Submission

Legislative Assembly of the Northern Territory

'Ice' Select Committee – Calls for Submissions

For further information contact:

John Rogerson

Chief Executive Officer

Australian Drug Foundation

PO Box 818

North Melbourne VIC 3051

PH: (03) 9611 6100

1 Background

On 25 March 2015 the Northern Territory Legislative Assembly resolved that**:**

'A Select Committee on the prevalence, impacts and government responses to illicit use of the drug colloquially known as "Ice" in the Northern Territory, be appointed.'

The Committee will investigate and report on:

a. The reliability of government data on Ice use and measures to enhance the collection of data to ensure that the scale of the problem and its impacts on the health, justice, drug and alcohol, and law enforcement efforts of the Northern Territory Government are understood and measured as accurately as possible;

b. A comprehensive survey of the various government responses to the abuse of Ice in the Northern Territory and assess their effectiveness or otherwise;

c. The social and community impacts of Ice in urban, community and remote settings;

d. Government and community responses to Ice use in other states and some assessment of the effectiveness of these responses in terms of prevention, education, family and individual support and withdrawal and treatment modalities;

e. The sources of Ice including cross border trafficking, local manufacture and derivation from legal pharmaceuticals and other legal precursors; and

f. Best practice work place health and safety measures for those in the health system who come into contact with users of Ice.

In consideration of these matters, the Committee should:

a. Consult widely with Territorians and those organisations and professionals with experience in Ice use;

b. Consider best practice models for effective early education, prevention, containment, treatment and withdrawal strategies; and

c. Seek the advice and experience of other jurisdictions regarding the options, costs and effectiveness of government and community approaches.

The committee is to report by 17 September 2015.

2 Purpose

This paper outlines the ADF's submission to the Legislative Assembly of the Northern Territory 'Ice' Select Committee. The ADF's focus is to predominantly work in the area of preventing the uptake of illicit drugs and preventing the harmful consequences experienced from their use. ADF has, over several decades, built a reputation as an organisation with a considerable level of expertise in this area. ADF's prevention work is undertaken in a range of settings to provide information and tools to prevent and reduce AOD related harms, as well as support those working in the sector through our Information Services unit, which is funded through the Victorian Department of Health.

3 Introduction

The Australian Drug Foundation (ADF) is a charitable, non-government, not-for-profit organisation and is widely regarded as one of Australia's leading alcohol and other drugs prevention agencies. For over 50 years the ADF has worked with communities to prevent alcohol and other drug problems. Our focus is prevention and early intervention and our strategies include community action, health promotion, education, information, policy, advocacy, and research. Our vision is an Australia that is composed of 'Healthy People, Strong Communities'.

The Australian Drug Foundation's (ADF) mission is working together to prevent alcohol and other drug (AOD) problems in communities. We aim to prevent harm caused by AOD by:

- informing members of the community about the harms of alcohol and other drugs,
- providing support for alcohol and other drug workers,
- developing and implementing community and workplace based solutions.

The ADF Information Services unit has developed a range of information products specifically relating to methamphetamine and/or ice use. All are based on the current scientific evidence on these substances. They include:

- Online resources
    - The DrugInfo website www.druginfo.adf.org.au
        - Amphetamine facts
        - Ice facts
        - How do amphetamine-type stimulants affect driving?
        - Ice (crystal methamphetamine)
    - The Other Talk website www.theothertalk.org.au
        - What do ice and speed look like?
- Print resources
    - Amphetamines and your body brochure
    - Amphetamines: how drugs affect you brochure
    - Ice: how drugs affect you brochure
    - Aware of amphetamines book

- Audio-visual resources
    - *Break the ice* DVD (created in partnership with Peninsula Health and Gay and Lesbian Health Victoria in 2009)

The ADF also provides information and advice on amphetamines and ice through a number of its general drug information services. These include:

- The DrugInfo phone and email information service (ph. 1300 85 85 84 or email druginfo@adf.org.au)
- The GET THE EFFECTS BY TXT! automated drug information via SMS service (0439 835 563)
- Drug information packs provided to 276 Good Sports clubs around Australia, as well as support for clubs wishing to develop alcohol and drug policies to address local issues.

