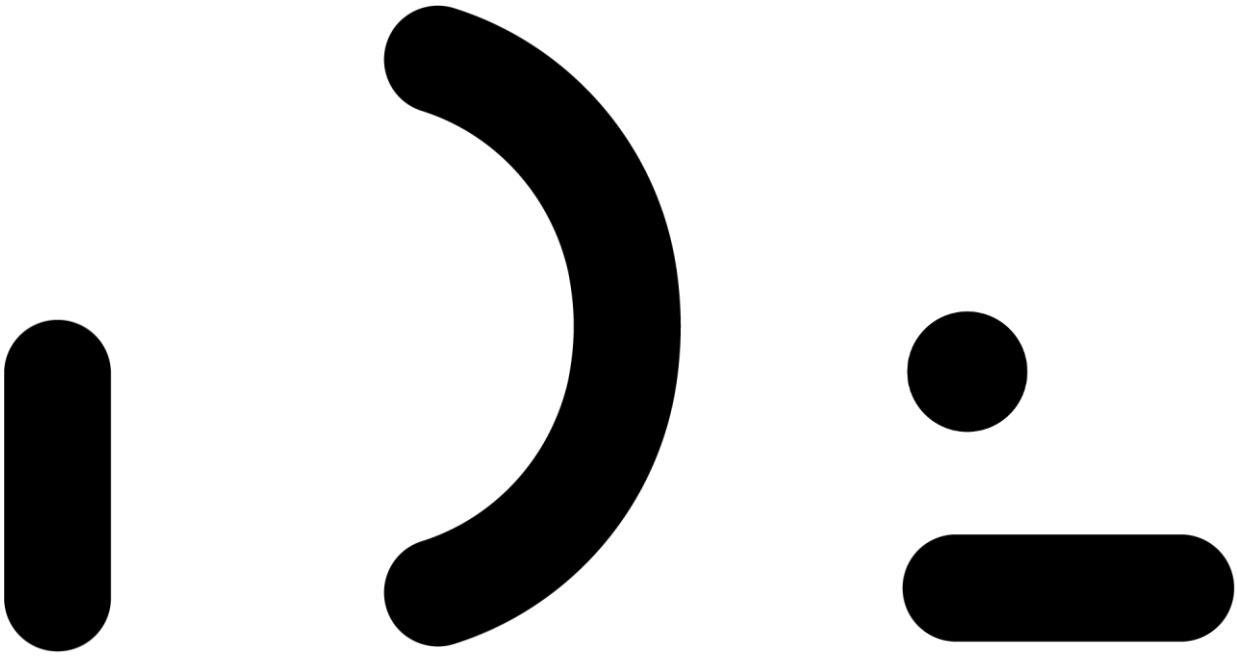
Alcohol and Drug Foundation

PREVENTING HARM IN AUSTRALIA



Select Committee Harm Reduction Strategy for Addictive Behaviours

For Legislative Assembly of the Northern Territory

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1 Table of Contents

Response to Select Committee Harm Reduction Inquiry

2 The Alcohol and Drug Foundation

Founded in 1959, the Alcohol and Drug Foundation (ADF) has contributed nearly 60 years of continuous service to communities across Australia.

The ADF is working to prevent and minimise alcohol and other drug related harms through information provision, education, health promotion, community action, policy development, advocacy, and research in communities across the country.

We co-design our evidence-based programs with communities and support them to build capacity to create change and we reach millions of Australians in metropolitan, regional, rural and remote communities in every State and Territory

Our information services are accessible to all Australians through our website (www.adf.org.au), SMS and telephone services. We conduct seminars and webinars for alcohol and other drug (AOD) and health professionals, researchers, academics, policy makers and the public.

Supported by the latest evidence, we advocate for change in policy and practice within government, business and society. We work to reduce misinformation and stigma about alcohol and other drugs.

The Alcohol and Drug Foundation appreciates the opportunity to inform the Select Committee inquiry into a Northern Territory Harm Reduction Strategy for Addictive Behaviours. The ADF would welcome an opportunity to elaborate on our submission if that would be helpful.

