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ICE Select Committee
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ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES (AADANT)
SUBMISSION TO THE 'ICE' SELECT COMMITTEE (NT)

EXECUTIVE SUMMARY

According to data (anecdotal and recorded) provided by the NT AOD sector and interested stakeholders there appears to be a **9% increase in the last 7 months alone, of clients reported as using and or exposed to meth/amphetamine.** This reflects urban, rural and remote data including remote Aboriginal communities.

Of the 9 key AOD Rehabilitation – residential or day – services in the NT, most report the inability to provide specialized ICE treatment such as withdrawal services for a number of reasons including infrastructure deficit in terms of appropriate treatment protocols, exclusionary parameters that protect the nature of current services (i.e families) and non specialized staff. Of the remaining AOD sector services there is limited specialized capacity to treat the harmful use of ICE.

As part of a joint submission to the National Ice Taskforce - Roundtable Discussion, the National AOD Peaks network (of which AADANT are a member) highlighted key points that are applicable in the NT as well as Nationally. AADANT feels it is important to highlight some of these in the context of this submission;

- Need to support services to continue to be responsive and adapt to emerging drug trends (which is currently methamphetamine), therefore capacity building investments are essential.
- An investment in treatment, harm reduction and prevention should be strengthened and built upon particularly in the NT.
- Drug use is dynamic and patterns of use are always changing, we see cycles of drug use and the sector has successfully responded to these changes in the past.
- We must not forget the other drugs - while methamphetamine presentations to services are increasing we continue to have larger issues with Cannabis and Alcohol in the NT.
- Research services are essential in maintaining and building our evidence base and capacity to develop new treatment approaches.
- Training and workforce development deficits are impacting on the sustainability of the sector, workforce retention, and access to treatment for consumers impacted by methamphetamine.
- Recognising current approaches to treatment and harm reduction work.
- We are an evidence based and cost effective sector.

AADANT has provided a list of recommendations at the end of the submission document.

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The Association of Alcohol and Other Drug Agencies NT (AADANT) wishes to make a submission to this important inquiry on the prevalence, impacts and government responses to illicit use of the drug colloquially known as "Ice" in the Northern Territory. The purpose of our submission is two-fold. Firstly, to summarise relevant Alcohol and Other Drug (AOD) sector responses regarding the prevalence, impacts and government responses to ICE in the NT. Secondly, we wish to highlight the potentially important role for treatment and harm reduction measures in the health sector.

INTRODUCTION

The Association of Alcohol and Other Drug Agencies (AADANT) is the peak body for alcohol and other drug (AOD) services in the Northern Territory. We provide support, leadership, information and resources, representation and advocacy on AOD issues both within and beyond the AOD sector.

As a territory-wide peak organisation, AADANT has a broad constituency. Our membership and stakeholders include non-government 'drug and alcohol specific' organisations (NGO), consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

As a peak organisation, AADANT's mission is to build and maintain a strong, sustainable and culturally diverse Alcohol and Other Drugs (AOD) sector that works together to reduce alcohol and other drug related harm across the Northern Territory. Our purpose is to ensure that the issues for both people experiencing the harms associated with AOD use, and the organisations that support them, are well represented in policy, program development, and public discussion.

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PREVALENCE OF METHAPHETAMINE USE

Australia has one of the highest rates of illicit methamphetamine use in the world and the highest use among developed nations. Around 2.5% of Australians over 14 years (around half a million people) have used methamphetamine over the past year, compared with around 9% who have used cannabis and more than 4% who have used ecstasy. (Ice age: who has used crystal meth – and why?. 2015. *Ice age: who has used crystal meth – and why?*. [ONLINE] Available at:http://theconversation.com/ice-age-who-has-used-crystal-meth-and-why-23031. [Accessed 28 April 2015].)

While there was no rise in meth/amphetamine use in 2013, there was a change in the main form of meth/amphetamines used. Among meth/amphetamine users, use of powder fell from 51% in 2010 to 29% in 2013 while the use of ice (also known as crystal) more than doubled, from 22% to 50% over the same period. More frequent use of the drug was also reported among meth/amphetamine users in 2013 with an increase in daily or weekly use (from 9.3% to 15.5%). Among ice users there was a doubling from 12.4% to 25%. (Illicit use of drugs (AIHW) . 2015. *Illicit use of drugs (AIHW)*. [ONLINE] Available at: http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs-2013/ch5/. [Accessed 28 April 2015].

The tables below indicate the proportion of people who inject drugs (PWID) who reported use of ice/crystal methamphetamine, last six months, 2003-2014 and the recent use of speed, base and crystal/ice, nationally. 2000-2014 as reported in the Australian Drug Trends 2014 Findings from the Illicit Drugs Reporting System (EDRS).
(NDARC. 2015. . [ONLINE] Available at:https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/2014%20Drug%20Trends%20Conference%20Handout%20IDRS.pdf. [Accessed 28 April 2015].)

Whilst it appears from this data that the usage of methamphetamines nationally demonstrates a significant increase, the NT percentage would appear to be stable, however, it is worthy to note this represents injecting drug users. As reported above it would appear that there is an increase in the use of the crystal form of the drug – ICE, and perhaps this is represented in the second table showing methamphetamine as primary drug of choice is on the increase nationally. The IDRS National report for 2015 is due out in April 2015. This report will contain current national and jurisdictional data.

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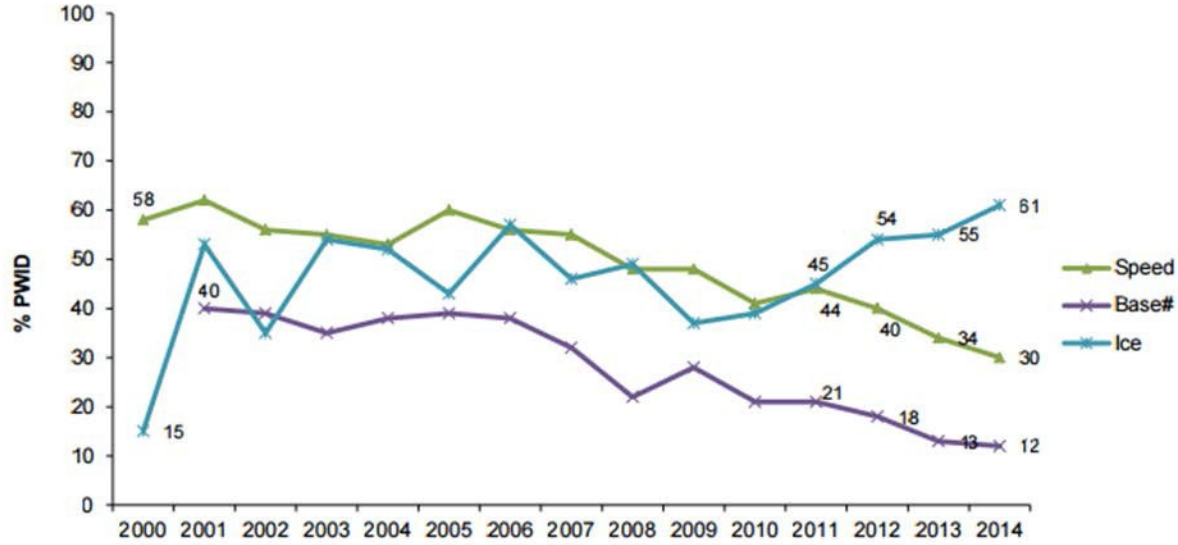
Proportion of PWID who reported use of ice/crystal methamphetamine, last six months, 2003-2014

	%National	NT
2003	54	34
2004	52	21
2005	43	29
2006	57	29
2007	46	29
2008	49	28
2009	37	15
2010	39	18
2011	45	28
2012	54	26
2013	55	30
2014	61 ↑	26

Source: IDRS PWID interviews

Figure 11: Recent use of speed, base and crystal/ice, nationally, 2000-2014



Source: IDRS PWID interviews
[1] Base asked separately from 2001 onwards.

In September 2014 AADANT provided an NT Meth/amphetamine Incidence Report (Appendix 1) to the Federal Government. This report collated submissions from various

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stakeholders and analyzed survey results from across the NT AOD sector. At that time our members indicated that the percentage of clients, anecdotal or recorded, presenting at their service/s using and/or exposed to meth/amphetamines was estimated at anywhere between 8 and 40%. These members represented urban, rural and remote jurisdictions with a predominant issue occurring in urban centres.

RESPONDING TO METHAMPHETAMINE – WHAT'S HAPPENING ON THE FRONT LINE

AADANT has again surveyed the sector with specific emphasis on the questions outlined in the Terms of Reference for the 'ICE' Select Committee. A summary of survey responses is provided below;

Representation and primary service delivery

The survey was sent to 200 participants across the NT AOD and associated sectors. The respondents represented the following service types;

- AOD NGO Treatment Services
- AOD Government Services
- Aboriginal Medical Services
- Youth Services
- Refugee and Trauma Services
- Community Services
- Education and Training Services

These operate in the service delivery areas of;

- Residential Rehabilitation
- Rehabilitation Services
- Outreach Programs
- Sobering Up Shelters
- Aftercare Services
- Community Development Programs
- Trauma Services
- Remote and Rural Workforce Development
- Case Management and Support Services

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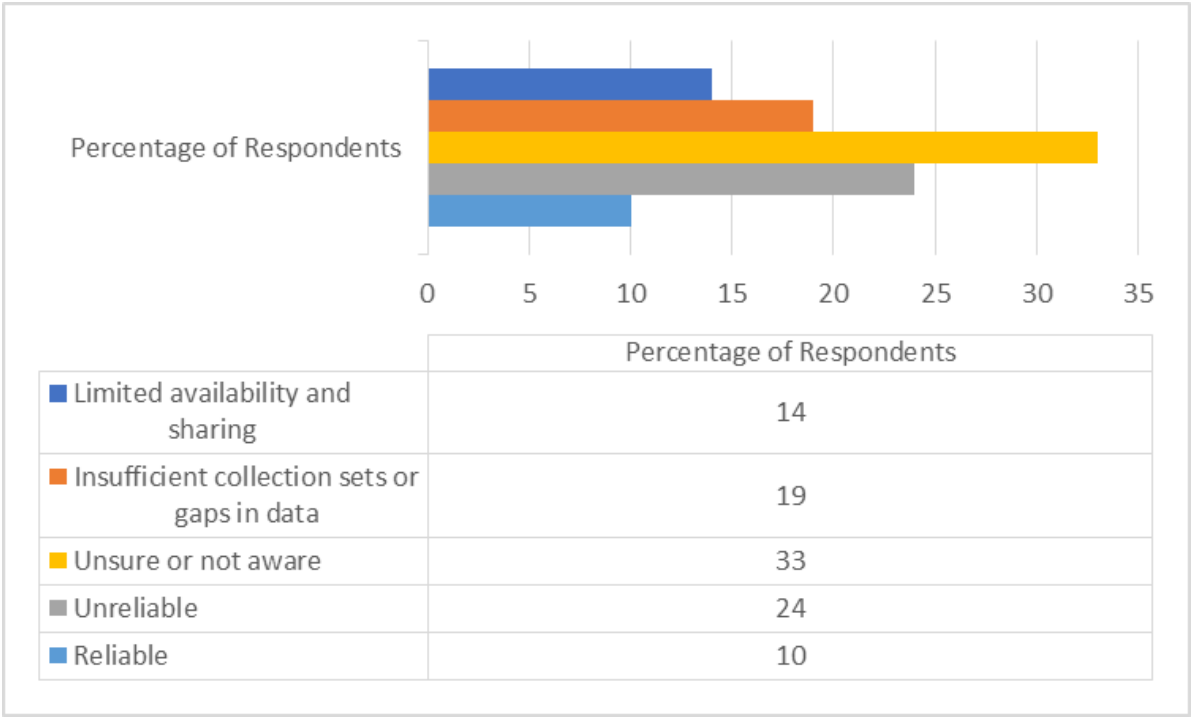
- Children and Family Services
- Behavioral Intervention Services
- Referral Services
- Pre-Court and Diversion Services
- Accommodation Services
- Social/Emotional and Life Skills Services
- Women's, Men's and Youth Services

How reliable is the current Government data on Ice use and its impact on systems such as health, justice, law enforcement and the AOD sector, both within your jurisdiction or within the Northern Territory?

Survey responses varied with comments ranging from unaware, not very good to comprehensive understandings of data collection mechanisms such as:
Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) and national collection sources.

Some of the issues/comments reported in the survey in regard to the reliability of the current Government (NT) data included;



	Percentage of Respondents
Limited availability and sharing	14
Insufficient collection sets or gaps in data	19
Unsure or not aware	33
Unreliable	24
Reliable	10

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What measures could be implemented to enhance collection and ensure accuracy of information and/or data?

Whilst a few respondents were unsure of potential new measures the majority provided a range of recommendations. These include;

- A clear direction on what data should be captured by all NT AOD service providers and a clear process for doing so.
- Collaboration between NTG agencies and NGO sector - including youth workers, police and DCF.
- Inclusive response - that all sectors are included not just those that work specifically in the AOD sector.
- Needs to be some collective opportunity to collate qualitative data so that quality information is available about the populations we are servicing (trends etc.).
- Address underreporting – creating better opportunities to collect data from 'using' population who do not actively engage with services and may not be captured in NMDS data (which overall is not incredibly helpful on understanding our 'using' population).
- Commission an Independent body to collect and distribute the data and information.
- Enhanced service data collection.
- Regular training opportunities around NMDS.
- Upgrades to NTG database inputs and integrated data collection from NTG and Department of Prime Minister and Cabinet (DPMC) funded agencies.
- Specific and consistent reporting mechanisms and data collection across both NTG, DPMC and NGO's including private health providers and pharmacies. Questions must be the same so the data is reliable.
- Police and Court feedback and data input.
- Holistic data collection - from police, court, hospital, AOD service providers, rehabilitation services, community services and other associated services (i.e counselling, relationship and family support services).
- ED presentations, rehab data, mental health services data.

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Other important suggestions included;

- Increased services, specifically rehabilitation - more people will generally ask for help or report if they know they can actually get support
- Education strategies - education and awareness. Refugee population was used as an example and identified utilizing improved understandings around the issues and aspects of trauma and how it leads to self-medicating. Identifying associated treatment and help available would raise awareness and reduce stigma increasing the level of attending and self-reporting.

What current government responses to the use of Ice are you currently aware of in your jurisdiction or in the NT?

Reponses to this question ranged from quite extensive including the detail provided below and in the accompanying graph.

Whilst a high level of understanding is acknowledged in the following comments it should be noted that some of the information is either not specific to methamphetamine usage or reflects National strategies or responses.

- An awareness of a range of prevention, intervention and protection strategies that have been implemented around illicit drug use throughout the Territory that are not specifically targeted at methamphetamine use.
- Methamphetamine targeted responses appear to address supply and include National Ice Taskforce (Federal Government), NT and Federal government to establish a Joint Law Enforcement Ice Strike Force.
- National Drug Strategy
- Some programs were specifically mentioned such as GP Education - responding to methamphetamine use with their client group and Headspace's new young people's program around illicit drug use and mental health.

