



LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

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

INTERIM REPORT

March 2019

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Chair's Preface

The Select Committee on a Northern Territory Harm Reduction Strategy for Reducing Addictive Behaviours (the Committee) was established on 10 May 2018 to investigate how best to prevent or mitigate the harms that stem from addictive behaviours in the NT. This interim report outlines the activities and preliminary findings of the Committee to date and identifies the actions required to complete the inquiry.

Addictive behaviours and related harms are a significant problem in the Northern Territory, with consumption of a range of licit and illicit drugs being substantially higher than elsewhere in Australia. A central aim of this inquiry is to identify an approach to reducing drug-related harms that takes account of new innovative approaches to harm reduction but which will also be effective in the unique NT environment.

The Committee is reviewing health focused strategies and regulatory changes that have been implemented both locally and internationally. Some countries, such as Portugal, have made significant changes to the regulatory environment and combined this with substantial investment in drug treatment, harm reduction and social reintegration policies. By contrast, Switzerland has focused primarily on the strengthening of health strategies through a four pillar approach which emphasises prevention, treatment, harm reduction and law enforcement. The four pillar model has also recently been recommended by the Victorian Parliamentary Inquiry into Drug Management and Reform.

The Committee has collected a substantial amount of evidence regarding the specific needs of the NT, the services being provided, the gaps in services and the unique challenges that service providers face when delivering programs to a widely dispersed population characterised by cultural diversity.





The next step for the inquiry is to hear from people in more remote parts of the Territory to better understand their particular needs and challenges. The evidence collected at a local Northern Territory level will be considered in conjunction with the broader review of health focused strategies and regulatory reforms to determine new approaches that are appropriate to the Northern Territory. The combined evidence will be used to develop options for a strategy to reduce addictive behaviours.



Mr Jeff Collins MLA

Chair

Committee Members

	Jeff Collins MLA Member for Fong Lim	
	Party:	Independent
	Committee Membership	
	Select:	Northern Territory Harm Reduction Strategy for Addictive Behaviours
	Chair:	Northern Territory Harm Reduction Strategy for Addictive Behaviours
	Sandra Nelson MLA Member for Katherine	
	Party:	Territory Labor
	Parliamentary Position:	Acting Deputy Speaker
	Committee Membership	
	Standing:	House, Public Accounts
	Sessional:	Social Policy Scrutiny
Select:	Northern Territory Harm Reduction Strategy for Addictive Behaviours	
Chair:	Public Accounts	
	Gary Higgins MLA Member for Daly	
	Party:	Country Liberals
	Parliamentary Position:	Leader of the Opposition
	Committee Membership	
	Standing:	House, Standing Orders, Members' Interests
	Sessional:	Economic Policy Scrutiny
Select:	Northern Territory Harm Reduction Strategy for Addictive Behaviours	
	Lawrence Costa MLA Member for Arafura	
	Party:	Territory Labor
	Committee Membership	
	Sessional:	Economic Policy Scrutiny
Select:	Northern Territory Harm Reduction Strategy for Addictive Behaviours	
<p>On 3 December 2018, the Member for Goyder, the Hon Kezia Purick MLA, was discharged from the Committee.</p> <p>On 1 February 2019, the Member for Port Darwin, the Hon Paul Kirby MLA, was discharged from the Committee and replaced by the Member for Arafura, Mr Lawrence Costa MLA.</p>		

Committee Secretariat

First Clerk Assistant:	Russell Keith
Committee Secretary:	Jennifer Buckley
Senior Research Officer:	Neil Wright (7/8/2018 – 19/10/2018)
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Acknowledgments

The Committee acknowledges the individuals and organisations that have provided written submissions to this inquiry or who have provided evidence at public forums and hearings. The Committee also acknowledges the Northern Territory Police, Department of Attorney-General and Justice and the Department of Health for providing input at a public briefing.

Acronyms and Abbreviations

AADANT	Association of Alcohol and Other Drug Agencies NT
ACT	Australian Capital Territory
ACCHO	Aboriginal Community Controlled Health Organisation
ADF	Alcohol and Drug Foundation
ADU	Automatic Dispensing Unit
AMSANT	Aboriginal Medical Services Alliance NT
AOD	Alcohol and Other Drugs
CAAC	Central Australian Aboriginal Congress
CAAPS	Council for Aboriginal Alcohol Program Services
CDC	Centre for Disease Control
CLANT	Criminal Lawyers Association of the Northern Territory
CRTIC	Culturally Responsive Trauma Informed Care
DORA	Drugs and Poisons Information System Online Remote Access
HASI	Housing Accommodation Support Initiative
HRA	Harm Reduction Australia
IDRS	Illicit Drug Reporting System
NAAJA	North Australian Aboriginal Justice Agency
NDSHS	National Drug Strategy Household Survey
NGO	Non-government Organisation
NSP	Needle and Syringe Program
NT	Northern Territory
NT DOH	Northern Territory Department of Health
NT PHN	Northern Territory Primary Health Network
NTAHC	Northern Territory AIDS and Hepatitis Council
RTPM	Real-Time Prescription Monitoring

Terms of Reference

The Legislative Assembly resolved on 10 May 2018 that:

1. A Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours be appointed comprising three (3) Government Members, one (1) Opposition Member and one (1) independent Member to be nominated in writing to the Speaker by the relevant Whip or non-party aligned Member by 18 May 2018
 - (1) Best practice, humanitarian approaches that effectively reduce the damage caused by illicit drug-use through effective harm reduction policies and legislation; and
 - (2) Identify best practice strategies that have a coordinated treatment approach to deal with the broad-range of addictive behaviours; including, but not limited to, alcohol, tobacco and gambling.
2. The Inquiry is established in the May Sittings 2018 and is to provide an interim report by 12 March 2019, and finally report back to the Assembly by 31 August 2019.

Proposed scope of Inquiry:

The Inquiry is to review the available evidence regarding effective harm reduction strategies used to address health problems associated with illicit drug-use and other addictive behaviours and, also, strategies for reducing the impact of these behaviours on families and the broader community.

The proposed Inquiry will look at:

1. The current scale and trends of illicit drug-use in the Territory and its impacts upon health, justice, drug and alcohol and law enforcement activities;
2. Current harm reduction measures available in the Northern Territory and other jurisdictions and their alignment with the National Drug Strategy;
3. A review of best practice evidence in the following areas to support the development of a revised harm reduction framework for the Northern Territory:
 - (1) Medical response and ongoing treatment,
 - (2) Health interventions such as:
 - i. Needle and syringe programs;
 - ii. Medically supervised injecting facilities; and
 - iii. Pill testing.
 - (3) The adoption of culturally relevant health and education interventions;
 - (4) Police and criminal justice responses to drug-related offending;
 - (5) Police and court diversion programs;
 - (6) Drug driving programs;
 - (7) Public awareness campaigns, including school-based education; and
 - (8) Support for affected families and communities.
4. Effective strategies for coordination across treatment facilities to also provide for addictive behaviours more broadly.

Resolved by the Legislative Assembly on 10 May 2018 and amended on 14 February 2019.

1 Introduction

- 1.1 The Select Committee on a Northern Territory Harm Reduction Strategy for Reducing Addictive Behaviours (the Committee) was established on 10 May 2018 in response to growing concerns about the adverse impacts of licit and illicit drug use in the Northern Territory (NT). These concerns are real and justifiable, with data showing that the NT consistently reports higher rates of daily smoking, risky alcohol consumption and cannabis use than is evident in other Australian jurisdictions¹. The seriousness of the issues facing the NT indicate the importance of exploring emerging new approaches to the management of drug related harms, such as those being applied in some overseas jurisdictions where the trend is to treat illicit drug use as a health issue rather than a criminal behaviour.² Similarly, a recent Victorian parliamentary inquiry has emphasised the need to better balance health and law enforcement approaches to drug use, with the emphasis on a health oriented approach.³
- 1.2 A central task of this inquiry is to identify the approach that is most likely to be effective in reducing drug related harms in the NT. In doing this, the Committee is taking into consideration innovative approaches and best practice harm reduction and treatment strategies being implemented in both Australian and overseas jurisdictions. However, it notes, also, the importance of assessing the extent to which such approaches can be successfully adapted to the NT, given its unique characteristics. For instance, the dispersal of a small population across a large geographic area, and the high proportion of Aboriginal residents in the NT, pose significant challenges to the development of a cost effective, culturally appropriate, and humane strategy for managing the harms associated with drug related and other addictive behaviours.
- 1.3 The purpose of this Interim Report is to describe the work undertaken to date and to identify the actions required to complete the inquiry. Although the report presents preliminary findings, it does not provide an analysis of the findings. The analysis is a critical next step in the inquiry and will form the basis for recommendations to Government regarding the development of a Harm Reduction Strategy for Addictive Behaviours.
- 1.4 The remainder of this chapter outlines the scope of the inquiry and the work undertaken to date. Chapter 2 provides an overview of the scale of licit and illicit drug use in the Northern Territory and how this has changed over time, while chapter 3 examines the policy context for drug management in the NT and other jurisdictions, both in Australia and overseas. Preliminary findings are presented in chapter 4, with evidence drawn largely from submissions and discussions during public hearings and

¹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, Drug Statistics series no. 31, Cat. no. PHE 214, Canberra: AIHW, 2017.

² European Monitoring Centre for Drugs and Drug Addiction, *Portugal, Country Drug Report 2017*, Publications Office of the European Union, Luxembourg, 2017.

³ Victorian Government, *Response to the Parliamentary Inquiry into Drug Law Reform*, August 2018, p. 5.

forums. Chapter 5 concludes the report with a summary of future actions required to meet the objectives of the inquiry in line with the Committee's Terms of Reference.

