through schools
 - 3.1.1 Content of drug information and education
 - 3.1.2 Who should provide school based drug education
 - 3.1.3 The broader school environment
- 3.2 Prevention through families
 - 3.2.1 Support to help the family play an educative role
 - 3.2.2 Support to minimise the potential negative impact of family circumstances
- 3.3 Prevention through social and structural change
 - 3.3.1 Prevention through social change
 - 3.3.2 Prevention through structural change

Services for those using drugs and their families, and proposals for improvement

Summary Of Section 4

- 4.1 Town based services for young people who use drugs
 - 4.1.1 Detoxification for users under 18
 - 4.1.2 Crisis accommodation for young people
 - 4.1.3 Rehabilitation services and support for users under 18
 - 4.1.4 Outreach services for youth
 - 4.1.5 Multi purpose drop in centres to provide access to information
- 4.2 Town based services for adult drug users
 - 4.2.1 Greater emphasis on outreach services
 - 4.2.2 Better access to information about what is available
 - 4.2.3 Holistic approach to service delivery
 - 4.2.4 Family based service delivery
 - 4.2.5 Better support for those who may be experiencing drug induced psychosis
 - 4.2.6 Ongoing support and after care
 - 4.2.7 Non judgemental attitudes to clients
 - 4.2.8 Detoxification in Alice Springs and Darwin
 - 4.2.9 Residential rehabilitation service in Alice Springs (and Darwin)
 - 4.2.10 Needle and syringe programs in Palmerston (and Darwin and Alice Springs)
 - 4.2.10 Crisis accommodation for men in Alice Springs and Tennant Creek
 - 4.2.11 Pharmacotherapies
- 4.3 Services for remote communities
- 4.4 Services for families of drug users
 - 4.4.1 Supporting families to help drug using family members
 - 4.4.2 Support for family members themselves
- 4.5 Criminal justice service gaps
- 4.6 Proposed changes to support improved service provision
 - 4.6.1 Training for alcohol and other drug service providers
 - 4.6.2 Formal support for collaboration between service providers
 - 4.6.3 Training and involvement of other service providers
 - 4.6.4 Support with development and implementation of organisational policies
 - 4.6.5 Enhanced collaboration with Government
 - 4.6.6 Integrated strategies
 - 4.6.7 Funding arrangements

INTRODUCTION AND SOME KEY POINTS

1.1 Introduction

An important role of the Illicit Drugs Taskforce was to hear public views about trends in use of illicit drugs, current approaches to prevention and support, and ideas about what is needed. Members of the Taskforce travelled to each of the five main regions of the Northern Territory to consult with the public and with service providers. The pages that follow summarise the main views that were expressed. It should be noted that in some cases observations or perceptions expressed at the consultations diverge from factual evidence or research findings, but they are reported here as an account of public perceptions.

Members of the Taskforce would like to thank all who attended consultations for their time and valuable comments.

1.2 Process for the consultations

Public hearings with the taskforce were held in Alice Springs, Tennant Creek, Katherine, Nhulunbuy, Darwin and Palmerston, during March and April 2002. The public meetings were held during the early evening in well-known local venues, and were advertised in the local newspaper and promoted through local radio. Additional meetings were held in each location with service providers, and in Alice Springs, Darwin and Palmerston with users of illicit drugs, and in Alice Springs with a youth group. In each location views were expressed about issues and services for remote areas in the region, as well as for the town itself.

Each meeting was attended by the Chair of the Taskforce and between two to four Taskforce members. Comments were recorded by a note taker, and all were audio taped, with permission from those present, with the exception of the youth and user groups for which only notes were taken.

Overall, 67 people attended hearings for the general public, 105 attended meetings for service providers, 19 people came to drug user meetings and 12 attended the youth meeting.

1.3 Format of the following pages

Although the views expressed reflect the diversity of the different regions of the Northern Territory, strong common themes and messages emerged. The main views and comments are reported in the following pages under three main headings:

- Reported trends in drug use and associated concerns
- Approaches to prevention
- Services for those using drugs and their families and proposals for improvement.

Common themes are reported with indications of regional differences where these occurred. Region-specific observations are referred to by the town in which the consultation was held (eg Tennant Creek, Nhulunbuy) though the observation often relates to the region itself (ie Barkly, East Arnhem).

A summary of the key points relating to each heading (trends in drug use, prevention, service provision) precedes each of the three sections of the report. The body of the report incorporates individual comments from those who attended the consultations, providing valuable insight into the ideas, concerns and experiences of those who live and work with illicit drugs or their consequences.

1.4 Summary of some key themes that emerged from the consultations

- In keeping with the terms of reference this report records the views expressed about illicit drugs, but in every location alcohol, inhalants and/or kava remain by far the most widely used drugs and, alongside cannabis, those that cause the greatest concern.
- There is very limited established use of illicit drugs other than cannabis outside the towns of Alice Springs, Darwin and Palmerston. In these towns availability and use of a broad range of illicit drugs is reported.
- In other areas the "huge" escalation in use of cannabis has raised considerable alarm amongst service providers and people in remote communities. Cannabis, often in conjunction with other drugs, is said to lead to mental disturbance, often associated with suicide or violence. This is reported chiefly in remote communities but also for youth in towns.
- Increased use of amphetamines and to a lesser extent benzodiazepines, was reported in all areas during the past two years, and this provokes anxiety about increased rates of injecting. Mixing of drugs, licit and illicit, is seen as a new and threatening trend that service providers feel ill equipped to address.
- In response to the perceived trend for more and younger use of drugs, a common response is to propose earlier and 'better' education to prevent drug abuse. But there is no clear agreement about what constitutes effective drug education: many favour early provision of factual information about drugs but others acknowledge research evidence that early provision of information is associated with increased use. The effectiveness of school based drug education is further limited by uncertainty about who should teach the message, the impact of the environment in which it is taught, and high rates of absenteeism.
- There is general agreement that resilience skills (building on strengths, self-esteem, coping skills) should be taught in schools as early as possible. Resilience and self esteem are recognised for their preventive value: they are also the central qualities that drug users said were frequently undermined when they enter treatment services. The significance of nurturing self-esteem and a sense of value is relevant to all levels of service provision.
- Another issue common to all levels of service provision is the question of who should provide drug information, education or advice. At all levels a common theme is the need for respect for and credibility of the person giving information. Peer educators may be a valuable component in a service for this reason, and for Indigenous clients, cultural values will determine who is the appropriately respected person.
- Quite apart from the content of messages and who provides them, the broader message provided by the environment in which they are presented has ongoing, and sometimes unintended impact. Many organisations could benefit from help to develop policies that promote a preventive approach to drug use and a supportive environment in which to access help.

- 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 and influential route to reach and assist the user. Agencies identify the need to reach families or individuals where they are (yet avoid overlap with other services).
- The need for holistic approaches to service delivery was emphasised many times. Alcohol and drug use should not be separated out from other aspects of a person's life. To achieve this, different approaches to funding and service provision must be explored. At the least, it would involve effective communication between agencies, and more effective communication about available services to the general public. Multi purpose centres where people can access information were proposed.
- Improved service planning could be achieved through regular meetings between service providers and Government, and through more involvement of users in service planning. Users have clear ideas about how services can be improved.
- The value and efficiency of a strategic integrated approach to drug use was raised in many contexts and at every level: between organisations, between sectors and between levels of government. There was much emphasis on the need for collaborative planning and funding that supports strategic approaches and avoids overlap.
- The importance of acknowledging and building on existing strengths was emphasised in communities, in towns and across sectors. In remote areas, information and support is needed to identify ways in which needs can best be met in an integrated way that builds on community initiatives. In towns, agencies need formal support to identify and work with each other. Training is also needed.
- More work is needed to identify funding arrangements that recognise and support the special requirements for working with remote Aboriginal communities.

REPORTED TRENDS IN DRUG USE AND ASSOCIATED CONCERNS

Summary of perceived trends in drug use and associated problems

Overview of drugs used

In each location the first and most frequently raised issue was the increase in use of cannabis over the past four to five years. Concern was expressed about widespread use in towns and remote areas, amongst most age groups and by Aboriginal and non-Aboriginal people. The rise in use was seen to be particularly problematic when cannabis is used in conjunction with other drugs, licit or illicit.

Other illicit drugs were far less widely used, but in all areas amphetamine use was seen to have increased among under 25 year olds in the past two years. Concern was also expressed about non-medical use of prescription drugs by young people.

It was only in Alice Springs, Darwin and Palmerston that significant use of opiates was reported, and in these towns morphine was said to be quite widely available. Similarly these were the only towns where a broad range of other drugs (ecstasy, cocaine, crack, shabu) appeared to be generally available and used.

It was acknowledged that there are significant gaps in our knowledge and data collection regarding numbers of people using illicit drugs, people using drugs in different ways (recreational or problematic use), effectiveness of existing services, and costs to the community of illicit drug use.

Problems attributed to drug use

While not directly asked to comment on problems associated with illicit drug use, it is notable that in each location those present spontaneously identified similar issues. These relate very largely to use of cannabis, generally in combination with other drugs.

Occasional concerns were raised that school children using cannabis would 'graduate' to other drugs, but by far the greatest concern was the 'paranoia' or 'psychosis' attributed to heavy use of cannabis, particularly when combined with other drugs. In each location except Nhulunbuy, this was seen as a problem for non Indigenous people too, but overwhelmingly discussion focussed on problems for Aboriginal people in remote communities. In Alice Springs and Darwin the resulting 'psychotic responses' were broadly perceived to be linked with attempted and completed suicides. In the other three locations 'paranoia' and 'psychosis' were associated with violence, especially family violence.

Other problems associated with drug use were the economic and/or disruptive impact on the families of users and sexual vulnerability among intoxicated young women.

The other issue raised as a current or potential problem was the increased numbers of young people injecting drugs, especially amphetamines and prescription drugs.

2.1 Trends in use of individual drugs and identified concerns

2.1.1 Cannabis¹

A "huge" increase in cannabis use was reported in each location, amongst Aboriginal and non Aboriginal people, amongst all age groups, and as a substitute or stopgap for licit or illicit drugs.

[Our clientele] are 99.9% Aboriginal... More and more the staff are saying that [the clients] are stoned as well, they're not just drinking, they're always stoned... they're coming in more intoxicated from cannabis. ... There's a really big trend within the Indigenous population with cannabis use. It's on the increase in a huge way.

In urban areas we are seeing a generational change: we're having young Aboriginals looking at alcohol and seeing the impact it's had on their families and saying - alcohol is not going to be our main drug of choice any more - so they're experimenting a lot more, which is why we've got the rise in cannabis and amphetamines.

in town [cannabis] is the drug you take when you can't get what you want to take. It is the baseline drug, when the heroin isn't here and the morphine's run dry. You can always get cannabis.

Perceived reasons for associated problems

The problems associated with cannabis are said to be a function of three factors: the increased strength of the drug, the effects of 'cocktailing' with other drugs, and the quantities that people (especially young Aboriginal men) are consuming. These three reasons were expressed consistently and with great conviction at each location.

There is a history particularly amongst the white community, of people accepting cannabis as a fairly light drug, soft drug. ... But I think that part of that comes from people who've used earlier forms of cannabis which have been much weaker. And I think that because the current gunja is a lot stronger, it's often hydroponically grown and its got much higher levels of THC so it's actually quite a different substance than the substance that was around 10 or 20 years ago.²

It is kids in a vulnerable age group who are using marijuana, they are often malnourished and are risking quite severe mental disorders by using gunja. They get it and smoke it until it's gone, not at all disciplined in the way they use it. And they are cocktailing with alcohol and petrol, so you're getting side effects of three substances.

¹ Cannabis is outside the remit of this Taskforce except when used alongside other illicit drugs. Nevertheless views on cannabis are reported here in some detail because of the extent of community concern and the tendency to combine and/ or interchange cannabis with other drugs, sometimes illicit, though more often not. Although much of the discussion focussed on cannabis, many of the views expressed relate to use of any illicit (or licit) drug.

² People remain convinced of the vastly increased strength of hydroponically grown cannabis despite accounts of research evidence that indicates minimal change.

Problems attributed to use of cannabis

Frequent reference was made in Alice Springs, and again in Darwin, to purported links between cannabis and suicide amongst Aboriginal people, but paranoia and psychosis were also reported amongst non-Aboriginal people.