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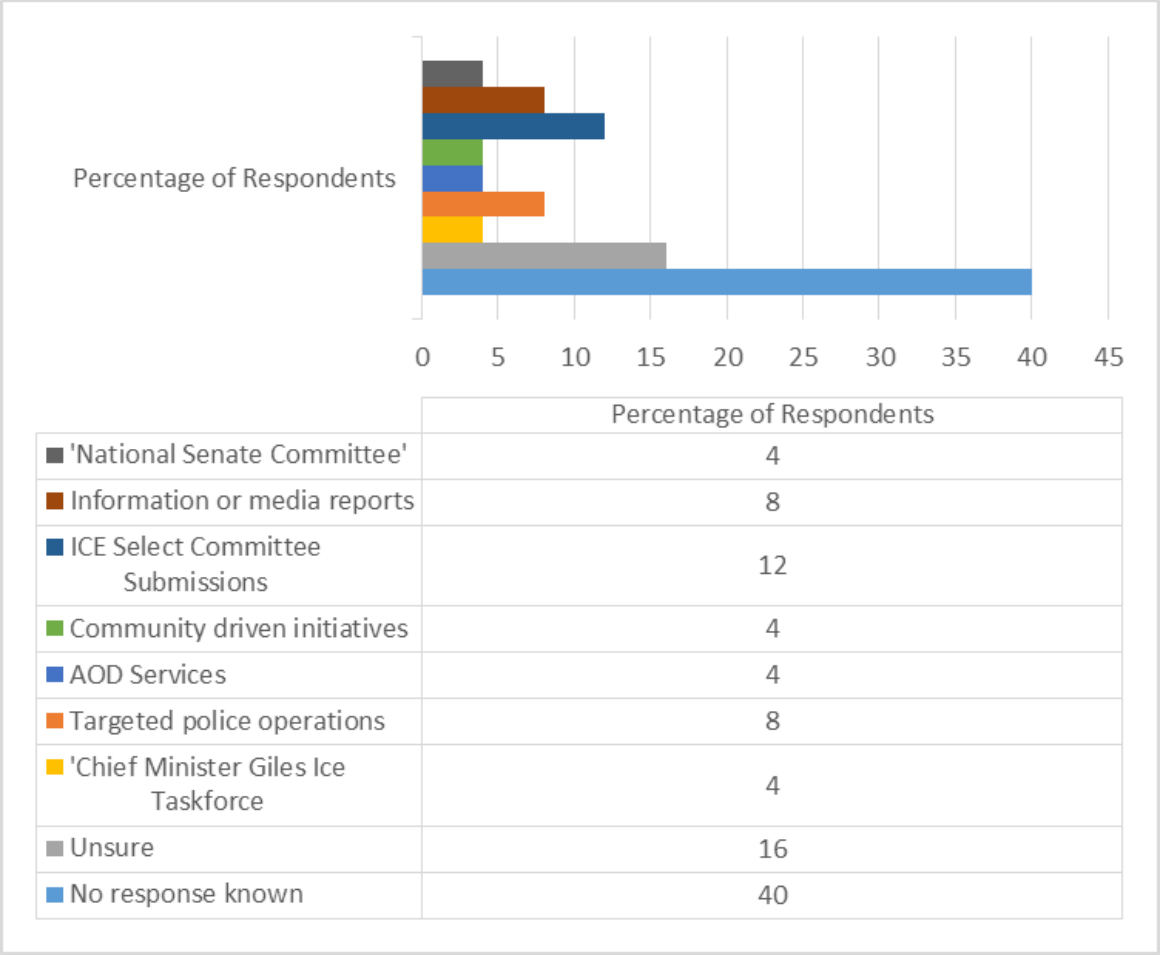
The remaining responses, specific to the NT, are reflected in this chart.



	Percentage of Respondents
'National Senate Committee'	4
Information or media reports	8
ICE Select Committee Submissions	12
Community driven initiatives	4
AOD Services	4
Targeted police operations	8
'Chief Minister Giles Ice Taskforce	4
Unsure	16
No response known	40

How effective are the current responses to the use and or prevalence of Ice in the Territory?

The following chart indicates the predominant responses to this question in the survey. Where a respondent indicated 'limited' they referenced policing responses. The 'adequate' response reflected the respondents opinions that there was little to no issue with ICE in the NT and therefore the response, or lack thereof, was adequate.

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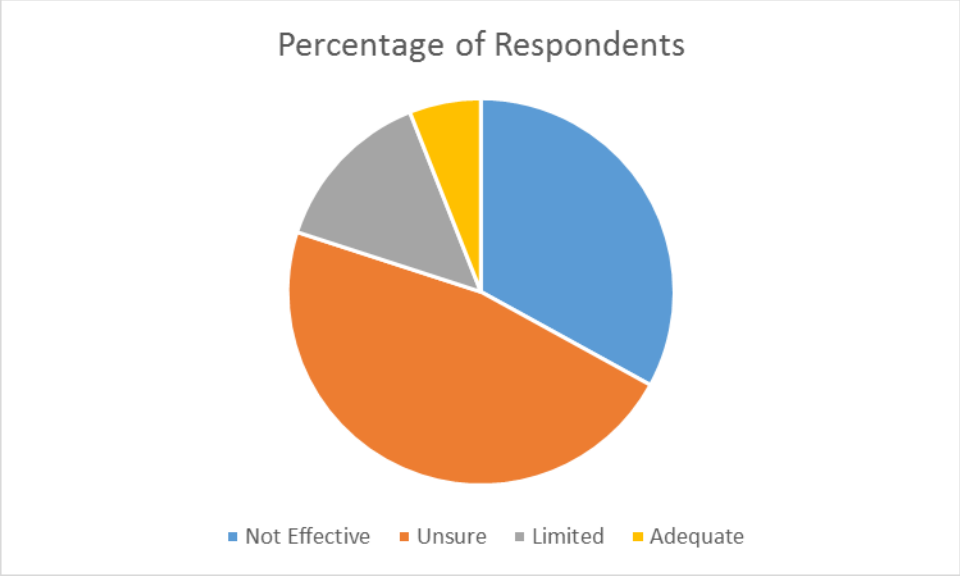

Finally one response indicated a thoughtful perspective on the question and provides some informative links to research;

- There are a number of papers that demonstrate responses are relying upon supply reduction and have not achieved the much hoped for results. For example: As discussed by Groves and Marmo (2009) “Australian policy responses have relied too heavily on a punitive approach.” (p. 414). “However, although these initiatives may aim to reduce supply of methamphetamine, they do not reduce demand …” (p. 414). Australia 21 – report: Alternatives to Prohibition. Illicit Drugs: How we can stop killing and criminalizing young Australians “Attempts to control drug use through the criminal justice system have clearly failed. They have also caused the needless and damaging criminalisation of too many young people, often with adverse life-changing consequences, including premature death from overdose.” And the Global Commission on Drug Policy – Taking control: Pathways to drug policies that work. “"We are driven by a sense of urgency. There is a widespread acknowledgment that the current system is not working, but also recognition that change is both necessary and achievable. We are convinced that the 2016 United Nations General Assembly Special Session (UNGASS) is an historic opportunity to discuss the shortcomings of the drug control regime, identify workable alternatives and align the debate with ongoing debates on the post-2015 development agenda and human rights." Fernando Henrique Cardoso Former President of Brazil (1994-2002)

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In your opinion, what responses are needed and how urgently?

Responses to this question all indicate an urgency in the following areas with details provided as to the specific areas our respondents see as important.

Workforce Development

- For AOD workforce
- For youth workers
- For police, paramedics and ED staff
- Clinical and non-clinical training

Training and Support

- Case management training
- ICE specific training
- Trauma training
- Clinical and non-clinical training
- Upgrading and upskilling of all AOD treatment services

Information and Education

- School based education
- Public or community education
- Media campaign
- For AOD clients - not currently exposed
- For AOD sector
- For health sector
- For legal sector
- For social and community services sector

Early Intervention and Treatment

- Extended treatment periods - beyond 3 months
- NT specific responses
- Integrated service delivery - comorbidities and cross sectorial

Infrastructure and Services

- Increased AOD sector services incl detox services
- Drug specific residential rehab
- Medical staff specialists
- Increased AOD staff
- Increased medical and allied health services

Research and Data

- Reliable data
- Shared police data and information
- Impact data - health
- Impact data - families and children
- Impact data - jurisdictional
- Impact data - housing
- What's working, what might work
- Usage characteristics - jurisdictional

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Further comments to note include;

- The empirical evidence regarding illicit drugs use, and more specifically around methamphetamine use, suggests that an overarching plan is required. For example we are aware that Victoria has recently released a comprehensive 'Ice Action Plan' that explores strategies in a range of areas e.g. helping families, supporting frontline workers, more support where it is needed, prevention is better than cure, reducing supply on our streets and safer stronger communities. As the NT is a small jurisdiction, we could take this opportunity to learn from others and adopt measures that would be transferrable to the NT.

  Along with a comprehensive plan it would be useful to have a commitment to resource allocation, a timeline for implementation and review of strategies to identify effectiveness of the plan, resources and strategies. We are aware some key resources such as: Turning Point's Methamphetamine dependence and treatment manual and the National Treatment Guidelines for Treatment approaches for users of methamphetamine: a practical guide for frontline workers. Our counsellors use psychological interventions when working with people presenting with a diverse range of substance use issues. Lee and Rawson (2009) found these types of interventions are effective in addressing methamphetamine use and dependence.

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- We would support workforce development for a diverse range of 'frontline workers' that may be responding to methamphetamine use within our community e.g. Police, Paramedics, Emergency Department staff and the Territory's AOD workforce. Also information and education to the broader health, legal and social sector (e.g. housing tenancy support workers, legal aid, domestic violence workers).

- Workforce capacity building, however more research needs to be done with local populations of ice users to identify unique characteristics, if any, which can then be used to inform practice. What we have learnt from our response to other substances is that a one size fits all approach does not work. We have a unique population in the Territory with very different needs, and so taking responses from other jurisdictions and applying them as our response will probably fall short of what is required to effectively address ice use in the NT.

- Very urgently, strategies such as a live in rehab with medical staff specialising in Ice with a longer duration period of 3 months. Provide education and training to existing AOD organisations and also education to Senior School students.

What, if any, are the social and community impacts of Ice in your setting? Please define your setting as urban, community or remote settings.

Following are the key responses from respondents. AADANT has indicated the location of the service where a region is not identified, however, some services cover multiple jurisdictions and their response may extend beyond the identified location;

- **Alice Springs** presently is seeing an increase in methamphetamine labs being found by police. The anti-social and violent behavior levels appear to be about the same as usual.
- It's tearing families apart. It's ruining young people's lives. I am working with several youth (some as young as 14) who are using Ice. They don't know or recognize the dangers, there is not enough suitable / available rehabilitation beds available and the youth are suffering terrible mental health or suicidal thoughts as a result. We are seeing more and more Aboriginal young people come through the youth justice system as a result and also a decline in youth completing a minimum high school education (**Katherine** Region).
- Impacts such as criminal/homelessness/Family violence/health/education - it's across the board. (**Darwin** Region)

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- We have identified a range of negative impacts that people in our community are reporting around alcohol and other drugs. These are not exclusive to people who use methamphetamines but are commonly experienced by people with methamphetamines issues. People report problems with: relationships; domestic and family violence; increased aggression; mental health issues (anxiety, paranoia, depression); physical health issues; child welfare and protection issues; housing issues; financial issues and legal issues. (**Darwin** Region)
- **Remote/rural setting**. My main role is delivery of training & education to **remote** health professionals and they are seeing the impact socially with ICE - increase in finical stress, parenting issues, family breakdown, health issues etc.
- **Urban** – however, we service a large population of clients from remote aboriginal communities in the NT. Anecdotal reports from community members in remote communities suggests that Ice is starting to be found in **remote communities**. If prevalence of use increases in these type of locations there could be devastating effects to families, children, community functioning, increased demand on services (allied health, child protection and police).
- Destroys families, people don't feel safe in the community and homes, business's get broken into, functional people are turned into dysfunctional, cultural breakdown, holistic breakdown of an individual, justice issues, employment plus many more. (**Darwin** Region)
- **Remote** - health impacts - bad reactions to the drug, or poorer quality - bad mix of chemicals due to lack of ingredient availability. Lack of service support options for users. Increase in violence within the community and to emergency responders.
- Increased violence, criminal activities and mental health issues. (**Darwin** Region)
- Well documented in the press and professional circles. (**Darwin** Region)
- Don't know of any particular examples at present but there is no doubt some messy lives out there from problematic use. Very little verified stories out bush amongst Aboriginal and Torres Strait Islander (ATSI) communities. (**Barkly** Region)
- **Katherine** is rural urban. Impact of ice becoming evident through perception of violence in licensed premises and domestic violence. Parents concerned about the implications for their children. "Gossip" about it being readily available. Questions from members of the public like, "If police know who is dealing, why aren't they arresting them?"
- **Urban**. Same impact on the families as all drug addiction, this time it's easier for the user to obtain and the effect more damaging at an earlier age and it is straight away devastation not gradual. (**Darwin** Region)

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- Urban Groundswell...unprepared. (**Alice Springs** Region)
- In **Katherine** no one uses Ice, just one person that was dealt with & he is now getting counselling & support.
- All three clients that I have worked with here in **Katherine** have experienced significant violence, domestic violence orders, breaches and ultimately family separation. I work in Katherine town. My clients all state that Ice use is significant and a major concern.

Please list any areas, communities or settings that you feel require urgent assistance with the management of Ice issues.

The following responses have been taken from the survey;

- Medical Services - the front line for extreme reactions to the misuse of any substance.
- Mental health services, Family support programs, Youth workers, Schools, NT police
- I think all communities in the area of prevention.
- Health impact on the body and brain but also on the parenting impact and increase risk to children?
- Anecdotal evidence suggests high prevalence of use in the **Palmerston** region. Reports of increasing use in **Boroloola** Community.
- Long Grassers, remote communities and community organisations.
- It covers all areas, communities and demographics.
- **Darwin/Palmerston.**
- Unknown maybe **Apitula** with Finke race coming up.
- Unsure but know that it is becoming more prevalent in the **Katherine** township. We have one residential rehab service which focuses on alcohol. I don't believe this service is equipped to deal with the treatment of Ice addictions.
- Younger adults 14-45.
- Facilities/Staff/Training/ Changes to legislation around restraint for Treatment services.
- Not that I am aware of.