Our phone and email information service regularly receives amphetamine and "ice" related calls, with almost half coming from family members or friends who are distressed and at a loss regarding the person using methamphetamine and/or "ice".[1]

While part of our work does support those engaging with alcohol and other drug issues from both personal and professional perspectives, as a prevention organisation we know that addressing the social determinants of health, or "working upstream", can positively affect people's exposure to health risks. It can furthermore build their capacity to avoid preventable harms such as those associated with problematic AOD use (Keleher & MacDougall, 2011). In this submission we provide our perspective on the scope of the current issues and harms relating to methamphetamine and "ice" in Australia, as well as propose a response that shifts the focus beyond reacting to existing problems into the prevention of future problems.

3 Summary of recommendations from ADF

The ADF has developed a number of recommendations which are detailed more fully in section 6 of this submission but which are included in brief below:

> **Recommendation 1:** Support the development of programs and resources that encourage and empower parents to have a positive influence in developing their children's resilience and good decision making skills.

[1] Some statistics to note from our service:

- In the period November 2013 to March 2015 we handled 485 calls related to Ice, the highest of any drug inquiry (next highest 309 which related to alcohol):
    - 98 were from partners, friends or other relatives (highest drug inquiry)
    - 43 were people using methamphetamine (fourth highest drug inquiry)
    - 57 were from parents (highest drug inquiry)

Recommendation 2: Support the development of programs and resources for schools and school communities to support children identified as at-risk with the aim of developing resilience and encouraging school retention and/or pathways to work contexts such as apprenticeships.

Recommendation 3: Provide increased access to existing services and programs such as school nurses, school focused youth services, primary welfare officers and student welfare coordinators.

Recommendation 4: Provide support local councils to develop local, relevant and attractive recreational and entertainment opportunities for young people who do not have access to those activities through lack of finances, training or opportunistic exposure.

Recommendation 5: Continued financial support and expansion of the Good Sports program.

Recommendation 6: Support drug diversion programs and initiatives, and support local councils and other organisations to develop local and relevant responses which do not require incarceration to rehabilitate drug users who interact with the justice system.

Recommendation 7: Support greater data sharing capability both at Territory, State and Federal levels.

4 Overview

4.1 Methamphetamine and "ice"

In pharmacological terms, crystal methamphetamine (or "ice") belongs to a group of substances known as amphetamine type-stimulants (ATS) that includes amphetamine, cocaine and ecstasy (Dietze, et al., 2013).

These substances stimulate and excite the central nervous system and produce a range of effects including euphoria, confidence, energy and wakefulness. "Ice" is a particularly potent form of methamphetamine as it acts more quickly on the brain and for a longer period (Carson, et al., 2012).

4.2 Why people take "ice" and other drugs

People who use psychoactive drugs do so for a range of reasons, including: to experience pleasure and enjoyment; to assist them in carrying out a task; to manage emotion; to increase a sense of belonging; to do what is thought normal; to expand their consciousness or heighten their awareness; to counter effects of other drugs; and to avoid the uncomfortable experience of drug withdrawal (Hall & Carter, 2013).

Drug use may be experimental, recreational, circumstantial, binge, regular or polydrug. There are strong differences between different drugs and different population segments as to typical use, and no broad statement can necessarily be applied to usage across Australia, as the data sources are

limited in the picture they can paint. For example, over past decades, Australian researchers have reported "ice" use amongst a number of social and demographic groups who use amphetamine type stimulants (ATS) for specific purposes, including the expression of identity. These include groups for whom use of ATS constituted an important difference between themselves and mainstream society, and used them in a non-dependent, functional way (Dance & Mugford, 1992). One group of young adults aged 18-30 years was reported to consciously limit their use of "ice" to weekends and holidays because they were determined to maintain control of their drug use and to enjoy it for its own sake (Dwyer, et al., 2012). For some gay men, "ice" facilitated a social lifestyle that involved clubbing and 'raving's where "ice" provided energy for all night dancing and to intensify sexual experiences (Dwyer, et al., 2012). More recently, researchers have posited that ATS for many young people is now an unremarkable mainstream drug (Duff, et al., 2007). In other contexts, "ice" is regarded as a facilitator of aggression and violence (Allsop & Lee, 2012).