Quite a few of the attempted suicides and successful suicides appear to have been either linked to using gunja or a mixture of gunja and alcohol. This is particularly so, I understand, in the Tiwi Islands and within town communities like Alice Springs and Elliott and Tennant Creek.

Seems to be high level of combined use of gunja and alcohol. And even the gunja on its own there seems to be a greater tendency perhaps among the non Aboriginal population for ... higher level of disturbance or paranoia or psychological upset to come from gunja. To the extent that maybe young people who are already concerned about issues or already unhappy about something and the gunja brings it up and reinforces it so there is a higher level of mental disturbance that comes from it. But this is anecdotal too.

In Tennant Creek, Katherine and Nhulunbuy 'psychosis' was also frequently mentioned, but almost always in relation to violence. This is mostly family violence, though violence against health staff was also mentioned.

...severe, extreme violence, women are in despair, they don't know what to do.

Less and less are the stories about violence associated with alcohol: now it's all gunja.

In Nhulunbuy combined use of cannabis and kava was also said to lead to audio and visual hallucinations, requiring people to be flown out of the community.

Other problems associated with use of cannabis are the financial impact of drug use on the family budget and sexual vulnerability amongst young women using cannabis, often combined with other drugs (alcohol in Tennant Creek, petrol in Katherine), leading to early pregnancies.

Women complain that their husband gave the key card over to the balanda ... all they want is their gunja.

And kids, young women becoming pregnant younger and younger, 12, 13, 14, so by the time they're 19 have 4 or 5 children, and quite often it's through being vulnerable, being high from sniffing or whatever, so they just don't have control.

Mixed perceptions of harm

Many service providers strongly believe that the impact of cannabis has been severely underestimated, especially because of the drug's perceived impacts when used with other drugs.

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.

... about 70% of the people presenting for some problem other than cannabis also use cannabis as well. It's 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, it's just something that they do - it's just like drinking water or having a cigarettes, it's just not the issue.

Mixed views about the impact of cannabis are said to be a source of extreme anxiety for elders in many remote communities.

There seems to be a sort of contradictory set of understandings out bush. White people are saying it's okay, don't worry, but senior people in the community are often very frightened of it. The senior people are frightened in an almost magical sense. They see it as very powerful and dangerous.

One of the reasons fuelling concern amongst service providers about perceived lack of knowledge about harm associated with cannabis, especially when combined with other drugs, is the potential for misinformed choices by users, and by leaders of remote communities. Drug transfer is sometimes a conscious choice by community elders, and the interchangeability of drugs is well recognised.

Individual decisions by users: Cannabis is usually the last thing they want to give up. Because they say it's safe. They know about the risk of overdose with heroin, or with amphetamines, and about all these diseases, but what do you get from cannabis? ... I don't die from it ... I just get stoned.

Decisions by community elders: Some communities have stepped away from alcohol and cannabis. What they've done is total acceptance of kava. They see it as a benign way of - in a sense - bombing out their young people. If they go to sleep they're not causing trouble, there's no fights there's no nothing, which is another whole range of issues in relation to health concerns etc. It's social acceptance, and especially by the elders in relation to a particular drug, not illicit, but as an alternative to what they see creeping into these communities"

2.1.2 Amphetamines

After cannabis, amphetamines were said to be the next most frequently used illicit drug, but by a far smaller section of the population. Nevertheless, concerns were raised in each location about increased use of amphetamines amongst the under 25 age group. Increased use was mentioned amongst school children, non-Aboriginal people, people on Aboriginal communities and opiate users in the absence of opiates.

Amphetamine use was almost always mentioned alongside, or as a substitute for other drugs.

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

Amphetamine availability appears to be more spasmodic in Katherine and Nhulunbuy than in the larger towns.

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

There is an increase when the universities and boarding schools have Christmas and mid year holidays.

Concern about amphetamine use centred around three different (though sometimes overlapping) issues: potential for associated harm resulting from injecting amphetamines; combined use of amphetamines with cannabis, especially in remote communities; and fear that the observed increase in amphetamines during the past two years will continue to escalate.

Amphetamines were said to be injected (though also used orally) by the non Aboriginal population in each location, and all reported increased numbers of needles exchanged over the past two years and/or increased requests for information about injecting tablets.

Limited use of amphetamines by Aboriginal people in remote communities was mentioned in all except the Katherine consultations. In Nhulunbuy there was some concern about a perceived growing trend for Aboriginal people to inject drugs, but more typically people in remote communities were said to use amphetamines orally or smoke them along with cannabis as 'snow cones'. As noted above, the impacts of polydrug use were seen to be extreme. In Nhulunbuy there were accounts of cannabis injected with speed.

People are getting cannabis that is injected with speed. The effect of that is for people to get out of control.

Concerns about polydrug use, combined with the perceived rapid increase and spread of amphetamines prompts service providers to feel anxious about future impact on remote communities, and about a general increase in injecting drug use.

2.1.3 Prescription drugs

People in Darwin, Palmerston, Alice Springs and Katherine reported non-medical use of prescription drugs. In Katherine the main concern was the 'quite common' use by school children.

Kids know what they are looking for - they steal them from their parents and hand them around.

Benzos are used during the week at school. Benzos washed down with alcohol.

In other locations experimental use of benzodiazepines by non-Indigenous young people was reported, as well as significant use by established users. The major concern was harm caused through injecting. User groups were especially concerned about harm they had seen through inexperienced injecting of benzodiazepines.

Occasional mention was made of other prescription drugs, particularly Ritalin.

2.1.4 Opiates

Very limited use of opiates, usually morphine, was reported in Katherine, Nhulunbuy and Tennant Creek, most often by people who had arrived from southern states.

The picture was very different in Alice Springs, Darwin and Palmerston, where morphine was generally available, having replaced heroin over the past two years.

It's not at all unusual for opiate users to come up to Alice Springs because they believe there are no opiates here. They come to leave heroin behind but they find morphine, and it's cheaper and better quality.

Users in Darwin and Palmerston reported that morphine was quite easy to access from doctors, and that ready availability of morphine had prevented small time heroin dealers from establishing a local trade. Morphine is recognised to be safer than heroin.

There's less chance of overdose with morphine, you know what you're getting.

One user noted the benefits of the contracting system between doctors and regular users: it limits doctor shopping and allows a respectful relationship between doctor and patient to develop. This supports establishment of a steady prescribing pattern and gentle reduction.

Two people voiced concern about people for whom morphine was originally prescribed for pain relief, but then become addicted, leading to the suggestion that a pain clinic is needed to identify those who genuinely need morphine for pain relief.

At some stage, in the doctor's eyes, you change from being someone who is taking prescribed drugs to being treated as an addict.

2.1.5 Other drugs

While other illicit drugs were occasionally mentioned in other locations, Darwin, Palmerston and to a lesser extent Alice Springs were the only places where a broad range of drugs appeared to be generally available and used, though availability of any specific drug fluctuates. The range includes ecstasy, cocaine, crack, shabu, fantasy, and occasional backyard manufactured drugs.

Users noted that as the supply of one drug dries up people experiment with others, hence users are exposed to a broader range of drugs.

2.2 General observations about drug trends and data collection

On several occasions reference was made to the limited data available about illicit drug use in the Northern Territory.

What is the extent of problematic use as against recreational use? How are existing programs contributing or not contributing to use later on?

Several people suggested increased efforts to improve data collection and/or to estimate costs to the Territory arising from illicit drug use, though all acknowledged the difficulties of collecting data about illegal activities.

Another issue concerning data collection is clarification of what we aim to measure, and where to focus our attention.

We should recognise that not all people who use drugs have a problem. There are some who use drug safely.

The importance of staying abreast of, and anticipating changes in drug use was also mentioned several times.

2.3 Perceived reasons for drug use

Although not specifically asked to comment on reasons for using drugs, those attending the consultations frequently raised or referred to their views on this topic. Perceived reasons for use influence views about effective approaches for addressing or preventing misuse or harm. In brief, the following main reasons were mentioned.

2.3.1 Boredom

In a remote community environment, one of the major issues is boredom, and peer pressure which stems from boredom. So the kids in particular have got nothing to do when school is over for the day, ... There's no organised activities for the kids, or if there are, it's dependent on a non Aboriginal person who'll run it till 5 o'clock, or

6 o'clock when they knock off for the day. And then the rest of the evening it's just left to the kids to amuse themselves

This view was most strongly voiced for remote areas around Alice Springs, but boredom and/or lack of organised activities in the evening was mentioned in other locations, particularly for non-urban areas.

2.3.2 Involvement, being part of a group

[Kids who come from broken homes or are under too much pressure] want to be with somebody where they're not going to get blamed or shamed, and there's no pressure. You know - 'my mates are all sitting around here, whether they're going to sniff petrol or smoke gunja or take tablets, I mean this is a little culture here my mates will look after me'.

The view that drug use provides an important sense of belonging was aired in most consultations, including those with users.

This theme blends with concerns that family disintegration, lack of support, and lack of authority structures are linked with drug use.

Implications for prevention are multi sectorial and long term, but recognition of the need for support and belonging has important implications for the way in which treatment services are delivered. Users spoke powerfully about negative attitudes towards drug users (by society in general but also by service providers) creating a barrier to change, leaving re-entry into drug using circles as the most supportive and attractive option.

2.3.3 Dealing with crisis and/or despair

What also needs to be remembered, is that a lot of young people who are using are not just using because of boredom, a lot of them are actually dealing with quite genuine crisis. A lot of the Aboriginal communities have to deal with crisis that is well beyond our imagination.

In another location there was acknowledgment of "the hopelessness of the situations people find themselves in, the inability to progress, the lack of capacity to improve".

So I think that putting programs into the remote communities is also about teaching people more constructive behaviours and constructive responses to some really quite serious things that they have to deal with.

2.3.4 Role modelling: impact of the family

Go and see how many primary school kids are getting their education outside the pub. They're not at school, how do we get to these kids. ... What's happening is with the Aboriginal kids they see mum and dad, aunty and uncle, they're sitting with the cards and the kids watching, ... so when you get to 14 or 15 years of age what do you do, you drink brother.

Recognition of the strong influence from the family lead to widespread demand for more services that operate on an outreach basis, providing support to families. This was seen as an essential component of a prevention approach.

2.3.5 Lack of information

In all consultations the need was voiced to provide more information to young and older people about risks attached to drug use. Various themes of this discussion are explored in more detail below, but enthusiasm for this view was balanced with recognition that information does not address the basic issues.

You can put out as much advertising as you want, but for some people drug taking is the only glimmer of hope in an otherwise fairly dark day.

APPROACHES TO PREVENTION

Summary of views about prevention

Comments on this topic reflect the varied perspectives and experiences of those attending the consultations. Some views derive from personal experience, some reflect public opinion, and others refer to research findings.

What is the goal of prevention?

An unstated but ongoing and unresolved theme underlying much of the discussion was the question of what we are aiming to prevent: drug use or harm? This question is particularly pertinent to prevention approaches directed towards young people, but it returns as a theme in other contexts.

Although, as indicated above, many of the factors believed to influence drug use are social and structural, discussion about prevention most readily focussed on school based education, perhaps as one area where most people have personal experience either directly and/or through their children.

Prevention through schools

Discussions about school based prevention essentially focus on three issues:

- (i) the content of school based education about drugs how factual should it be, and/or should it focus on skills training;
- (ii) who should provide the education;
- (iii) how to support prevention through the broader school environment.

A broad range of views were expressed, but common themes relating to the three issues are as follows:

- (i) information should be truthful, accurate and up-to-date. We should separate issues of harm from issues of legality, but also must focus on developing resilience;
- (ii) information should be delivered by well informed people who students consider credible;
- (iii) more attention should be paid and support given to creating school policies and environments that promote prevention.

Prevention through families

Alongside engaged debate about school based prevention, there was frequent recognition of the factors that limit what schools can achieve, and widespread agreement that more emphasis should be placed on actively supporting families as a means of promoting prevention. Families should be supported to educate their children about drugs. Families who are struggling should be supported as a way of intervening early in a child's development. In every region outreach workers were identified as a necessary addition to existing prevention approaches. Outreach workers could be attached to schools, though community based family support outreach workers are also needed to access children in the 0-5 year age group.

