Amity
Community Services Inc

Submission to Legislative Assembly of the Northern Territory

Methamphetamine Select Committee

Preamble

Amity Community Services Inc. (Amity) is a non-government, non-denominational, not-for-profit agency that has been providing prevention and intervention services, in the form of counselling, information, education and training, to the Darwin and broader Northern Territory community in relation to behaviours of habit since 1976. Amity believes in helping people help themselves. Amity supports the view that health is more than the absence of disease, and sees health as a complete state of physical, mental, emotional and spiritual well-being.

Amity accords with the World Health Organisation description of health as a resource for life and a product of lifestyles and living conditions. At Amity it is recognised that lifestyles contain different patterns of human behaviour encompassing both benefits and costs to the individual, family and the community. Amity aspires to be a leading community based organisation that values and actively promotes the adoption of healthy habits and lifestyles. Amity has been involved in the field of harm minimisation and community education and development for almost four decades.

Amity espouses a public health view to illicit substances in the Northern Territory. Public health is the science and art of prevention and of promoting health through the organised efforts and informed choices of society, public and private organisations, communities and individuals.

Amity acknowledges the devastating effects that drug use can have for individuals, families, friends and the broader community. There is a growing body of evidence on the harms associated with regular methamphetamine use, including mental and physical health, dependence, violent and aggressive behaviour, involvement in criminal activity, injecting drug use, sexual risk and in some cases death (Degenhardt et. al., 2008).

Methamphetamine

Drugs such as amphetamine, methamphetamine and dexamphetamine are all from the amphetamine drug group and are based on the amphetamine molecule. Methamphetamine is the most common type of amphetamine available in Australia. Methamphetamine is sold in various forms and potency:

Powder: Commonly known as speed. This is usually white or slightly pink, yellow or brown substance, ranging from fine powder to coarse crystal. Can be snorted, injected or swallowed.

Base: Also known as paste. Oily or waxy paste, often yellow or light brown in colour. Usually swallowed or smoked.

Crystal: Commonly known as **ice**. This is translucent or white crystals or crystalline powder. Can be smoked, snorted, injected or swallowed. This is the most potent form of methamphetamine.

(Illicit Drug Data Report)

Executive Summary

This paper explores *The Harm Minimisation Approach* that is built on the three pillars of harm minimisation - demand, harm and supply reduction. Each pillar is equally important to the success of the strategy. Prevention is an integral component across all three pillars.

The health, social and economic impacts of methamphetamine use include illness, disease, crime, assaults, stress and burden on the families and friends, family and domestic violence, child neglect and abuse, family breakdown and employment issues.

Methamphetamine use heightens the risk for negative health, psychological and social outcomes.

Methamphetamine use is best addressed through the development of an overarching plan. A plan would be useful to identify strategies, allocate resources, define timelines for implementation as well as the requirement for a review and evaluation of the plan and strategies.

Associate Professor Nicole Lee at the National Centre for Education and Training on Addiction at Flinders University (2015) 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".

To address methamphetamine problems there needs to be a strong focus on use as a health issue. The 'best practice' response to people with issues around drugs, in particular methamphetamine use is through the provision of the continuum of treatment options. This includes prevention, community education, early intervention, brief intervention, counselling, detoxification and residential care.

Where people come into contact with the criminal justice system an important policy intervention is the diversion of illicit drug users to a broad range of programs with different levels of interventions and access for offenders. Amity supports the reinvestment into a specialist alcohol and other drug court for the Territory.

Amity 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. In addition to frontline workers' development, the provision of information and education to the broader health, legal and social sector (e.g. housing tenancy support workers, legal aid, domestic violence workers) is required. Also ensuring appropriate resource allocation for infrastructure for the provision of safe work environments.

Recommendations for Responding to Methamphetamine in the NT

- The development of a comprehensive plan for, the Northern Territory that addresses the three pillars of harm minimisation – demand, harm and supply reduction measures.
- Alcohol and other drug responses are solidly founded in evidence that focuses on health outcomes rather than a primarily criminal justice approach.
- The reinvestment into a specialist alcohol and other drug court for the Territory.
- Workforce development across a broad range of frontline and specialist workers and resources for infrastructure for the provision of safe work environments.