3 Terms of Reference

The Terms of Reference for the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours are

1. That a Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours be appointed comprising three (3) Government Members, one (1) Opposition Member and one (1) independent Member to be nominated in writing to the Speaker by the relevant Whip or non-party aligned Member by 18 May 2018

    (1) Best practice, humanitarian approaches that effectively reduce the damage caused by illicit drug-use through effective harm reduction policies and legislation; and
    (2) Identify best practice strategies that have a coordinated treatment approach to deal with the broad-range of addictive behaviours; including, but not limited to, alcohol, tobacco and gambling.

2. That the Inquiry is established in the May Sittings 2018 and is to report back to the Assembly by 31 August 2019.

Proposed scope of Inquiry:

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

The proposed Inquiry will look at:

1. The current scale and trends of illicit drug-use in the Territory and its impacts upon health, justice, drug and alcohol and law enforcement activities;

2. Current harm reduction measures available in the Northern Territory and other jurisdictions and their alignment with the National Drug Strategy;

3. A review of best practice evidence in the following areas to support the development of a revised harm reduction framework for the Northern Territory:

(1) Medical response and ongoing treatment
(2) Health interventions such as: i. Needle and syringe programs; ii. Medically supervised injecting facilities; and iii. Pill testing.
(3) The adoption of culturally relevant health and education interventions;
(4) Police and criminal justice responses to drug-related offending;
(5) Police and court diversion programs;
(6) Drug driving programs;
(7) Public awareness campaigns, including school-based education; and
(8) Support for affected families and communities.

4. Effective strategies for coordination across treatment facilities to also provide for addictive behaviours more broadly.

4 Summary of Recommendations

Recommendation 1*: That the Select Committee recommend that sporting clubs that hold a liquor licence be required to participate in the Good Sports program to help clubs develop policies and practices to comply with their licence, prevent the misuse of alcohol and the use of illicit drugs.*

Recommendation 2: *That the Select Committee recommend that the Northern Territory Government provide support the Good Sports program to develop alternative models so the program can access hard to reach clubs and clubs in remote areas, so they can gain the benefits of participation in the program*

Recommendation 3: *That the Select Committee recognise the value of broad based community prevention programs and recommend that the Northern Territory Government include support for such programs in the Harm Reduction Strategy.*

Recommendation 4: *That the Select Committee recommend the Northern Territory Government increase access to Needle and Syringe Programs by expanding the number of and access to primary NSP services and setting up Syringe Dispensing Machines in regional and remote communities which lack NSP services.*

Recommendation 5: *That the Select Committee recommend the Northern Territory Government legislate to allow peer distribution of injecting equipment to reduce the burden of disease due to blood borne viruses.*

Recommendation 6: *That the Select Committee recommend the Northern Territory Government legislate to enable the establishment of needle and syringe services in prisons to prevent the transmission of blood borne viruses.*

Recommendation 7: *That the Select Committee recommend that the Northern Territory trial of a clinically supervised injection facility based on the successful experience of the Medically Supervised Injection Centre in Sydney and the current trial in Melbourne.*

Recommendation 8: *That the Select Committee recommend the Northern Territory conduct trials of officially approved front-of-house drug checking services at future music and youth festivals in the NT.*

Recommendation 9: *That the Select Committee recommend the Northern Territory Government establish a real-time monitoring system which can intersect with other jurisdictional systems to ensure a nationally comprehensive system.*

Recommendation 10: *That the Select Committee recommend that training be instituted urgently for prescribers and dispensers of pharmaceutical drugs in providing non-pharmacological treatment of physical and mental health conditions and in providing access to such treatments in other services.*

Recommendation 11*: That the Select Committee recognise the synergy between the social determinants of health and the prevalence of alcohol and other drug problems in Aboriginal and Torres Strait Islander communities.*