Prevention through social and structural change

There was general recognition of the need for a better informed general public. In towns, an emphasis was placed on reducing the stigma attached to use of drugs so that parents, service providers and friends feel more ready to broach issues of illicit drug use. Public education campaigns play an important role, though negative media reporting is often a significant setback. Public education campaigns should be non-blaming and strategically and collaboratively planned.

It was reported that in remote areas more factual information is often requested by community members. Appropriately designed resources are needed and community educators to deliver the information.

Structural changes may include exclusion of certain drugs from remote communities. Changes for youth include better environments in which young people meet and youth based activities in remote areas. Employers can play a significant role in establishing drug free employment policies.

3.1 Prevention through schools

In all locations people reported visits to schools from Life Education, DARE, and occasionally other service providers. Assessments of the value of Life Education and DARE spanned the spectrum from positive to negative. It was recognised that the school curriculum requires teaching staff to present health, and drug information to secondary students. All agreed that some education should be provided in schools, but views varied about the content, and about who should present it.

3.1.1 Content of drug information and education

A sense of urgency drove people to believe that drug specific information should be introduced into schools at an earlier age.

We need to educate our kids, not wait until they get to high schools, get into primary schools.

Kids can understand early. Kids who get into the juvenile justice system have most likely never had drug education. They need teachers to give them information in the Second Grade.

Many voices supported the provision of drug education that is "sensible and realistic":

... a no-holes-barred education, from beginning to end. We need to explain to kids and address the facts of why it feels good to take drugs and why it feels bad.

There was strong support for education to focus on drugs from a health, rather than a criminal or moral perspective.

Give information about the effects of the drugs, apart from the effects of the drugs being illegal.

Several service providers expressed the need to go beyond providing information *about* drugs, but to address harm minimisation by presenting information about safe use. They recognised however, that issues of legality officially prohibit this for those under 18.

We seem to be in denial as to the age group of people using illicit drugs. ... We seem to have some sort of fear of utilising harm minimisation techniques for youth, it's seen to be maybe encouraging them to use. And if we show them that maybe to roll a joint with a filter is much safer than using a bong, it's seen as, oh my gosh, you're advocating the use of cannabis

We need to see a concerted effort by the Education Dept to actually want to address issues around drugs, and it needs to be candid in a form that young people can actually relate to. There's the element of just saying no to drugs, and there'll be students that works really well for, but there's going to be some young people, who the only tool that we can provide them with, is with appropriate information so they know exactly what they're doing, and they can have informed decisions.

Alongside the demand for fuller information, a few voiced caution:

The resources are very explicit and children will experiment. I'm not sure if that's the right thing or not. Are we exposing them to that at too early an age?

In several locations people cited research evidence that supports this view: factual information tends to increase experimentation with drugs.

Where this view was accepted, 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, 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.

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.

At one consultation information was provided about a range of initiatives that are currently, or soon to be in place in schools, addressing resilience and coping skills. Service providers were supportive, but emphasised the need for an ongoing, coordinated approach.

Programs start then stop. We need ongoing prevention and education programs.

3.1.2 Who should provide school based drug education

As noted above, a range of views were expressed about the advantages and disadvantages of police involvement in drug education. Those who support police involvement pointed to the reduced number of School Based Constables, who are now shared between schools. In Alice Springs one Constable covers all the schools in remote areas. Those not in favour questioned the relevance in remote areas of someone who is "seen as the coercive side of white fella law", or asked why a doctor was not more appropriate if we are taking a health rather than criminal perspective. The following statement accurately summarises the views:

The value of the School Based Constable depends on what the school wants from them and it depends on their relationship with the school.

The importance of, and reliance on teaching staff was discussed in each location, and in most locations three main limitations were acknowledged:

- drug education gets pushed out by an overcrowded curriculum;
- teachers vary in their interest, confidence, and expertise in this area;
- absentee rates are high, and it is often the kids most at risk who fail to attend.

Health tends to get pushed to the back, you know, there's a focus on literacy and numeracy, which is important, but, increasingly ... what is in the curriculum and what actually happens on a day to day basis in the classroom - you can't teach kids that aren't there and often, unfortunately they're the ones most at risk.

Nevertheless, 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.

In addition to information from teachers, the value of peer education was mooted in a number of consultations.

Kids will listen to their peers, but they won't listen to authority.

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.

3.1.3 The broader school environment

In some locations service providers emphasised that reliance on what is officially taught in schools may be misplaced.

There isn't much evidence to support health education as being a moderating factor in later 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.

This speaker referred to decisions by schools on whether or not to serve alcohol at school functions, and teachers' capacity to handle drug related issues.

At another location a speaker pointed to the potential for unanticipated impacts of school policies, and the value to be gained from providing schools with support as they develop drug-related policies.

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.

One proposal, which met with enthusiastic support in one consultation, was to create a position for a Student Advocate, attached to, but not employed by the school. This person would be responsible to ensure that the broad needs of individual students are adequately represented and advocated for within the school system.

3.2 Prevention through families

As indicated above, high rates of absenteeism (reported as 20% in some areas) limit the potential impact of school based prevention, often for those most in need.

Kids are often not at school because of drug problems at home or family breakdown.

Discussion in one consultation focussed on decreasing absenteeism by providing more compelling schooling options, nevertheless in all locations there was agreement that more emphasis should be placed on the family as a means of preventing use of or harm from drugs.

Recognition of the family as a "prime site of social learning" prompted much discussion about active ways of supporting families to play a more effective preventive role. In both Aboriginal and non Aboriginal settings the potential for the family to have either a positive or negative role was recognised, and support could be seen to fall into two main categories:

- (i) support for the family to play a pro-active educative role
- (ii) support to minimise potential negative impacts of family circumstances³.

3.2.1 Support to help the family play an educative role

At every consultation there was agreement that families have a responsibility to proactively educate their children about drugs. Views about why this fails to happen included lack of information, discomfort, and lack of skills to address the issue.

Families feel so powerless because they don't have the information or education. We need to get the information to families, don't just put it on TV. Families don't get the skills from that, they don't know what to do.

Several people advocated for schools to play a role in providing information to parents, suggesting parents' evenings, newsletters and other community events. Others pointed out that the 'Health Promoting Schools' project attempted this, but with little response from parents.

³ Support for families of users was also discussed and is addressed separately in the following section on service provision. Comments here focus on support to families from a preventive perspective.

Parents don't come to organised events. People only attend when their child is in big trouble.

For non Aboriginal families the only approach identified as a means of reaching parents prior to the emergence of problems was to change general societal attitudes towards drugs through public education campaigns. This is discussed in more detail below.

At one consultation a clear message was delivered about how to engage Aboriginal families in education about drugs. The proposal emphasised the importance of education through appropriate channels and involved two components: first, selection by the community of an appropriate person to deliver information; and second, education through the family.

It's not what you take to kids but how you present it to the kids and who's giving it to the kids. If you've got a respected Aboriginal person sitting down with an Aboriginal family giving them the information they want they will hand this information on. When we have European people coming to communities trying to give them information, yes it works to a certain extent, I'm not saying it doesn't work, but I think it would work better if Aboriginal people educated their people. Aboriginal forms of education is 100% different to what ours is.

3.2.2 Support to minimise the potential negative impact of family circumstances

The need, identified above, for a respected person to work with individual families was echoed in almost every consultation when discussing approaches to prevention for children in families that may be struggling for any reason. Active support for the family was clearly acknowledged as an essential component of a preventive approach. Almost every consultation identified the need for outreach workers to work with families, the chief difference being where that worker should be based.

In several consultations it was proposed that an outreach worker be attached to schools. Not all schools currently have school counsellors and, as pointed out below, even if there is a school counsellor, parents may not choose to visit the school to access their services.

More help is needed in supporting people at home, helping families stay together. Outreach is needed. We need social workers attached to schools. A counsellor needs to go into people's homes and actually meet the needs of the people. ... outreach, rather than people having to go to school to get a counselling session. We must look at the needs of the people.

In a different location an identical need was identified, with the proposal that Family Support Services be established to play a responsive, holistic, early intervention role with families.

We need workers to go out to the people, not wait for people to come in to a centre somewhere. ... Family Support Services would take a preventive approach. Community services would identify certain families where it would be good to find someone to work with the family at that time, provide counselling, educative life skills relevant to the situation. A lot of people don't have the skills to deal with their lives.

In situations where families are using drugs in harmful way themselves, the need for home visiting was even more strongly emphasised, stressing the urgency of reaching children early, before the damage happens. It was said that outreach workers are needed on communities who can drop in on families with the attitude "I've just come to have a yarn".

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

Role modelling is the greatest dictator of a person's adult behaviour. And so you do need to look at educating the kids, but if the adults are using drugs, alcohol, whatever, there's the greatest chance that with those kids they're going to grow up to mimic their parents. So you've got take that holistic approach or we're going to get nowhere.

In two consultations people pointed to the need to identify and target children most likely to be at risk, specifically mentioning children placed with foster carers. It was proposed that these people may need additional information and support.

3.3 Prevention through social and structural change

3.3.1 Prevention through social change

Why do we load it all on the school? As the community we need to take more responsibility.

In all locations people believed that the general public or community should be better informed, with some expressing the view that it is more productive to educate the public than to provide more information to young people.

The young people that we see, they all know other people who [have been affected by drugs], no use in telling them that if you use drugs you'll end up with a fried brain, they know that, they'll tell you that my friends have got fried brains. That's never stopped anyone from using tobacco, it's not going to stop anyone from using drugs, ...that's not going to work. But I do believe that the campaign of talking about it is going to work.

Two key reasons for educating the public were implicit in the discussions. One, discussed most explicitly in Darwin, is to reduce the stigma attached to drug use. The other reason is to provide people with information that will practically assist them to make informed decisions. The need for the latter was most specifically discussed in relation to remote communities. Different approaches to educating the public were also discussed for towns and for remote areas.

Public education to reduce stigma

In Darwin and Alice Springs the value of large scale public education campaigns was discussed. People expressed varied opinions about the effectiveness of recent 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".

In many consultations people referred to the negative role the media plays by demonising drug users, promoting a debilitating sense of victimisation amongst the general public. Users spoke of this too, referring to recent newspaper headlines (for example 'Druggies' body left in house for two days') and the negative way in which public debate is conducted:

The terminology is so negative: addict, junkies, war on drugs, prohibition...

No solutions were offered about how to address the media's role, but there was strong support for ongoing campaigns that further reduce stigma, making it easier for service providers, parents, and people in their own networks to raise issues of drug use.

Service providers in Darwin emphasised the importance of coordinated, strategic approaches to public education campaigns. Federal campaigns should 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

Community education to support informed decisions

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 or families of users: their needs are discussed in the following section of this report.

Nevertheless in remote communities the dividing line between service providers, family members and the general public is less distinct, and in many locations it was reported that community members, especially elders and women, require information to help them determine appropriate responses.

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.

A need was identified for appropriately targeted information and more community educators. On several occasions people referred to the fact that it is not adequate or effective to rely merely on producing educational materials: people are needed to convey the information.

3.3.2 Prevention through structural change

Prohibition

Leaders in some remote communities effect very significant structural changes by, as indicated above, cutting the supply of certain drugs, and/or by applying strict sanctions on those who import or use forbidden drugs. Examples were offered of successful prohibition in isolated communities with strong, acknowledged leadership, but there are limited situations where this is feasible.

Activities and meeting places for young people in towns

In some, but not all locations it was suggested that better facilities should be provided for young people to meet, either formally or informally. Others suggested funding sporting or musical events, though in one small town it was acknowledged that "there are ample activities for kids, but the at-risk kids don't want to go".

In Tennant Creek it was suggested that enforcement of the Two Kilometre Law and better street lighting in specific areas where young people gather would create a safer environment and limit harm from drug use.

Activities for young people in remote communities

The case for creating alternative activities to occupy young people in remote communities was particularly strongly argued in Alice Springs.

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.

Workplace restrictions

Successful application of workplace drug policies was referred to in Katherine. It was recently anticipated that the incoming itinerant population for the railway construction would result in increased availability and use of illicit drugs. In fact this has not happened, chiefly it is believed, as a result of the strict drug testing and zero tolerance drug policy established by the railway construction companies.