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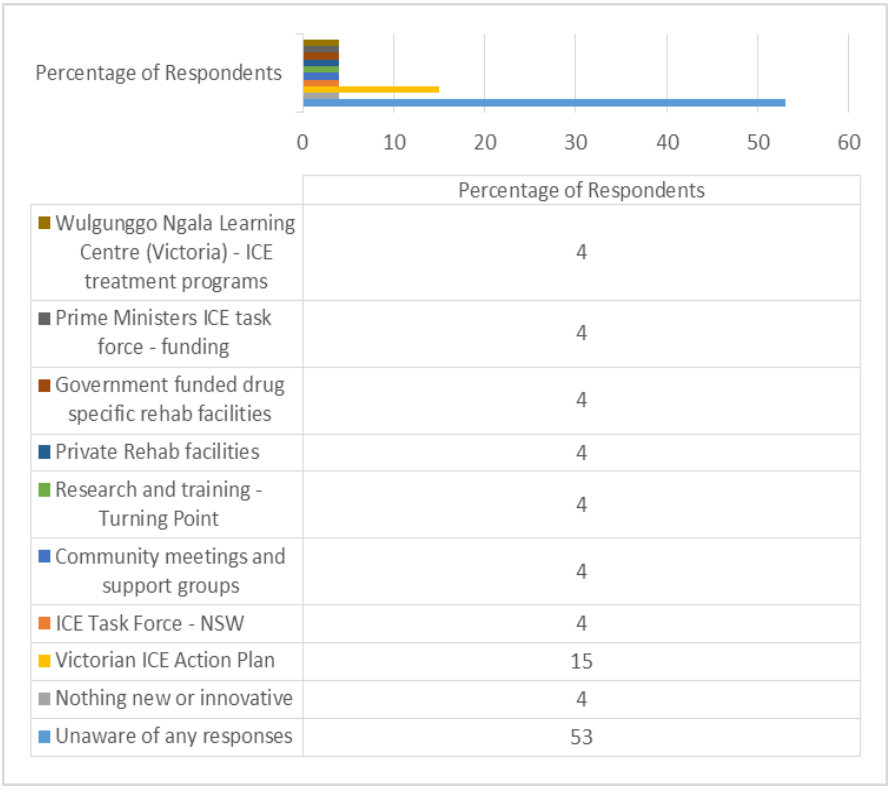
Are you aware of any Government responses in other states in terms of prevention, education, family and individual support, and withdrawal and treatment modalities? If so, please describe them and how effective you think they are, or might be.

The most comprehensive information recorded under this question includes the following information;

- We are aware of the Victorian Ice Action Plan and Framework, Turning Point's Methamphetamine Dependence and Treatment Manual, DoHA's Treatment Approaches for Users of Methamphetamines, DoHA's National Psychostimulant Initiative, ANCD's Methamphetamine Position Paper, Of Substance's Methamphetamine, Rehab and Recovery paper. All of these are based in empirical evidence and are currently seen as 'best practice' in responding to people with issues around methamphetamine use. More broadly we are aware of a few papers that explore options for drug policy based in evidence: Australia 21 – report: Alternatives to Prohibition. Illicit Drugs: How we can stop killing and criminalizing young Australians and the Global Commission on Drug Policy – Taking control: Pathways to drug policies that work.

Remaining responses have been collated below:



	Percentage of Respondents
Wulgunggo Ngala Learning Centre (Victoria) - ICE treatment programs	4
Prime Ministers ICE task force - funding	4
Government funded drug specific rehab facilities	4
Private Rehab facilities	4
Research and training - Turning Point	4
Community meetings and support groups	4
ICE Task Force - NSW	4
Victorian ICE Action Plan	15
Nothing new or innovative	4
Unaware of any responses	53

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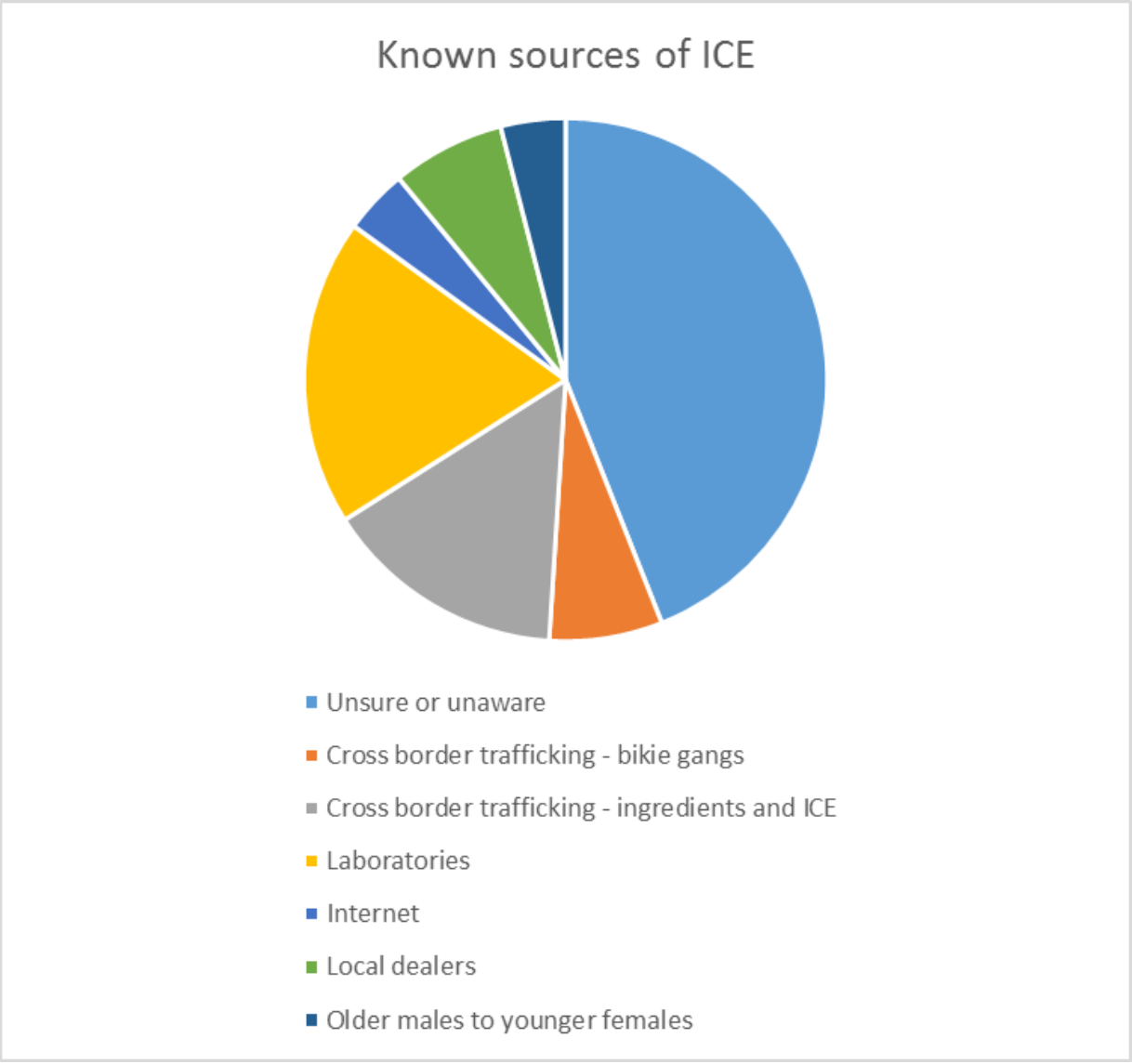
Have you heard or do you know the source of Ice, if any, in your setting? Please describe whether this includes cross border trafficking, local manufacture and/or derivation from legal pharmaceuticals and other legal precursors.



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Has your organisation implemented any new best practice work place health and safety measures for staff who may come into contact with Ice users? If no, do you know where to obtain workforce support in regard to this?

25% of respondents reported not having implemented any Ice specific measures within their organisations. The remaining key comments are below;

- Not as yet. We are currently seeking appropriate PD and resources in preparation for the need (should it arise).
- Not really- but we have policy and procedures in place and work collaboratively with NT police, DCF, mental health and department of health.
- In about 2010 we sourced federal funding through the National Stimulant Program to build a purpose built counselling environment to meet current WHS standards for counselling. This building is equipped with counselling rooms with two exits, duress alarms, fixed workbenches (so furniture cannot be picked up and thrown around) and temperature controls to manage a cool environment. The building also has noise control/lessening carpets and furniture in it to ensure it is a quiet environment with minimum stimulus. Our counsellors regularly engage in internal and external supervision and professional development in the substance use and associated mental health fields. We participate in inter-service collaborations and information sharing sessions around alcohol and other drugs and health.
- NIL - but I deliver training in child abuse and neglect to remote health practitioners so I need to be up to date with support for the primary health care sector and there is very little around.
- We maintain a high level of work place health and safety for staff who may come into contact with clients who are Ice users.
- No, but we need to - we recently had an at risk situation and workers were unprepared for the situation.
- All staff operate within a WHS framework.
- No, not yet tools and policies in development stage.
- No. I have sourced information myself from the AOD Counsellor with NTG.
- Have investigated Victorian models. Need funding to further work safety issues.

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Please feel free to provide any other comment or opinion in the space provided below.

The following provides further comment from our participants;

- We have seen clients who have used Ice however at this stage alcohol is by far our predominant drug of concern for most of our clients, with Cannabis the second most listed primary drug of concern.
- It appears, from some reading in this area that the "third wave" of methamphetamine use is upon us. We support and advocate for a comprehensive plan to address the three pillars of harm minimisation – supply, harm and demand reduction measures. We view alcohol and other drugs issues as a health issue rather than an exclusive criminal justice approach and advocate for responses that are solidly founded in evidence that focus on health outcomes. Associate Professor Nicole Lee at the National Centre for Education and Training on Addiction at Flinders University states "We know that for every dollar spent on drug treatment we save A$7 to the community, compared with A$2 for stronger policing. We need to ensure that treatment is a significant part of the solution to the problems created by changes in methamphetamine use".
- We don't need to reinvent the wheel with regards to a response, look at the literature, research and existing frameworks and adapt these to the NT context.
- We have plenty of data and research we just need leadership for action...enough learning..please...just act.
- All persons need greater information on this new drug, we need to have a new catch cry to make us all aware of the loss we all will suffer from this WAR.
- This drug is obviously highly addictive and users do not seem to be able to identify their addiction or associated issues.

FURTHER DATA COLLECTED

On the 29th April 2015 AADANT was invited to participate in the National Ice Taskforce - Roundtable Discussion to be held in Brisbane next week. As a consequence we resurveyed the sector using the same questions as found in our NT Meth/amphetamine Incidence Report (appendix 1).

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In this follow up survey respondents include;

- Residential rehab services (NT wide)
- Community services – general
- Community services – housing and tenancy (NT wide)
- Community services – post release support services (NT wide)
- Community services – mental health (NT wide)
- Community services – family, parenting and children (Darwin location)
- AOD treatment services including volatile substance programs (NT wide)
- Youth services including residential (NT wide)
- Needle and Syringe Programs (NT wide)
- Blood Borne Virus Prevention (NT wide)
- Aboriginal Community Associations (Katherine region)
- Regional Councils
- Sobering Up shelters (NT wide)
- Aftercare services (NT wide)
- Counselling services (Darwin location)
- National Drug support services

Review of the survey responses indicate a rise in ICE/Methamphetamine usage across services when compared to their original data. As previously stated, at that time of our initial report (Appendix 1) our members indicated that the percentage of clients, anecdotal or recorded, presenting at their service/s using and/or exposed to meth/amphetamines was estimated at anywhere between 8 and 40%. From this recent survey we can see that this percentage has now changed with the percentage of clients, anecdotal or recorded, presenting at their service/s using and/or exposed to meth/amphetamines estimated at anywhere between 3 and 85%.

The mean percentage is then 32% of clients reported as using and or exposed to meth/amphetamine. This demonstrated an increase from the previous mean of 23% of clients reported as using and or exposed to meth/amphetamine. **This represents a 9% reported increase in the last 7 months.** Note: some of the data received is anecdotal.

The graph on the following page indicates the percentage of clients presenting at services across the NT. The information provided comes from multiple sources including service data and approximation. It includes clients reporting ICE as both their primary drug, secondary drug or recently used drug (these are identified in the graph).

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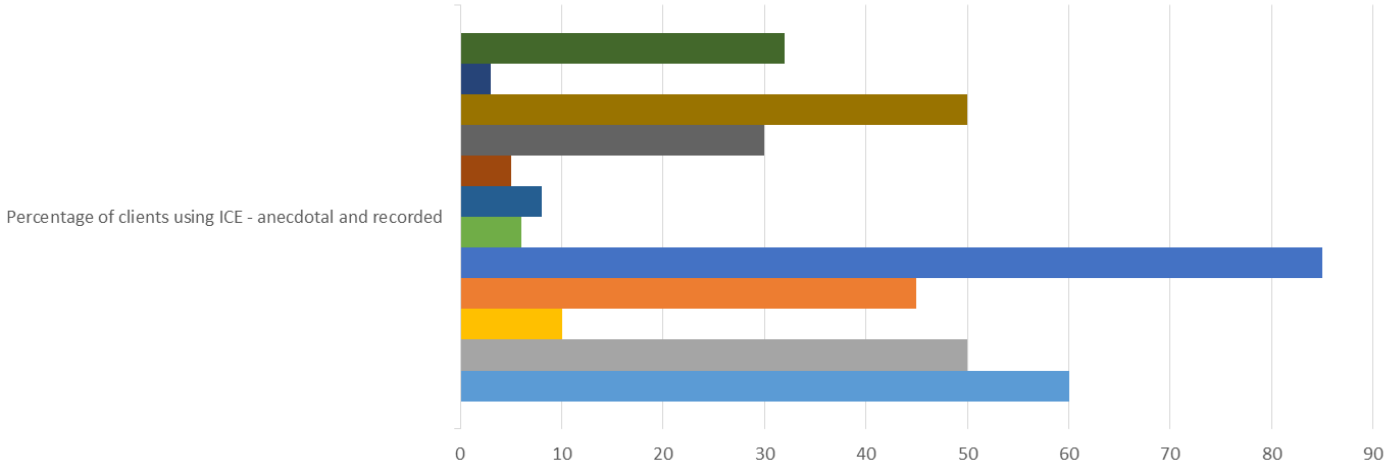
Anecdotally respondents also provided the following information;

- An Aboriginal Community Association (Katherine region) reported not being equipped but currently having a client/s with ICE problems
- An Alice Springs service that reported a 10% usage also reported “and growing”
- A regional council (central NT) reported anecdotal evidence of widespread use of ICE on remote communities in their region
- One residential rehabilitation service (Darwin region) reported 8% but noted an increasing number of clients being turned away from the service due to unsuitability (within a family program) due to criminal history



	Percentage of clients using ICE - anecdotal and recorded
National Support Line	32
Community service - mental health - Katherine	3
Community service - AOD, Mental health, support - Katherine	50
AOD service - resi rehab, counselling, family, parenting and children - secondary drug - Darwin	30
Community service - housing, mental health and post release	5
AOD service - rehab - Darwin	8
AOD service - Alice Springs	6
AOD Service (rehab) - recently used - Darwin	85
AOD service (rehab) -primary use - Darwin -	45
Therapy and Outreach - Alice Springs	10
Community Service - NT wide	50
Needle and Syringe Program - NT	60