Recommendation 12: *That the Select Committee recommend actions to address alcohol and other drug problems and harms among Aboriginal and Torres Strait Islander populations must include the active participation of Aboriginal and Torres Strait Islander people and organisations at every stage of development and implementation.*

Recommendation 13: *That the Select Committee recommend the Northern Territory Government encourage the Australian Government to implement the National FASD Strategic Action Plan including the commission of a national public awareness campaign over four years to raise awareness about the risks of drinking during pregnancy*

Recommendation 14: *That the Select Committee recommend the Northern Territory Government encourage Food Standards Australia and New Zealand to implement mandatory pregnancy warnings on all alcohol products and include designs that communicate effectively with Aboriginal and Torres Strait Islander people.*

Recommendation 15: *That the Select Committee recommend that the Northern Territory Government undertake a formal investigation of the merits of a dejure decriminalisation of illicit drugs, with special reference to the Portugal model.*

Recommendation 16: *That the Select Committee recommend the continuing implementation of Justice Reinvention programs throughout the Northern Territory to address drug related offending and where appropriate include Aboriginal and Torres Strait Islander bodies in the design and implementation of the programs.*

Recommendation 17*: That the Select Committee recommend the establishment of Drug Courts in the Northern Territory as a matter of urgency.*

Recommendation 18*: That the Select Committee place the provision of publicly accessible and accurate information on drug related matters at the heart of the advice it provides to the Northern Territory Government.*

Recommendation 19: *That the Select Committee recommend that schools conduct alcohol and other drug education according to the national drug education guidelines published by the Australian Government.*

Recommendation 20: *That the Select Committee advise the Northern Territory Government that the national drug education guidelines indicate school teachers are best placed to provide students with drug education and that they require appropriate support and professional development to do so effectively.*

Recommendation 21: *That the Select Committee recommend the Northern Territory government take account of emerging and innovative models of naloxone distribution to ensure ready access to people at risk of opioid overdose.*

5 Comment on Terms of Reference

1 (1) Best practice, humanitarian approaches that effectively reduce the damage caused by illicit drug-use through effective harm reduction policies and legislation;

The ADF agrees that the means adopted to prevent and reduce illicit drug harms should reflect both best practice (i.e. based on, or at least informed by evidence) and humanitarianism. Humanitarianism is the view that all human beings deserve and should be treated with respect and dignity. Humanitarianism places priority on the saving of lives and alleviation of suffering and the promotion of human dignity. Humanitarianism is summed up in a comment by Albert Schweitzer: "Humanitarianism consists in never sacrificing a human being to a purpose." (Humanitarianism, 2018) This view implies support for the harm reduction approach which aims to maintain the optimal health and wellbeing of people who experience drug dependence without compromising efforts to prevent the occurrence of that condition.

6 Comment on Proposed Scope of Inquiry

1. Licit and Illicit drug trends in the Northern Territory

Though the Northern Territory has experienced declines in the per capita use of tobacco, alcohol and some illicit drugs in recent years, consistent with national trends, it still has relatively elevated levels of non-medical of legal and illicit substances. Levels of daily tobacco smoking, risky drinking of alcohol and recent illicit drug use are the highest of any jurisdiction in Australia (Australian Institute of Health and Welfare, 2017).

Over one-quarter (28%) of Territorians exceed the lifetime risky drinking guidelines and over one-third (36%) exceed the single occasion risky use guidelines. Territorians in their 50s are more likely to exceed the lifetime guidelines – 36% compared to the national average 17.1% (Australian Institute of Health and Welfare, 2017). The Territory has the highest rate of tobacco smoking in Australia at 18.5% in 2016. Over one-quarter (27%) of people in their 50s were smokers, at a rate 2.2 times higher than the national average of 12.2%.

The Territory also has the highest reported rate of use of illicit drugs in the last 12 months (22%), and the highest overall use (20%), One in five people Territorians used illicit drugs in the last 12 months and the Territory has the highest annual use of cannabis (Australian Institute of Health and Welfare, 2017), a higher than average ecstasy use and the second highest rate of cocaine use (Northern Territory Government , 2018). Nearly three-quarters of injecting drug users inject methamphetamine and they report it is easy to obtain. (Northern Territory Government , 2018).