Harm minimisation

Users in Darwin suggested safe places for injecting, drug testing and places in clubs where intoxicated people can rest.

SERVICES FOR THOSE USING DRUGS AND THEIR FAMILIES, AND PROPOSALS FOR IMPROVEMENT

Summary of proposed improvements to drug related service provision

Some specific gaps in service provision were identified and are outlined below, but many of the improvements suggested did not require new services, but rather changes or additions to existing approaches to service delivery.

Town based services for young people who use drugs

Clear and specific service gaps were identified for town based services for youth. For some of these there were clear ideas about what is needed to fill the gaps. In Alice Springs and Darwin there was definite agreement about the need for detoxification services for youth. Another proposal on which there was much agreement in Darwin and Palmerston, and some overlap of ideas in Katherine, was the need for a multi purpose drop in centre where young people can access information. Outreach workers for youth were mentioned again, as in discussions about prevention, and obviously, were these positions created, the same outreach workers would meet both needs. Rehabilitation services for youth were also identified as a gap, but there was less clarity about how this need should be met. Additional needs for short stay crisis accommodation were noted for young people fleeing others' use of drugs.

Town based services for adults who use drugs

In many locations users, service providers and members of the general public discussed ways in which services could be improved. There was strong support from service providers for developmental change in the services they provide, but it was stressed that they would require additional training, and additional and/or more flexible funding.

The following changes were discussed:

- more emphasis on outreach services;
- better access to information about what is available;
- a holistic approach to service delivery;
- family based service delivery;
- better support for those who may be experiencing drug induced psychosis;
- ongoing support and after care;
- non judgemental attitudes to clients.

Specifically identified gaps or concerns about town based services for adults related to detoxification services in Alice Springs and Darwin, residential rehabilitation in Alice Springs, needle and syringe programs in Palmerston, Darwin and Alice Springs and crisis accommodation for men in Alice Springs and Tennant Creek.

Access to pharmacotherapies in Alice Springs, Darwin and Palmerston is required for established opiate users. Users and service providers agreed that these medications should be available as part of a broader spectrum of support and services.

Services in remote areas

In some communities there is a strong sense of responsibility to address substance related issues, but information, support and infrastructure is often lacking. Communities need support to identify and develop their own approaches, building on the strengths and resources available to them. Several references were made to requests from community members for more drug-related information.

Support for families

In remote communities support from family members is an existing strength on which to build. Clients from remote areas could benefit from a family member accompanying them if they leave their community to attend a rehabilitation service. Provision of information and support to family members in remote areas and in towns is increasingly seen as the most effective means of accessing users and creating an environment conducive to change.

Family members often need support for themselves, but they report that this is not easy to find. Issues of confidentiality limit the support service providers can offer other family members of an existing client.

Proposed changes to support improved service provision

Service providers proposed several ways in which service provision could be improved. These included specific and ongoing training for staff from drug and alcohol agencies and formal support for better collaboration between them.

Training is needed for non-specialist service providers to recognise substance related issues and help for organisations to develop policies that

support assistance with substance related issues. Improved partnerships with Government would enable better planning at the individual agency level and overall, and intersectoral planning could promote more strategic responses. Finally, different approaches to funding remote communities are required that recognise the need for integrated, long term solutions and that rely on demonstrated qualitative rather than quantitative changes.

Perceived gaps in current services and approaches to addressing them reflected the variety of settings covered by the consultations. Identified service gaps and proposals for addressing them are reported below, first for towns, and then for remote communities.

4.1 Town based services for young people who use drugs

One of the most strongly expressed needs in Alice Springs, Darwin and Palmerston, by service providers, users and the general public was for services for drug users under the age of 18.

4.1.1 Detoxification for users under 18

In Darwin and Alice Springs there was a clearly identified need for detoxification services for those under 18. It was agreed that besides allowing young people to detoxify, the service should also provide some assistance for those who wish to address their drug use.

Different groups in both locations consistently expressed the same needs. The first statement below describes what is needed by a user, the second by a service provider in Darwin, and the third by a service provider in Alice Springs.

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

... 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...

There was total agreement that this is not a service that families can be relied on to provide, for a variety of reasons. The first statement below is from a service provider, the second from a parent.

Where else do you go, do you go to outpatients at the hospital, where do you go?... So the whole emphasis is put back on the family so to speak...do you have a relation you can stay with? The relations are probably in dysfunction themselves. So the obvious lead ons from that are the high risk of suicide.

... for parents who have a drug using child, it's too scary to have your child detox at home.

4.1.2 Crisis accommodation for young people

In addition to the specifically identified need for places for young people to detoxify, other short term crisis accommodation requirements for young people were raised in Alice Springs and Tennant Creek. These needs are generally seen to result from drug use by others, though the young people seeking accommodation may also use drugs themselves. The need for a hostel, a refuge, or crisis accommodation was at times discussed alongside the need for detoxification services, but the two needs are distinct and it is important that they be considered separately.

4.1.3 Rehabilitation services and support for users under 18

Rehabilitation for those under 18 was also recognised as a need in Alice Springs, Darwin and Palmerston. The minimum age for admission to Banyan House in Darwin is 18. People in all three towns pointed to this gap with widespread recognition that professional support is needed for young people, but there was little or no discussion about the most effective way to meet the needs.

4.1.4 Outreach services for youth

In Darwin, Palmerston and Katherine service providers stressed the inadequacy of current counselling services that rely on young people coming in to access the service, and the importance of being able to reach young people where they are.

... a lot of young people don't like coming in to formal counselling and there's no capacity to go out and do outreach work in my role Having the ability or the capacity for a worker to become more involved with young people's programs...

The need for outreach workers attached to Family Support Services, or to schools, as identified in the previous section of this report overlaps with this requirement.

4.1.5 Youth multi purpose drop in centres to provide access to information

In Katherine, Palmerston and Darwin people suggested the need for a central location that is open in the evenings, where people can access information about a range of needs, extending beyond alcohol and drug issues.

In the latter two towns the centre was proposed for general use, not specifically for young people, however the ideas have much in common. In Darwin and Palmerston there was support for the service to be staffed by users who successfully manage their drug use and/ or by ex-users who could offer education and information from a personal perspective.⁴ It was suggested that staff at such a centre could, when needed, play an advocacy role for those who need help to access services or systems.⁵

Besides offering information, the service could also arrange for counselling, meeting the identified need for young people who want a "central point for emotional support that is confidential".

⁴ Multi purpose drop in centres staffed by users or ex users would also meet some of the needs identified in the previous section of this report for peer based preventive education.

⁵ This suggestion has much in common with the Student Advocate, described in the previous section (3.1.3).

4.2 Town based services for adult drug users

While specific gaps in service provision were identified in individual locations, some of the more common themes that emerged refer not so much to lack of existing services, but rather to ways in which services should be delivered. Service providers and users had strong, and in some instances shared views, that could be addressed by workforce development and by increased and/or flexible funding arrangements. The main re-occurring suggestions about ways in which services should be developed are outlined below.

4.2.1 Greater emphasis on outreach services

The need for staff who are funded to "get to people where they are" was discussed above. In every setting - town and remote, Aboriginal and non Aboriginal, preventive work, youth and family work - it was emphasised that:

We need workers to go out to the people, not wait for people to come in to a centre somewhere. Often you don't get to the people at risk, you need to get information out there in order to get to the people you need to reach.

On the other hand, people reported the wasted resources used by overlap of agencies, each visiting the same communities. This is discussed further in Section 4.6.7.

4.2.2 Better access to information about what is available

Confusion or ignorance about where to go for help was seen to be particularly problematic in Darwin and Palmerston, though it was also raised in other locations. People spoke of the need to obtain information about available options across a range of sectors, including health, education and justice, and for government and non-government services. Service providers spoke of their difficulties in maintaining awareness of available services, hence their limited capacity to advise clients.

Multi purpose centres to access information, as described above for youth were proposed to address this problem. In addition people in Darwin and Palmerston asked for concise, well presented listings of available services.

4.2.3 Holistic approach to service delivery

Service providers, users and the general public all raised the need for services that can address the range of issues that people are dealing with, describing the ways people get "bounced around the service structures".

In the community in general there is a lack of services to help people work though a multiple lot of issues. And that people seem to have to go to this place to deal with this kind of issue and this place to deal with this sort of issue. Not many agencies are actually 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. But rather we're squeezing people into, well this is what our agency provides, if you come here this is what you get. Rather than I think there needs to be flexible options for people.

Users felt strongly that they need "holistic support with all types of needs" and stressed that support should not be contingent on a decision to stop using drugs.

...need services that help users during their period of usage as well as the time they want to stop. There will always be more people using them than wanting to stop.

Service providers returned frequently to the way in which funding arrangements prevent them from offering the type of holistic support that, theoretically, the Government encourages.

I do find it interesting that the Govt has turned to the SOEWELL program that has incorporated Health Development, Alcohol and other Drugs and Mental Health, because it's seen that a holistic approach to health is really what is going to create the outcomes. And yet we still seem to fund agencies on this separate specific role stuff. We haven't opened up our funding process to holistic agencies, saying okay, in the community, which agency is going to be taking care of a number of issues.

While supporting the emphasis on holistic service provision some agencies stressed the importance of retaining specialist skills, and of not "spreading ourselves too thin". This is particularly important for smaller agencies who fear that a simplistic solution to holistic service provision is to fund only large multi purpose agencies. Instead, they proposed that clients should work chiefly with one service provider, and specialist skills from other agencies could be brought in as required. Agencies believed that a change from current funding arrangements would be required to support this type of work.

Competitive tendering has forced agencies into doing things as affordably as possible, so we aren't able to spend the money on things like case conferencing.

4.2.4 Family based service delivery

Several agencies in different locations spoke of their efforts to involve family members in service delivery. This does, however, require specialist skills.

Most agencies do try to respond to families, but it hasn't been a policy of funding bodies before, it's a new initiative. We need to have more understanding of that, and need to have people trained in that area. It's difficult to know sometimes how you're going to see 7 or 8 family members together, we need some more skills in that area.

Other agencies pointed out that it is often time consuming and costly to contact and arrange meetings with a range of family members and funding arrangements do not support these costs.

4.2.5 Better support for those who may be experiencing drug induced psychosis

The perceived increase in psychotic episodes attributed to the significant rise in polydrug use has heightened service providers' concerns about how to deal with people who may be experiencing drug induced psychosis.

The challenge of where to place violent people to detoxify before they can be assessed for mental health problems or drug induced psychosis was raised by service providers in Tennant Creek. A similar question about where to take violent family members experiencing drug induced psychosis was raised at the public consultation in Palmerston; discrepant views were expressed about whether or not family members could admit them into the hospital.

In almost every location service providers want training and, when necessary, specialist assistance to assess and address the more complex problems associated with drug induced psychosis. Again, the need for a collaborative approach was raised.

We don't want ping pong therapy, we must devise a strategy for a case management type of model.

4.2.6 Ongoing support and after care

Drug users pointed to the tendency for prison and rehabilitation services to "push people out the door, setting you up to fail".

Service providers acknowledged that "treatment alone is no good", but others commented that without additional funding they had no spare resources to provide after care.

When are we supposed to provide after care? After-care - after hours?

For another town based agency with clients from other locations, after care involves establishing supportive links for their ex-clients in the area to which they are returning. This is not easy to achieve and there was general agreement that more attention and resources are required to find ways of effectively providing ongoing support.

We need to educate people in communities - we're not even talking just about remote communities - need to educate people about how to provide that follow up service for people coming out of treatment here in Darwin. ... For people coming out of services from heavy drug use, they're really out on a limb.

4.2.7 Non judgemental attitudes to clients.

Drug users in Alice Springs, Palmerston and Darwin were very clear about the type of service provision that would support changes in their lives. Respect for clients is central, both in the way clients are treated, and in the services they are offered. Clients need to:

... feel like you have some value...need to keep some self respect

Respect is also reflected in client driven choice and client driven goals.

[don't] devalue people's opinions. Every point degrades you further, so you just go back to the drug culture: they at least accept you. You don't have the self-esteem to stand up to it.

People wanting treatment should be given the choice of what they have 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.