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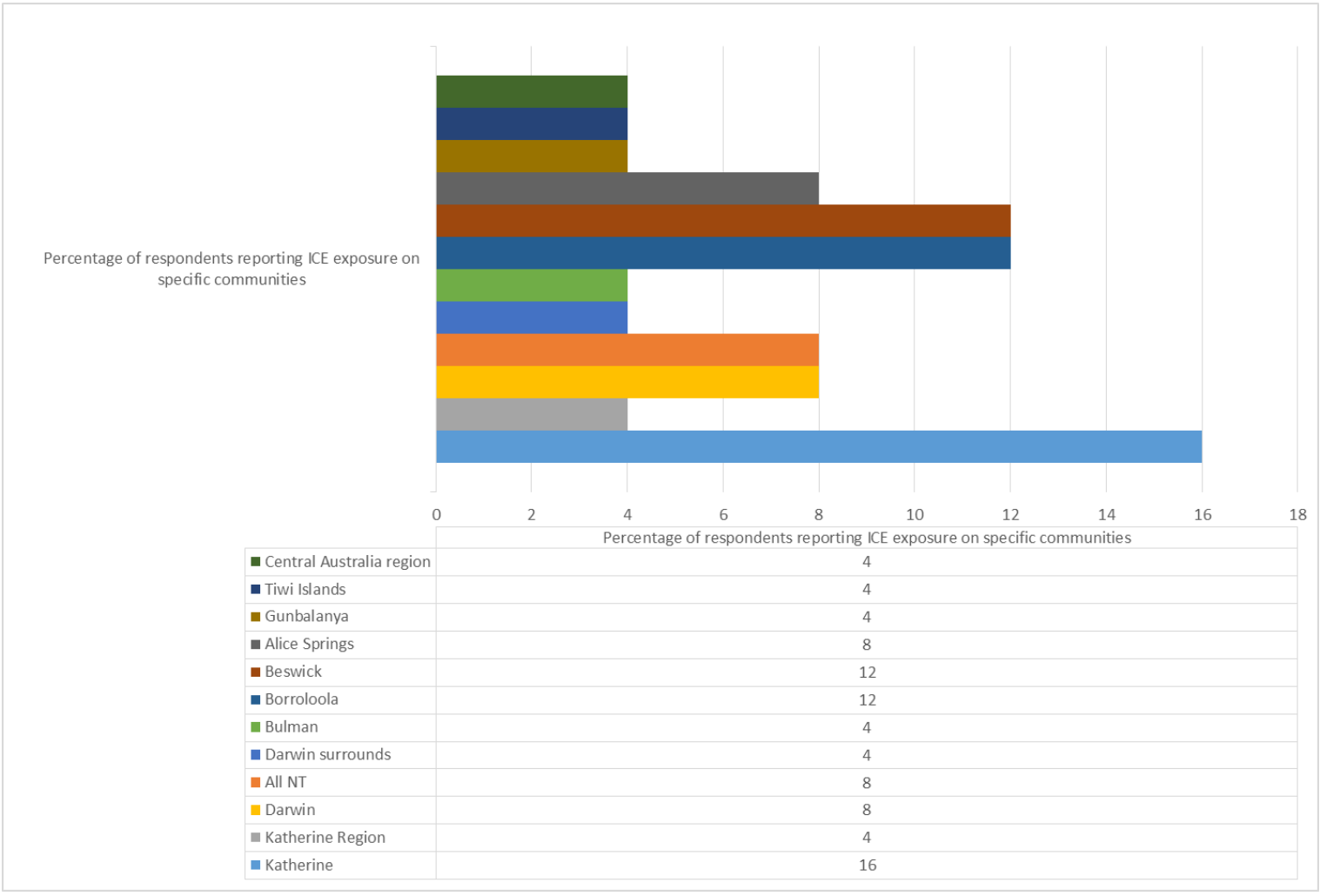
In this survey respondents noted the following populations as identified as having exposure to methamphetamines/ICE;

- PWID communities
- Gay men
- Aboriginal
- Sex workers
- Young people

They also identified the communities of Barunga, Manyallaluk, Mataranka, Jilkminggan, Ngukkurr, Numbulwar, Minyerri, Robinson River as being at risk primarily due to identified usage in the region and the transient nature of the populations.

This graph identifies the communities that were specifically identified by respondents as currently having exposure to methamphetamine/ICE.



	Percentage of respondents reporting ICE exposure on specific communities
Central Australia region	4
Tiwi Islands	4
Gunbalanya	4
Alice Springs	8
Beswick	12
Borroloola	12
Bulman	4
Darwin surrounds	4
All NT	8
Darwin	8
Katherine Region	4
Katherine	16

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Of these identified communities respondents were asked to identify the problem as serious minor or emerging.

MINOR

- PWID communities
- Gay men
- Aboriginal
- Sex workers
- Young people

EMERGING

- Alice springs
- Bulman
- Borroloola
- Gunbalanya ,
- Bathurst,
- Yuendemu,
- Beswick,
- Regional and remote communities in the NT
- Katherine surrounding region

SERIOUS

- Major towns in the NT
- Darwin
- Katherine

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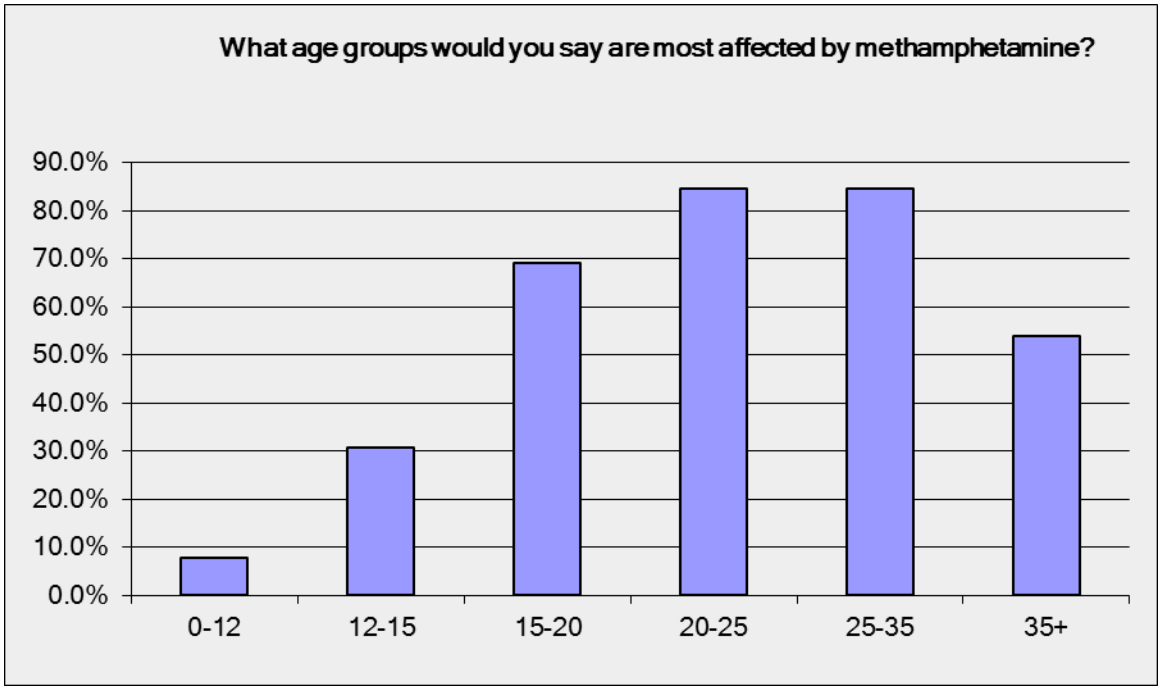
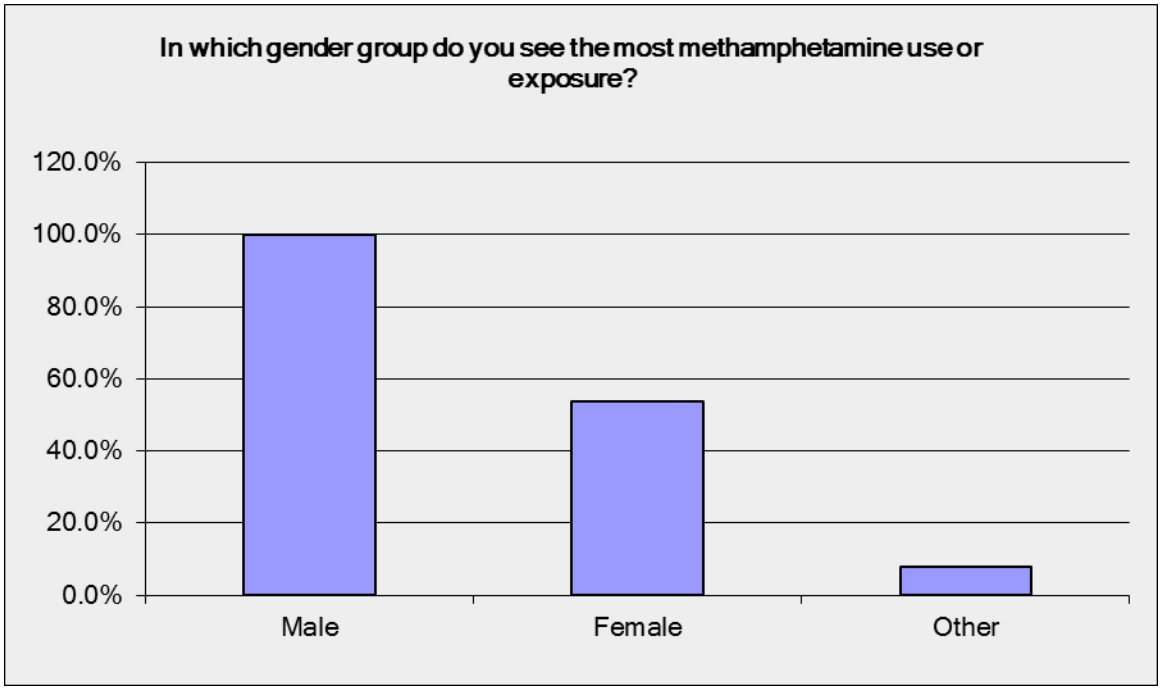
Respondents identified the user age groups presenting at their services and the gender data.





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FURTHER COMMENTS

Respondents to this survey took the opportunity to provide further feedback which identified some of their concerns. It is appropriate to include them here;

- Concerned about the reduction in funding to address alcohol treatment and the fact that we have no funding or resources for drugs and other issues such as volatile substances abuse.
- Albeit Ice is a major national issue, the use of cannabis is a more overt concern in remote communities.
- All AOD treatment Services need additional funding for staff and training. Need to also consider legislation around use of restraint/seclusion.
- One of our clients has informed us that the largest users/suppliers in Alice Springs of meth/ICE are the 'tradies' (tradesmen).
- Scare tactics and inaccurate media reports are not helpful.

BURDEN OF METHAMPHETAMINE AND HARM REDUCTION MEASURES – NOT TO BE OVERLOOKED.

The economic cost of methamphetamine use in the United States reached more than an estimated $23.4 billion in 2005 — the true economic burden is somewhere between $16.2 billion and $48.3 billion. Most of the expense results from the intangible burden that addiction places on dependent users and their premature mortality and from crime and criminal justice costs. Although the cost estimates focus attention on the primary cost drivers, more work is needed to identify areas in which interventions to reduce meth-use harms could prove most cost-effective. (The Costs of Methamphetamine Use: A National Estimate | RAND. 2015. *The Costs of Methamphetamine Use: A National Estimate | RAND*. [ONLINE] Available at:http://www.rand.org/pubs/research_briefs/RB9438/index1.html. [Accessed 29 April 2015].)

Locating current data on ecomonic cost burdens in Australia is difficult but one can take from the American experience a suggestion that whilst criminal justice and policing approaches have their place we cannot overlook harm reduction, treatment and intervention strategies as a cost effective and ethical measure in dealing with Methamphetamine issues.

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In the Victorian Government INQUIRY INTO THE SUPPLY AND USE OF METHAMPHETAMINES, PARTICULARLY ICE, IN VICTORIA Final Report there is significant consideration to alternate policy options and the value of prevention and treatment options in combatting ICE. The report notes;

It is also important, however, to consider alternate policy options with respect to reducing the methamphetamine problem. The work of Manning, Ransley, Smith, Mazerolle and Cook (2013) in Queensland, for example, suggested the use of a framework for synthesising expert opinion and evaluating alternative policy options. A hierarchical model was developed in order to identify the best policy alternative from amongst Project STOP, outright bans, prescription-only supply, increased reactive policing and a do-nothing approach. It was concluded that 'there is strong support from experienced practitioners and policy makers for more regulatory approaches aimed at prevention of illicit methamphetamine problems, and surprisingly little support, across a range of dimensions, for increased policing as the strategy of choice' (Manning et al. 2013, p.392). Ransley et al. (2011) also canvassed alternative approaches:

> A viable alternative option to mandatory recording and reporting, adopted by the New Zealand Government in October 2009, restricts pseudoephedrine products to being available on a prescription only basis … and an even more drastic solution would be an outright ban on the products. Pharmacists have an interest in preserving their share of profit in pseudoephedrine sales, which would be significantly restricted under either of these options. Failure to reduce the methamphetamine problem through measures such as Project STOP may well lead to the adoption of a more drastic option (p.25).

(http://www.parliament.vic.gov.au/images/stories/LRDCPC/Tabling_Documents/Inquiry_into_Methamphetamine_text_Vol_02.pdf - p94)

Diversion programs, partnership policing, alternative courts, therapeutic justice and justice reinvestment are ways of addressing the problems related to relatively low level drug offending from a different perspective. As Magistrate Peter Mellas told the Committee:

> Once upon a time there was a very blunt tool kit: you did something wrong, you got punished, and it was something that either hurt you financially or hurt you in terms of taking away your liberty. We moved on from that to then trying programs that addressed the reasons why you were offending, and that became probation and community corrections orders. We have now come to the conclusion that perhaps even before you do that, that whilst the person is before the court and under the court's control you try something at the bail stage and therefore you have programs like CISP, you have programs like CREDIT/bail, the therapeutic justice ideas… The more tools we have, the more you can tailor them to a particular person's needs.

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Despite there being some excellent diversionary processes and alternative dispositions to incarceration in Victoria at both the arrest, pre-trial, trial and sentencing stages, the programs and interventions can only work in as much as there are sufficient support and treatment services to be referred to. Intensive wraparound programs that address criminal offending in a holistic manner are needed to support such diversionary interventions. But many witnesses have told the Committee that, particularly in rural and regional areas, these services are relatively few.
(http://www.parliament.vic.gov.au/images/stories/LRDCPC/Tabling_Documents/Inquiry_into_Methamphetamine_text_Vol_02.pdf p485)

This should not preclude strong prevention strategies as further outlined in the Victorian report;
Addressing methamphetamine use and abuse is more than dealing with the problems once they have occurred. Prevention strategies should be paramount. However, prevention is more than simply supplying information about a drug in the hope that it will deter people from commencing or continuing its use. It requires whole of community strategies that reduce the risk factors leading to problematic drug use whilst promoting the factors that may contribute to wellbeing and healthy lifestyles.
(http://www.parliament.vic.gov.au/images/stories/LRDCPC/Tabling_Documents/Inquiry_into_Methamphetamine_text_Vol_02.pdf p489)

Prevention models for addressing drug use have traditionally invoked three levels of prevention: Primary prevention (e.g. preventing the uptake of any illicit drug use); secondary prevention (e.g. reducing the update of risky methamphetamine use, such as preventing the transition from oral to injecting drug use; and tertiary prevention (e.g. reducing behaviours or practices that lead to significant social and/or individual harms, such as reducing the risk of overdose) (Allsop 2012, p.174 Inquiry Into the Supply and Use of Methamphetamines, Particularly Ice, in Victoria — FINAL REPORT)

Allsop observes that an alternative structure has been used in the United States that also employs three levels of intervention. These are: universal prevention (targeting whole populations); selective prevention (targeting specific groups who have above average risk); and indicated prevention (targeting individuals with emerging problems) (Allsop 2012, p.174). There is significant overlap between these systems and both approaches have been used in Australia. However, as Allsop indicates, the important point to note is that irrespective of the favoured model: [i]t is evident that there is no single approach to prevention and there is a need to consider diverse approaches and strategies targeting distinct issues, contexts, behaviours and/or populations.