2. Current harm reduction measures available in the Northern Territory and other jurisdictions and their alignment with the National Drug Strategy

2.1 The Good Sports Program

Community based sporting clubs are an invaluable public health asset and their role deserves recognition in the NT's Harm Reduction Strategy. Regular participation in physical activity and sport provides people with physical, social and mental health benefits. Sports clubs provide non-playing as well as playing members of a sporting club with regular social contact, and broader social connections which helps community bonding, reduces isolation and loneliness and promotes mental as well as physical health. Physical inactivity, overweight/obesity and excessive alcohol use are three of the five most important risk factors for disease in Australia (Department of Health and Ageing, 2013). It is critical that sporting clubs do not allow alcohol (or other drugs) to undermine the health promoting aspects of their activities.

The ADF's Good Sports program has demonstrated success in reducing excessive alcohol consumption and related harms in the community sports setting. Good Sports assists community sporting clubs to control the use of alcohol and to promote community safety by implementing effective alcohol management policies and practices. It is the first primary prevention alcohol program in community sport in the world to be proven successful.

A randomised control trial showed the Good Sports program reduces the likelihood of risky drinking by club members (down by 37%) and risk of club members experiencing alcohol related harms (down by 42%) (Kingsland, et al., Tackling risky alcohol consumption in sport: a cluster randomised controlled trial of an alcohol management intervention with community football clubs, 2015). It demonstrates that Good Sports materially reduces problematic drinking in an important community setting and substantially reduces the level of alcohol related harm experienced by community members (Kingsland, et al., Tackling risky alcohol consumption in sport: a cluster randomised controlled trial of an alcohol management intervention with community football clubs, 2015).

By changing their environment from a 'boozy culture' to a 'family friendly' environment sporting clubs attract more members. The community gains an amenity that promotes positive connection and models low risk alcohol consumption to adults and juniors alike. By developing strong community bonds, Good Sports is likely to promote mental health and thereby reduce a spur of excessive drinking and drug use.

The Tasmanian Liquor and Gaming Commission now requires sporting clubs that are granted a liquor permit to participate in the Good Sports program to increase the prospect that the club will comply with its licence conditions and implement an alcohol management plan.

Good Sports is now working in over 8,000 sporting clubs nationwide and 197 clubs registered with Good Sports in the NT are located within the following LGA areas: Alice Springs Town Council; Barkly Regional Council; Central Desert Shire Council; East Arnhem Shire; Katherine Town Council; Palmerston City Council; Tiwi Islands Shire Council and West Arnhem Shire Council.

However, over time it has become is apparent that the Good Sports model is less suited to the NT as the governance structure of clubs is different especially in the more remote areas of the Territory. In particular, the work at Katherine provided Good Sports with insights on what is needed to facilitate Aboriginal community gatherings. It would be helpful if the NT Government was able to support the Good Sports program to develop alternative models that would enable remotely based clubs to adapt the program to gain the benefits that are evident in Good Sports elsewhere.

A recent innovation has Good Sports helping sporting clubs reduce the risk of illicit drug use within their jurisdiction. This is addressed in the next section.

2.2 Tackling Illegal Drugs in Community Based Sports Clubs

Communities often express concern about their perceived inability to act to combat the prevalence of illegal drugs. However, every town and suburb typically includes sporting clubs and when they adopt a policy that rejects illegal drug use (without stigmatising those who may consume them) it can return to the community a sense of agency and control.

Good Sports is addressing illegal drugs via the Tackling Illegal Drugs (TID) program that supports community sporting clubs to implement club practices and policies to prevent and manage illegal drug-related issues. The key objectives of the TID program are to:

- Build the confidence of club leaders and members to prevent and manage illegal drug-related issues in a supportive, structured and consistent manner;
- Support community sports clubs to develop, implement and promote a tailored illegal drugs policy;
- Build local networks where ideas and experiences can be shared and ongoing support can be obtained;
- Promote other ongoing opportunities to build healthier club environments through participation in other modules of the Good Sports program.