Realistic acknowledgment of the time needed to change and acceptance of relapse are other aspects of the non-judgemental approach that users need.

Must allow long enough, up to 18 months or 2 years, and have follow up support.

Just because you fail doesn't mean you've f***ed up. Some people find it hard to stop, but you need to be able to try again.

Finally, users must have confidence in the credibility and authenticity of service providers. Users in Alice Springs stressed the importance of service providers having up to date and adequate knowledge and skills, but also the need for them to check their values about users. There was frequent reference to the benefits of including more users or ex-users in service provision.

A lot of the people are authority figures who are the very people you're trying to get away from. People who've never used a needle, never used drugs, talking down to you.

You'd prefer to talk to someone who can say what worked for [them]

People who can use drugs sensibly and/or have stopped - they're the people who can help.

Besides these general proposals for change, specific service gaps were identified for detoxification, rehabilitation, crisis accommodation, needle and syringe programs and provision of pharmacotherapies.

4.2.8 Detoxification in Alice Springs and Darwin

Drug users in Alice Springs spoke about the inadequacy of the existing detoxification service to meet their needs. At a separate consultation staff from the detoxification service described the impact of limited funding, requiring them to close their service when they exceed the number of client for which they are funded, and their limited capacity to provide counselling. Users also spoke of their perception that the service "is really for Aboriginal people" and believed more support was needed for people detoxifying from opiates or amphetamines. Some spoke about the need for detoxification services that allow mothers to bring children with them.

In Darwin and Palmerston much concern was expressed by users, the public, and service providers about the forthcoming change towards home detoxification, with numerous examples of people for whom home detoxification will not be suitable and concerns about how their needs will be met.

4.2.9 Residential rehabilitation service in Alice Springs (and Darwin)

In Alice Springs, users, service providers and members of the public all spoke about the need for local residential rehabilitation. They stressed the inadequacy of current arrangements whereby those wanting to rehabilitate must travel interstate, breaking contact with their family and support networks.

Currently people have the choice of trying to abstain at home or going interstate. And that's not an option for some people.

Many people spoke in favour of a residential service that operated voluntarily for a few months last year, suggesting that a similar service be funded and re-opened. Those involved intend the service to operate collaboratively, incorporating counselling support from other agencies. Other agencies supported this view, but stressed that they could not provide additional support without additional funding.

There were mixed views about whether the residential facility would include rehabilitation from alcohol as well as other drugs, and whether or not it would provide detoxification facilities. It was agreed that women should be able to bring children to the service with them. Another family support service would provide care for the children during the day, for a fee.

Users in Darwin spoke about difficulties for women with children who want to undertake rehabilitation. Even when a residential program provides accommodation for the children, women generally cannot afford fees for childcare during the day.

Alongside a need for locally based rehabilitation, users and some service providers stressed that the option to travel interstate for rehabilitation should be retained.

4.2.10 Needle and syringe programs in Palmerston (and Darwin and Alice Springs)

Needle and syringe programs (NSP) currently operate in Darwin and Alice Springs, but in both places users wanted the hours extended. In Darwin, users wanted more outlets where needles can be collected from non-stigmatising places, that are "part of your life". Pharmacies may be a good option, though discriminatory attitudes by pharmacy staff were noted.

People in Darwin and Palmerston stressed the need for a NSP in Palmerston: it is unreasonable and impracticable for people to travel by bus into Darwin to collect needles and to return them. Needle disposal units are needed in Palmerston.

The potential for needle distribution points to operate as a source of information and education was noted. Again, the concept of a multi purpose drop in centre was mooted, where people could access needles, advice and information.

4.2.11 Crisis accommodation for men in Alice Springs and Tennant Creek

Two situations were described in Alice Springs where lack of accommodation for non Aboriginal men creates significant problems, though probably each requires a different solution. One is for newcomers to town. The following situation was said to be quite typical, requiring short-term accommodation while service providers work with the client to identify the next steps.

... a typical presentation is coming on a bus from Sydney, 2 days, haven't been using a substance here, withdrawing very heavily, they've got no money, they need medication, we've got no medical information about them, and where do we put them? And if they're a white adult male it becomes very difficult.

The second is for non Aboriginal men who have undergone detoxification, and need affordable drug free accommodation. Since the closure of the Alice Springs Red Shield hostel the only budget accommodation is far from drug free.

Lack of emergency accommodation for men was also noted as a problem in Tennant Creek.

4.2.12 Pharmacotherapies:

Service providers in each location were invited to discuss the introduction of pharmacotherapies for those who are opiate dependent. Reflecting reported trends in drug use, it was only in Alice Springs, Darwin and Palmerston that this treatment was seen to be relevant. Within these three towns drug users and service providers definitely wanted availability of all possible choices. People in Palmerston and Alice Springs stressed that whatever is provided in Darwin must also be available in their town.

Users were realistic about what medications can achieve: "all methadone does is give you time to organise your life". As another person said: "it allows you to recognise that you can have a life", freeing up time and energy to make choices and "put other aspects of my life together".

Users and service providers were each emphatic about the need to see pharmacotherapies as only part of a range of supporting services. For users this meant that the perspective of the client remains paramount:

The same things don't work for everybody - must tailor it to the individual. Treat the client not as an addict, or a junkie - as a person. Recognise they have money problems, housing problems, all sorts of other problems... You need methadone, naltrexone, buprenorphine - as many solutions as possible, it's how they interact with their lives.

Pharmacotherapies as part of a broader service

Service providers stressed too, that "one thing [medication] on its own doesn't work". People receiving treatment must be connected to a service provider for support, with a range of other services such as counselling and life skills available. It was proposed that whatever decision is made about administration of pharmacotherapies, joint planning must be undertaken to identify ways in which existing agencies can provide appropriate support.

Others pointed to the need for "consumer friendly protocols" for clients to access pharmacotherapies when they decide they need them: "don't make people jump through hoops, we lose people that way".

The service must be resourced to ensure clients' needs will be consistently met. One agency expressed concern that if provision of medication relies on a limited number of professionals without adequate funding for backfilling, other agencies will frequently be required to provide crisis management for clients.

Concern was also expressed about how clients without suitable homes in which to detoxify will be supervised while they reduce their opiate intake to a sufficiently low level to access pharmacotherapies.

Prescription and administration

Service providers were keenly aware that those prescribing and administering pharmacotherapies must be thoroughly trained, and must have time to develop a relationship with the client. Doubts were voiced in Darwin and Alice Springs about whether enough GPs and pharmacists would be willing and available, especially for more complex clients, and it was pointed out that provision through a centralised service would be easier. Discussions in each location were inconclusive, but the most commonly agreed solution amongst service providers appeared to be a mixture of individual providers and a centralised service.

Although very keen for pharmacotherapies to be available in Alice Springs, users there did not discuss how they should be administered.

Drug users in Darwin and Palmerston had very clear views about access: they were adamant that they did not want to collect pharmacotherapies from a central location, and certainly not from the hospital. Users had strong feelings that centralised collection increases stigmatisation, as well as re-grouping ex-users who are trying to establish new networks.

Users want to be able to collect medication from places that are part of normal life: the pharmacy or GP. They also stressed that users in Darwin and Palmerston are far too dispersed for collection from one location to be a feasible option.

Users supported the availability of take-away prescriptions, particularly for people living in more remote areas, and believed that this should be available when trust has been developed and demonstrated. While acknowledging that "there will always be people who abuse the system", they stressed that the service should not be developed around the assumption that everyone will.

Constant threat of withdrawal, punitive stuff, doesn't work.

4.3 Services for remote communities

Services for people in remote areas were most comprehensively discussed in Nhulunbuy, where a re-occurring theme in other locations was very clearly enunciated: the importance of building on existing strengths and resources.

Discussions in Nhulunbuy focussed almost entirely on the Aboriginal communities and Homelands and the needs and views of people living there. It should be noted however, that these views were expressed largely by service providers, rather than by community members themselves (who were not present).

Service providers discussed the inadequacy of the current solution, where those experiencing substance-related problems are generally sent out of the community to Darwin. Often people experience language problems and service providers in Darwin are not familiar with the person's issues. Families are the most obvious resource on which to build and it was suggested that family members should be able to accompany those attending treatment programs. Obviously this has implications for resources and facilities.

If people go into a centre somewhere family members want to be part of this too. A family member may need to go into the program with them to be that support person, so that when they come out, I'm still here for you, and they know what it's all about.

Much of the discussion in Nhulunbuy focussed on the wish, expressed by elders and other community members, for community-based solutions.

Communities want rehabilitation on or near communities. They've been very strong on that, they want to be part of it, they feel a responsibility to help, but they don't get the chance.

Nevertheless, there was frequent reference to the lack of local infrastructure.

As a nurse doing education on the Homelands, I knew the people who were doing drugs and alcohol and everything that goes with that. They might say, well yes, we would like not to be doing this, but then you'd say well what process are we going to go through now? The elders in the communities, they would show great concern about this, they would say, we want them to come home to us, that's our job to look after our people, they wanted drug users to come home to them, but still we couldn't find how to get this to happen. What was going to be that link to the Homeland, keeping them there, to stop the cycle happening again, getting them support, that type of thing.

The answer is 'send them to the Homelands so they can dry out', but the resources aren't there to do that. It sounds good, but it doesn't work.

There is no simple or affordable solution to the lack of local infrastructure. The only answer is that communities need individual approaches to build on what they have.

There are 13 different communities, they have individual needs. We must look at them individually. Lumping them together doesn't work.

Examples were provided of communities with strong leaders who have successfully used their authority to exclude petrol sniffing. Strong women, councils, police and night patrols were all mentioned as potential resources on which communities can build, working with and supporting family authority.

Nevertheless, solutions are not easy: interactions of power are complex and not all are necessarily united. Remote communities often aim for intervention in the supply of drugs as their main response, yet complications arise when elders may have connections with using or dealing drugs.

In Nhulunbuy, as elsewhere, it was said many times that "elders want to understand more about drug issues so that they can take control of the solutions". Clearly provision of relevantly presented information is an essential starting point.

Service providers in Nhulunbuy suggested employing one or two people (presumably in addition to the existing positions) to provide education and support for locally based solutions, possibly with availability of a house in each community to use for drug and alcohol related issues.

Other proposed solutions were a traditional healing centre to support people to regain a sense of culture and identity. It was mentioned that women have already been discussing this idea. Opportunities for people from different communities to meet and share solutions were also seen to be constructive.

One organisation in Alice Springs illustrated the same emphasis on building on existing strengths. This organisation works with communities who have already identified issues they want to resolve. They first work with community members to develop a program that is acceptable to them, then find other partners who can help to deliver the relevant services.

If the community is going to control and own the program it is best to support community-led initiatives, and let them set the tone and direction.

4.4 Services for families of drug users

The importance of working with families of drug users has already been emphasised in both Aboriginal and non Aboriginal settings.

4.4.1 Supporting families to help drug using family members

Increasingly in remote areas, work with families is seen as a better use of time than focussing on providing more information to users, as described in the following account from a worker in a remote setting:

I would say that most kids out there do have a good knowledge of the effects and the harms of drugs and alcohol, particularly tobacco, petrol, alcohol and gunja. They generally do have an idea of the problems it causes, and what we've been doing in the last 6 months is focussing more on providing family support. Because we can't make the people change so we've changed our focus a bit, and we now work with individuals and groups within the communities, trying to develop their skills. So they make the problem drug user look at their own behaviour so they see that it's not acceptable, and by skilling up the family we've found that we've had more success in helping support them, and that in turn reacts with the behaviour of the drug user.

Workers in a different remote setting spoke about the importance of providing family members with information and support, so that they can assist users who return to the community.

People come out of jail and go back to communities because they don't want to live in a town area where there's so much emphasis on substance abuse. Families tend to turn a blind eye to these problems because they don't understand and they don't know how to cope with it.

As already noted, remote area service providers are convinced that more funding to conduct outreach work with families is the most effective way to support users and prevent harm for younger children.

Going and giving information talks, and talking to parents, spending a bit of time there. The education work with parents and [users], that's the best way to work but instead [we keep] working in a reactive way, having to race off to the next crisis.

Similarly in a town setting, one agency described the emphasis placed on maintaining family relationships.

And our aim is to maintain some relationship between the parent and the child. Whatever threads there are with the parents, to build on that.