Public Health

Public health is a term applied across broad areas of health of diverse populations. Public health is viewed as the science and art of protecting and improving the health of communities through the promotion of healthy habits and lifestyles.

The Harm Minimisation Approach

The approach is built on the three pillars of harm minimisation - demand, harm and supply reduction. Each pillar is equally important to the success of the strategy. Prevention is an integral component across all three pillars. The National Drug Strategy provides this framework for action to work to minimise harms for individuals, families and the wider community from tobacco, alcohol and other drugs. Harm minimisation acknowledges that people will engage in substance use regardless of the legality status.

- Demand Reduction

Demand reduction means working to reduce people's desire to engage in substance use. Demand reduction strategies and actions are those that aim to prevent the uptake and/or delay the onset of use, reduce the potential for problematic use and/or dependence of substances and support people to change habits around substance use.

- Harm Reduction

Harm reduction includes practical strategies and interventions aimed at reducing negative consequences associated with substance use. Harm reduction is a diverse range of services that are designed to work with people to reduce their current drug use and/or strategies to reduce the negative consequences experienced from drug use.

- Supply Reduction

Supply reduction means strategies and actions that focus on controlling supply. This pillar works to prevent, stop, disrupt or otherwise reduce the production and supply of those substances.

Drug use and harms - Methamphetamine use and harm in a broader context

The mission of the National Drug Strategy (NDS) is to work to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities (NDS, 2011).

The health, social and economic impacts of methamphetamine use can include infections, illness, disease, crime, assaults, stress and extra burden on family relationships, family and domestic violence, child neglect and abuse, family breakdown, housing and employment issues.

The range of licit and illicit drug use in Australia causes a variety of harms in the community and can be noted in different ways for example death related to drug use is a blunt measure that highlights the harms of various drugs.

The harm caused by tobacco smoking is a public health problem in Australia. The Australian Institute of Health and Welfare (2015) states that out of all the risk factors for ill health tobacco smoking is responsible for the greatest burden on the health of Australians. Tobacco smoking is a major risk factor for: coronary heart disease, stroke, cardiovascular disease, various cancers and other

diseases. Approximately 15,000 people die every year in Australia from tobacco related disease (2004-05).

The rate of tobacco smoking is consistently falling Australia wide. These falling rates could be attributed to the effectiveness of harm minimisation strategies and public health initiatives working together over long periods of time.

Much has been researched and written about the harms and costs of alcohol use. Alcohol use has been found to have devastating effects on health, welfare and wellbeing of Territorians in rural, remote and urban communities for a long time. The South Australian Centre for Economic Studies & Menzies School of Health Research (2009) showed that the cost per person of alcohol-related harm in the Territory was more than four times the national level. The total social costs of alcohol consumption in the NT in 2004-05 were estimated at $641.8 million. In Australia chronic disease and injury related to alcohol is the cause of death for about 5, 500 people each year (2010).

Key findings from the 2013 National Drug Strategy Household Survey (NDSHS) identified that the number of people participating in illicit drug use in Australia has remained relatively stable over the past decade at around 1 in 7. In 2013 about 8 million people (42%), aged 14 and over, in Australia indicated they had ever illicitly used drugs, including misuse of pharmaceuticals. The most common drug used both recently and over the lifetime was cannabis. Death attributed to all illicit drugs (including illicit use of pharmaceuticals) in 2001 was 1,038 people (ABS, 2003). In 2010 there were a total of 88 “drug induced” deaths in which methamphetamine was mentioned among those aged 15 to 54 years (the ages when most drug related deaths occur), and 93 deaths across all ages. (NDARC, 2010).

In relation to methamphetamine specifically the National Drug Strategy Household Survey (2010-2013) provides this snapshot:

- Recent and lifetime population use rates of methamphetamine are stable
- Recent use of crystal methamphetamine (ice) more than doubled
- Recent use of powder (speed) almost halved
- Recent use of base dropped significantly
- Overall methamphetamine use is becoming more frequent
- Weekly and monthly ice use increased

(Australian Institute of Health and Welfare, 2014)

While methamphetamine is causing significant problems for individuals, families and the community methamphetamine use is best viewed in the context of the harms associated with all drug use in the Territory. A continuous focus is required on the various drugs causing health, legal and social problems as well as major costs to the community.