Good Sports has already run TID forums and workshops for sporting clubs in Darwin and Katherine and all clubs in the NT have access to online resources and advice on the development of comprehensive illicit drug policies and procedures via the Good Sports website.

***Recommendation 1**: That the Select Committee recommend that sporting clubs that hold a liquor licence be required to participate in the Good Sports program to help clubs develop policies and practices to comply with their licence, prevent the misuse of alcohol and the use of illicit drugs.*

***Recommendation 2:** That the Select Committee recommend that the Northern Territory Government provide support the Good Sports program to develop alternative models so the program can access hard to reach clubs and clubs in remote areas, so they can gain the benefits of participation in the program.*

2.3 Community-led Primary Prevention

The NT Harm Reduction Strategy will be strengthened by adopting a long-term perspective to improve public health sustainably by giving priority to community led preventive strategies that shift the focus "upstream": these aim to promote interpersonal, social and environmental factors that encourage healthy living and reduce those factors that predict unhealthy behaviours including isolation, inadequate relationships, conflict, early and excessive alcohol and other drug use, and mental illness. By strengthening and supporting personal and social protective factors (Hawkins, Catalano, & Miller, 1992) the likelihood is lowered that people will engage in AOD use, and excessive use, thus improving their life chances. An upstream approach that helps to prevent Territorians from initiating early alcohol and other drug use will reduce the need for more complex interventions by the health system, drug treatment sector, and more broadly, emergency workers, law enforcement and the justice system.

A concerted, sustained implementation of interlocking, community based health promotion programs over two decades in Iceland has contributed to an impressive reduction in adolescent use of tobacco, alcohol and cannabis (Kristjansson AL, 2016) while leading to improved relationships between parents and children and the development of community social capital. (Sigfusdottier I.D., 2008) Key components of the 'Icelandic model' are support for parents in forming and maintaining positive relations with children, adolescent participation in organised sport and supervised work and recreational activities with respected adult role models outside the home. The creation of social environments that are high in protective factors and low in risk factors not only reduce the likelihood of young people engaging in substance use but promote physical and mental health more generally. The ADF considers families, community sporting clubs and schools as key settings for the prevention of alcohol and drug problems and wider health promotion activities.

Three large scale community prevention programs that share features with the Icelandic model are operating in Australia presently: apart from Good Sports, the Community Drug Action Team Program operates in New South Wales and the national Local Drug Action Team Program operates across the nation.

2.3.1 Community Drug Action Teams (CDATs)

In NSW the Community Drug Action Team Program has been operating since 2000 and at June 2018, there were 72 CDATs across NSW. CDATs enable people to be involved in addressing AOD issues in their local communities through volunteering and taking community action. CDATs thereby build community strengths and capacity for community participation. The overall objectives for the CDAT program are —

- To build strong partnerships amongst community members, businesses, local Service providers, and government and non-government organisations across a range of sectors by enabling stakeholder and community engagement and participation.
- To identify legal and illegal drug and alcohol related problems in the local community.
- To increase community knowledge and awareness of legal and illegal drug and alcohol harms and consequent social, health and well-being problems.
- To increase communities' capacity to develop locally based initiatives to prevent the uptake of illicit drug use, and the misuse of legal drugs and alcohol, to reduce drug and alcohol related harms; and
- To facilitate coordinated and collaborative action between agencies and groups who share common goals in addressing local legal and illegal drug and alcohol issues.

The central coordination body (ADF) supports the CDATs through small grants and provision of community action resources, enabling CDATs to deliver best practice prevention and early intervention focused activities to reduce alcohol and drug related harm at the local community level.