Scope of the inquiry

- 1.5 The term 'addiction' is often understood in various ways according to particular contexts and specific objectives.⁴ However, a synthesised definition describes it as 'a strong and habitual want that significantly reduces control and leads to significant harm'.⁵ In other words, addiction is a continually repeated behaviour that, over time, diminishes an individual's self-control and ultimately results in harm to self and/or others. It is in this context that the report applies the term 'addictive behaviour' when referring to harms associated with the consumption of alcohol, tobacco, other drugs and gambling.
- 1.6 The Terms of Reference (ToR) for the inquiry are very broad and specify a focus on illicit drug use and other addictive behaviours. In addition, the ToR state that the inquiry should identify best practice harm reduction strategies and strategies that have a coordinated treatment approach for dealing with addictive behaviours.
- 1.7 It is the Committee's view that the intent of the ToR is for the inquiry to focus on addictive behaviours associated with misuse of licit and illicit drugs and gambling. Consequently, while acknowledging the importance of other addictive behaviours, the scope of the inquiry will be limited to substance use issues and gambling. Within this broad scope, the inquiry will address:
- The current scale and trends of licit and illicit drug use in the Territory;
 - Policy and legal frameworks for drug management in the NT, Australia, and overseas;
 - Current harm reduction measures being applied in the NT and other Australian and overseas jurisdictions;
 - Treatment programs; and
 - Coordination of treatment programs across government agencies and non-government organisations.

Resources for the inquiry

- 1.8 Taking into account the volume of work which is currently managed by the Committee Office, the Committee wrote to the Minister for Health on 5 June 2018 requesting additional resources to assist with the inquiry. The request was granted on 6 July 2018 through the secondment of a Senior Research Officer whose primary role is to assist with the collection and analysis of evidence and the preparation of the final report. This position remains wholly funded by the Department of Health. All other

⁴ RA Wise & GF Koob, 'The development and maintenance of drug addiction', *Neuropsychopharmacology*, vol. 39, 2014, pp. 254-262.

⁵ W Sinnott-Armstrong & H Pickard, 'What is addiction?', in KWM Fulford, M Davies, RT Gipps, G Graham, J Sadler, G Strangellini & T Thornton (eds), *The Oxford Handbook of Philosophy of Psychiatry*, OUP Oxford, 2013, pp. 851-864.

aspects of the Committee’s work will be managed through the usual Committee Office processes.

Work undertaken to date

- 1.9 The Committee’s initial focus has been on collecting evidence from a wide range of sources including: drug related datasets; academic literature; submissions; and public briefings, hearings and forums.
- 1.10 The Committee called for submissions on 23 July 2018 by advertising through the Legislative Assembly website, Facebook, Twitter, media release and the Committee’s email subscription service. The Committee also directly contacted relevant stakeholders to advise them of the call for submissions. A total of 33 submissions were received from a wide range of organisations and individuals (Appendix 1).
- 1.11 In addition to the call for submissions, the Committee developed a comprehensive program of public hearings and forums. These were planned for both urban and regional locations to ensure that the inquiry captures and considers the viewpoints and experiences of stakeholders from across the Northern Territory. To date, public hearings and forums have been held in Darwin, Katherine, Tennant Creek and Alice Springs. The list of attendees at these public hearings and forums is provided in Appendix 2. Four more public forums are scheduled, three in the East Arnhem region and one in the Tiwi Islands. Tables 1 and 2 provide a summary of the Committee’s past and planned activities, from its establishment in May 2018 to the tabling of the final report in August 2019.

Table 1: Committee activities - completed

DATE	TASK
1 June 2018	Deliberative meeting
23 July 2018	Call for submissions
23 July 2018	Deliberative meeting
16 August 2018	Deliberative meeting
30 August 2018	Public briefing with Police, Fire and Emergency Services; Department of the Attorney-General and Justice; and Department of Health
7 September 2018	Submissions due
September 2018	Consideration of submissions
25 September 2018	Deliberative meeting
27 September 2018	Public forum in Darwin
31 October 2018	Deliberative meeting
5 November 2018	Public hearing in Tennant Creek
5 November 2018	Public forum in Tennant Creek

DATE	TASK
6 November 2018	Public hearing in Alice Springs
6 November 2018	Public forum in Alice Springs
15 November 2018	Deliberative meeting
15 November 2018	Public hearing in Darwin
28 November 2018	Deliberative meeting
10 December 2018	Public hearing in Katherine
10 December 2018	Deliberative meeting
15 February 2019	Public hearing in Darwin
15 February 2019	Deliberative meeting
6 March 2019	Deliberative meeting
12 March 2019	Public hearing with Dr Nuno Capaz, Vice-President, Commission for the Dissuasion of Drug Addiction of Lisboa, Portugal

Table 2: Committee activities - in progress

DATE	TASK
28 March 2019	Public forum in Nhulunbuy
28 March 2019	Public forum in Gunyangara
29 March 2019	Public forum in Yirrkala
April 2019	Public forum and hearings in Tiwi Islands
May - July 2019	Consideration of evidence and development of recommendations
July 2019	Revision of first draft report
August 2019	Adoption of final draft report and tabling of report in the Assembly

Meetings on Canadian reforms

1.12 In addition to the Committee activities described above, the Chair of the Committee took advantage of travel to Canada for other business to set up meetings with key stakeholders involved in Bill C-45. Bill C-45 legalised the personal use of marijuana in Canada and was enacted on 17 October 2018, during the Chair's visit. Meetings were held with:

- Members of the Standing Committee of Social Affairs, Science and Technology which conducted the inquiry into Bill-C45;
- Dr Mark Ware, Vice Chair of the Task Force on Cannabis Legalisation and Regulation;

- Valerie Gideon, Senior Assistant Deputy Minister, First Nations and Inuit Health Branch; and
- Dr Amy Porath, Director of Research and Policy at the Canadian Centre on Substance Use and Addiction.

These meetings, which took place between 12-23 October 2018, provided useful insights into the challenges associated with drug management and reform, with minimal expenditure by the Committee.

2 Scale and Trends Of Illicit Drug Use In The Northern Territory

- 2.1 Establishing the scale and trends of illicit drug use in the Northern Territory poses significant challenges as the NT does not currently have a discrete system for collecting this type of data. Publicly available data on illicit drug use in the NT are primarily sourced through national datasets, with states and territories providing local input. As there is no single data source that provides comprehensive and accurate data on prevalence, the inquiry has drawn on several different types of datasets in order to build as accurate a picture as possible of the scale and trends of illicit drug use in the NT. The type of information contained in these datasets is included in Appendix 3.
- 2.2 This chapter provides a brief overview of drug use in the NT in relation to the following illicit drugs: cannabis, methamphetamine (e.g. ice, speed, uppers, crystal), MDMA (ecstasy), cocaine and heroin. In order to provide a comparison with licit drugs it also briefly examines data on alcohol and tobacco use. Illicit drug use encompasses:
- Illegal drugs such as cannabis, heroin, hallucinogens and methamphetamine;
 - Pharmaceutical drugs that are misused or used illicitly, such as morphine, oxycodone, fentanyl, tranquilisers/sleeping pills, methadone and buprenorphine; and
 - Other psychoactive substances which can be legal or illegal such as kava, synthetic cannabis, and inhalants.⁶

Overview of Illicit drug use in the NT

- 2.3 Based on findings from the 2016 National Drug Strategy Household Survey (NDSHS), the percentage of people using illicit drugs in the NT has remained consistently higher than that in other Australian jurisdictions.⁷ This is despite the fact that the rate of illicit drug use in the NT has decreased considerably, from 28.7% in 2001 to 21.6% in 2016 (Table 3).
- 2.4 The 2016 NDSHS survey found that recent illicit drug use⁸ in the NT was higher among males (25.4%) than females (17.3%). In terms of age groups, recent use was highest among Territorians aged 20-29 (28.7%), followed by those aged 14-19 (25.6%). However, the 30-39 and 50-59 age groups also had quite high usage at 22.0% each. Data for the 14-19 age group should be treated with caution due to a high level of sampling error.

⁶ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 53.

⁷ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 15.

⁸ In the NDSHS, recent illicit drug use refers to drug use within the 12 months preceding the survey.

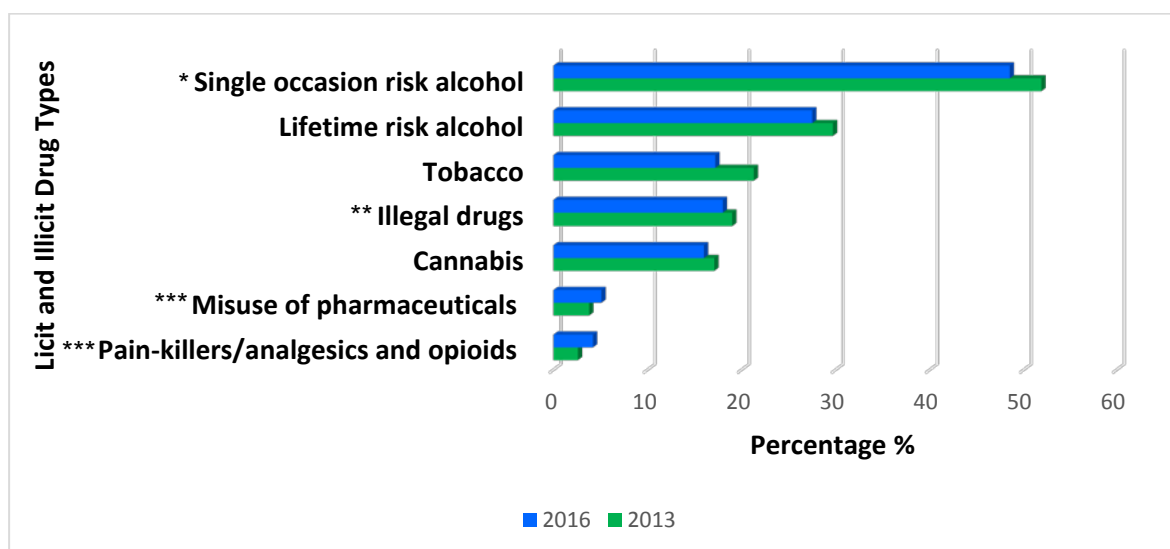
Table 3: Percentage of people aged 14 years or older who recently used illicit drugs^(a), by state/territory (2001 – 2016)

State/territory	2001	2004	2007	2010	2013	2016
NSW	15.6	14.6	12.1	13.8	14.2	14.7
Vic.	15.9	14.3	12.8	13.7	14.3	15.0
Qld	16.3	15.9	13.7	15.1	15.5	16.8
WA	21.7	17.3	16.2	18.6	17.0	16.8
SA	17.6	15.4	14.7	14.9	15.7	15.7
Tas.	14.4	15.4	14.8	12.0	15.1	17.4
ACT	17.8	17.6	13.8	13.9	15.3	12.9
NT	28.7	26.0	20.4	21.3	22.0	21.6
Australia	16.7	15.3	13.4	14.7	15.0	15.6

Source: NDSHS 2016. ^(a)Used at least 1 of 16 illicit drugs in 2016 – the number and type of illicit drugs used varied between 1998 and 2016 (includes pharmaceuticals).