Drug dependence is increasingly being understood as a health disorder (UNODC, 2009), and many environmental factors can influence the likelihood that someone will experiment with drugs and if they will develop dependence. These include:

- Long history of social and personal disadvantage,
- Temperament and personality traits,
- Prenatal problems,
- Adverse childhood experiences,
- Poor education,
- Lack of bonding to family and social isolation,
- Psychiatric disorders.

4.3 Harms relating to methamphetamine and "ice" use

A 2010 UK study evaluating the relative harms of a range of drugs found that while alcohol is rated the most harmful substance (due to its widespread use coupled with the significantly increased harms to others), methamphetamine was the fourth most harmful drug overall (after alcohol, heroin and crack cocaine) (Nutt, et al., 2010).

4.3.1 Harms

Harms related to methamphetamine use can include:

- dehydration
- weight loss
- skin problems
- teeth problems
- sleep disorders
- nausea and vomiting
- tremors
- weight loss from decreased appetite
- cardiac problems such as chest pains, increased heart rate and palpitations

- cognitive disturbances such as impaired concentration and memory loss
- mental health problems including anxiety, panic attacks, paranoia, mood swings, hallucinations, suicidal thoughts and depressed mood
- aggressive and/or violent behaviour
- psychosis
- seizures, stroke or coma.

Many of these effects occur during intoxication and consequently even occasional users are at high risk of harm from using methamphetamine. Some of the harms listed above can resolve after use is stopped; however, others might experience problems that may last for weeks or months (Jenner & Lee, 2008) (Lee, et al., 2007).

One fifth (20.8 per cent) of recent methamphetamine users reported high or very high levels of psychological distress, and one quarter (25.6 per cent) reported being diagnosed or treated for a mental illness in the previous 12 months (AIHW, 2011). Another study found that two thirds of methamphetamine users were suffering some level of mental health disability, with one in five (22 per cent) having a severe disability in their mental health functioning (McKetin, et al., 2005).

4.3.2 Psychosis

Methamphetamine psychosis is one of the most serious health impacts resulting from chronic methamphetamine use. It is characterised by confusion, delirium, and panic as well as a range of hallucinations (United Nations Office on Drugs and Crime, 2007). The prevalence of psychotic symptoms among methamphetamine users was reported in one study as 11-12 times that seen among the general Australian population (McKetin, et al., 2005). Within the past year 23 per cent of users had experienced clinically significant psychotic symptoms of suspiciousness, hallucinations or delusions, and people who were dependent on methamphetamine were three times more likely than their non-dependent peers to have experienced psychotic symptoms (McKetin, et al., 2005).

4.3.3 Polydrug use

Methamphetamine toxicity is increased when it is combined with alcohol and/or other drugs. Mixing it with alcohol can increase blood pressure, placing greater burden on the heart. Methamphetamine can also disguise the intoxication effects of alcohol, which may increase the risk of alcohol poisoning or accidents due to a false sense of feeling sober and in control.

Concurrent use of cannabis and methamphetamine has been shown to increase psychotic symptoms in some individuals, particularly those with schizophrenia (Jenner & Lee, 2008). The combination of heroin and methamphetamine can cause respiratory depression which may induce cardiac failure, particularly among people where cardiac disease is present (Darke, et al., 2008). Methamphetamine can also increase the risk of heroin overdose, as the effects of heroin might be muted by the methamphetamine effects and so more heroin could be used than intended (Jenner & Lee, 2008). The combination of methamphetamine and cocaine has shown to substantially increase the cardiotoxic effects of both drugs (Darke, et al., 2008). People often smoke more tobacco when using methamphetamine and so nicotine-related health risks are increased (Jenner & Lee, 2008).

4.3.4 Deaths from methamphetamine use

Deaths are typically caused by seizures, cardiac arrest or arrhythmias, or respiratory failure. Other fatal consequences of methamphetamine use include brain haemorrhage, ischaemic stroke and kidney failure (Darke, et al., 2008). In its *Drug Trends* 2012, The National Drug and Alcohol Research Centre analysed Australian Bureau of Statistics data and reported that in 2008, there was a total of 82 "drug-induced" deaths in which methamphetamine was mentioned, and 16 in which methamphetamine was deemed to be the underlying cause (Stafford & Burns, 2013).