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Effective prevention in relation to [methamphetamine] use is likely to include a range of strategies, from whole-of-community approaches that aim to prevent the uptake of [methamphetamine] use, to more targeted programs aimed at those who are currently using (Allsop 2012, p.174).

If we are to take anything from this research it would seem that the existing knowledge would support a holistic approach to the prevention (education strategies), treatment (detox, rehabilitation, specialized treatment, through care, after care, outreach, support and counselling) and control (policing and justice) of ICE in the Northern Territory and indeed, Australia. However, in order to do that we need to address the issues that prevent effective servicing and response.

As part of a joint submission to the National Ice Taskforce - Roundtable Discussion, the National AOD Peaks network (of which AADANT are a member) highlighted key points that are applicable in the NT as well as Nationally. They include (abridged);

- Need to support services to continue to be responsive and adapt to emerging drug trends (which is currently methamphetamine), therefore capacity building investments are essential.
- An investment in treatment and harm reduction is already being made and this should be strengthened and built upon particularly in the NT.
- Drug use is dynamic and patterns of use are always changing, we see cycles of drug use and the sector has successfully responded to these changes in the past.
- We must not forget the other drugs - while methamphetamine presentations to services are increasing we continue to have larger issues with Cannabis and Alcohol in the NT.
- Research services are essential in maintaining and building our evidence base and capacity to develop new treatment approaches.
- Current reviews of the AOD sector are impacting on the sustainability of the sector, workforce retention, and access to treatment for consumers impacted by methamphetamine.
- Recognising current approaches to treatment and harm reduction work.
- We are an evidence based and cost effective sector.

This included with the information gleaned from the survey participants and the research conducted have led AADANT to make the following recommendations.

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RECOMMENDATIONS

Development of an NT ICE Action Plan in consultation with the NT AOD sector

Improved data collection and sharing providing drilled down jurisdictional data, data as identified in this report and a standardized data collection program for all agencies (implementation and support funding required) – potentially cross sectorial. Included in this recommendation is effective data sharing that is both current, regular and reliable.

Infrastructure investment recognizing increased demands on the AOD sector. Increase and improvement in current NT AOD sector services. This would include funding considerations for staffing levels to match. Currently AOD services are experiencing competitive wage issues and rising salary requirements. Current expectations are not financially viable under many service agreements and quality services are at risk of disappearing without the appropriate competitive funding considerations. This would also include investment in new holistic services which responds to current needs, such as live in drug rehabilitation with specialist medical staff, after care services and the ability to respond to future needs.

Capacity Building Investment utilizing, and providing adequate funding to, the existing AOD peak body will ensure AOD services have a central point of information, access to available and newly developed resources, access to brokered education and training that is responsive to emerging and identified needs and gaps, access to current research, policies and information, networking and mentoring opportunities, inclusive consultation and feedback opportunities, advocacy and support. This also ensures ongoing National representation and a commitment to progressing the needs of the Northern Territory AOD sector as part of the National dialogue.

Workforce Development

- Significant investment in workforce development including enabling agencies to access available training and support. New strategies/funding required.
- Ongoing needs analysis and immediate attention to identified service or knowledge gaps.
- Develop strategies to address staff retention, current high turnover and improved induction and training practices specific to the AOD workforce.
- Support/Implementation of continuous quality improvement practices.

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- Develop or improve service planning responsive to emerging needs including effective evaluation practices.
- Identify and target training and education priorities such as;
    - New and emerging drugs and their treatment
    - Youth/AOD workers responding to ICE
    - Suicide prevention
    - Mental Health and comorbidities
    - Trauma informed care and practice
    - Family and social support
    - Clinical and Non-Clinical training
    - Through and after care practices

Prevention Strategies that demonstrate innovation in addressing the underlying causes of drug use and addiction and respect the rights of the client to ethical and respectful treatment and services need to be a priority with the appropriate investment to ensure development, production and dissemination across the general public, user groups and AOD, health and community sectors.

Training and Education including that already listed in workforce development, a NT wide public education campaign which includes AOD sector support – in-house education and training, implementation of local strategies or responses to campaign. Development of school, client and workforce training specific to ICE.

Research and Development

- Foster and support research organisations to continue to develop evidence based recommendations for treatment and servicing.
- Support initiatives such as Flinders University "Professional development needs assessment of the AOD workforce in relation to methamphetamine" (AADANT is currently participating in this project) with sector development funding to implement recommendations.

AADANT would like to thank the ICE Select Committee for the opportunity to submit this document. Should you have any questions regarding the information or data please do not hesitate to contact our office.

Prepared and submitted by

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APPENDIX 1

NT Meth/amphetamine Incidence Report

September 2014

NT Meth/amphetamine Incidence Report

Michelle Kudell | Association of Alcohol and Other Drug Agencies NT | AADANT 290914V1

AADANT

ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES NT

Together we make a difference

Methamphetamine use in the NT – a snapshot

The information in this first section – Methamphetamine use in the NT – A snapshot, has been prepared by the NT Department of Health Alcohol and Other Drugs Services at the request of the Association of Alcohol and Other Drug Agencies NT (AADANT). The information will assist AADANT in preparing a briefing paper to be presented to the Senator the Hon Fiona Nash, Assistant Minister for Health (Australian Government).

This section of the report draws on a number of sources including the National Drug Strategy Household Survey (2005, 2007, 2010), the Illicit Drug Reporting System survey and the Alcohol and Other Drugs Treatment Services National Minimum Data Set (AODTS-NMDS). There is still work to be done in accurately assessing the prevalence of methamphetamine use across the Northern Territory.

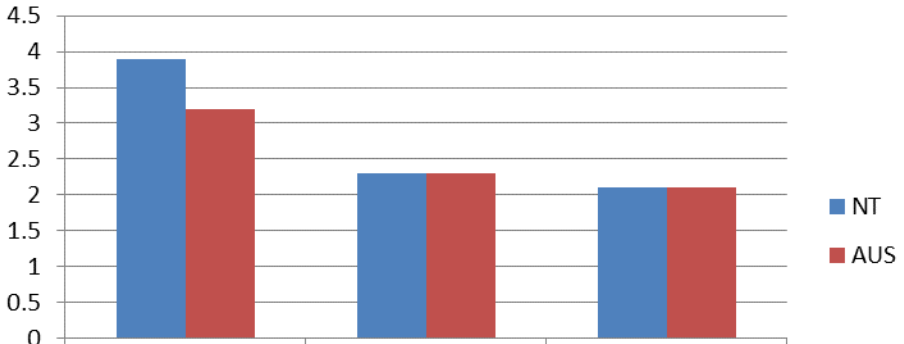
The following should be considered when reading this section of the report:

- The data DoH AODS has provided is primarily about methamphetamine use rather than crystal meth/ice use (other than where crystal meth is specifically referred to in IDRS findings)
- Note that the IDRS sample is a sentinel sample and is the best information we have about the people who inject drugs (PWID) population in Darwin, but the proportions found can't be extrapolated to the population (including remote communities) and so should be interpreted as indicative only
- We do not have a clear or full picture of what is happening in communities from the data provided

Methamphetamine use in the NT – a snapshot

The 2010 National Drug Strategy Household Survey (NDSHS) estimates that 2.1% of the NT population aged over 12 had used some form of methamphetamine within the previous 12 months. This proportion was unchanged since the 2007 survey and declined compared to the 2004 survey (see figure 1 below).

Figure 1: Recent methamphetamine use: proportion of the population aged 14 years and over.



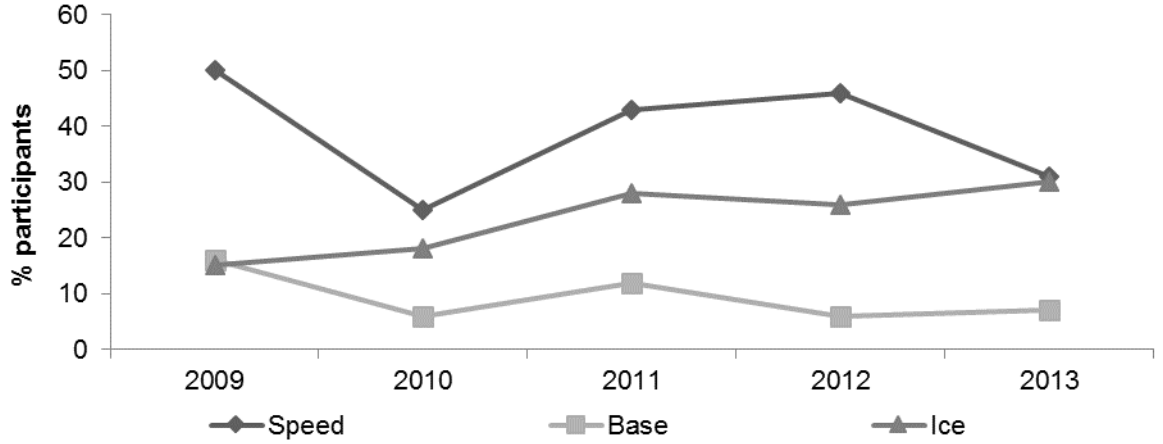
	2004	2007	2010
NT	3.9	2.3	2.1
AUS	3.2	2.3	2.1

Source: NT DOH Alcohol and Other Drug Services.

Methamphetamine use in the NT – a snapshot

The annual Illicit Drug Reporting System (IDRS) surveys a sentinel sample of the hidden population of injecting drug users. While the proportions found in this sample cannot be statistically extrapolated to that population they can be treated as indicative of potential changes. Figure 2 suggests that recent use of the crystal form of methamphetamine ('ice') among the IDRS samples taken between 2009 and 2013 has increased while the recent use of the other two main forms (base and speed powder) has declined.

Figure 2: Proportion of participants reporting methamphetamine and pharmaceutical stimulant use in the past six months, 2009-2013

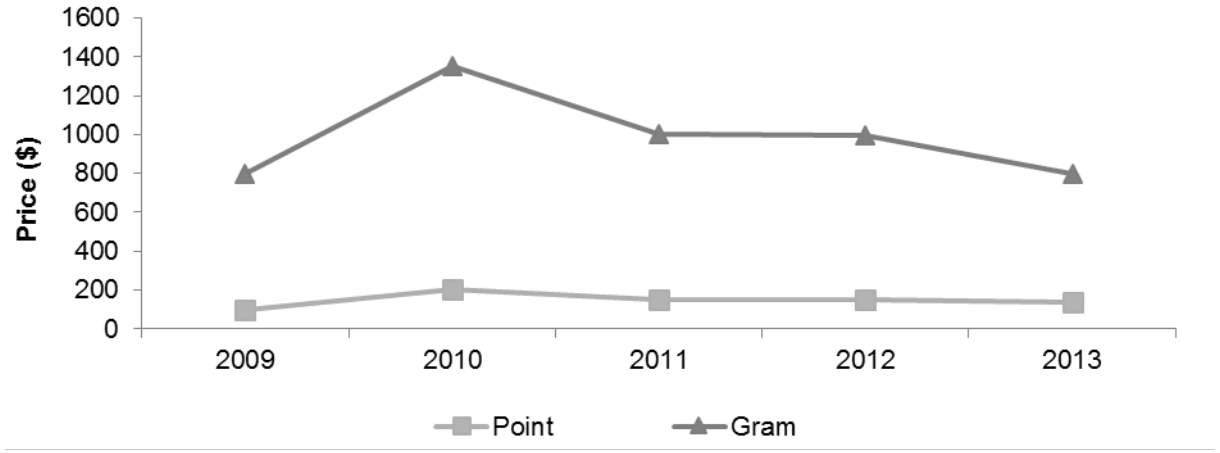


Source: IDRS participant interviews.

Methamphetamine use in the NT – a snapshot

Crystal methamphetamine is most commonly purchased in point (0.1 gram) amounts but is also purchased in grams. The gram price of crystal methamphetamine has fluctuated over time although declining since 2010 (Figure 3). The point price has been relatively stable.

Figure 3: Median prices of ice/crystal estimated from participant purchases, 2009-2013



Source: IDRS participant interviews.

Methamphetamine use in the NT – a snapshot

A small proportion of the IDRS samples have been able to comment on the availability of crystal methamphetamine. Crystal methamphetamine has typically been reported to be easy or very easy to obtain by a majority of those able to comment. In 2011 and 2012 speed powder was reported to be easy or very easy to obtain by larger proportions of the samples than was the case for crystal methamphetamine, but this pattern was reversed in 2013, with all participants able to comment reporting it as easy or very easy to obtain and none reporting that it was difficult or very difficult to obtain.

Table 1: Participants reports of methamphetamine availability in the past six months, 2011-2013 (%)

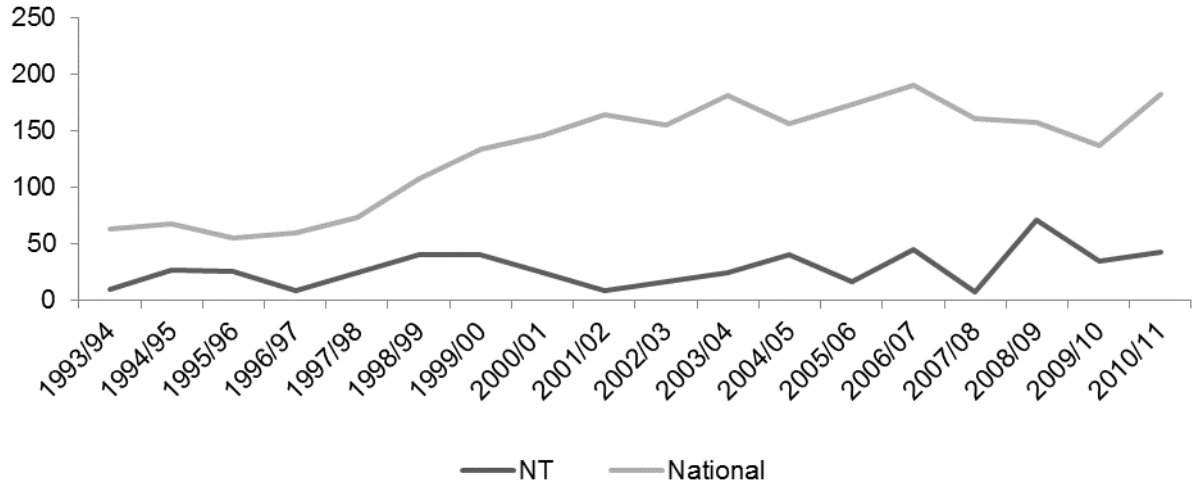
	Powder			Ice/crystal		
	2011	2012	2013	2011	2012	2013
Easy or very easy	80	89	81	77	67	100
Difficult or very difficult	21	11	19	23	33	0

Source: IDRS participant interviews.