2.5 Figure 1 shows that alcohol continues to be the most commonly used drug in the Territory. Similarly, a substantial proportion of Territorians continue to use tobacco, however, there have been significant decreases in tobacco use, from 40% in 1998 to 17% in 2016.⁹ In 2016, the percentage of Territorians using any illegal drug was slightly higher than the percentage using tobacco. Similar findings regarding alcohol and tobacco are available from the National Wastewater Drug Monitoring Program (Wastewater Analyses) which found the Northern Territory to have the highest consumption of nicotine and alcohol.¹⁰ By contrast, misuse of pharmaceutical drugs has increased from 3.8% in 2013 to 5.1% in 2016.¹¹

Figure 1: Licit and Illicit Drug Use in the NT, 2013 and 2016



Source: NDSHS 2016. *Single occasion risk includes weekly, monthly and yearly; **Excludes pharmaceuticals; ***Excludes over the counter (OTC) drugs

⁹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 18.

¹⁰ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6*, December 2018, p. 12; note that Wastewater Analyses measures nicotine instead of tobacco.

¹¹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*.

Cannabis

- 2.6 Findings from both the 2016 NDSHS and the Wastewater Analyses¹² indicate that cannabis use is higher in the NT than any other Australian jurisdiction, with 16% of Territorians reporting recent use in 2016 compared to 10.4% for Australia overall.¹³ Wastewater analyses similarly showed that, of all the sites tested across the country, regional NT has the highest overall use, with this far exceeding the national average.¹⁴
- 2.7 Cannabis use is substantially higher among injecting drug users in the NT than in users who do not inject drugs, with 60% of survey respondents reporting use of cannabis in the last six months.¹⁵ Daily use of cannabis is common (46% of recent users) and the majority most often use hydroponic (86%) rather than 'bush' cannabis (9%).¹⁶
- 2.8 Cannabis accounts for the largest number of charged drug offences in the NT: 51% in 2017-18 and 61% over the period 2000-01 to 2017-18.¹⁷ Analyses of the overall figures show a 40% increase in cannabis-related offences in the 2017-18 period compared to 2000-01.

Ecstasy

- 2.9 Data from both NDSHS and Wastewater Analyses suggest that, proportionally, ecstasy use is more common in the Territory than in other Australian jurisdictions, with 2.9% of participants reporting ecstasy use compared to 2.2% nationally.¹⁸
- 2.10 In all jurisdictions, more males than females used ecstasy, however, the gender difference in the NT is considerably larger than elsewhere. Nationally, 2.6% of recent ecstasy users were male and 1.8% female, while in the NT 4.3% were male and only 1.3% female.¹⁹

Methamphetamine

- 2.11 Methamphetamine is available as powder/pills (speed), crystal methamphetamine (crystal meth or ice) and a sticky paste (base), with ice being the most pure form.²⁰ Although the 2016 NDSHS survey reported a significant decline in recent

¹² Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6*, 2018.

¹³ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*.

¹⁴ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6*, 2018.

¹⁵ C Moon, *Northern Territory Drug Trends 2018: Key Findings from the Illicit Drug Reporting System Interviews*, National Drug and Alcohol Research Centre, UNSW Sydney, 2019, p. 20.

¹⁶ C Moon, 2019, p. 21.

¹⁷ Department of the Attorney-General And Justice, Submission No. 6, 2018, p. 9; These are drug offences that were charged at apprehension (not including infringement notices) and proceeded to court.

¹⁸ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 16.

¹⁹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*.

²⁰ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*.

methamphetamine use across Australia, the use of ice as the predominant form has increased from 22% in 2010 to 57% in 2016.²¹ Ice poses higher risks than speed in terms of the potential for dependence and physical and mental problems, and data suggest that a preference for ice tends to correspond with more frequent use.²²

- 2.12 Based on 2018 Wastewater Analyses, regional NT had the lowest levels of methamphetamine use of all Australian test sites.²³ However, in the capital city site, methamphetamine use was on a par with or above the national average and was only surpassed by South Australia and Western Australia.²⁴
- 2.13 Recent use of any methamphetamine in the NT injecting drug user population declined substantially between 2002 and 2014 but recent results show that it has increased beyond 2002 levels (73%) to 75% in 2018.²⁵ The majority of NT respondents reported use of ice rather than speed or base.²⁶ NT Illicit Drug Reporting System (IDRS) survey data suggest that ice is easier to obtain than other forms of methamphetamine, with 93% of respondents reporting that it was 'easy' or 'very easy' to obtain.²⁷

Cocaine

- 2.14 Based on NDSHS data, cocaine use has increased both nationally and in the NT between 2010 and 2016. These data place cocaine use in the NT on a par with Victoria, with usage increasing from 0.5% in 2010 to 2.5% in 2016. New South Wales is the only state/territory with a higher proportion of users (3.4%).²⁸ These findings are echoed in Wastewater Analyses which found that the number of doses per 1000 people in the NT capital city site was higher than the average of capital city sites elsewhere in Australia, with only NSW having higher consumption in capital city sites.²⁹
- 2.15 Cocaine use in the NT occurs primarily in the city, with the NT having the lowest regional rate of use. Although NDSHS data suggests that, nationally, cocaine is the second most commonly used illegal drug after cannabis³⁰, the 2018 Wastewater Analyses suggest that methamphetamine is the highest consumed illegal drug across

²¹ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 8.

²² Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 69.

²³ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6, 2018*.

²⁴ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6, 2018*, p. 45.

²⁵ C Moon, 2019, p. 14

²⁶ C Moon, 2019, p. 15

²⁷ C Moon, 2019, p. 18

²⁸ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 91.

²⁹ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6, 2018*, p. 28.

³⁰ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*, p. 9.

all Australian jurisdictions.³¹ In the NT, the increase in cocaine use has been for males, with use among females decreasing from 1.6% in 2013 to 0.8% in 2016.

Heroin

- 2.16 Data from the NDSHS indicates that the number of injecting drug users is relatively small across Australia and in the NT, and has generally been stable between 2013 and 2016. Although recent use of heroin and other injecting drugs is low in the NT, these drugs are highly addictive and are associated with risk factors for transmitting blood borne viruses. In addition, the frequency of use is much higher than for other drugs, with users often injecting twice a week or more.
- 2.17 Only 8.0% of participants in the 2018 NT Drug Trends Survey injected heroin in the previous six months, of these, 22% injected heroin daily compared to 67% who injected weekly or less.

Illicit pharmaceuticals

- 2.18 Comparing results on misuse of pharmaceuticals across different data sources is difficult as each source examines different drugs. Broadly, the pharmaceutical drugs most likely to be subject to misuse can be divided into the following categories: painkillers/analgesics and opioids; tranquilisers/sleeping pills; drugs to treat opioid dependence (e.g. buprenorphine, methadone); and steroids.
- 2.19 Based on NDSHS data, misuse of pharmaceutical drugs is highest in states and territories with older populations, such as Tasmania (5.6%) and South Australia (5.5%). However, despite its young population, the NT proved the exception to this trend, and had the third highest percentage of people misusing pharmaceutical drugs (5.1%).³² This contrasts with data from Wastewater Analyses which suggest misuse of pharmaceutical drugs is comparatively low in the NT compared with other Australian jurisdictions.
- 2.20 In the Territory, misuse of these pharmaceuticals is primarily related to drugs classified as painkillers/analgesics and opioids (excludes over the counter drugs), with 4.2% misusing these types of drugs, compared to only 1.8% misusing tranquilisers/sleeping pills, and negligible numbers misusing steroids or methadone/buprenorphine.³³ Data from the NT Drug Trends Survey of injecting drug users indicates that morphine is the most commonly misused opioid (76% in 2016), with the percentage misusing other opioids considerably smaller.³⁴

³¹ Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report 6*, 2018.

³² Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*.

³³ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: detailed findings*.

³⁴ C Moon, *Northern Territory Drug Trends 2017: Findings from the Illicit Drug Reporting System*, Australian Drug Trend Series No. 188, National Drug and Alcohol Research Centre, UNSW Sydney, 2018, p. 20.