4.3.5 Further harms

The feelings of invincibility that methamphetamine intoxication can evoke can increase the likelihood of engaging in risky behaviour, such as drug driving and unsafe sex (Jenner & Lee, 2008).

Other potential harms include:

- harms related to injecting drug use such as contracting or transmitting blood-borne viruses
- family and relationship strain
- financial and legal problems
- aggressive or violent behaviour leading to interpersonal conflict.

5 "Ice" in Australia

5.1 Historical perspectives

Illicit use of amphetamine in Australia in the 1960s was driven by the diversion of amphetamines from medical purposes (for controlling obesity, depression, narcolepsy, etc.) until tighter controls on prescribing were introduced in the 1970s (Hall & Carter, 2013). An upsurge of illicitly manufactured amphetamine occurred in the late 1980s and early 1990s, and actions taken to reduce the supply of the precursor chemicals ultimately led illicit manufacturers to use pseudoephedrine as a precursor. In turn this enabled illicit producers to supply a higher quality methamphetamine which could be smoked or injected in the early 2000s when the supply of heroin was low.

Crystalline methamphetamine, or "crystal" or "ice", emerged in Australia in the mid-1990s during a rise in amphetamine use and gained popularity because it enabled a more intense high (McKetin, et al., 2005).

Particular drugs rise and fall in popularity over time, and the use of "ice" has fluctuated over the years. A decline occurred after 2006/7 as the proportion of methamphetamine users consuming "ice" fell from 49 per cent in 2006 to 15 per cent in 2009. This could be due to a rise in price from $50 per point in 2006 to $79 in 2009 (Black, et al., 2007) (Sindicich & Burns, 2009). However use of "ice" trended upwards again when regular users in 2010 increased from 39 per cent to 45 per cent in 2011 (Macgregor & Payne, 2011).

We saw "ice" on the rise in 2008 and since then have seen other drugs rise and fall in popularity, with alcohol remaining the constant drug still used by the majority of the population and causing the greatest harms both to individuals and others.

At this stage it is difficult to determine the exact extent of the methamphetamine problem in the Northern Territory. Anecdotal evidence, including reports from the Association of Alcohol and Other Drug Agencies in Northern Territory suggests that the use of 'Ice' is increasing, particularly within indigenous communities. There are, apparently major concerns reflected through the media about the impact of 'ice' on rural and remote aboriginal populations.

5.2 Current/recent data

5.2.1 Australian and Northern Territory trends

Prevalence levels for annual use of crystal methamphetamine in Australia at 2.3 per cent are higher than in the USA (0.3 per cent) and Europe (0.5 per cent) although not as high as New Zealand's rate of 4.0 per cent (Allsop & Lee, 2012).

In the 2010 National Drug Strategy household survey (NDSHS), over 1 million (6.3 per cent) Australians reported having ever tried methamphetamine, and over 386,000 (2.1 per cent) reported using it at least once in the past year[2] (AIHW, 2011). It is worth noting in that survey the Northern Territory had the highest proportion of any persons having used an illicit drug (across all types) in the past 12 months. In terms of specific methamphetamine use, the same survey revealed that 3.6% (estimated) of males in the Northern Territory reported use within the past 12 months, which was well above the national percentage of 2.5% for males.

In Australia, the peak of methamphetamine usage was recorded in 1998 at 3.7 per cent. In 2010, within those 2.1 per cent of Australians who used methamphetamine in the past year:

- almost half (48.8 per cent) only used it once or twice in that period
- 9.3 per cent used it daily or weekly
- for one in five (21.7 per cent), "ice" was the main form of amphetamine used (AIHW, 2011).

20–29-year olds were the age group most likely to have ever used methamphetamines, and males are almost twice as likely as females to report using the drug (AIHW, 2011).

Past estimates have indicated that there are close to 73,000 dependent methamphetamine users in Australia (McKetin, et al., 2005). Nationally, the National Hospital Morbidity Database records amphetamine-related hospital separations as second highest to opioids among the four major illicit drug classes (amphetamine, cocaine, opioids and cannabis) – noting that this system cannot distinguish between hospital separations related to amphetamine, methamphetamine and ecstasy (Roxburgh, et al., 2011).