Responding to the Terms of Reference

a) *The reliability of government data on methamphetamine (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.*

There is a range of data collection that occurs through diverse systems in Australia. For example there are number of reports from the Australian Institute of Health and Welfare (AIHW) 'Drug statistics series' such as: the National Drug Strategy Household Survey, Alcohol and Other Drug Treatment and Diversion from the Australian Criminal Justice System, National Opioid Pharmacotherapy Statistics to identify just a few key data sources. Some statistics from these reports have already been presented in this submission.

The Australian Institute of Health and Welfare is referred to as a valuable source of statistics and related information about alcohol and other drug use and treatment services. The AIHW state that no sample attained for their data collection and research purposes will be fully representative of the population however data collection is carefully designed and implemented and can be "highly representative" (p. 124) for drawing conclusions about characteristics about a population (AIHW, 2013).

As a publically funded AOD Treatment service the main source of data collection is the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). This data collection source captures such things as: client characteristics; drugs of concern; episodes of treatment; treatment provided and referral source. Reporting produced from this data includes information from other data sources such as: hospitals; specialist homelessness services; national opioid pharmacotherapy statistics annual data and prisoner health. There are manuals and guidelines produced to support workers in this sector to understand the data collection tools and methods. A range of reports are written and released into the public domain.

In relation to monitoring drug use trends and drug markets, Australia has the Illicit Drug Reporting System (IDRS), Ecstasy and Related Drugs reporting System (EDRS) and the National Illicit Drug Indicators Project (NIDIP). In particular the IDRS is a national drug monitoring system intended to serve as a strategic warning by identifying emerging trends of local and national concern. The IDRS consists of three components: interviews with people who inject drugs regularly; interviews with key experts, who are professionals who have knowledge of drug trends and/or regular contacts with people who use illicit drugs, through their work; and analysis and examination of indicator data sources related to illicit drugs.

For drug monitoring in Australia the Drug Use Monitoring (DUMA) program is a partnership between the Australian Institute of Criminology, state police services and local researchers. This system examines relationships between drugs and crime, local drug markets and drug use patterns by detainees across time. There is also the Illicit Drug Data Report (IDDR), produced by the Australian Crime Commission and this report looks at illicit drug arrests and seizures as well as the current illicit drug state and national impact and emerging trends and threats of illicit drugs in Australia.

It appears that all of these data collection methods and reports are consistent, with transparent methodology that could be easily replicated.

The NDSHS (2013) reports that between 2004 and 2010 questions relating specifically to amphetamine use were refined to more accurately capture use of amphetamines. In 2007 the term methamphetamine was introduced and in 2010 clarification was provided about non-medical methamphetamine use.

It would seem that some limitations to some data collection methods are in identifying methamphetamine by form (e.g. powder, base or crystal). Also a collection of specific information about the range of harms being experienced (e.g. financial, health, family).

b) *A comprehensive survey of the various government responses to the use (abuse) of methamphetamine (Ice) in the Northern Territory and assesses their effectiveness or otherwise.*

The National Drug Strategy encompasses the three pillars of harm minimisation: demand reduction, harm reduction and supply reduction. Amity is aware of a range of prevention, intervention and protection strategies that have been implemented around drug use throughout the Territory that are not specifically targeted at methamphetamine use but work to reduce the harms experienced from a range of drugs.

The NT Department of Health engages in sector-wide community consultation around the Territory's plan for alcohol and other drugs.

Some current responses to methamphetamine use appear to have an exclusive supply focus e.g. National Ice Taskforce (Federal Government), NT and Federal Government to establish a Joint Law Enforcement Ice Strike Force.

We are unclear of any significant government initiatives that are working to address demand reduction.

c) *The social and community impacts of methamphetamine (Ice) in urban, community and remote settings.*

Our service predominately works in the greater Darwin area. We assist approximately 300 new clients each year who experience problems related to alcohol, other drugs and gambling. Additionally we work with three Darwin Aboriginal town communities also known as town camps. We are aware that there is an emerging issue as community member indicate extended family members' use of methamphetamines. In the face-to-face counselling approximately 22% of the clients identify as ATSI.