3 Policy Context

Framing drug policy as a health issue

- 3.1 There is an emerging global trend to approach the management of drug misuse through a health lens. Methods for implementing this concept vary but include both the development of more sophisticated strategies to manage the adverse impacts of drug use and, to varying degrees, the decriminalisation of drugs. For example, Switzerland has introduced a four pillar drug policy framework which facilitates a more focused approach to strategies related to prevention, treatment, harm reduction and law enforcement. Although it has introduced a low level of decriminalisation with respect to cannabis, the possession and consumption of all other illicit drugs continues to be a criminal offence. Portugal has combined decriminalisation of all illicit drugs for personal use with intensive investment in drug treatment, harm reduction and social reintegration policies. At a more local level, recommendations made by the Parliament of Victoria, Law Reform, Road and Community Safety Committee strongly emphasise the adoption of a health approach to drug management and specifically recommend the adoption of a four pillar model.
- 3.2 Drug-related strategies and programs are framed and influenced by the legislative environment in which they are developed and implemented. Consequently, the development of recommendations for the formulation of a harm reduction strategy for the Northern Territory also requires consideration of the current legislative environment.
- 3.3 From a legislative perspective, drugs are generally managed through prohibition, decriminalisation or legalisation. Under prohibition, the production, sale and possession of illicit drugs is a criminal offence.³⁵ By contrast, legalisation removes any criminal and civil penalties for the possession, use, production and/or supply of drugs that would otherwise be deemed illegal.³⁶ Decriminalisation functions as a mid-way point and reduces, rather than removes, the legal penalties for specific drug offences, usually possession of drugs for personal use and, in some instances, cultivation of drugs.³⁷
- 3.4 Traditionally, prohibition has been the most common model both in Australia and overseas, however, there is growing debate as to whether this is the most effective model for managing drug use and addiction. The decriminalisation and legalisation of drugs is a contentious subject with vociferous advocates on both sides of the debate. A key concern is that a move away from prohibition will result in an increase in drug use. Conversely, advocates for decriminalisation and legalisation argue that these models would have positive effects by removing the stigma and fear of prosecution associated with drug use and thereby encouraging users to seek

³⁵ HG Levine, 'Global drug prohibition: its uses and crises', *International Journal of Drug Policy*, vol. 14, 2003, pp. 145-153.

³⁶ Commonwealth, Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice) Final Report*, 2018, Chapter 6.

³⁷ Commonwealth, Joint Committee on Law Enforcement, *Inquiry into crystal methamphetamine (ice) Final Report*, 2018, Chapter 6.

treatment. Central to the debate is whether drug use and addiction should be treated as a health problem or a crime.

- 3.5 Australia predominantly operates under a prohibition model except for alcohol, tobacco and, to some extent, cannabis. Cannabis is largely decriminalised in Australia through a mix of *de jure* and *de facto* schemes,³⁸ with the ACT, NT and South Australia operating *de jure* decriminalisation schemes and the remaining jurisdictions operating *de facto* schemes.
- 3.6 The type of legislative framework in place affects the type of programs that can be implemented, the nature of the strategies that are developed, and the allocation of funding. In this respect, a recent report by the Victorian Law Reform, Road and Community Safety Committee noted that:

While Australia's official approach to drugs is based on harm minimisation, the predominant focus is law enforcement to reduce the supply of illicit drugs in the community.³⁹

- 3.7 Although supply reduction through law enforcement is a legitimate focus it has been argued that it receives a disproportionate amount of funding compared to harm reduction, treatment and prevention initiatives.⁴⁰ In this respect, Professor Lee noted the following:

When you look at the implementation of the policy across Australia, and implementation is largely a matter for the states and territories, it is quite unbalanced. An analysis from the Drug Policy Modelling Program based in New South Wales, showed that only about 2% of drug funding is explicitly spent on harm reduction activities and about 66% on law enforcement or supply reduction. The remainder is on prevention and treatment. Harm reduction itself as an exclusive strategy is poorly resourced.⁴¹

Northern Territory policy context

- 3.8 The legislative framework in the Northern Territory is effectively a prohibition model, with all drugs other than alcohol and tobacco classed as illegal. Alcohol is dealt with under a range of Acts including the *Liquor Act 1978* (NT), the *Liquor Commission Act 2017* (NT) and the *Alcohol Harm Reduction Act 2017* (NT). Tobacco is covered under the *Tobacco Control Act 2002* (NT). Use of Illicit drugs is dealt with under the *Misuse of Drugs Act 1990* (NT) (the Act). Cannabis continues to be classed as an illicit drug but has been decriminalised for personal use.
- 3.9 In relation to cannabis, the Act provides that a police officer may issue a drug infringement notice to a person found cultivating not more than 2 cannabis plants or in possession of up to 50 grams of cannabis plant material (or up to 10 grams of

³⁸ *de jure* schemes entail legislation that removes or replaces criminal penalties with civil or administrative penalties; *de facto* schemes occur through non-enforcement of the law through permitted police discretion or police or prosecutorial guidelines.

³⁹ Parliament of Victoria, Law Reform, Road and Community Safety Committee, *Inquiry into Drug Law Reform*, 2018, p. 2.

⁴⁰ Parliament of Victoria, Law Reform, Road and Community Safety Committee, *Inquiry into Drug Law Reform*, 2018, p. 79.

⁴¹ N Lee, 360Edge, Darwin Public Hearing transcript, 15 November 2018, p. 39.

cannabis resin, 10 grams of cannabis seed, or 1 gram of cannabis oil).⁴² The prescribed amount for an infringement notice offence is 2 penalty units which is currently \$308. It is important to note that Part IIB of the *Misuse of Drugs Act 1990* (NT) does not require an infringement notice to be issued, therefore it is at the discretion of the police officer whether a notice is issued or the person is charged with an offence.

- 3.10 To avoid any further action after an infringement notice has been issued, offenders must pay the prescribed amount within 28 days. Alternatively they may elect to have the matter dealt with by a criminal court. If they do not respond to the infringement notice and the offence has not been expiated, criminal proceedings may be initiated.
- 3.11 The Northern Territory does not currently have an overarching alcohol and other drugs strategy. In 2015, it released a methamphetamine specific action plan, *Tackling Ice in the Northern Territory* and, more recently, the *Northern Territory Alcohol Harm Minimisation Action Plan 2018-2019*. Both of these action plans are based on the three pillar model as described in the section below.

National Drug Strategy

- 3.12 The overarching policy framework for the formulation of national and jurisdictional alcohol, drug and tobacco policies in Australia is the National Drug Strategy (NDS). The NDS is underpinned by the objective of minimising the harms associated with alcohol, illicit drugs, tobacco and pharmaceutical drug use. In contrast to some European addiction strategies, and recommendations contained in the recent Victorian Parliament's Inquiry into Drug Law Reform, Australia's national harm minimisation framework continues to be based on the three pillars of harm reduction; supply reduction; and demand reduction.
- 3.13 Demand reduction strategies aim to prevent uptake and delay first use, reduce harmful use and support people to recover from drug-related problems. Demand reduction can include: reducing the availability of licit drugs through price mechanisms; building community knowledge of the impacts of substance use; reducing stigma and promoting help seeking; restrictions on marketing; treatment services and brief interventions; targeted approaches to at risk groups; addressing underlying social, health and economic determinants of substance use; and diversion initiatives.
- 3.14 Supply reduction strategies are based around controlling licit drug and precursor availability, and preventing and reducing the availability and accessibility of illicit drugs. Supply reduction strategies include: regulating retail sale of licit substances; age restrictions; border control; regulating or disrupting production and distribution; and real-time monitoring of prescription drugs.
- 3.15 Harm reduction strategies aim to reduce risk behaviours and provide safer settings. These strategies can include: safe transport and sobering up services; promoting safer injecting practices and preventing the spread of blood borne viruses; reducing

⁴² Part IIB and Schedule 3 *Misuse of Drugs Act 1990* (NT)

driving under the influence of alcohol or drugs; and pharmacotherapy for opioid maintenance and other drug use.

Drug management strategies in other Australian jurisdictions

3.16 Drug and alcohol strategies vary between states and territories in terms of whether they focus solely on drugs; alcohol and drugs; or mental health, alcohol and drugs. In addition to an overarching alcohol and other drugs strategy, a number of jurisdictions have also developed methamphetamine specific action plans. Most alcohol and other drugs strategies in Australian jurisdictions are predominantly based on the three pillar harm minimisation model espoused in the National Drug Strategy.

3.17 Table 4 provides an overview of the alcohol and other drugs strategies and action plans currently in place.

Table 4: Alcohol and drug strategies by jurisdiction

Jurisdiction	Strategy
Commonwealth	<ul style="list-style-type: none"> • <i>National Drug Strategy 2017-2016</i> • <i>National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019</i> • <i>National Tobacco Strategy 2012-2018</i> • <i>National Ice Action Strategy (2015)</i> • <i>National Alcohol and Other Drug Workforce Development Strategy 2015-2018</i>
Victoria	<ul style="list-style-type: none"> • <i>Reducing the alcohol and drug toll: Victoria's plan 2013-2017 (lapsed)</i> • <i>VicHealth Alcohol Strategy 2016-2019</i> • <i>Ice Action Plan (2015)</i> • <i>Drug Rehabilitation Plan (2017)</i> • <i>Victorian Health and Well-being Plan 2015-2019</i>
New South Wales	<ul style="list-style-type: none"> • The Centre for Population Health is finalising the <i>NSW Health Alcohol and Other Drugs Strategy</i>
South Australia	<ul style="list-style-type: none"> • <i>South Australian Alcohol and Other Drug Strategy 2017-2021</i> • <i>Stop the Hurt: South Australian Ice Action Plan (2017)</i>
Western Australia	<ul style="list-style-type: none"> • <i>Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025</i> • <i>Western Australian Methamphetamine Action Plan (2017)</i>
Queensland	<ul style="list-style-type: none"> • <i>Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019</i> • <i>Actions on Ice (2018)</i>
Tasmania	<ul style="list-style-type: none"> • <i>Tasmanian Drug Strategy 2013-2018</i>
Australian Capital Territory	<ul style="list-style-type: none"> • <i>ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 (lapsed)</i> • <i>ACT Drug Strategy Action Plan 2018-2021</i>

Drug Management and Reform at the International Level

3.18 Over the last two decades, there has been a global trend to decriminalise the possession of illicit drugs for personal use, particularly cannabis. To a lesser degree, there is an emerging global trend to legalise cannabis for recreational use, with this already implemented in Uruguay, Canada and a number of jurisdictions within the United States of America. Of the countries that have decriminalised drug use, the

majority have only applied the decriminalisation to cannabis, while a smaller number have applied the policy to possession of all illicit drugs for personal use.⁴³ Advocates for drug policy reform argue that prohibition has failed, and drug use and addiction should not be criminalised but treated as a health issue.