4.4.2 Support for family members themselves

Besides needing help to assist the user, family members need support themselves. During the consultations drug users spoke of their parents' needs:

My mother needed someone to take her aside and tell her that it wouldn't be like that forever. People get through it. To cope, parents go into denial. ... When their kids start using parents feel like a failure.

One parent described the difficulty of finding support, reporting that it took two years until the parents found counselling support for themselves.

I actually did feel like we were the intruders. I wanted to be told by his caseworker, if there were things that we could be doing, and that would help for us too... We asked a few times for help, but the big problem that was brought back to us was confidentiality for our son. ... I actually felt that we needed treatment as well as our son.

Other similar cases were reported where family members tried to access their relative's service provider but were turned away because of confidentiality issues. There was a call for more support for families of users.

In Darwin and Tenant Creek reference was made to workshops that will soon be available for Aboriginal families, providing training in coping skills for families of drug users. These were welcomed but the importance of family support service that can respond on an individual level was emphasised.

4.5 Criminal Justice Service Gaps

A service provider from Alice Springs prison noted that although prisoners request drug education, none is available. Substance related counselling is now available in Berrimah prison.

A problem was noted for drug users who appear before court and are offered the option of Banyan House, rather than jail. Although Banyan House is a preferable option, instant abstinence is often too hard for clients to maintain. Entry, then exit, of these clients into the program has a negative impact on other clients. It was suggested that court supported detoxification should be available for these people prior to their entering rehabilitation.

4.6 Proposed changes to support improved service provision

During the consultations many suggestions emerged about barriers to effective service provision and ways they could be addressed. Some were raised in the context of general service delivery, rather than specifically for services to address illicit drugs, nevertheless they are reported here for their relevance to the topic.

4.6.1 Training for alcohol and other drug service providers

During the consultations service providers from alcohol and other drug agencies named specific topics and skills for which they want further training. Most have been mentioned above: they include information and skills to address polydrug use; issues relating to substance misuse and mental health; and skills to work with a wider family group. When pharmacotherapies are introduced, various levels of information and training will be needed for a range of service providers extending beyond those who prescribe and administer the medications.

Service providers spoke on behalf of remote area staff, particularly night patrols, indicating an urgently felt need on their part to understand and know more about cannabis and amphetamines and how to deal with people who are intoxicated from their use.

Some users believed agency staff could benefit from help to examine their values in relation to drug users, and it is possible that exposure to users' views could support positive changes.

Besides the specific areas identified above, the need for ongoing training and updating of skills was raised in several other locations. Service providers indicated that this is particularly important in small towns where staff often begin work in the area with very limited training. They want training that is initiated and funded by the government.

4.6.2 Formal support for collaboration between service providers

The need for collaboration and integration was frequently returned to by service providers in all locations, though it was perceived as more difficult to achieve in larger towns.

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.

As one service provider described it, networks exist informally between individuals, but not formally between agencies. In smaller areas informal networking may be adequate, but it becomes less adequate the larger the town. Agency staff in Alice Springs, and even more in Darwin and Palmerston insisted that they need formal support to learn more about other agencies and to plan together.

Collaboration is time consuming. [Government] should make provision for structures to be created so that bridges and networks can be created.

Agencies are trying to network and for example to put in joint applications, but there isn't time to negotiate so it is an ad hoc approach, and not strategic.

Agencies identified specific improvements to service delivery (outlined above in Section 4.2) that require cooperative planning and current knowledge of the services provided by other agencies. Holistic service delivery, a broader family approach and improved after care all require initial planning and familiarisation to establish processes, then ongoing case conferencing for specific situations. Agencies express commitment to working in this way, but need additional support and funding to do so.

People need to be able to deal with the systemic issues: how are they funded to do this?

4.6.3 Training and involvement of other service providers

A service provider in Alice Springs spoke enthusiastically about training provided recently to skill front line workers from a range of services to conduct alcohol and drug related assessment, brief intervention and referral. As a result, it was noted that services in the area, including disability, youth and women's services, are better able to provide holistic care⁶.

⁶ Successful application of this training has raised a new challenge for data collection. Clients of non specialist services who receive drug and alcohol related support from that agency are not recorded in the drug and alcohol statistics. This was noted as an issue that requires attention.

A need for training of this type was spontaneously identified in Darwin and in Katherine. In Darwin, agency staff expressed concern that drug related issues are identified chiefly among people aged twenty to forty. It was proposed that professional development is needed for service providers who work with people with physical or intellectual disabilities, carers, women, youth, older people, those in supported accommodation and a range of other services. Staff should be trained to raise drug related issues with their clients and if needed, specialist alcohol and other drug agencies could contract their services to the other agencies to provide education, advice or further support.

General Practitioners were identified as a particularly important profession to train and encourage to identify and address drug related issues.

Service providers in a small town emphasised the special need in rural and remote areas for education of staff across all sectors in alcohol and drug related issues. They stressed that they cannot rely on specialist staff, who are over stretched already: "we must use the resources that already exist".

There are no counsellors, I've been going 12 months without a break.... You're talking about burn out, you're talking about total burn out, you're not even any good for an office desk. And that's what's happening to us mob around [here], it's just ongoing.

4.6.4 Support with development and implementation of organisational policies

On several occasions conundrums were raised in which organisational policies either limit the support an agency can provide, or operate in a counter productive way.

Examples raised earlier relate to school policies (Section 3.1.3) and issues of confidentiality (4.4.2).

Service providers pointed to legal restrictions that limit provision of harm reduction information to users aged under 16 without consent from their parents.

Other important cases are those where organisational policies make it not in the client's interests to disclose substance related problems. Three examples mentioned during the consultations are situations where:

- a mother with substance related problems fears to ask for help because of the risk that her child will be taken from her;
- women entering a women's refuge cannot acknowledge substance related problems because of the organisation's drug-free policy;
- school students fear to reveal or ask for help with illicit drug use for fear that they will be expelled from school.

The range of examples indicate a currently unmet need for organisations to access skilled help, not just with staff training, but with development and interpretation of policies in ways that support prevention of and help with substance related problems.

4.6.5 Enhanced collaboration with Government

Service providers identified a need for better and more regular communication and an increased sense of partnership with Government. Currently the only communication is the drug and alcohol data agencies provide, and interactions initiated by agencies when they request funding.

We could provide government with information about what services are required, even those not especially in our own area. For instance in alcohol and other drugs we can identify needs for mental health services... need regular opportunities to talk to Government about what's needed.

In other consultations agencies spoke of the limitations of the current relationship between agencies and Government. They referred to the difficulty of accessing data from Government, and ongoing insecurity due to lack of feedback that indicates whether or not they are seen to be performing adequately. Lack of shared planning with Government leaves agencies only ever able to plan one year ahead: "we're never sure what the next move will be".

Drug users also want to contribute to service planning at both the Government and agency level, pointing to the inefficiency of developing services that users will not use.

Government should consult as they develop policy. That way users gain self respect and users get the service that they want. ... should be users on the boards of organisations, helping them set it up.

4.6.6 Integrated strategies

Commonality was noted between efforts to address drug use and work conducted by other agencies or sectors. In one location, suicide intervention training that provided young people with coping skills was said to result in reduced alcohol and drug use.

We could consider how can existing services be adapted: not just those that are classically considered as alcohol and other drug services. When looking at young people, there are the opportunities to work with some of the youth services.

... I guess it's coming back to what I've said - don't put things in boxes, that's often been part of the problem, not the solution.

The need for an integrated approach has already been mentioned at the level of agencies, but it was also seen to be important at the governmental level. In one location, the establishment of a Territory-wide committee was proposed to develop a drug strategy similar to that for domestic violence. It was suggested that representatives from the Departments of Health, Education and Justice should be involved, along with Aboriginal and non government organisations.

4.6.7 Funding arrangements

Issues relating to funding have already been mentioned. Many agencies feel themselves to be under-funded for the needs they meet and there is a sense that funding arrangements limit the provision of more holistic services (4.2.3). A more collaborative approach to planning could support more constructive use of available funds (4.6.5).

Remote communities are disadvantaged with the emphasis on quantitative data.

But another specific problem relates to the difficulties remote communities, or those applying for funds on their behalf, experience when attempting to access funds that are made available for competitive tendering.

We need to find a better way to get the money to remote communities than having the communities being placed in a position where they have to write a grant and compete with everybody else for a small bucket of funds.

Communities are disadvantaged if they do not have demonstrated expertise, but also because of their small numbers.

If you're looking at numbers, just numbers, obviously there's a bigger population in the bigger centres, but the problems are interlinked with a whole lot of other problems as well out bush. And the problems are far worse because of the very limited access to resources and expertise that people in remote areas have, and part of it is to do with the accountability requirements of the funding bodies.

The emphasis placed by funding bodies on quantitative measurements to indicate need and success severely limit access to funds and effective use of them in remote areas.

Until you have built the level of trust, people won't access the information. This doesn't match the funding agenda where you're supposed to say that you've seen 20 people a day.

Funding on a quantitative basis leads to overlap and ineffective service provision.

The inefficiency of funding in this way was emphasised in several consultations. Agencies reported with frustration the wasted time for service providers and community members caused by numerous agencies visiting the same communities, each with limited time to spend because of the requirements that they meet their funding quota.

Out bush, if people can't develop a relationship with the person they're talking to then you've got no hope. You need a level of trust before they'll take in any information, and when you get 10 different agencies going out and delivering the same message in a variety of different ways and people are out there for 2 days, then they disappear and not seen for several months, it's much less relevant than having a continuing organisation coming out on a regular cycle and spending time in the community getting to know people.

Many communities cannot usefully utilise small grants

The problems raised above relate chiefly to the difficulties remote communities experience in accessing larger grants that are open for competitive tendering. In a different consultation the problem with provision of small grants was raised.

A lot of agencies offer small brokerage projects and little buckets of money you can apply for. And just from our experience, that is not the best way to go because communities are usually so stressed and so under-skilled with people who are able to carry out these short term programs, so just giving them 5 thousand dollars to go out run this, it doesn't usually work. And then [the funding body] keep[s] saying, 'why aren't you using all this money we're giving you to do all these little community programs and projects?' ...but it doesn't seem to be the best use of the money.

Long term funding is essential for confidence and skills to develop

The long term nature of work in remote communities was stressed and the need for funding that allows the development of relationships and skills, and that accepts these as measures of success.

People become disheartened ... must be long term, giving the people on the communities the resources to be able to sustain it, not just these ad hoc programs.

Realistic funding is 4 years for any project. 12 months is not long enough for anything. It takes you 12 months to get established and build a rapport. You're not going to have good outcomes until you've been there for a substantial amount of time. You need 4 years and you'll have a better idea of whether this is working or not.

Appendix B SUBMISSIONS TO THE TASKFORCE ON ILLICIT DRUGS

BY DR VALERIE ASCHE, CHAIRPERSON

There were 79 submissions from individuals as well as from organisations and service groups (see attached list). Some of the organisations had consulted other community groups so that the submissions were from a large body of opinion in the NT. All submissions demonstrated awareness of the problems of illicit drugs and offered general advice directed to the Terms of Reference.

This summary has abstracted practical solutions from the recommendations made by the respondents.

A common theme in many of the submissions was that the NT had the highest or near the highest rate of licit and illicit substance use in Australia. This rate comes from much publicised tables in the annual Australian Illicit Drug Reports. The statistical analysis may not be sound as the population of the NT has a significantly lower mean average age, paralleling the "risk taking" group; and the NT has a much higher indigenous population compared with other Australian jurisdictions (28% c.f. <3%).

The submissions concede that alcohol followed by cannabis were the most popular drugs of choice. While it is acknowledged that studies of cannabis and alcohol are not generally within the Terms of Reference of this Taskforce, it is important to recognise and emphasise that polydrug use is common.

TRENDS

Some of the submissions addressed one of the Terms of Reference: *Trends in the pattern of illicit drug use and associated harm (including crime)* in the NT, especially among young people.

1. It was disappointing that there were not many statistics to support the trends of drug use in the NT. The most comprehensive came from the NT Police Force (74). The annual Australian Illicit Drug Report with an up-to-date report from the NT Police Drug Enforcement Unit coupled with the 1998 Household Surveys and recent Menzies School of Health Research data on indigenous Top End communities, confirms that the annual Report presents a picture which is accurate from a police perspective. Each illicit drug is addressed separately and includes manufacture, distribution, prices and seizure by police.