Recently we did a random sample of 50 client files and found: 30% of these clients identified current domestic and family violence and 76% of the files indicated that violence was a co occurring factor in their problem substance use or gambling issue. We also identified if past trauma and violence were related in the current alcohol and drug problems with 60% of these clients indicating that it was. While we know violence is associated with alcohol, other drugs and gambling currently we are

seeing increased presentations where violence is also associated with methamphetamine use. This is consistent with national and international research.

Much of our work is with harm reduction although the education component of service delivery fits with demand reduction strategies. The 'best practice' response to people with issues around drugs, in particular methamphetamine use is through the provision of the continuum of treatment options. This includes prevention, community education, early intervention, brief intervention, counselling, detoxification and residential care.

Amity also has a small project that works to provide a health promotion campaign around illicit drug use and referral pathways into treatment. This project was federally funded through the Non-Government Organisation Treatment Grants Program with the key objectives being to improve drug and alcohol treatment service outcomes, increase the number of treatment episodes available and work to reduce harm for individuals, families and communities.

It is apparent from the research that methamphetamine use heightens the risk for negative health, psychological and social outcomes (Sommers et. al., 2006). People attending Amity have disclosed a range of negative impacts associated with alcohol and other drugs use. These are not exclusive to people who use methamphetamines but are commonly experienced by people with methamphetamines issues. People report problems with: relationships; relationship breakdown; domestic and family violence; increased aggression; mental health issues (anxiety, paranoia, depression); physical health issues; employment issues or unemployment; child welfare and protection issues; housing issues; financial issues and legal issues.

Amity counsellors use psychological interventions when working with people presenting with amphetamine type substances related problems or diverse range of substance use problems and associated mental health issues. Lee and Rawson (2009) found these types of interventions are effective in addressing methamphetamine use and dependence.

A brief snapshot of Amity's counselling service data for the first quarter (January, February and March) over the past three years has shown that there has been an increase in people seeking treatment for methamphetamines. In 2013 approximately 8% of new clients presenting at our service indicated methamphetamine as their primary drug of concern, approximately 10% of new clients in the first quarter of 2014 and this year about 19% of new clients have indicated methamphetamine use as their primary issue of concern. In the six month period 1 July to 31 December 2014 the two highest primary substance of concern for Amity clients was: methamphetamine 39% and cannabis 22%, for the six months prior to that data showed cannabis at 44% and methamphetamines at 23%, demonstrating a shift in primary substance of concern for our service.

It is not clear why there has been an increase in methamphetamine presentations. It could be as a result of an increase in people using methamphetamines, the unavailability of other drugs (e.g. clients have said they would prefer to use other drugs, including cannabis but they are as readily available) or as a result of a public health focussed project over the past 3 years around providing people with information about treatment options available for illicit drug use (with a particular focus

on providing general practitioners information about referral pathways into Amity's services for illicit drug use).

d) Government and community responses to methamphetamine (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.

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.

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.

In addition to the Victorian Ice Action Plan and Framework there are, to name a few:

- Turning Point's Methamphetamine Dependence and Treatment Manual;
- The National Treatment Guidelines for Treatment approaches for users of methamphetamines: a practical guide for frontline workers;
- Department of Health and Ageing's Treatment Approaches for Users of Mathamphetamines;
- Department of Health and Ageing's National Psychostimulant Initiative;
- ANCD's Methamphetamine Position Paper; and
- 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 drugs, in particular methamphetamine use through the continuum of treatment options.

More broadly we are aware of a few papers that explore options for drug policy based in evidence. Numerous papers demonstrate that responses relying mainly upon supply reduction and have not achieved the much hoped for results. For example:

- 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 (Mr Mick Palmer past NT and Federal Police Commissioner is Deputy Chair of Australia 21).

  "*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."*

- 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)

Associate Professor Nicole Lee at the National Centre for Education and Training on Addiction at Flinders University (2015) 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 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. In addition to frontline workers' development, the provision of information and education to the broader health, legal and social sector (e.g. housing tenancy support workers, legal aid, domestic violence workers) is required.