- 3.19 The trend towards treating addiction as a health problem, rather than a crime, has resulted in a number of countries implementing substantial reforms to enable the implementation of new and innovative approaches to managing addictive behaviours associated with drug use. Given the relevance of these reforms for the inquiry, two examples have been included below.

Portugal

- 3.20 In 2001, Portugal decriminalised the use and possession of all illicit drugs in response to the country's prolific heroin addiction and high rates of HIV infection. The law stipulates a personal possession threshold for each drug, based on a ten day supply of the drug for personal consumption. When a person is found in possession of drugs under the personal use threshold, police issue a citation referring the person to the local Commission for the Dissuasion of Drug Addiction (CDT). The CDT is a three person panel comprising one legal professional and two members with a clinical or social work background. Each CDT is supported by a multidisciplinary staff with expertise in drug addiction. The CDT aims to provide information about the consequences of drug use and to dissuade people from using drugs. The drug user is assessed to determine: whether they are drug dependent; the circumstances surrounding the drug use; and whether they have had contact with police.⁴⁴
- 3.21 There are a range of legislated sanctions that can be imposed by the CDT based on their assessment of the drug user. Sanctions include treatment for drug dependent users, regular reporting to the panel, community service, suspension of driving or professional licence and, as a last resort, fines. The panel will almost always suspend proceedings for a non-dependent first-time offender and impose no sanction, with this occurring in 83% of cases in 2013. Approximately 82% of cases referred to a CDT in 2013 were for cannabis possession alone, 6% involved heroin, 6% involved cocaine and the remaining referrals involved poly drug use.⁴⁵
- 3.22 The decriminalisation of illicit drugs in Portugal reframed the drug policy approach from a criminal justice framework to a public health model with a focus on, and substantial investment in, drug treatment, harm reduction and social reintegration policies. The broad range of health interventions provided to drug users include counselling, needle exchange programs and opioid substitution treatment. Many of these are publicly funded, making them accessible to drug users.

⁴³ C Hughes, A Ritter, J Chalmers, K Lancaster, M Barratt & V Moxham-Hall, *Decriminalisation of drug use and possession in Australia—a briefing note*, UNSW, Sydney, 2016, p. 4.

⁴⁴ CR Fonseca, *The implementation of Portuguese drug policy: issues for CDTs*, meeting on Portuguese drug policy – Domestic and International perspectives, 2015, <http://www.issdp.org/wp-content/uploads/2015/09/Implementation-of-portugueses-drug-policia-Issues-for-CDTs.-September-2015.pdf>

⁴⁵ N Eastwood, E Fox & A Rosmarin, 'A quiet revolution: Drug decriminalisation across the globe', *Release – Drugs, The Law and Human Rights*, March 2016, p. 28.

- 3.23 The Portugal model is underpinned by the core principles of humanism and pragmatism where drug users are viewed as people in need of treatment, rather than as criminals. It considers that a drug free society is not obtainable and that better results are more likely to accrue from implementing policies that focus on reducing drug use and related harms through education, harm reduction and treatment than through prohibition. Portugal no longer has national drug and alcohol strategies, these have been replaced with the *National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020*.

Switzerland

- 3.24 The catalyst for drug policy reform in Switzerland was the proliferation of heroin injecting in public spaces and resulting high rates of HIV infection. In response to this crisis, harm reduction strategies, including safe injecting rooms and needle exchange programs, were introduced in the late 1980s. In 1994, Switzerland developed a four pillar drug policy focussed on prevention, treatment, harm reduction and law enforcement. In the 1990s, the federal government approved heroin assisted treatment which consists of the prescription of diamorphine as a substitute for heroin.⁴⁶
- 3.25 Between 1991 and 2016, the four pillar drug approach was adopted through three iterations of the 'Package of measures to reduce drug problems'. In 2017, Switzerland introduced the *National Strategy on Addiction and Action Plan 2017-2024*. The strategy's key objectives include: prevention of addictive disorders; provision of help and treatment for individuals with addiction problems; mitigation of social harms and damage to health; and reduction of negative impacts on society.⁴⁷
- 3.26 The possession and consumption of all illicit drugs remains a criminal offence in Switzerland, however, in 2013 the Swiss Parliament changed the penal code so that an adult found in possession of less than 10 grams of cannabis is not subject to prosecution and would, instead, be issued with an administrative fine of CHF 100 (approximately AUD\$130). Heroin assisted treatment has continued for users who have been unresponsive to other treatments and is now classified as a 'regular medical treatment'. Although public support for this type of treatment was expressed through a 2008 referendum, it is still significantly less common than opioid substitution treatment.⁴⁸

Addiction and Drug Strategies

- 3.27 The decriminalisation of drugs for personal use has shifted perceptions of drug use, at both the policy and community level, from drug users as criminals, to people with a health problem. This has led to an increased emphasis on the development of interventions to reduce the individual and societal harms that can result from drug use. Drug policy reform has contributed to the emergence of addiction strategies as

⁴⁶ N Eastwood, E Fox & A Rosmarin, 2016, p. 33.

⁴⁷ Swiss Confederation, *National Strategy on Addiction and Action Plan 2017-2024*, p. 10.

⁴⁸ N Eastwood, E Fox & A Rosmarin, 2016, p. 34.

a replacement for traditional drug and alcohol strategies, with these used in Portugal, Germany, Austria and Switzerland. Addiction strategies emphasise that addiction is, and should be, treated as a disease and health issue, not one of personal or moral failure, or a lack of will power. The *Austrian Addiction Prevention Strategy* states:

Prevention and addiction policy is neither moralistic nor dogmatic, but oriented towards the needs of both the general public and those people who use psychotropic substances, or show other patterns of addiction-related behaviour. The goal is to reduce to a minimum the negative consequences and harm related to substance use or behavioural addictions for the persons concerned, as well as for society. This includes endeavours to preserve or achieve the social integration of those who have displayed risky or harmful patterns of substance use or addiction-related behaviour.

Stigmatisation, discrimination and exclusion make people ill, and constitute a risk both to the success of individual treatment and to social cohesion.⁴⁹

- 3.28 Although the terminology varies, a number European addiction strategies have adopted the four pillar model which focusses on: (1) prevention and early detection; (2) treatment and counselling; (3) harm reduction and risk minimisation; and (4) regulation and enforcement. These strategies place a higher emphasis on prevention and harm reduction than on regulation and enforcement.
- 3.29 In Australia, the three pillar model continues to be the model of choice for nearly all jurisdictions. As part of this inquiry the three pillar model and its relevance for the Northern Territory will be assessed. The inquiry will also examine the potential benefits associated with a four pillar model as adopted in some overseas jurisdictions and as recommended in the Parliament of Victoria's Law Reform, Road and Community Safety Committee in their Inquiry into Drug Law Reform.⁵⁰

⁴⁹ Austrian Federal Ministry of Health, *The Austrian Addiction Prevention Strategy*, 2015, p. 8.

⁵⁰ Parliament of Victoria, Law Reform, Road and Community Safety Committee, *Inquiry into Drug Law Reform*, 2018, p. 74.

4 Preliminary Findings

- 4.1 Early analysis of evidence collected to date has identified a number of recurring themes. These have been categorised under the following three headings: key issues of concern; gaps in service provision; and harm reduction initiatives. Each area is discussed below.

Key issues of concern

Insufficient funding for treatment providers

- 4.2 Lack of sufficient funding was one of the most frequently mentioned issue of concern for service providers, many of whom described it as a source of ongoing frustration. The consensus among service providers is that the funding allocated to harm reduction efforts is minimal compared to what is provided for demand and supply reduction strategies. The Centre for Disease Control (CDC) calls for this imbalance to be redressed in order for harm reduction efforts to yield maximum success.
- 4.3 Of particular concern to some organisations is the lack of ongoing funding which means that service providers spend time that should be put into treatment provision reapplying for short-term funding. For the Aboriginal Medical Services Alliance NT (AMSANT), funding is the main impediment to the broad-scale delivery of their Culturally Responsive Trauma Informed Care (CRTIC) workforce training program:
- Funding for an expanded social emotional wellbeing service within Aboriginal primary health care is not secure and is not sufficient to meet the needs, with many areas under resourced... We have been working with our member services. At the moment we are working with seven of the member services... It is a capacity issue in that we are a small team and there is only so much funding... At the moment we only have funding until 30 June [2019].⁵¹
- 4.4 Others face the frustration of not being able to retain staff due to lack of ongoing funding.⁵² As the regional leader for Mission Australia commented:
- Year on year funding is the bane of every organisation's and every NGO's existence. We spend six months writing up tenders and processes only to be granted and then have to start the process again... Often we are in a position where we are not sure whether the funding is going to continue and whether they [our Staff] have any job security. It is a constant churn in the Territory for staff.⁵³
- 4.5 Central Australian Aboriginal Congress (CAAC) commented that this type of tendering process inevitably leads to 'fragmented, complex service delivery environments with multiple providers of health services'⁵⁴. Organisations would prefer programs to be given long term sustainable funding, so as to maximise effectiveness and build relationships in communities. At present, some communities face situations

⁵¹ Aboriginal Medical Services Alliance (AMSANT), Darwin Public Hearing transcript, 15 November 2018, p. 13.