The range of strategies adopted by CDATs include AOD information sessions for groups including parents, students, young people; providing entertainment and recreation activities for youth; leadership camps; organising parent/child education on AOD; providing links to services; running local campaigns (such as Stop the Supply and Safe Partying) and participation in local liquor licensing issues.

2.3.2 Local Drug Action Team Program

The Local Drug Action Team Program is partly modelled on the CDAT program and is operating on national basis. LDATs provide a platform for communities to develop evidence-informed social change projects that prevent and reduce alcohol and other drug harms. LDATs are required to align their local community action plans to broader social and health plans of local, regional or state authorities and typically include combinations of non-government organisations, community groups, local government, police, sporting clubs and health services.

Three Local Drug Action Teams are already established in the Northern Territory at Alice Springs, Wurrumiyanga, and Palmerston and are engaged in implementing or developing their plans to prevent AOD misuse via cultural programs, leadership initiatives, youth services, advocacy for policy change and in developing community capacity. Several other groups in the Territory have applied to join the LDAT program and it is only capacity restraints that has prevented those groups from being accepted into the

program. We have provided further information below about two innovative LDAT projects in the Northern Territory in the following sections.

2.3.2.1 Right Tracks Program

A partnership established in 2017 between the Alcohol and Drug Foundation (ADF), the NT Department of Health, the Central Australia Aboriginal Congress (CAAC) and the Redtails Pinktails began a project to develop and evaluate a primary prevention model of activities across 7 communities (and up to 2000 males and females). This activity is one of the ADFs Local Drug Action Team (LDAT) investments, known as the Right Tracks Program – owned and delivered by the Red Tails/ Pink Tails and auspices through CAAC.

The Right Tracks LDAT is taking a holistic approach to preventing alcohol and other drug-related harm among young people in Central Australia – its focus is on building protective factors for participants, including improving young people's health and wellbeing, fostering their leadership and personal development, lifting their employment skills and opportunities, and furthering community connections through sport – as a powerful medium to engage with remote communities.

The Right Tracks Program aims to engage up to 2,000 Aboriginal young people through football, netball, softball and other sporting clubs across various remote communities over 2-year partnership.

The Central Australian Aboriginal Congress and other partners has given the LDAT's activities strong links to local services, while the ADF has provided support through its evidence-based approaches (resources and programs) to prevent harm from alcohol and other drug misuse.

To date some of the activities undertaken across the 5 communities currently involved have included:
- alcohol and other drug awareness sessions in sporting club and school environments
- supporting the creation of healthier club environments around alcohol and other drugs by connecting sporting clubs with the ADF's Good Sports Program
- developing employment skills and pathways for young people including 22 participants engaged with a local catering company
- leadership program "Swimming the River" conducted with inmates from the Alice Springs Correctional Centre
- leadership development sessions in secondary schools and a women's correctional centre.

2.3.2.2 Wurrumiyanga LDAT

The Wurrumiyanga Community has identified the problematic use of cannabis across the population as a serious matter. The Wurrumiyanga LDAT engages the Tiwi population on Bathurst Island and the Tiwi Islands and has the following partners: Xavier College, Melville Community Primary School, Tiwi Island Regional Council, Tiwi Islands Regional Training Employment Board, Catholic Care and the local drug and alcohol worker based on Melville Island. Current activities include Tiwi Skin Group Leaders providing educating for particular groups about AOD issues within a culturally appropriate context. The target groups include students in primary school (Years 5 & 6) and secondary school, and adult males who are reached via community social events. The Australian Red Cross provides a youth drop in centre and delivers sport and healthy lifestyle activities and aims to engage older youth of 18 to 25 years who have problems with the use of substances.