Methamphetamine use in the NT – a snapshot

The rate of amphetamine-related admissions to NT hospitals increased in 2010/11 compared to 2009/10 (Figure 4) and it can be seen that this rate has fluctuated considerably in recent years, although possibly trending upwards. The national rate for the same period shows a reverse of the reasonably steady decline observed between 2006/07 and 2009/10.

Figure 4: Amphetamine-related admissions to NT hospitals by financial year, rate per million persons, 1993/94-2001/12



Source: AIHW.

Methamphetamine use in the NT – a snapshot

Table 2 shows that the proportion of closed episodes in specialist Alcohol and Other drug Treatment Services (AODTS) is where an amphetamine type stimulant is the principal drug of concern is low when compared to some other drugs, such as alcohol and cannabis, but has been increasing over recent years. Note that this category is not limited to crystal methamphetamine.

Table 2: Proportion of closed episodes of care for selected treatment types in AODTS^ by principal drug of concern.*

	2009/2010	**2010/2011**	**2011/2012**	**2012/2013**	**2013/2014**
Alcohol	65	65	65	67	64
Nicotine	2	3	2	1	1
Cannabis	12	13	13	12	17
Amphetamine Type Stimulants	4	4	5	6	7
Opioids	12	12	10	7	5
Volatiles (inc. Petrol)	3	2	3	5	4
Other	2	1	2	2	1
Total count	1,450	1,889	1,817	1,707	2,191

** Inc. withdrawal management, counselling, rehabilitation, pharmacotherapy, support and case management.*

^Alcohol and Other Drug Treatment Services.

Source: AODS

Methamphetamine use in the NT – a snapshot

The IDRS also collects qualitative information via semi-structured interviews with key experts (KE), selected because their work brings them into regular contact with illicit drug users. In 2013, most KE discussed the methamphetamine market in Darwin, consistently suggesting that some changes had occurred over the previous 12 months.

Both treatment and law enforcement KE felt that methamphetamine use generally had become more common and that a stable market had been established. They noted in particular the increased availability and use of crystal methamphetamine and that this had displaced powder as the most commonly used form.

Some treatment KE had noted a movement from smoking as the most common route of administration to injecting, saying that their clients were using each method "about 50/50". These KE also reported increased use among young, urban Aboriginal people, primarily injecting and split evenly between male and female.

All health KE reported an increase in the number of 'significant others', often parents or partners, who had been contacting them either for information about crystal methamphetamine use or to initiate a referral for treatment. They felt that this may reflect an increase in use among young, employed people in a stable family situation who had moved from a pattern of occasional use to more regular use. All health KE noted that they were seeing more young people employed in the building, construction and mining industries than was the case previously.

Methamphetamine use in the NT – a snapshot

References:

Moon, C. (2014). Northern Territory Drug Trends 2013. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series No. 116. Sydney, National Drug and Alcohol Research Centre, UNSW Australia.

Australian Institute of Health and Welfare 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

Australian Institute of Health and Welfare 2008. 2007 National Drug Strategy Household Survey: State and territory supplement. Drug statistics series no. 21. Cat. no. PHE 102. Canberra: AIHW.

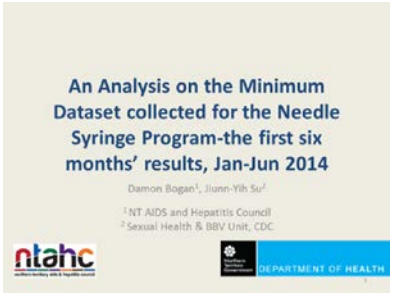
Australian Institute of Health and Welfare 2005. 2004 National Drug Strategy Household Survey: State and territory supplement. AIHW cat. no. PHE 61. Canberra: AIHW.

Meth/amphetamine use in the NT

This information has been prepared by the Association of Alcohol and Other Drug Agencies NT (AADANT). Comments or views expressed in the following do not necessarily represent the comments or views of AADANT, and do not represent the comments or views of NTG DoH. The position that the war on drugs has failed, etc, is not an NTG DoH position.

The remaining section of the report draws on a number of sources including AADANT member agencies and NT AOD sector records/anecdotal evidence and AADANT survey results - ICE and Methamphetamine Survey (29/09/2014). The participants have been de-identified to protect their identity.

It also includes the NTAHC report presented at Centre for Disease Control Conference in August 2014 -



Meth/amphetamine - Anecdotal

The following de-identified anecdotal evidence was sourced from AOD service providers in the NT:

- *We are seeing the emergence of injecting drug use within the Aboriginal community. We have seen direct evidence of this in Borroloola and in one of the Darwin town camps. Approximately **20%** of clients accessing the NSP identify as Aboriginal.*
- Katherine: *The percentage of clients, anecdotal or recorded, presenting at our service/s using and/or exposed to meth/amphetamines is estimated at **25%**.*
- Alice Springs: *The percentage of clients, anecdotal or recorded, presenting at our service/s using and/or exposed to meth/amphetamines is estimated at **8**%.*
- *The percentage of clients, anecdotal or recorded, presenting at our service/s using and/or exposed to meth/amphetamines is estimated at **15%**. ICE is a very dangerous drug and is destroying young people. In Darwin it is hard for people to detox and get appropriate support.*
- *The percentage of clients, anecdotal or recorded, presenting at our service/s using and/or exposed to meth/amphetamines is estimated at **40%**, including recreational. Most users take Ice. Ice users in Darwin are reporting Perth as a source of supplies and indicating that the Ice coming from Perth is stronger and cheaper. There is a large amount of contamination within the prison system where inmates are introducing other inmates to Ice and Speed once they are released.*

Meth/amphetamine - Anecdotal

- *Of a sample of 447 clients, **22%** identified methamphetamine as their primary drug of choice, with **26%** identifying methamphetamine as their secondary drug of choice. Clients who identified methamphetamines their drug of choice were from the Darwin region, although this was not necessarily their original home community*
- *We currently only collect data for ATS (amphetamine type substances). Although anecdotally it is suggested that more people are indicating meth as the type.*
- *The percentage of clients, anecdotal or recorded, presenting at our service/s using and/or exposed to meth/amphetamines is estimated at **26%**. The media hype and misinformation has not helped.*
- *From 30/6/13 to 1/7/14, **17.7%** report methamphetamine as primary with **15%** reporting Ampohetamine as primary drug of choice. However many of those in the cohort group report switching between both substances. Anecdotal or recorded presentations suggest there is approx **25%** of our client group for the 12 month period have used methamphetamine with that figure rising to approx **35%** being exposed to methamphetamine during the period.*

Meth/amphetamine - Anecdotal

- Nhulunbuy - *The percentage of clients, anecdotal or recorded, presenting at our service/s using and/or exposed to meth/amphetamines is estimated at 30%.*
- *I am not currently working at a client service however, anecdotally I have heard that Darwin, Katherine and Borroloola have exposure to methamphetamines.*

Impact on communities in the NT – Organisational Information

Information in the following slides was independently collated by a de-identified party on 26/9/2014 | and sourced through an AOD sector wide survey conducted by AADANT on 29/09/2014

Health Service/NGO	Actual Incidence of ICE usage	Rumour of ICE in Community	Perceived Seriousness	Age and Sex	Comments
De-Identified	Yes	A Lot			2 Weeks, 5 Clients
De-Identified	Yes	Not evident to the eye but we hear about it from clients and word on the street.			1 x Client
De-Identified		Yes – Communities identified include Ngukkur, Katherine, Jilkminggan, Lajamanu,Dagaragu and Binjari. Alice Springs		Male and Female Age Range – 12-35yrs Male 25-35yrs	
De-Identified		Darwin – Urban Aboriginal Communities		20 – 25y-rs	
De-Identified		In order of seriousness starting with worst Humpty Doo, Moulden, Palmerston, Howard Springs		Male 25 – 35yrs	
De-Identified		Clients who identified methamphetamines their drug of choice were from the Darwin region, although this was not necessarily their original home community		Male 25+	

Impact on communities in the NT – Organisational Information

Information in the following slides collated 26/9/2014 by Remote AOD Remote Alcohol and Other Drugs Workforce Alcohol & Other Drugs Services | Strategy and Reform Department of Health 6 Gap Rd, Alice Springs and an AOD sector wide survey conducted by AADANT on 29/09/2014

Health Service/NGO	Actual Incidence of ICE usage	Rumour of ICE in Community	Perceived Seriousness	Age and Sex	Comments
De-Identified		In particular males who frequent Mitchell St.	Emerging	Male 25 - 35	
De-Identified		All communities	Emerging	Male 35+	
De-Identified		Darwin - this is not necessarily their home community Palmerston - this is not necessarily their home community Clients presenting from Interstate	Darwin - emerging Palmerston - emerging Anecdotal information suggests Ngukurr - emerging Darwin & Palmerston town camps - emerging	Male 15 – 35	
De-Identified		Nhulunbuy	Emerging	Male 20 - 25	
De-Identified		Darwin, Katherine, Borroloola	Darwin - considerable - I don't know whether I would say serious Katherine - emerging not sure about Borroloola - minor	Male 20 - 35	

Impact on communities in the NT

Community	Actual recorded incidence of ICE usage	Anecdotal ICE prevalence	Perceived Seriousness	AGE and SEX	Comments
Borroloola	No				
Gunbalanya	No	No			Speed – Yes ICE - No
Groote	No	No			
Elliott	No	No			
Finke	No	No			
Tennant Creek	No	Yes			April/ May; cases of gunja being laced with ICE
Santa Teresa	Yes	No			4 Clients – since relocated to Nhulunbuy
Gove	No	No			
Ngukkur		Yes	Serious		
Katherine		Yes	Minor		
Jilkminggan		Yes	Minor		
Lajamanu		Yes	Emerging		
Dagaragu		Yes	Emerging		
Binjari		Yes	Serious		

Impact on communities in the NT

Community	Actual recorded incidence of ICE usage	Anecdotal ICE prevalence	Perceived Seriousness	AGE and SEX	Comments
Darwin		Yes	Serious	Male 25 - 35	
Palmerston		Yes	Serious	Male 25 - 35	
Humpty Doo		Yes	Serious		
Moulden		Yes	Serious		
Howard Springs		Yes	Serious		
Nhulunbuy		Yes	Emerging	Male 20 - 25	

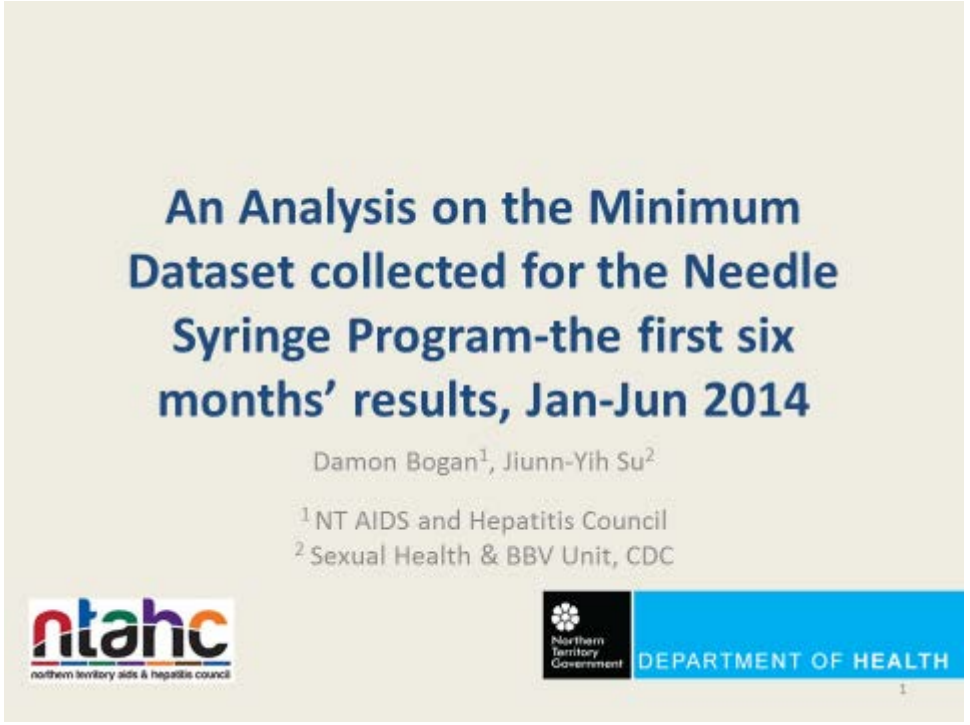
Comment from Survey:

It is clear throughout the world that the war on drugs has failed and it is killing and criminalising our young people. Methamphetamine is a particularly nasty substance. I am aware that people are choosing it because they are seeking a substance and this one appears to be readily available and cheaper than others. If Australia could employ evidence into their drug policies then we could control and regulate substances such as cannabis and MDMA (see Australia 21's report on Illicit Drugs) and remove criminal elements from the market and keep people safer.

As Andrew Weil in his book 'From Chocolate to Morphine' eloquently states - humans have always and will continue to seek to change the way the think, feel and behave and substances are an option for most.

The war on drugs has not reduced use.

NTAHC report presented at Centre for Disease Control Conference in August 2014



NTAHC report presented at Centre for Disease Control Conference in August 2014

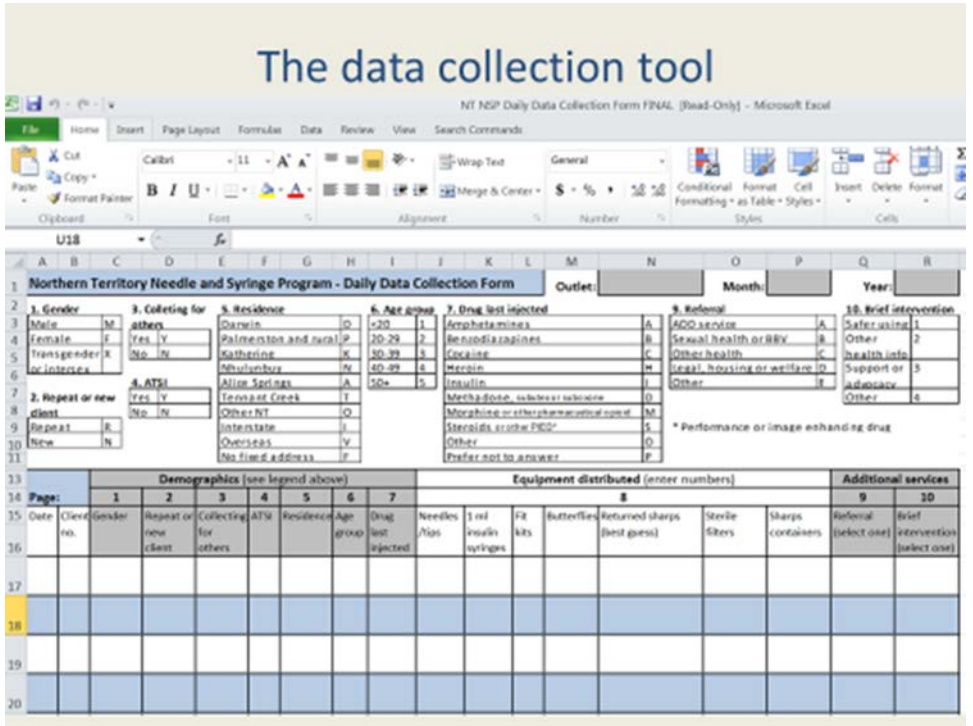
Introduction

- Comprehensive and consistent NSP data collection an initiative of NT NSP Working Group. Katherine Moriarty the terrier!
- Development and fine tuning by SHBBV and NTAHC.
- 6 month in-house trial by NTAHC (pest control)
- NT implementation commenced January 1st 2014
- This 6 month report a prototype for annual reporting.