Briefly, the market for **amphetamine type substances** (eg. speed) is diverse and present in all major NT towns. Established Crime Networks (ECNs) control it, with their control of the industry diminishing as individuals learn to manufacture the drugs. Most of the drugs are manufactured locally with some trafficking from interstate. No seizures have been made from Asia in the last 18 months. There is a significant market surrounding nightclubs and backpacker tourists.

MDMA (ecstasy) continues to be the drug of choice amongst nightclub patrons.

Heroin is available in limited quantities and the distribution is consumer based.

With the reduction in availability of heroin there was a marked increase in the dispensing of **morphine** based prescription drugs. This increase has declined due to the DH&CS controlling "doctor shopping".

The distribution network of cocaine is small and consumer based.

2. There is clear and convincing information of an unambiguous direct link between illicit drug use and criminal behaviour (74).

The statistics from the Corrections Medical Services (42) gave recent trends for 2001-2002 for all NT prisons. Hepatitis C (HCV) rates were low compared with southern major prisons (1.9 - 4.6% compared with 50%). Rates of HCV positive tests amongst Aboriginal people were only one third of the remainder which were almost entirely Caucasian. HIV disease has never been a problem.

The identified intravenous drug users in prisons in 2002 were: Top End 120 of 1122 (10.7%), Central Australia 32 of 860 (3.7%).

This submission points out that prisons are important sentinels for observation of community trends particularly as they affect changes in our Aboriginal communities.

Recommendation:

 That prison drug and alcohol data be further developed and co-ordinated through DH & CS.

YOUTH AND FAMILIES

A common theme in the submissions was the lack of facilities (treatment, information, counselling) for youth (22, 33, 39, 48, 49, 51, 75).

There are limited family services for illicit drug use in the NT that deliver a holistic approach to the family in need. The Salvation Army Sunrise Centre Bridge Program (33) offers help as residential and outreach rehabilitation to clients. In the last 6 months of 2001, 19 of 63 clients were assessed. The reasons for the rest were alcohol and cannabis. This centre will be expanding to assist families within the next two years.

CASY House Youth Refuge has accommodated 78 young people, under the age of 18 years in the last 9 months (51). These clients used ecstasy, morphine, LSD, amphetamines with cannabis (61 persons) and alcohol (72 persons). There is no accommodation for families.

The NT Youth Affairs Network (75) surveyed the existing services throughout the NT and recommended that services for youth and families be supported:

- Youth-specific services need to attend to location and access; youth oriented hours of operation; youth-friendly staff; affordability; youth-orientated environment; strong links with other youth services; transparent polices; innovative services and information in a variety of styles.
- Families: Consider the need of couples, clients with children, families of clients and the need to educate/support family members to work with the client.

DUAL DIAGNOSIS

The co-morbidity between mental illness and drug dependency is often called *dual diagnosis*. Provision of services is difficult and when combined with poverty, the impact on people's lives can be dramatic (4, 15, 24, 42, 44, 50). In one submission, a Mental Health Resource worker (24) reported consulting 28 agencies in the first three months of 2002. All are funded under the Supported Accommodation Assistance Program in the NT. This submission stated that:

- (a) There is no appropriately resourced supported accommodation for young people with dual substance abuse/mental illness.
- (b) There is no appropriate accommodation for homeless young people. Children as young as ten years indulging in *chroming* have been clients.
- (c) There are no youth specific treatment services; these clients cannot access those available for adults.

This submission (24) recommended two strategies:

- A co-ordinated approach to services and support. The nomination of a person located in either of the Mental Health Services and/or in Drug Treatment Services to run this co-ordinated service.
- An increase in resources to specifically address the needs of the homeless with dual substance misuse/mental health issues.

One psychiatrist (4) who had treated 30 patients in the past 3 years for dual diagnosis, stated that unless the severe anxiety state was also treated, then drug withdrawal programs were likely to be unsuccessful.

The submission from Corrections Medical Services (42) points out that the NT Correctional Services has no secure facility for holding those who are mentally ill.

Three recommendations are made:

- That further study of dual diagnosis in NT prisons be made to further inform public policy and decision making.
- That rehabilitation strategy be targeted.
- That the care of the mentally ill, disturbed and organically brain damaged within prisons be medicalised rather than criminalised.

TREATMENT SERVICES

Detoxification Services

There were 15 submissions discussing treatment services (11, 18, 25, 31, 32, 36, 42, 46, 48, 53, 54, 55, 56, 59). The majority deplored the lack of a residential detoxification service for Darwin (36) and Alice Springs (11) but acknowledged the value of home-based withdrawal services. A strong recommendation was made for financial support for the re-opening of Greengates in Alice Springs. A purpose built residential drug treatment centre was recommended to replace the existing sub-standard accommodation at Banyan House in Darwin.

Recommendations from 9 Alice Springs agencies (in 25):

- Access to rapid detoxification facilities for 52 weeks per year.
- Detoxification and rehabilitation facilities to cater for clients and families.
- Inpatient detoxification/withdrawal access and facilities.
- Resources to cope with expected rise in home detoxification.
- Medium to long term rehabilitation facilities for all age groups.

PHARMACOTHERAPY/MEDICAL SERVICES

Most of the submissions (8, 10, 14, 21, 27, 28, 34) recommended that the full range of pharmacotherapies be available in the NT. The Pharmacy Board (21) stated that pharmacists, particularly in Darwin, are supportive of pharmacotherapy.

It recommends:

Pharmacists be used if possible to dispense and supervise therapy. Continue to supply needles. The present voluntary contract system between the prescriber, pharmacist and client be made mandatory through use of legislation. A system of "accrediting" pharmacy premises be considered. Pharmacists may need training and on-going advice. Appointment of a responsible person to hold and administer "take-away" doses.

The Top End Division of General Practice (34), representing 142 General Practitioners as well as 41 Associate members, also recommended that the voluntary contract system be maintained and strengthened. At present in the Darwin and Palmerston population there are over 250 patients on voluntary contracts. The Division recommended a number of measures designed to deal with lack of Allied Health support services, psychological services, treatment services and specialist drug services.

The AMA NT Inc (38) recommended the continuation of the voluntary contract system.

In addition a recommendation:

- Adequate resources be available to recruit at least one Drug and Alcohol Specialist.
- Recommendations of the S8 Working Party in response to the Coroner's recommendations be implemented.

One submission from a medical practitioner (40) suggested that a mandatory permit system would reduce the illicit use of prescribed opiates for "chronic pain". There is need for support for practitioners who are under considerable pressure from patients for increased doses of oral opiates.

The pharmacotherapies primarily for the treatment of opioid dependence viz. methadone, buprenorphine and naltrexone were discussed and some submissions stated that the NT should have treatment options which are available in other states.

EDUCATION

Almost all of the submissions pointed out the value of education in prevention of drug use.

The recommendations included:

- Education beginning in early childhood to urban, rural and remote areas in a culturally appropriate manner and targeted at all levels of literacy.
- Innovative education models might be explored eg. successful programs run by the Institute of Aboriginal Development and by the Tangentyere Council targeting petrol sniffers (48).
- The family is the key resource in the prevention, intervention and treatment of the drug problem. The family needs to be supported with information and education to face and positively engage in programs for the users (32).

INFORMATION

Nearly all the submissions deplored the lack of an information service.

The Family Drug Support (22) recommended:

■ The provision of a 24 hour 365-day"hotline"with a data base of all relevant resources in the NT. Family telephone support is already supplied to the NT by the Family Drug Support.

ABORIGINAL COMMUNITIES

ATSIC (NT) and CAAC (9, 12, 41) believe the problem of substance misuse can only be effectively addressed in the long term by the Aboriginal community taking responsibility for the issue and doing something about it.

The CAAC (41) recommended:

- The introduction of methadone, buprenorphine and naltrexone to the primary health care and primary medical care sectors.
- Needles and syringes be readily available.
- NT Government investigates the introduction of "drug courts"; undertake a review of the current legal status of drugs.
- Funding for health and welfare assistance for users be increased.
- Implementation of "Learning Lessons" review of education; implementation of the Primary Health Care Access Program; effective employment programs; Framework Agreements that allow Aboriginal people and communities to be in direct negotiation with government about policies and programs.
- ATSIC (9) supported the "Health is Life" recommendation 24:
- Programs to include: early and opportunistic intervention by health professionals; diversionary and sobering-up shelters, including night patrols; detoxification; rehabilitation including residential and family rehabilitation; follow up after-care.

SUBMISSION LIST

1	BUSHMOB
2	Anonymous
3	Anonymous
4	Consultant Psychiatrist
5	Aust Drug Law Reform Foundation Inc
6	Life Education Top End
7	East Arnhem AOD program
8	General Practitioner
9	ATSIC - NT State Policy Office
10	General Practitioner
11	Green Gates Inc Association
12	Name Withheld by Request
13	Holyoake
14	Name Withheld by Request
15	Anonymous
16	AODP, DHCS
17	(NTU) Northern Territory University
18	Banyan House
19	Heathcliff Distribution
20	(AIVL) Australian Illicit & Injecting Drug Users League
21	Pharmacy Registration Board
22	Family Drug Support
23	Anonymous
24	Team Health
25	(CAAODS) Central Australian Alcohol & Other Services, DHCS
26	(NTAC) Northern Territory Aids Council
27	Pharmacist
28	Medical Board
29	(TUF) Top End Users Forum

30	Name Withheld by Request
31	Family and Children's Services
32	(AAFR) Alcohol Awareness & Family Recovery
33	Sunrise Centre - Salavation Army
34	(TEDGP) Top End Division of General Practice
35	Pharmacy Guild of Australia
36	(NTCOSS) NT Council of Social Services
37	Amity Community Services
38	(AMANT) Australian Medical Association NT
39	Teacher
40	Medical Practitioner
41	Central Australian Aboriginal Congress
42	NT Correctional Services
43	Name Withheld by Request
44	Alice Springs Womens Shelter
45	Mental Health Program
46	Name Withheld by Request
47	(AODP) Alcohol & Other Drug Program - DHCS
48	Name Withheld by Request
49	Wellness Promotion - DH&CS
50	Mental Health Association of CA
51	YWCA
52	Health and Aging
53	Community Mental Health Team Darwin
54	Mental Health Unit Alice Springs
55	Barkly Mental Health Services
56	DH&CS - Mental Health
57	(NDARC) National Drug & Alcohol Research Centre
58	(NDRI) National Drug Research Institute
59	Corrections Medical Service

60	(TEROND TO FE 1.0 1 N. 1 DUICO
60	(TESN) Top End Services Network - DHCS
61	(DEET) Department of Education Employment & Training
62	Amity Community Services
63	(TEDGP) Top End Division General Practice
64	Magistrate
65	Darwin City Council
66	Chief Magistrate
67	Dept of Community Development, Sport & Cultural Affairs
68	Multicultural Council of the NT
69	(CAAPS) Council for Aboriginal Alcohol Program Services
70	Office of the Chief Minister
71	Defence Community Organisation
72	Magistrate
73	Judge
74	NT Police
75	NorthernTerritory Youth Affairs Network
76	Department of Justice
77	Corrections Medical Service
78	Alice People Services
79	Darwin Prison

Appendix C CURRENT SERVICES AND STRATEGIES

INTRODUCTION

This listing of current services and strategies addressing illicit drugs in the Northern Territory has been developed by the Taskforce on Illicit Drugs to indicate what is currently available and what may be the current gaps in services. The 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.

This listing does not attempt to indicate a definitive assessment as to how effective the programs and services are.

1. YOUTH

Currently there are no youth specific alcohol and drug treatment services in the Northern Territory.

Life Choices in Alice Springs and Danila Dilba in Darwin have Commonwealth funded youth specific outreach workers, under the National Illicit Drug Strategy funding.

A number of youth specific services such as ASYASS and CASY House report high numbers of their clients have problems directly related to their substance use.

2. FAMILIES

Alcohol Awareness and Family Recovery (AAFR) in Darwin provides an outpatient service for partners, families, teenagers and children. Provides groups and counselling.