⁵² CatholicCare, Submission No. 21, 2018.

⁵³ M Soler, Mission Australia, Darwin Public Hearing transcript, 15 November 2018, p. 30.

⁵⁴ Central Australian Aboriginal Congress (CAAC), Submission No. 32, 2018, p. 7.

of 'overuse and oversupply' whereby funding is so dispersed among multiple agencies, and effort so replicated, that it renders services ineffective.

I did hear something earlier around small communities where there are 16 services providing 400 people. I have seen that and it is just a procession of banners on cars coming in and out... There are some communities where there are four services delivering exactly the same program just in a different name... It is overuse and oversupply.⁵⁵

Unaddressed but underlying social disadvantage

- 4.6 Several service providers expressed concerns that current approaches for treating substance misuse are less effective than they could be because they tend to ignore the factors that either lead to or perpetuate the addictive behaviours.^{56,57,58} As the Northern Territory Primary Health Network (NT PHN) explained:

We know that addressing the social determinants that underlie these issues, and that includes things like providing good education, housing and health support and family support, all of those aspects play into the symptom of AOD [alcohol and other drugs] coming out... As long as we focus and address the symptoms and do not address the causative factors, we will really struggle.⁵⁹

- 4.7 Sharing the same view, AMSANT and North Australian Aboriginal Justice Agency (NAAJA) recommend that AOD organisations adopt a culturally responsive trauma-informed care model which accounts for the social determinants of health.⁶⁰ AMSANT adds that something as fundamental as housing can provide users with the stability they need to successfully overcome their addiction. Homelessness, on the other hand, is deleterious to treatment efforts and has been identified as a common factor in the commission of crimes by people with addictive behaviours.⁶¹
- 4.8 In recognition of the importance of housing in resolving addictive behaviours, the NT Department of Health (NT DoH) has identified a model that has been used to support people with mental illness and which might have some utility for people undergoing treatment for substance misuse.⁶² This model, Housing Accommodation Support Initiative (HASI), is a partnership between multiple agencies including the NT DoH, Anglicare NT, Top End Mental Health Services and the Department of Housing and Community Development, among others. The driving objective of the initiative is to help people with mental illnesses to retain their tenancies in public housing so that they do not become homeless. The same could be replicated for people undergoing treatment for substance misuser.

⁵⁵ M Soler, Mission Australia, Darwin Public Hearing transcript, 15 November 2018, p. 30.

⁵⁶ Northern Territory Primary Health Network (NT PHN), Submission No. 18, 2018.

⁵⁷ Mission Australia, Submission No. 23, 2018.

⁵⁸ North Australian Aboriginal Justice Agency (NAAJA), Submission No. 29, 2018.

⁵⁹ P Burnheim, NT PHN, Darwin Public Hearing transcript, 15 November 2018, p. 69.

⁶⁰ AMSANT, Submission no. 24, 2018; NAAJA, Submission No. 29, 2018.

⁶¹ Department of the Attorney-General and Justice, Submission No. 6, 2018.

⁶² NT Department of Health, Submission No. 5, 2018.

Alternatives to incarceration

- 4.9 CatholicCare expressed a view held by many organisations that there is a need for greater investment into alternatives to incarceration.⁶³ Submissions especially called for the reintroduction of specialist courts like the SMART Court which allowed for people who commit crimes as a result of their addictive behaviours to be dealt with using therapeutic rather than punitive means.⁶⁴ As the president of Harm Reduction Australia (HRA) put it, 'criminal convictions for drug use can leave ongoing and permanent stains on people's lives', a burden that he believes is borne mostly by the young and poor.⁶⁵
- 4.10 The president of the Criminal Lawyers Association of the Northern Territory (CLANT) expressed a similar viewpoint based on his experience with the justice system:
- What we want to try to do is have fewer people in the criminal justice system by addressing these issues earlier... For the ones who do ultimately slip through the cracks, we want to set up a system in which the criminal justice system acknowledges addiction as a health issue primarily and, as a consequence, finds a more therapeutic and needs-based approach to dealing with people who offend, where the underlying issue is an addictive issue.⁶⁶
- 4.11 The Alcohol and Drug Foundation (ADF) recommends the reintroduction of drug courts to the NT as 'a matter of urgency... to reduce preventable, long term drug-related harm'.⁶⁷ The ADF identified several evaluations which demonstrate the efficacy of drug courts in Victoria and New South Wales. Among other benefits, the courts were found to reduce recidivism among participants, improve their employment prospects and facilitate their recovery from substance misuse. One of the identified merits of drug courts over imprisonment is that offenders are not isolated from society, so the period of readjustment upon completion is far less than is the case with incarcerated offenders.
- 4.12 Similarly, Amity Community Services points out that a measure of the success of drug courts is that offenders are forced to 'confront their addiction and repair the damage they have done to themselves, their families and their community'.⁶⁸ This gives them a better chance at rehabilitating than imprisonment would, since that approach keeps them isolated from society. Amity commented that drug courts are not only effective at achieving rehabilitation of offenders, but they are also a more cost-effective harm reduction measure than imprisonment.

⁶³ CatholicCare, Submission No. 21, 2018.

⁶⁴ Criminal Lawyers Association of the Northern Territory (CLANT), Submission No. 30, 2018.

⁶⁵ G Vumbaca, Harm Reduction Australia, Darwin Public Hearing transcript, 15 February 2018.

⁶⁶ M Aust, CLANT, Darwin Public Hearing transcript, 15 November 2018, p. 56.

⁶⁷ Alcohol and Drug Foundation, Submission No. 15, 2018, p. 17.

⁶⁸ Amity Community Services, Submission No. 28, 2018, p. 7.

Gaps in service provision

Lack of family-inclusive treatment

- 4.13 A common theme echoed across many submissions is the need for more treatment programs and services that include and cater for families.⁶⁹ NT DoH, for instance, highlighted the need for 'day AOD programs that allow people to engage in treatment and support whilst engaging with supportive friends and family.'⁷⁰ Mission Australia add that young people, in particular, benefit from having families close by during treatment since it is family members who often keep users safe, reach out to support services and provide ongoing support after treatment.⁷¹
- 4.14 Another group that would benefit from the provision of more family-inclusive services is Aboriginal Territorians. Many delay or decide against going into treatment, especially if located away from their community, because they have children that would be unattended and therefore more likely to be removed from their custody.⁷² Reunification between Aboriginal clients and their children is also often delayed because the treatment facilities do not accommodate children and other family members.⁷³
- 4.15 Council for Aboriginal Alcohol Program Services (CAAPS) recommends that the provision of more residential rehabilitation services for family members and 'concerned others' be made a priority in the development of a NT harm reduction strategy.⁷⁴ They highlight research which shows that family inclusion in the treatment of substance misuse yields positive outcomes such as early intervention and prevention, and improving child safety.⁷⁵

Expansion of NSP services

- 4.16 It is generally accepted that needle and syringe programs (NSP) are a cost-effective method of discouraging the sharing or reuse of injecting equipment, and help to prevent the spread of blood-borne diseases like Hepatitis C virus. There was, however, a shared perception among service providers that the NSP currently lacks sufficient geographic coverage in the Northern Territory.⁷⁶ Of particular concern are remote communities⁷⁷ and the prison population,⁷⁸ two areas considered to be severely lacking in these services and therefore vulnerable to the health risks associated with injecting drug use.

⁶⁹ NT Department of Health, Submission No. 5, 2018; Mission Australia, Submission No. 23, 2018; Amity Community Services, Submission No. 28, 2018.

⁷⁰ NT Department of Health, Submission No. 5, 2018, p. 21.

⁷¹ Mission Australia, Submission No. 23, 2018.

⁷² NAAJA, Submission No. 29, 2018.

⁷³ NAAJA, Submission No. 29, 2018.

⁷⁴ Council for Aboriginal Alcohol Program Services (CAAPS), Submission No. 16, 2018.

⁷⁵ CAAPS, Submission No. 16, 2018.

⁷⁶ Penington Institute, Submission No. 27, 2018; Alcohol and Drug Foundation, Submission No. 15, 2018; Centre for Disease Control, Submission No. 22, 2018.

⁷⁷ Northern Territory Aids and Hepatitis Council (NTAHC), Submission No. 26, 2018; Penington Institute, Submission No. 27, 2018.

⁷⁸ Association of Alcohol and Other Drug Agencies NT (AADANT), Submission No. 25; Alcohol and Drug Foundation, Submission No. 15, 2018.

- 4.17 The Northern Territory AIDS and Hepatitis Council (NTAHC) manages the three primary NSP outlets in the NT and described the unique challenges that the NT presents in terms of delivering this service:

The population of the Northern Territory is spread over a very large and difficult to service land mass... Remote and regional services are limited and service delivery could be greatly improved with the installation and servicing of ADUs [automatic dispensing units] to allow 24 hour access, and provide an anonymous service modality for those who feel shame in accessing a service in a small town... Extra funding would [also] allow the establishment of a Mobile Outreach Service in Darwin and Alice Springs, which could provide NSP services to marginalised homeless populations and housebound clients.⁷⁹

- 4.18 The ADF described the lack of NSP services in prisons as a 'major gap' that needs to be addressed with some urgency in order to safeguard the health of prisoners, prison staff and the general public. To provide even better coverage, the ADF calls for peer distribution of sterile injecting equipment in order to reach injecting drug users who may not be able, or willing, to attend regular NSP outlets. The CDC expressed a similar concern about injecting drug users in the Darwin and Palmerston areas who may find it difficult to attend the fixed site outlets and might be engaging in unsafe injecting practices. Common recommendations to address this gap include the provision of more ADUs and piloting of mobile outreach units.