Methods

- Most primary and secondary NSPs use standard data collection tool.
- Self-serve and hospital based NSPs use abbreviated form.
- Fitkit chemists not covered.
- Principle: only ask if it is useful!
- Daily records entered into spread sheet, which generates monthly summaries, sent to SHBBV.

NTAHC report presented at Centre for Disease Control Conference in August 2014



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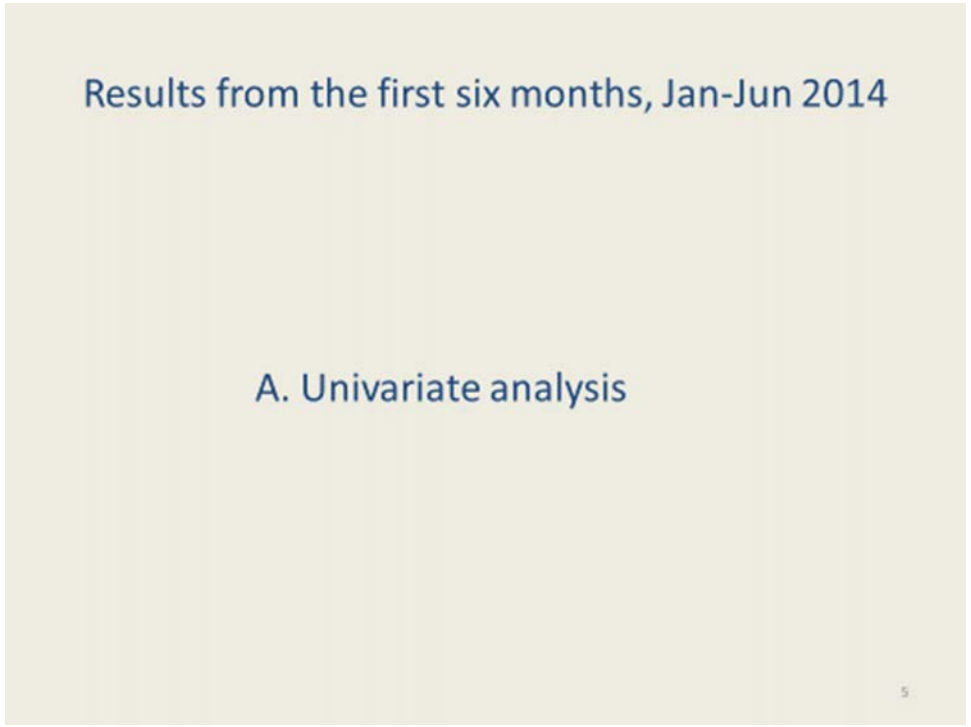

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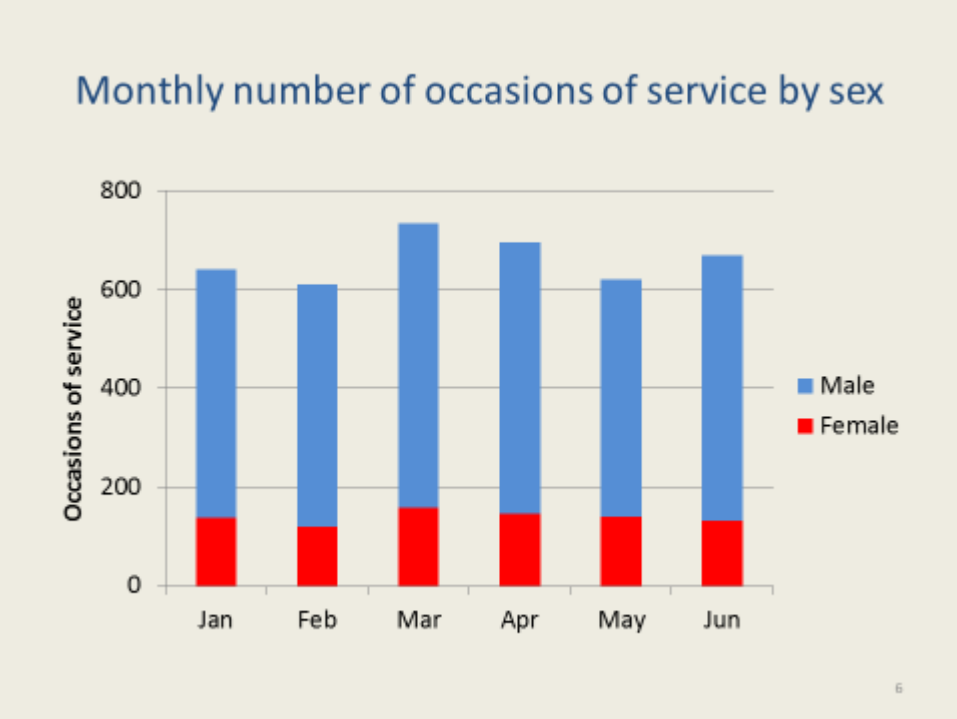

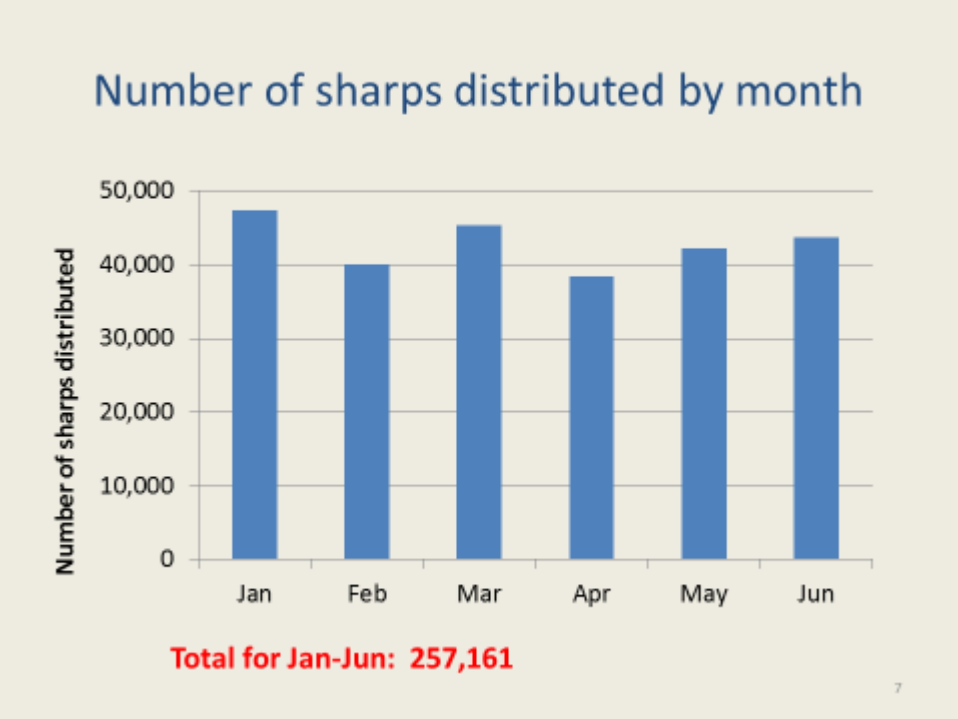

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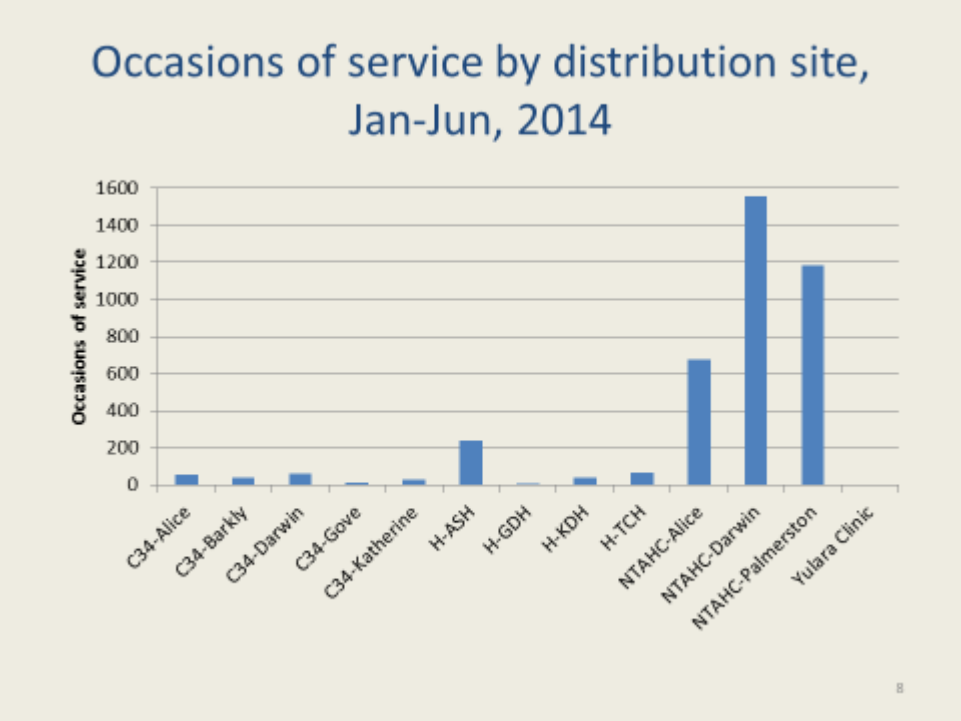

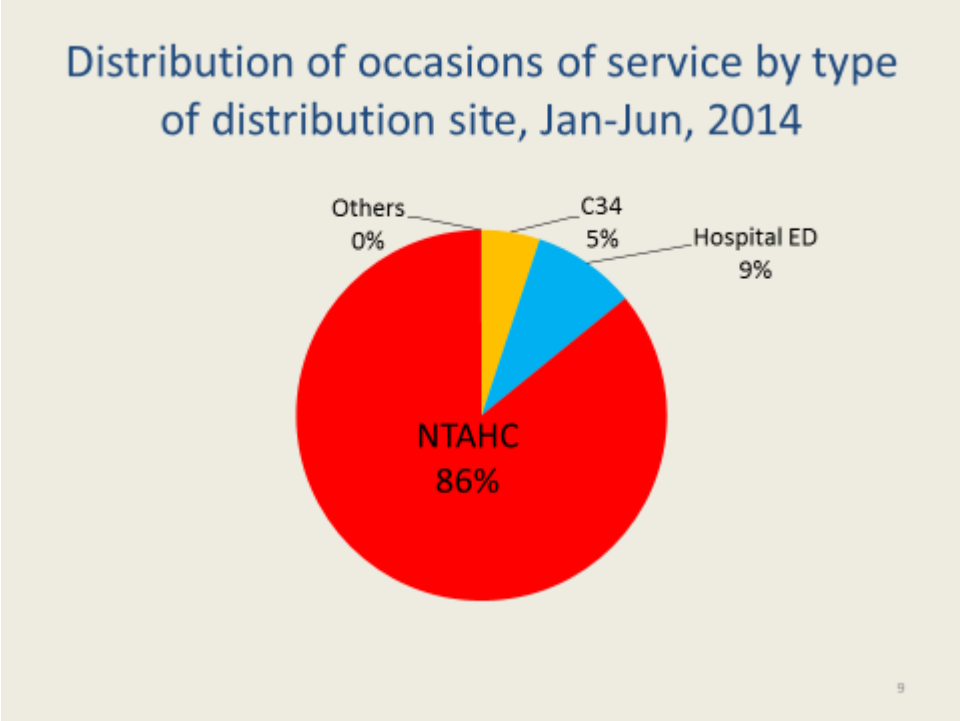

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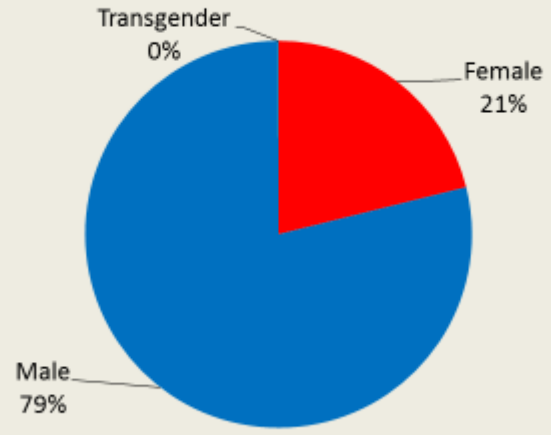
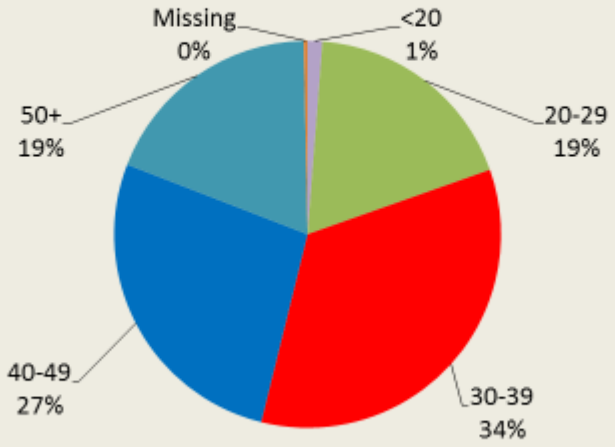
Distribution of occasions of services by sex



* Sex info missing for 2 occ of services (0.1% of all)

10

Distribution of occasions of services by age



* Age group info missing for 13 occ of services (0.3% of all)

11

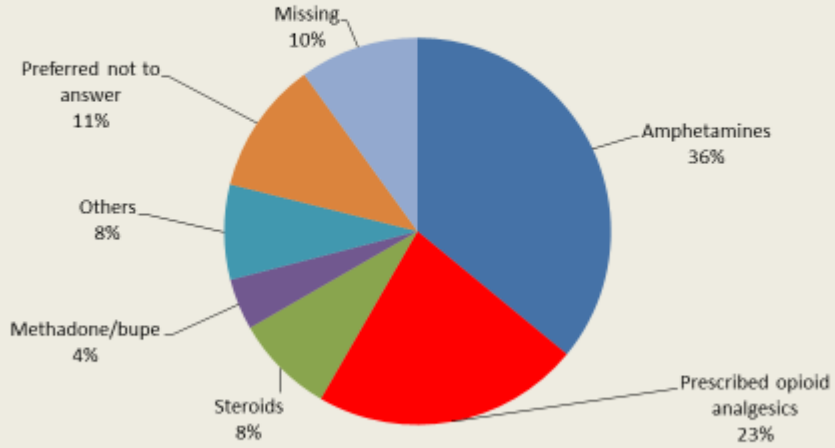
NTAHC report presented at Centre for Disease Control Conference in August 2014