Council of Aboriginal Alcohol Program Services (CAAPS) provides a residential program that takes a family approach.

Holyoake in Alice Springs provides a range of services for families with specific programs for parents, partners, siblings and children of drug users.

There is no designated service at present to provide accurate and accessible information, support and referral information to families when the need arises.

3. PREVENTION AND EARLY INTERVENTION

3.1 School Education

The School Drug Education Project within the Department of Education is currently under review with a high level intergovernmental committee investigating this.

The Drug Awareness and Resistance Education (DARE) program currently conducted by School Based Constables throughout the Northern Territory. School based policing is currently under review at present.

Life Education provides one-off interactive education events for primary schools, together with teacher support materials.

The AODP support school drug education to varying degrees through, for example, provision of information materials, school policy development, and activities for parents and young people in the community. The Cannabis flipchart has recently been developed and widely disseminated through Indigenous communities, and a range of agencies, as a resource tool.

3.2 Parent Education

There is a range of parent education courses and activities available in the Territory, including:

- Parenting programs such as the Triple P program conducted through Community Health Centres and Family and Children's Services.
- The private program How to Drug Proof Your Kids is occurring in some regions.

The DH&CS AODP has produced as well as distributed a range of local and National educational pamphlets, booklets and other material for parents.

4. COMMUNITY ACTION AND PARTNERSHIPS

4.1 Community Partnerships

Partnerships with a range of sports promote the drug free message and involve use of role models. Partnerships have been developed with the NTFL, NTRL, Basketball, and other sporting organisations.

A workplace strategy kit "Taking Care of Business" encompassing workplace policies, education and training, and links to professional services was launched in 2001.

The Top End Services Network and Central Australian Services Network have Community Support Officers, which offer programs for training and supporting

Aboriginal local volunteer alcohol and drug workers to deliver treatment services as well as community development work.

4.2 Early Intervention

Screening and brief intervention services, which detect drug problems prior to dependency and involve education, self-help materials or brief counselling, are being promoted through the DH&CS AOD program.

5. TREATMENT AND REINTEGRATION

5.1 Telephone Information, Advice and Counselling

The Alcohol and Drug Information Network (ADIN) - web based information, is widely promoted in the Territory.

ADS in Darwin and CAAODS in Alice Springs provide telephone information, advice and counselling during business hours.

Amity Community Services in Darwin provide telephone information, advice and counselling during business hours and includes a toll free number for callers outside of Darwin.

NSW Specialist Advisory Service - available to health professionals looking for specialist alcohol and drug information.

5.2 Outpatient Treatment

Outpatient treatment is provided by:

Government

ADS (Darwin) and CAAODS (Alice Springs), specialist drug and alcohol services, which provide outpatient treatment following assessment by a medical officer and/or counsellor.

Alcohol and Other Drug Program in East Arnhem, provides limited outpatient counselling.

Non-government organisations in the Northern Territory.

Darwin - Amity Community Services, Alcohol Awareness and Family Recovery, Employee Assistance Service (EAS), Council for Aboriginal Alcohol Program Services (CAAPS).

Katherine - EAS.

Tennant Creek - BRADAAG, Anyinginyi Alcohol Aftercare

Alice Springs - Drug and Alcohol Services Association (DASA), EAS

5.3 Detoxification Services

Darwin

Darwin Detoxification Unit - government service currently under review, new model to be implemented 1/7/02. At present the unit provides a medical residential detoxification service, with 10 beds

Alice Springs

DASA provides a four- bed detoxification 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.

CAAODS provides a home detoxification program.

Medical detoxification 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.

5.4 Residential Rehabilitation

The following services are funded to provide residential rehabilitation services.

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 historically funded to provide only services for alcohol, with the exception of Banyan House. Service Level Agreements are now being broaden 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.

5.5 Pharmacotherapies

5.5.1 Methadone

3-month withdrawal program, as per ministerial guidelines. Community based pharmacies dispense to all methadone patients.

5.5.2 Naltrexone

Naltrexone treatment is provided by a limited number of GPs following detoxification by conventional methods.

5.5.3 Buprenorphine

6 - 12 month withdrawal program, as per Ministerial Guidelines. Community pharmacies dispense to all buprenorphine clients.

General practitioners have been trained, registered and supported to provide this methadone and buprenorphine as per the current Ministerial Guidelines.

Training has also involved other relevant alcohol and drug, health and pharmacy services.

5.7 Reintegration

Potential need for a development project to increase the extent of support provided for reintegration of people undertaking or leaving drug treatment with respect to:

- Accessing and maintaining housing;
- Improving their education standards and qualifications; and
- Accessing and holding employment.
- Consultation and agreement with providers of housing, vocational education and employment assistance, in the Commonwealth and Territory government and the nongovernment sectors.

6. BROADENING THE PROVISION OF TREATMENT THROUGH OTHER HUMAN SERVICES

6.1 Health Sector

The Social and Emotional Wellness Clinics in the Independent Aboriginal Medical Services, throughout the Northern Territory, including Danila Dilba, Wurli Wurlinjang, Central Australian Congress, Anyinginyi Congress, Miwatj Health.

GPs currently involved in the Opiate Withdrawal Program and the former GP clinic. Alco providing a range of medical services to clients who are attending residential rehabilitation agencies throughout the Territory.

Mental Health Services - in all regions.

The Clinical Advisory Service provided on an adhoc basis by NSW involves specialist doctors providing telephone advice and consultation to general practitioners on a 24-hour basis.

Screening and brief intervention services, which detect drug problems prior to dependency and involve education, self-help materials or brief counselling, are being promoted through the Health sector, particularly in RDH and ASH.

A specialist alcohol and drug medical position has been recently recruited to at ADS, with a primary role to involve other health professionals in this area.

Potential need for a range of initiatives to broaden the provision of alcohol and drug treatment through the mainstream health sector, particularly in regards to frontline workers.

GP strategy - to provide education and support in a range of areas including brief intervention, drug withdrawal, management, and pharmacotherapies.

6.2 Justice Sector

Current investigation and development of a Drug Court system for the Northern Territory by the Department of Justice.

The Department of Correctional Services has a small, dedicated alcohol and drug service, who provide court assessments, individual counselling, group work and referral for medical interventions if necessary. These services are provided at the Darwin and Alice Springs Correctional Centres with some limited outreach to Don Dale Juvenile Detention Centre.

Current project being undertaken to provide advice and recommendations to the Chief Executive Officers (CEO) of the Department of Justice and Department of Health and Community Services regarding use of alcohol and other drug services by clients of Correctional Services and the Courts. Working Group is due to report by 31 May 2002. Particular issues leading to this project were:

• the use of residential alcohol and other drug services as a half-way house for post-release individuals, clients on bail, other court orders and for home detention;

- the provision of assessments for the purpose of court reports and reports for other sections of the Criminal Justice System, such as probation and parole;
- data from the Alcohol and other Drug Client monitoring system indicating the between 20% and 25% of all client admissions to alcohol and other drug services are on conditional status of some sort.

In general, treatment opportunities throughout the prison sentence are limited. Group programs are currently being offered, in Darwin and Alice Springs Correctional Centres.

Need for a Prison to Parole program to support prisoners and young people in detention completing sentences and continuing treatment upon release.

In February 2000 the former Cabinet approved development of the Illicit Drug Pre Court Diversion Program (IDPCDP) and its application to adult and juvenile drug offenders in the Northern Territory. This was in response to the Council of Australian Government (COAG) endorsing the National Illicit Drug Diversion Scheme in April 1999 to enable the police diversion of illicit drug offenders to assessment and treatment rather than prosecution through the courts. This program has recently been agreed to at the Commonwealth level and the implementation process is currently being oversighted by the Diversions Advisory Group (DAG).

6.3 Community Services Sector

A range of generic services in the areas of health, justice, housing, welfare, and youth are involved either directly or in an indirect way in the provision of services to drug users and their families.

The following provides a general list of those that are most likely to be involved in the absence of any specific data in this area.

Darwin

Somerville Community Services; Vietnam Veterans Counselling Service; Centacare; Anglicare; YWCA; A New Start Towards Independence (ANSTI); Coalition of Low Income Earners (COLIE); Sexual assault Referral Centre (SARC); Ruby Gaea House; Dawn House; Darwin Aboriginal and Islander Women's Shelter; Domestic Violence Counselling and Legal Assistance; St Vincent de Paul

Relationships Australia; GROW; Family Law Court Counselling; Centrelink; Territory Housing; Community Corrections; Mission Australia.

Nhulunbuy

Crisis Accommodation; Domestic Violence Counsellor; Miwatj Health; Centrelink; Territory Housing; Community Corrections.

Katherine

Somerville Community Services; Anglicare; Katherine Family Link Up (Centacare); YMCA; St Vincent de Paul - Ormonde House; Katherine Women's Crisis Centre; Domestic Violence Counsellor; Sexual Assault Counsellor; Missionaries of Charity; Centrelink; Territory Housing; Community Corrections.

Tennant Creek

Domestic Violence Counsellor; Sexual Assault Counsellor; Tennant Creek Women's Refuge; Centrelink; Territory Housing; TC Raiders; Community Corrections.

Alice Springs

ASYASS; Anglicare; Centacare; Domestic Violence Counsellor and Legal Service; Sexual Assault Counsellor; Centrelink; Territory Housing; Community Corrections; Relationships Australia; Central Australian Aboriginal Congress; Tangentyere Council; Bill Braitling Centre

7. LAW ENFORCEMENT

7.1 Legal Framework

The major source of Northern Territory legislation in relation to illicit drugs is the Misuse of Drugs Act.

The Poisons and Dangerous Drugs Act (PADDA) currently prohibits the use of Schedule 8 medications (methadone, buprenorphine) for the purposes of addiction, except for provisions set out in Ministerial guidelines.

Need for legislation in line with other jurisdictions, which would require medical

practitioners to notify a delegated individual when they become aware of a person who is "addicted to drugs". The Health Department would maintain a register of such notifications. The purpose would be to control inappropriate access to "drugs of addiction" (Schedule 8 drugs).

The Commonwealth Government's Customs Act 1901 creates offences in relation to the importation of "narcotic goods" and operates in conjunction with the Narcotics Drugs Act 1967, to give effect to Commonwealth's obligations under the United Nations Single Convention on Narcotic Drugs 1961.

The Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act which came into force in February 1993, was enacted to meet treaty obligations under the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.

The United Nations Single Convention of Narcotic Drugs states that "possession, use, trade in, distribution, import, export, manufacture and the production of drugs is exclusively limited to medical and scientific purposes".

The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances was established to improve the range of international cooperative measures to be applied against drug trafficking. This is affected by obliging States and Territories to implement measures to counteract cross border drug trafficking and related criminal activities, which can be targeted against money laundering, and the unregulated movement of precursor and essential chemicals. It also provides a framework for the extradition of those involved in drug trafficking outside a jurisdiction and for cooperation between law enforcement bodies across national boundaries.

7.2 Diversion Programs

7.2.1 Police Diversion

A national framework to compel early offenders into compulsory assessment and participation in treatment through police diversion, which allows for differences between States and Territories, has been endorsed by the Northern Territory.

The current Northern Territory approach is still under development and it is intended that first time minor drug offenders will be eligible for police diversion. Participation is at the discretion of police and requires the informed consent of the offender.

8. HARM REDUCTION

8.1 Needle and Syringe Programs

Needle and syringe programs, including education, are the key strategy to reduce the spread of blood borne viruses (principally HIV-AIDS, hepatitis C).

Currently there are 2 primary NSPs, Darwin at the Aids Council (NTAC) and in Alice Springs at Life Choices.

Injecting equipment is also available though Clinic 34s in the regional centres and from selected Hospital Accident and Emergency departments.

8.2 Top End Users' Forum (TUF)

TUF is a peer-based organisation that currently receives only project funding.

9. LINKING DRUG STRATEGY INTO OVERALL SOCIAL POLICY

Potential need for a high level intergovernmental group comprising representatives of all agencies with social policy responsibilities: Health, Police, Justice, Education, Community Development including Youth, Aboriginal Affairs, Housing, Training, and the AODP.

A number of prevention and early intervention strategies can impact on multiple risk behaviours and social problems though their primary focus is on drug misuse.