The National Drug and Alcohol Research Centre (2008) discuss how an important policy intervention is the diversion of illicit drug users. It is suggested that diversion involves the use of the criminal justice system to provide alternate responses such as referral into education and treatment. This policy intervention has gained increasing prominence (NDARC, 2008).

Previously the Territory has had court diversion programs, most recently, from 2011, the Substance misuse assessment and referral for treatment court (SMART court). This specialist court was able to hear criminal matters in the Magistrate or Youth Justice Court in the Northern Territory where offenders had committed an offence and a history of serious alcohol and/or other drug use. The Smart court was able to issue bans on the consumption of alcohol and other drugs and mandate treatment orders. Essentially the court, monitored by qualified court clinicians, becomes the case manager for people in diversionary courts. This specialist court is no longer operating and no evaluation of the program is in the public domain.

Prior to the SMART court the Territory had an alcohol and illicit drug, CREDIT NT, specialist court. The CREDIT NT specialist court was a court diversion program targeting individuals whose offences were drug related. Treatment type is determined on the identified needs of the client as assessed by qualified court clinicians. Court clinicians become the case manage of the person in the diversion program.

Drug courts around the world have been evaluated and despite differences in the drug court structures, jurisdictional compositions, methods employed in evaluation these courts have been found to be "more successful than other forms of community supervision" (p. 12) and to generally reduce recidivism while offenders are in the program (National Centre on Addiction and Substance Abuse, 1998)

In a report on drug courts in Texas, Martinez and Eisenberg (2002) discuss the goals of drug courts are to provide court-supervised treatment to reduce drug usage, arrests and recidivism and to lower

costs in the criminal justice system. In general research has found “lower recidivism rates for drug court participants” (p. 8) and savings in criminal justice costs.

Levin (2006) suggested in his review of drug courts being the ‘right prescription for Texas’ that instead of isolating people in prison, drug courts force people to confront their addiction and repair the damage they have done to themselves, their families and their community. He further stated “drug courts are not soft on crime” (p. 3) and they are “the right prescription for Texas” (p. 3).

The National Drug and Alcohol Research Centre (2008) suggest that best practice principles of diversion need to include a broad range of diversion programs with different levels of interventions and access for all offenders.

Mitchell (2012) suggested that there were better and cheaper ways of reducing drug-related offending other than prison. In the research of drug courts’ effect on criminal offending for adults and juveniles it was found that court programs that work to reduce drug related offending through rehabilitation with supervised drug treatment programs and support services have been shown to be cost effective ways of reducing re-offending. An independent evaluation of the NSW Drug Court Completion Program found participants to be 37% less likely to be reconvicted during the follow-up period.

Amity supports the reinvestment into a specialist alcohol and other drug court for the Territory. 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.

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

Generally we have heard from a diverse range of people that methamphetamines are manufactured in the Darwin area. Also that some people source illicit drugs through the Internet and others tell of methamphetamine coming into the NT over state borders.

f) *Best practice work place health and safety measures for those in the health system who come into contact with people who use methamphetamine (users of Ice).*

In 2010 Amity 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.

Consideration to environment is an important component of WHS measures. However consideration to the client group we work with and the problems this group of people are likely to be experiencing when they access the service requires due consideration. For example people who are experiencing issues related to their drug use may require environments free of stimulus or with limited stimulus.

This may mean that the emergency department at the hospital or the lock-up at the police station need to review the level of stimulus in their environments when assisting people to reduce their impulsive and/or aggressive behaviour.

Other consideration may need to be given to environments that are not purpose built counselling environments. Often community organisations are working out of buildings and premises that have been built for other purposes (e.g. a house) and remodelled to provide a work environment.

Further to these points consideration about workers' safety when visiting people through community development and outreach project work. Often, due to resource allocation and funding provisions, project workers are required to attend outreach work alone. To ensure best practice with regard to workers' safety, individuals will need to partner with workers from other agencies. This has implications for agencies' financial and human resources.

Ongoing commitment to worker training and professional development is required throughout the AOD sector and would be best delivered to a wider workforce to ensure that a diverse range of people who may be required to respond to people who have used methamphetamines.

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