In terms of increased use, one indicator of this comes from the Drug Use Monitoring in Australia (DUMA) program. A 2011 study on methamphetamine use from this program (Macgregor & Payne, 2011) found that:

[2] The NDSHS is known to underestimate the prevalence of illicit drugs, so the actual prevalence is likely to be somewhat higher.

- There has been an increase in the use of methamphetamine among adult police detainees
- 21 per cent of police detainees tested positive to methamphetamine use in 2011, compared to 16 per cent in 2010 and 13 per cent in 2009
- Self report data indicates that the drug is considered to be higher in quality and easier to obtain in 2011 compared to previous years
- Those using the drug also reported an increase in the number of people selling it.

This is reinforced by data collected in the Illicit Drug Reporting System (IDRS) scheme – an ongoing project which gathers information on use from a national sample of regularly injecting drug users. The 2012 data (Burns, 2013) found that:

- Around two thirds of the national sample (67 per cent) reported using one or more forms of methamphetamine in the past six months
- Recent use of "ice" was significantly higher compared to the previous year
    - 56 per cent named "ice" as their preferred form, compared to other forms (36 per cent for speed and 6 per cent for base)
- All forms of methamphetamine were reported as "easy" or "very easy" to obtain
- Several key experts reported an increase in the prevalence of "ice" in 2012.

6 Policy and intervention perspectives – Australia and beyond

6.1 Global approaches

The United Nations Office of Drugs and Crime (UNODC) has reported the strong increase in use of methamphetamine at a global level (Allsop & Lee, 2012). Many countries have drug laws and policies to reduce the supply of drugs such as methamphetamine via border controls, policing, and specific bans of over the counter supply of pseudoephedrine.

A 2011 review of methamphetamine precursor regulations found some promising results from a number of U.S. interventions, though more research is needed to establish whether such approaches are transferable to other countries and within the context of the broader synthetic drugs market (McKetin, et al., 2011). According to the US Drug Policy Alliance, New Mexico is the only state to have developed a state-wide methamphetamine strategy that incorporates prevention, treatments, policing and harm reduction. It brings together a number of key stakeholders to achieve this (Piper, 2008). This is a trend we are seeing in a number of countries, especially in relation to the restriction of pseudoephedrine where law enforcement, pharmacists, youth sector and private practice come together to develop strategies.

New Zealand developed a targeted *Methamphetamine action plan* in 2003 (Ministerial Action Group on Drugs, 2003) but, like most policies, the focus was heavily oriented towards supply and harm reduction, rather than prevention. In fact the majority of evidence based policy and/or interventions are more focused on supply and harm reduction issues, with very little being trialled in the prevention space. One reason for this may be that prevention interventions are longer term and require much greater commitment. We have seen from the Australian .05 drink driving campaign that the continued messaging in conjunction with punitive measures has helped reduce the road toll and the number of

drunk drivers on the road. However, according to one U.S. study, methamphetamine use prevention programs that leverage family-based and school-based approaches can both reduce use and be economically feasible (Guyll, et al., 2011).

6.2 Australia

Australia developed its own national amphetamine-type stimulant (ATS) strategy in 2007, which aimed to guide all levels of government to reduce availability, demand and harms (Australia. Dept of Health and Ageing, 2008). This strategy expired in 2011, and has been replaced by the National Drug Strategy 2010-2015 (MCDS, 2011). To our knowledge the ATS-specific strategy has not undergone public review.

Policies in the past have introduced some effective supply reduction measures, however as we see from history the rise and fall of drug use will continue unless we can take an upstream approach to preventing drug use in the beginning. In practice that means reducing initiation of drug use and the subsequent prevalence and incidence of drug use across the whole population.

7 What can we do?

Those who develop problematic substance use often come from a position of vulnerability or disadvantage. Many people become vulnerable through no "fault" of their own – their disadvantage can come from environmental or biological factors over which they have little control or influence. These can include (but are not limited to):

- People who are emotionally distressed, disengaged and disconnected from society through issues such as lack of employment or mental health problems
- Young people who are disengaged from the school system – children with learning difficulties, or from families that do not function well
- Young people without role models who might otherwise be guided towards more constructive life choices
- Young people who grow up with drug use within their family or peer settings.