Recommendation 3: *That the Select Committee recognise the value of broad based community prevention programs and recommend that the Northern Territory Government include support for such programs in the Harm Reduction Strategy.*

3. Review of best practice evidence to support the development of a revised harm reduction framework for the Northern Territory

3.1 Health interventions

3.1.1 Needle and Syringe Programs

Needle and Syringe Programs (NSPs) are a cost-effective method of preventing the shared use of injecting equipment to reduce the dissemination of the blood borne viruses human immunodeficiency

virus (HIV), hepatitis C (HCV) and hepatitis B (HCB) and associated morbidity and mortality among people who inject drugs. (Decolongon & Sidaway, 2017) (Heard, Iversen, Kwon, & Maher, 2017) To that end NSPs offer various services including the provision of injecting equipment, information and education, referrals for drug treatment services, medical care, and referral to legal and social services. (Wilson, 2009) The equipment NSPs provide includes needles and syringes, swabs, sterile water, and sharps bins for the safe disposal of injecting equipment. Clients of NSPs are unlikely to use another person's syringes if they have convenient access to sterile needles and syringes (Wilson, 2009). NSPs also provide condoms and safer sex education to reduce the potential for sexual transmission of infections.

The NT need for further support of people who inject drugs is indicated by the fact that the NT has the highest prevalence of HCV infections in the country and the lowest rate of treatment uptake. (McLachlan , 2016) While over half a million (529,359)units of sterile injection equipment was distributed in 2015, (Decolongon & Sidaway, 2017) access to clean injecting equipment is limited to fixed sites in major population centres, while in remote areas there is limited access to needles and syringes and in some cases no access.

The Northern Territory NSP comprises three primary outlets, 10 secondary outlets, 19 pharmacy-based outlets and three Syringe Dispensing Machines (Heard, Iversen, Kwon, & Maher, 2017). Primary outlets are managed by the Northern Territory AIDS and Hepatitis Council (NTAHC) and are located in Darwin, Palmerston and Alice Springs. Secondary outlets are mostly found in clinics run by the Department of Health and in hospital emergency departments. (Leglisative Assembly of the Northern Territory "Ice" Select Committee , 2015) Except for the Yulara Medical Centre in Uluru National Park, only hospital emergency departments operate outside of office hours.

The current NSP programs in the NT do not provide sufficient geographic coverage to meet the needs of people who inject drugs. (Heard, Iversen, Kwon, & Maher, 2017) Although other states have legislated to allow for peer distribution of needle and syringes as a harm reduction mechanism, peer distribution is currently illegal in the NT under the Misuse of Drugs Act. (Heard, Iversen, Kwon, & Maher, 2017). Peer distribution of sterile injecting equipment involves recruitment and training of 'peers' in safer injecting practices and in providing education about safer drug use. Peer distribution allows clean injecting equipment to be accessible for those who may not be able, or do not choose, due to stigma, fear of discrimination or other reasons to access an NSP.

A major gap in NSP services is the lack of sterile injecting equipment in prisons which presents a serious risk to prisoner health and to the wider public health. Of all prison entrants, nearly half (45%) have injected drugs previously, 31% have tested positive for hepatitis C, and 18% have tested positive for hepatitis B. (Australian Institute of Health and Welfare, 2015) One in ten (10%) of prison dischargees reported injecting drugs while in prison and 4% reported sharing injecting equipment in prison, although both results are regarded as conservative (Australian Institute of Health and Welfare , 2015). While NSPs are provided in some overseas gaols, no service has been established in an Australian prison; however, the ACT has given in-principle support for one. (Australian Institute of Health and Welfare, 2017) The Australian Medical Association is among health bodies that have called on Australian prisons to provide needle and syringe services as a frontline service to reduce the transmission of blood borne viruses and to create safer environments for prisoners and prison staff. (Australian Medical Association, 2017)

Recommendation 4: *That the Select Committee recommend the NT government increase access to NSPs by expanding the number of and access to primary NSP services and setting up Syringe Dispensing Machines in regional and remote communities which lack NSP services.*

Recommendation 5: *That the Select Committee recommend the NT government legislate to allow peer distribution of injecting equipment to reduce the burden of disease due to blood borne viruses.*

Recommendation 6: *That the Select Committee recommend the NT government legislate to enable the establishment of needle and syringe services in prisons to prevent the transmission of blood borne viruses.*