Lack of treatment coordination

- 4.19 The lack of coordination between treatment agencies is identified by frontline treatment providers as one of the key factors that hinders seamless delivery of services in the NT. Of particular concern is the potential for clients to become fatigued when they are repeatedly asked by multiple treatment agencies to provide the same information and undergo similar assessments. This can frustrate clients to the extent that they abandon seeking treatment altogether:

The bottom line is we represent the NGO [non-government organisation] drug and alcohol sector, the agencies, but what we represent is the people; the people wanting to turn up to a place, tell one story and get referred to treatment. I do not need to be telling my story 20 times. I do not need to keep dropping out of the system and trying to come back into it. Add on to that, if I have mental health issues as well, how do I circumnavigate a system that does not seem to be able to work together.⁸⁰

- 4.20 CAAPS gave a similar account of the frustration some of their clients have experienced due to this lack of coordination:

Clients are required to undergo [a] comprehensive assessment when accessing each separate agency involved in their care. Some of the information collected from each agency will be specialised and related to the specific intervention they are providing, while some of the information remains the same during the period that the person is accessing these agencies simultaneously (such as drug use history, social, legal and family histories). This can result in clients feeling fatigued and distressed at a process whereby they need to repeat their stories and information at each assessment.⁸¹

⁷⁹ Northern Territory AIDS and Hepatitis Council (NTAHC), Submission No. 26, 2018, p. 7.

⁸⁰ R Michell, AADANT, Darwin Public Hearing transcript, 15 November 2018, p. 6.

⁸¹ CAAPS, Submission No. 16, 2018, p. 6.

- 4.21 To address this gap, CAAPS suggests the introduction of an information sharing system that is similar to the electronic health records used by health professionals. The Pharmacy Guild and Top End Health Service similarly recommend the introduction of real-time prescription monitoring (RTPM) which would allow a patient's history to be seamlessly shared between relevant health service personnel.⁸² Examples of this system currently in use include SafeScript in Victoria and DORA (Drugs and Poisons Information System Online Remote Access system) in Tasmania, both of which allow drugs such as morphine, oxycodone and benzodiazepines to be monitored.
- 4.22 The ADF also supports the introduction of RTPM in the NT but adds that the version adopted in the NT needs to be in sync with what is being used in other jurisdictions. Otherwise, patients would be able to cheat the system, and obtain multiple prescriptions, by crossing jurisdictional borders.

Harm reduction initiatives identified

Workforce training

- 4.23 Extensive research has been done around social and emotional wellbeing which shows that intergenerational (and other) trauma plays a significant role in Aboriginal people's vulnerability to, and engagement in, addictive behaviours.⁸³ Other research similarly states that the substances to which people become addicted are often used as a means of 'escaping' trauma, which can be ongoing.⁸⁴ In line with these findings, several organisations called for more targeted workforce training around the provision of trauma-informed care.⁸⁵
- 4.24 The CRTIC program run by AMSANT would meet the needs identified above. It has demonstrated success in improving the care and treatment provided to Aboriginal people, and is supported by several organisations including NAAJA, AADANT, Territory Families and the NT Department of Health
- 4.25 The Team Leader of the CRTIC program explained that:
- It is a two-pronged approach – there is workforce development and also organisational change to become trauma informed. We support organisations with that, which involves an audit tool and a whole lot of other things.⁸⁶

⁸² The Pharmacy Guild of Australia – NT Branch, Submission No. 10, 2018; Top End Health Service, Submission No. 7, 2018.

⁸³ Commonwealth of Australia, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, Department of the Prime Minister and Cabinet, Canberra, 2017.

⁸⁴ E Wilkes, D Gray, W Casey, A Stearne, & L Dadd, 'Harmful substance use and mental health', in *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Commonwealth of Australia, ACT, 2014, pp. 125-146.

⁸⁵ AMSANT, Darwin Public Hearing transcript, 15 November 2018; ADANT, Submission No. 25, 2018; NT Department of Health, Submission No. 5, 2018.

⁸⁶ D Dyall, AMSANT, Darwin Public Hearing transcript, 15 November 2018, p. 13.

- 4.26 Several organisations emphasised the importance of involving Aboriginal communities in the design and delivery of treatment programs and services.⁸⁷ They called for greater capacity-building among existing Aboriginal Community Controlled AOD organisations, as they are best placed to provide culturally appropriate services. AMSANT called for these organisations to be ‘the preferred providers of services to Aboriginal people in all procurement and grant processes’.⁸⁸ Doing so would not only increase the likelihood of achieving intended outcomes for these communities but it would also prevent unnecessary expenditure on ineffective programs.⁸⁹
- 4.27 Conceding that such Aboriginal organisations are not always available, service providers insist that Aboriginal people must always be involved in every stage of the design and implementation of services targeted at Aboriginal populations.⁹⁰ This consultation, as NAAJA explained, should persist from program conception to after its delivery:

There is a need to evaluate how to better involve Aboriginal elders and communities in the design and delivery of AOD programs and services, as well as in Aboriginal clients’ exit from these addiction services and the process of community re-integration.⁹¹

Pill-testing

- 4.28 Several organisations highlighted the apparent success which pill testing has had in the ACT and overseas, calling for it to be trialled in the NT as a potential harm reduction measure.⁹² Drawing on findings from the recent trial conducted at the ‘Groovin’ the Moo’ festival in Canberra, advocates point to the life-saving potential of pill testing demonstrated by its detection of lethal substances in some pills at that festival.⁹³
- 4.29 Although one submission⁹⁴ argued that pill testing encourages illicit drug use, this was refuted by the president of Harm Reduction Australia (HRA) who stated that:

What people need to understand is that it is not a mechanism to tell people it is safe to use drugs or to give them the green light as some people have highlighted in the media that we are giving a green light to drug use... What we actually do is provide a lot of information to people who are already in the festival, gone the gauntlet of security and dogs and police and everybody else out there, so they are quite committed to using that drug, and we are in a way like the last line of defence or information for them to receive about what it is they are about to do... In Canberra, we found that people were more likely to moderate their drug use, or in some cases not take the drug they were considering taking, based on the advice and information we could provide them. At no time do we tell people it is safe to use drugs.⁹⁵

⁸⁷ CAAPS, Submission No. 16, 2018; NAAJA, Submission No. 29, 2018; AMSANT, Darwin Public Hearing transcript, 15 November 2018; CatholicCare, Submission No. 21, 2018.

⁸⁸ AMSANT, Submission No. 24, 2018, p. 6.

⁸⁹ CAAPS, Submission No. 16, 2018; AMSANT, Submission No. 24, 2018.

⁹⁰ Alcohol and Drug Foundation, Submission No. 15, 2018; CAAPS, Submission No. 16, 2018.

⁹¹ NAAJA, Submission no. 29, 2018, p. 11.

⁹² M Noffs, Darwin Public Hearing transcript, 15 February 2018; G Vumbaca, Harm Reduction Australia, Darwin Public Hearing transcript, 15 February 2018; 360Edge, Submission No. 13, 2018.

⁹³ 360Edge, Submission No. 13, 2018; Alcohol and Drug Foundation, Submission No. 15, 2018.

⁹⁴ Drug Free Australia, Submission No. 2, 2018.

⁹⁵ G Vumbaca, Harm Reduction Australia, Darwin Public Hearing transcript, 15 February 2018.

- 4.30 The Chief Executive Officer of the Ted Noffs Foundation, Matt Noffs, expressed similar sentiments but also highlighted the importance of having doctors at the pill testing site:

Pill testing is not about purely analysis. That is about a third of what goes on... The most important part of pill testing for me, and where I believe we are going to lead the rest of the world is, it should always be a doctor in a tent... say I am going to get this tested and where a doctor can intercept that young person and say, 'now, listen', as we said to all the young people in Canberra last year, 'the safest way to take this drug, ecstasy or not, is not at all'... When the young person has still decided to pass that safety net and say 'I am still going to take the drug', the doctor, not any of us, but a medical doctor can say... how their body is going to react... But let a doctor decide that and give that information to a young person.⁹⁶

- 4.31 Pill Testing Australia, the consortium responsible for running the Canberra pill testing trial, provides free pilot programs as follows:

Pill Testing Australia is prepared to provide a free pilot program in every jurisdiction ... to collect the data, show the government how it operates, work with local police about collection of information ...about what drugs are being consumed in the area, as well as interact with people... I highly recommend that the NT government consider the offer from Pill Testing Australia for a free pilot program. We provide a full report on what happened... Our key issue is that we need government support to do it... I do not mean funding.⁹⁷

⁹⁶ M Noffs, Darwin Public Hearing transcript, 15 February 2018.

⁹⁷ G Vumbaca, Harm Reduction Australia, Darwin Public Hearing transcript, 15 February 2018.