People experiencing hardship or difficulties in coping often find some comfort or relief in heavy use of legal drugs (e.g. alcohol, tobacco or pharmaceuticals) or illegal drugs such as methamphetamine or "ice". There is a current spike in methamphetamine -related harms in Victoria, but this replaced a spike in interest relating to synthetic drugs, and may be superseded again by interest in another substance that becomes more available. Many people who use illicit drugs tend to favour the substance that is most readily available or is the easiest to obtain. A real problem is by focusing on dealing with drug problems 'drug by drug' we lose the opportunity to respond to drug problems by removing the drivers of drug use.

The prevention approach has been shown to be successful in improving public health in a range of areas such as tobacco smoking, childhood immunisation, reductions in the prevalence of HIV/AIDS, road trauma and heart disease (Russell, et al., 2008). Yet funding for prevention suffers in comparison with funding for drug treatment which addresses the urgent needs of people experiencing current

problems. While tertiary health services assist people to recover from current drug problems, they do not reduce the future prevalence of problems in the population as they do not address the factors that produce drug problems in the first place (Holder, 1998). Instead, the "rule of rescue" leads to the priority of saving 'current lives' over interventions that do not have an immediate life-or-death impact but which may save 'future lives' (Musgrove, 1999). We do not dispute or downplay the need to provide harm reduction strategies such as needle and syringe exchange programs or adequate treatment for people with drug use problems, but we need to recognise the value of prevention strategies which offer long-term economic and community benefits. We need a systematic, integrated, coordinated long term approach to the prevention of drug problems, and a planned approach will allow successful programs and strategies to be identified through rigorous evaluation and replicated for the benefit of all.

The ADF advocates for the use of preventive strategies to shift the focus "upstream" – preventing people from commencing drug use rather than waiting for their drug use to become a problem that requires reactive "downstream" approaches. An upstream approach means taking action to prevent people from getting into trouble with drug use, thus reducing need for (subsequent) interventions by justice officers, emergency workers or the treatment sector. It is about strengthening and supporting those protective factors (Hawkins, et al., 1992) that can reduce the likelihood that young people engage in AOD use and improve their life chances. These factors include:

- School retention – completing school, enjoying it and doing well
- Positive relations with parents and other family members
- Attachment to adult role models outside home – for example teachers, sporting coaches and/or youth leaders
- Development of future-oriented recreational pursuits
- Communities with low levels of drug use.

There are a range of key strategies that should be considered that enhance and strengthen communities' (especially disadvantage groups such as indigenous communities) ability to reduce the impact of drugs such as ice including:

-develop a range of resources targeted at individuals, parents and families that enable increased knowledge and skills to address and provide help on the impact of methamphetamines including web-based resources – develop culturally specific resources to meet the needs of CALD, indigenous and LGBTI communities

-strengthen primary prevention programs, especially school-based programs that are focused on identification and early intervention of young people with problematic drug use – increase the capacity of teachers, welfare coordinators, school nurses, school-based youth workers, other staff and the broader school community to effectively respond to issues related to the impact of methamphetamine

-strengthen school and communities' capacity to enhance primary prevention programs that address risk and protection factors for young people including increasing schools' capacity to identify 'at risk' and vulnerable young people

-increase the knowledge and skills on the impact of methamphetamine of allied health professionals, child protection, GPs, nurses, ambulance officers and other medical/health/social/welfare agency staff to provide more effective immediate responses and facilitate pathways to treatment options

-build 'social capital' by identifying and strengthening responses to the social determinants of poor health and social outcomes that underpin problematic illicit drug

-undertake community mobilisation campaigns by providing communication, information and education resources that build a greater understanding and equip individuals to take effective action to address the impact of methamphetamine – work through existing forums such as sporting groups, faith-based organisations, service clubs, professional societies etc.

7.1 Parents and families

Families, and especially parents, influence the AOD use of their children. Parents' influence comes via role modelling of good behaviour, general discipline, good parent-child relationships based on communication, and parental involvement in their children's lives (Hawkins, et al., 1992). Especially for families experiencing difficulties, parenting programs can help parents improve their skills in these dimensions. One example of a successful program is the Triple P Positive Parenting Program which has five levels of intervention to accommodate the various needs of families whose function is disrupted, or whose children have behavioural problems, at different levels of severity (Ralph & Sanders, 2004). Another is the Resilient Families program, which combined school and family interventions in Melbourne schools and which led to reductions in adolescent drinking in the experimental schools compared to adolescents in the control schools (Toumbourou, et al., 2013).