Distribution of occasions of services by ethnicity

* Indigenous info missing for 297 occ of services (7.5% of all)

12

Distribution by last drug injected



* Info on last drug injected was missing for 397 occ of services (10.0% of all)

13

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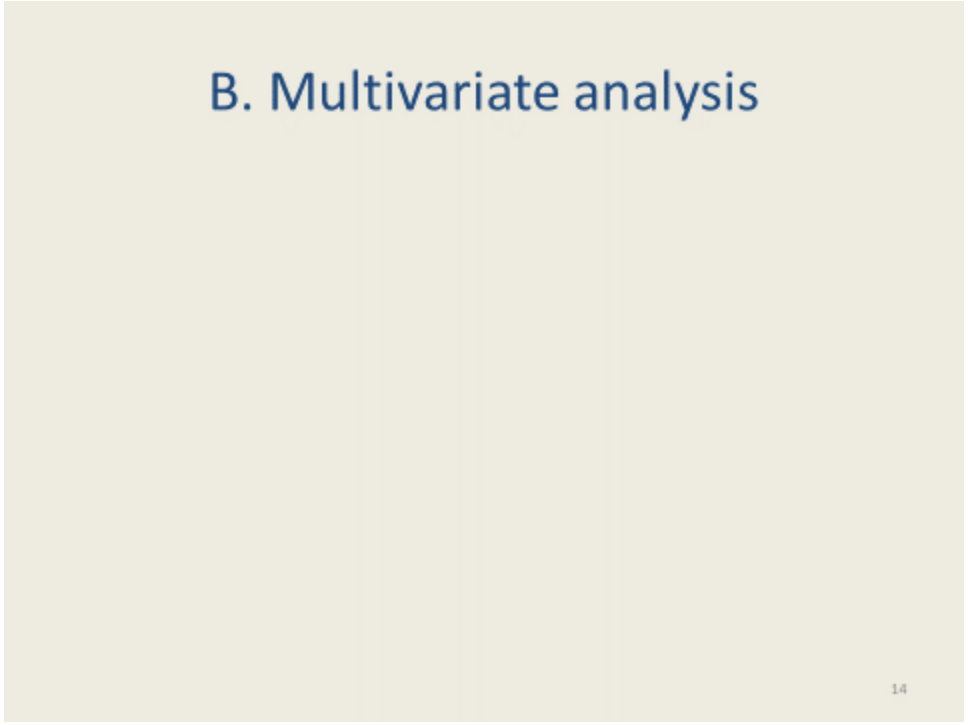

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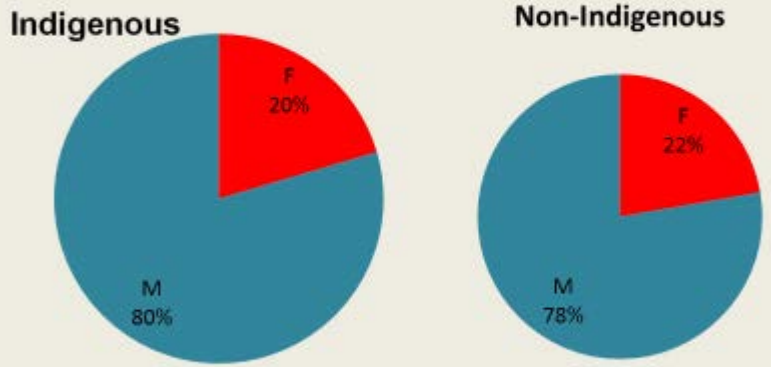
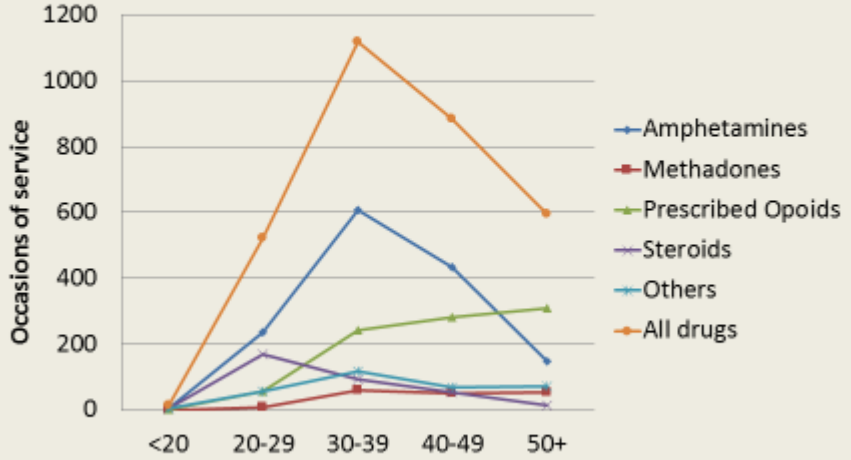
Distribution of occasions of service by sex and ethnicity (%)



15

Distribution of occasions of service by age group and last drug injected



16

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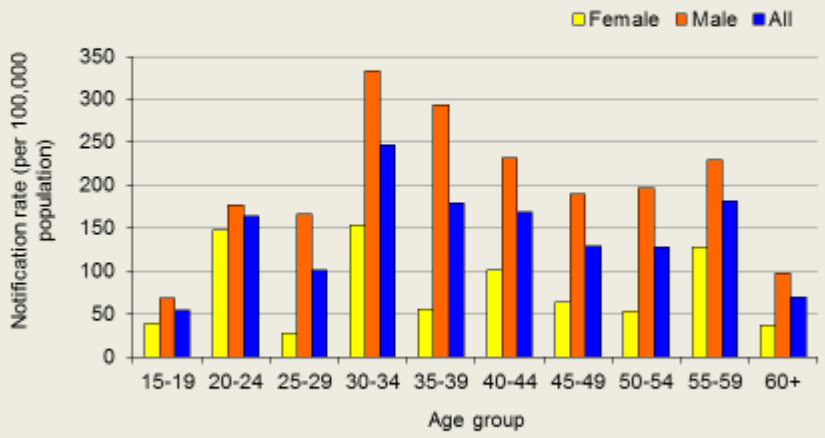
Notification rates of hepatitis C virus infection by age group, NT, 2013



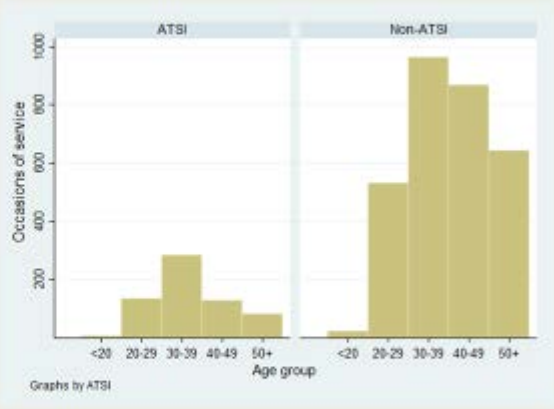
17

Distribution of occasions of service by ethnicity and age group

Chi-Squared analysis, $p<0.0005$

→age distribution was significantly different between Indigenous & Non-Indigenous clients

→Non-Indigenous clients were comparatively older



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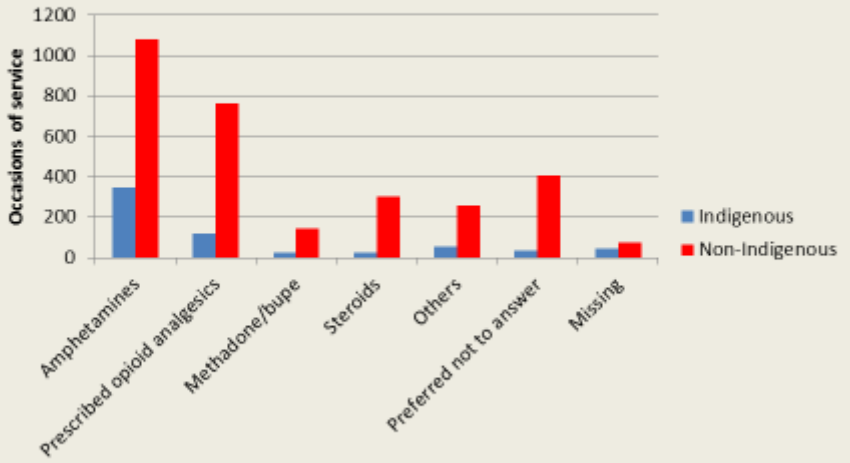
Distribution of occasions of services by ethnicity and last drug injected



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Distribution of occasions of service by ethnicity and last drug injected (%)

Last drug injected	ATSI	Non-ATSI	Total
Amphetamines	77.2	60.4	63.8
Methadone/bupe	5.4	8.2	7.6
Others	12.1	14.5	14.0
Steroids	5.4	16.9	14.6
Total	100.0	100.0	100.0

- The profile of last drug injected differed significantly between Indigenous and Non-Indigenous clients (Chi-squared $p<0.0005$)

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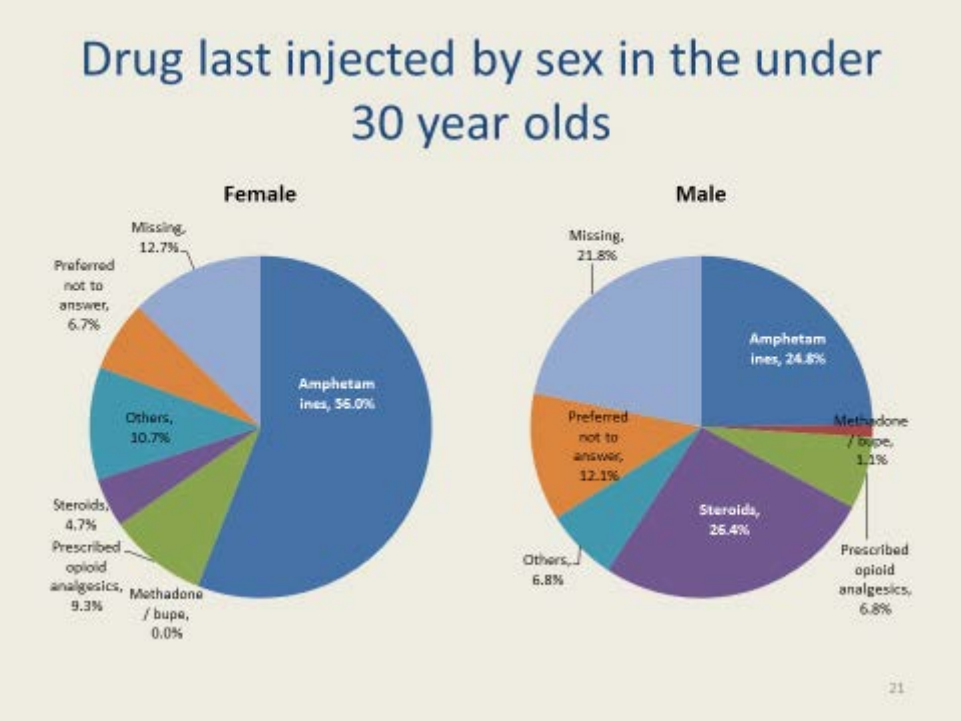
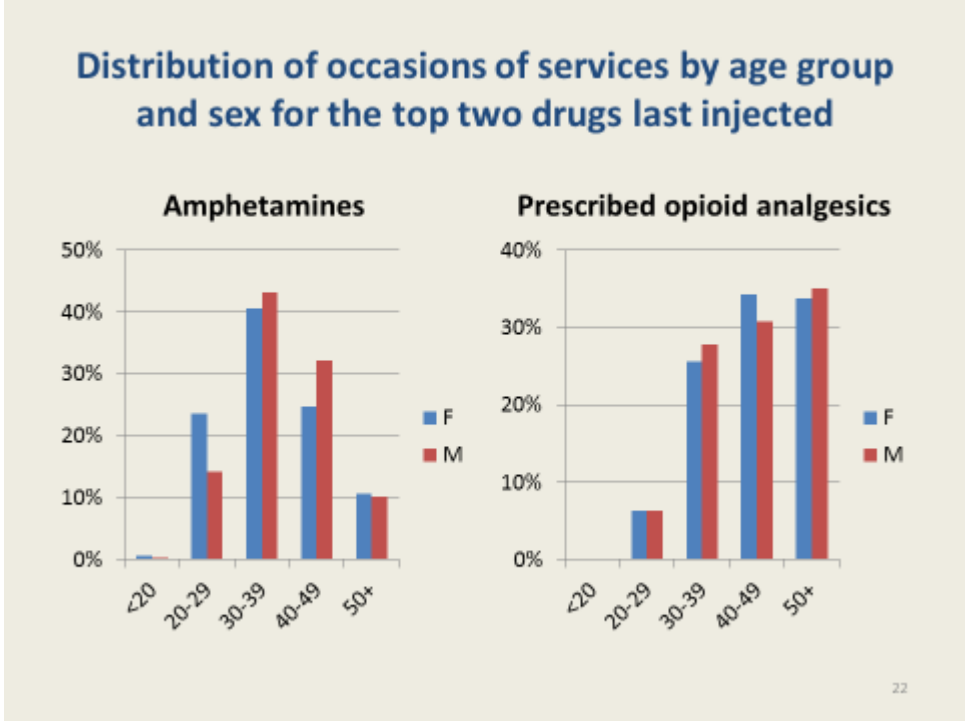
NTAHC report presented at Centre for Disease Control Conference in August 2014





NTAHC report presented at Centre for Disease Control Conference in August 2014

Summary

- Against historic NTAHC data, POA declining, but with 20% missing data this cannot be confirmed – a trend to watch.
- Methamphetamine most used drug overall
- PIEDs (performance and image enhancing drugs, i.e. steroids) - no.1 for young males
- Indigenous PWID - younger, more likely to use meth.
- Age profile curve of NSP clients similar to Hep C notifications.

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Acknowledgement

Katherine Moriarty, BBV Officer, was one of the major drivers for establishment of the collection of the Minimum Data Set for the NSP.

Thanks to Section Head Nathan Ryder and all partners on NSP Working Group.

ntahc
northern territory aids & hepatitis council

Northern Territory Government DEPARTMENT OF HEALTH

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NT Meth/amphetamine Incidence Report

Michelle Kudell | Association of Alcohol and Other Drug Agencies NT | AADANT 290914V1

This report was prepared and collated by the Association of Alcohol and Other Drug Agencies NT (AADANT).

AADANT would like to acknowledge the NTG Department of Health and AADANT Members and the NT AOD sector for the provision of this information.

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AADANT

ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES NT

Together we make a difference