5 Future directions for the inquiry

- 5.1 It is evident that the Northern Territory has a significant problem with addictive behaviours, the highest consumption in Australia of a range of licit and illicit drugs.
- 5.2 It is also apparent that there have been innovations world-wide in how to reduce the harm that such addictive behaviours can cause. These innovations centre around new health-focused strategies to address such behaviours and what is often referred to as a four pillar approach.
- 5.3 In some jurisdictions this new approach has been accompanied by significant changes to the regulatory environment, such as Portugal's general decriminalisation of personal possession of illicit drugs. In other jurisdictions health-based strategies to address such behaviours have not been accompanied by significant decriminalisation.
- 5.4 The Committee has collected a substantial amount of evidence regarding specific needs in the Northern Territory, the services being provided, the gaps in those services and the potential for new approaches.
- 5.5 The next step for the inquiry is to hear from people in more remote parts of the Territory to better understand the services provided and the challenges they face.
- 5.6 The Committee will then consider these global trends and local experiences to develop options for a strategy to reduce addictive behaviours. Based on the Committee's initial review of the evidence, some of the core elements that will be considered when developing these options include:
 - Strengthening of harm reduction initiatives for Territorians who persist with drug use, acknowledging that not every user is willing or able to abstain. NSPs and pill testing are examples of initiatives that have a sound evidence base for reducing harms.
 - Amendments to the Misuse of Drugs Act to allow for clearer and more uniform decriminalisation, removing the inconsistencies that currently exist in the application of police discretion. Spain and the Netherlands have taken a similar step by allowing 'cannabis clubs'⁹⁸ to operate with impunity.
 - Development of systems to improve coordination, avoid unnecessary duplication of services and ensure the most effective distribution of resources, especially for remote communities.
 - Reducing funding application fatigue among service providers and increasing efficiency by providing longer term funding cycles and greater certainty.
 - Capacity building for service providers to attract, train and retain staff.

⁹⁸ N Eastwood, E Fox & A Rosmarin, 2016, pp. 31-33.

- Mandatory program evaluations for service providers who receive government funding, so that programs with demonstrated success receive sufficient funding to maximise their impact. AMSANT's CRTIC program is one such example.
- More extensive involvement of Aboriginal people and organisations in the design and delivery of programs for Aboriginal Territorians, led by Aboriginal Community Controlled Health Organisations (ACCHOs) where possible. CRTIC is one initiative that would facilitate this. Another is the partnering approach being collaboratively developed by Territory Families and AMSANT to provide early intervention support that is specifically tailored to Aboriginal families.⁹⁹

5.7 The need for such a harm reduction strategy is acute. The Committee anticipates that through careful consideration of the evidence received, the recommendations that will be put forward will help address this critical issue.

⁹⁹ Territory Families, Submission No. 33, 2018, p. 3.

Appendix 1: Submissions received

1. Submission No. 1 - Professor Stuart Reece
2. Submission No. 2 - Drug Free Australia
3. Submission No. 2a - Drug Free Australia
4. Submission No. 3 - Harm Reduction Australia
5. Submission No. 4 - SICAD Portugal
6. Submission No. 5 - Department Health
7. Submission No. 6 - Department of the Attorney-General and Justice
8. Submission No. 7 - Top End Health Service
9. Submission No. 8 - National Drug Research Institute
10. Submission No. 9 - Paul Tolliday and Diane Biritjalawuy Gondarra
11. Submission No. 10 - The Pharmacy Guild of Australia - NT Branch
12. Submission No. 11 - The Kirby Institute
13. Submission No. 12 - Michael Byrne
14. Submission No. 13 - 360Edge
15. Submission No. 14 - Top End Women's Legal Service Inc.
16. Submission No. 15 - Alcohol and Drug Foundation
17. Submission No. 16 - Council for Aboriginal Alcohol Program Services
18. Submission No. 17 - Confidential
19. Submission No. 18 - Northern Territory Primary Health Network
20. Submission No. 19 - Menzies School of Health Research
21. Submission No. 20 - Department of Infrastructure, Planning and Logistics
22. Submission No. 21 - CatholicCare NT
23. Submission No. 22 - Centre for Disease Control - NT Department of Health
24. Submission No. 23 - Mission Australia
25. Submission No. 23a - Mission Australia
26. Submission No. 24 - Aboriginal Medical Services Alliance NT
27. Submission No. 25 - Association of Alcohol and Other Drug Agencies NT
28. Submission No. 26 - Northern Territory AIDS and Hepatitis Council
29. Submission No. 27 - Penington Institute
30. Submission No. 28 - Amity Community Services
31. Submission No. 29 - North Australian Aboriginal Justice Agency
32. Submission No. 30 - Criminal Lawyers Association of the Northern Territory
33. Submission No. 31 - Department of Education
34. Submission No. 32 - Central Australian Aboriginal Congress Aboriginal Corporation
35. Submission No. 33 - Territory Families

Appendix 2: Public Hearings and Forums

Public Hearings

Tenant Creek – 5 November 2018

1. Central Australian Health Service
2. Anyinginyi Health Aboriginal Corporation
3. Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG)
4. Julalikari Council Aboriginal Corporation
5. Tennant Creek High School
6. Tennant Creek Women's Refuge
7. Barkly Youth (Barkly Regional Council)

Alice Springs – 6 November 2018

1. Central Australian Health Service
2. Central Australian Aboriginal Congress
3. BushMob Aboriginal Corporation
4. Drug and Alcohol Services Association
5. Remote Alcohol and Other Drugs Workforce Program, NT Department of Health
6. Mental Health Association of Central Australia

Darwin – 15 November 2018

1. Alcohol and Other Drug Agencies Northern Territory
2. The Pharmacy Guild of Australia - NT Branch
3. Aboriginal Medical Services Alliance Northern Territory
4. CatholicCare NT
5. Mission Australia
6. Council for Aboriginal Alcohol Program Services (CAAPS)
7. 360Edge
8. Menzies School of Health Research
9. Northern Territory AIDS and Hepatitis Council
10. Criminal Lawyers Association of the Northern Territory (CLANT)
11. Top End Women's Legal Service
12. Northern Territory Primary Health Network (NT PHN)

Katherine – 10 December 2018

1. Wurli-Wurlinjang Aboriginal Health Service
2. Sunrise Health Service
3. Top End Health Service
4. Katherine Women's Information and Legal Service
5. Katherine Doorways Hub, Salvation Army
6. Venndale Rehabilitation and Withdrawal Centre (Kalano Community Association)

Darwin – 15 February 2019

1. Drug Free Australia
2. Ted Noffs Foundation and Australia 21
3. Harm Reduction Australia
4. Penington Institute
5. Territory Families
6. Department of Infrastructure, Planning and Logistics
7. Department of Education
8. North Australian Aboriginal Justice Agency
9. Amity Community Services
10. Alcohol and Drugs Foundation
11. Michael Byrne - private individual

Darwin – 12 March 2019

1. SICAD Portugal

Public Forums

Darwin – 27 September 2018

1. Paul Tolliday
2. Vicki Borzi – Somerville Community Services
3. Kerry Boswell – Somerville Community Services
4. Michael Borzi
5. Nicola Coulter – Amity Community Services
6. Georgie Mumford – Fong Lim Electorate Office

7. Matt Stevens – Menzies School of Health Research
8. Tomoko Okozaki
9. Jennifer Jenkins – Remote AOD Workforce, Department of Health
10. Peter Burnheim – NT Primary Health Network
11. Alan Graham – NT Primary Health Network
12. Leon Gailitis – Banyan House
13. Rikki Fisher – FORWAARD
14. Bernie Dwyer – Team HEALTH
15. Maxine Atkinson
16. Paul Dent – Private Consultant
17. Katie Flynn – Association of Alcohol and Other Drug Agencies Northern Territory
18. Natalie Sarsfield – CatholicCare NT
19. Marie Fox - DCIS
20. Belinda Davis

Tennant Creek – 5 November 2018

1. Steve Edgington – Barkly Regional Council
2. Ron Miliado – Barkly Region Alcohol and Drug Abuse Advisory Group (BRADAAG)
3. Sarah Pickles – Central Australian Aboriginal Family Legal Unit
4. Gerry McCarthy – Member for Barkly
5. Sid Vashist – Barkly Electoral Office

Alice Springs – 6 November 2018

1. Eric Neil
2. Dr Bernard Hickey – Central Australia Health Service
3. Nick Guthrie
4. Sally Underdown – Alcohol and Drug Foundation
5. Margaret Borger – Holyoake Alice Springs

6. David Dwyer
7. Nikki McCoy
8. Tom Neville – Anglicare NT
9. Philippe Perez – Central Australian Aboriginal Media Association (CAAMA)

Public Briefing

Darwin – 30 August 2018

1. Northern Territory Police Force
2. Department of the Attorney-General and Justice
3. Department of Health

Note: Copies of transcripts are available at: <https://parliament.nt.gov.au/committees/RAB>

Appendix 3: Datasets on illicit drug use in the NT

Dataset	Type of Data
National Drug Strategy Household Survey 2016 (NDSHS)	This is a self-report survey that collects data on a wide range of drugs – illicit, licit and pharmaceutical. Data, particularly for drugs with low prevalence, can be unreliable, especially in the NT where sample sizes are comparatively small. In addition, although NT participants are drawn from a random sample of the population aged 12 years or over, they are only drawn from households in Darwin and Palmerston. Consequently, the sample does not capture people living in remote areas or those who were institutionalised or homeless.
NT Drug Trends, Illicit Drug Reporting System (IDRS) (2017 and 2018)	Data is collected through surveys of small ‘sentinel’ samples of injecting drug users at both national and jurisdictional level. A sentinel sample aims to identify emerging trends in drug use but cannot establish prevalence. To be eligible, participants must use injecting drugs but many also use other illicit drugs such as cannabis.
Illicit Drug Data Report, Australian Criminal Intelligence Commission (ACIC) 2015-16	Law enforcement data including: seizures of drugs; drug arrests; and purity of drugs. Available at national and jurisdictional level.
National Wastewater Drug Monitoring Program (NWDMP) 2018	The program analyses wastewater collected from sites across all Australian jurisdictions to monitor drug use by identifying the number of doses of particular drugs found in the sewer system. Key drugs monitored in this program include: cannabis (2018 only), nicotine, alcohol, methamphetamine (ice), cocaine, MDMA (ecstasy), and fentanyl and oxycodone (opioids). Note that nicotine consumption was reported instead of tobacco use because the analyses did not distinguish between nicotine sourced from tobacco and that derived from nicotine replacement products like gums and patches.

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