> **Recommendation 1:** Support the development of programs and resources that encourage and empower parents to have a positive influence in developing their children's resilience and good decision making skills.

7.2 Schools

One in five (20 per cent) of all school students require some form of intensive and/or targeted intervention due to personal and social difficulties caused by various forms of disadvantage including developmental delays, physical and emotional abuse, neglect and trauma. The act of intervention identifies these children as being disadvantaged, and therefore vulnerable to drug use and drug problems. Schools provide a setting and an institutional framework for interventions that can include drug prevention.

> **Recommendation 2**: Support the development of programs and resources for schools and school communities to support children identified as at-risk with the aim of developing

resilience and encouraging school retention and/or pathways to work contexts such as apprenticeships.

Recommendation 3: Provide increased access to existing services and programs such as school nurses, school focused youth services, primary welfare officers and student welfare coordinators.

7.3 Councils

Social connectivity is another protective factor against risk behaviours such as AOD use (Hawkins, et al., 1992). Many youth related recreational activities and entertainment can be prohibitively expensive for disadvantaged young people, which prevents them from participating in pro-social activities in which they mix with a diverse range of peers, and/or responsible and caring adults.

Recommendation 4: Provide support local councils to develop local, relevant and attractive recreational and entertainment opportunities for young people who do not have access to those activities through lack of finances, training or opportunistic exposure.

7.4 Sporting clubs

Sporting clubs have an unrealised capacity to provide a focus for community action and community connectedness. Voluntary sporting clubs operate in most towns and suburbs across the state and bring together a diverse range of people with a common activity or interest. Health promotion programs in these clubs offer a mechanism to reach individuals in the community and effect change (Kingsland, et al., 2013). The ADF's Good Sports program has for over ten years helped Australian community sporting clubs to develop policy and practices to control the use of alcohol and to promote community safety. Good Sports provides free support to over 6,500 sporting clubs to help them change their culture and reduce high risk drinking, and has a presence in over 160 clubs in Northern Territory. It supports the real benefits to a community that local sporting clubs can bring, such as increased community engagement and positive role modelling through coaches and senior players.

While the Good Sports program has led sporting clubs to control the use of alcohol and reduce their risk of experiencing alcohol related problems, clubs are increasingly seeking assistance in being better informed about illicit drugs, including amphetamine-type stimulants. The ADF is currently working on how it can best provide that support.

Recommendation 5: Continue financial support for and expansion of the Good Sports program.

7.5 Drug diversion

Incarcerating drug offenders in prisons is expensive and does little to help the offenders' substance use problems and/or reduce drug use in the wider community. Diverting drug offenders into treatment is the less expensive option and offers the best chance of recovery (Deloitte Access Economics, 2013). Drug courts and neighbourhood justice centres can support the judicial system by working in partnership with local health and other services to tackle crime and safety issues within a local context. They prevent crime and recidivism by tackling the underlying causes of offending.

Recommendation 6: Support drug diversion programs and initiatives, and support local councils and other organisations to develop local and relevant responses which do not require incarceration to rehabilitate drug users who interact with the justice system.

7.6 Data collection

It can be challenging to make clear, unqualified statements about drug use and harms, as there is a multitude of monitoring systems and parameters that operate within Australia that make it hard to definitively compare data or draw conclusions. Building and improving the evidence base is an important strategy to ensure that directions are endorsed by current thinking and knowledge.

Recommendation 7: Support greater data sharing capability both within each State and Territory and nationally.

8 Conclusion

Use of any drug, whether legal substances such as alcohol and tobacco or illegal substances such as methamphetamine or cannabis, can lead to problems for the individual, those around them, and the wider community. Reducing preventable harms leads to benefits that resonate well beyond the individual, and investing in upstream interventions reduces the economic and social burdens of drug misuse. The ADF is pleased to have had the opportunity to contribute to this *Inquiry*, and is happy to work further with the Northern Territory Government in exploring what more can be done to minimise the impact of and harms relating to methamphetamine through upstream thinking.

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