3.1.2 Medically Supervised Injecting Facilities

Medically supervised drug injection facilities (MSIF) have been found to protect and improve the health and wellbeing of people who inject drugs and to protect the public health. Under the supervision of trained health care workers, these facilities bring hazardous injecting practices into a structured, clinical environment that is integrated with health and welfare services (Wright & Tompkins, 2004). Facility staff follow strict guidelines: they do not help users to inject but provide advice, clean injecting equipment, a

structured environment (Rhodes, 2010) and employ resuscitation equipment when needed (Wright & Tompkins, 2004). Not only do they prevent fatal overdoses, they reduce the risk of blood borne infections, including HIV, Hepatitis B and Hepatitis C, and injuries and diseases such as abscess, thrombosis and endocarditis that are associated with unhygienic drug use (The Salvation Army, 2016). Since its beginning in 2001, the Sydney medically supervised injecting centre has supervised more than 965,000 injections, including 5925 overdoses, but without a single fatality (Uniting, 2016).

Support for an MISF does not condone, encourage or support drug use. It acknowledges the existence of a public health crisis and is proven to minimise risks to both the individual PWID and the wider community. The ADF understands public concern about the establishment of a supervised injecting centre: some people worry that it would condone drug use, attract more drug users to the area, create a hazardous environment and increase the rates of drug use. These concerns are unfounded. Evidence from 90 established centres around the world, including Sydney, demonstrates the 'honey pot' theory is not borne out in practice (Donnelly & Snowball, 2006). Supervised injection facilities are likely to benefit law enforcement resources as police can spend less time charging users and focus on targeting large scale drug dealers (Rhodes, 2010).

The factors that lead people to inject in public places are diverse and complex: they include limited access to safe and secure accommodation; a need to cope with symptoms of drug withdrawal; fear of apprehension by police; a sense of their own 'community' and comradeship among other street-based peers. Nevertheless, injecting drug use in open streets presents serious risks including overdose, unhygienic practices, transmission of blood-borne viruses, soft tissue injury due to poor injection practice, and risk of arrest.

Providing a space for vulnerable people who inject drugs to do so in hygienic conditions under supervision of medically trained staff is a logical accompaniment to needle and syringe services. Following the State Coroner's recommendation that a supervised injecting centre would constitute a life-saving initiative, (Bucci & Preiss, 2017) the government of Victoria established a trial of a medically supervised injection centre in 2018. The ADF believes the Northern Territory can adopt the same approach to save lives, prevent disease, improve access to health services for vulnerable people who inject drugs.

Recommendation 7: *That the Select Committee recommend that the Northern Territory trial of a clinically supervised injection facility based on the successful experience of the Medically Supervised Injection Centre in Sydney and the current trial in Melbourne.*

3.1.3 Pill testing

Pill testing or 'drug checking' is a form of risk mitigation for people who consume illicit substances. Established in several European countries (Ritter, 2014), it enables drug users to determine the nature and concentration of constituents of their pills/drugs at the critical moment. (Ventura, et al., n.d). Drug checking also enables drug users to access counselling in a non-judgmental setting and referral to treatment services (Camilleri & Caldicott, 2004) (Johnston, 2005) (Ritter, 2014) (Kriener, et al., 2001). Additional collateral benefits include law enforcement and emergency agencies gaining accurate knowledge of the substances that are being consumed (Tregonning, 2016) and understanding provision of demographic data and patterns of use in monitoring trends (Ventura, et al., n.d) (Camilleri & Caldicott, 2004).

Australia's first drug checking trial took place at the Groovin' the Moo festival on 29 April 2018, on the grounds of the University of Canberra. The trial, run by STA SAFE consortium, offered a front of house testing facility where consumers could have their substances testing *in situ*. A 'front-of-house' drug testing facility allows for consumers, who are already in possession of a substance, to purposefully engage in a low threshold service. A front-of-house facility informs and educates consumers by testing drug samples in real time – allowing services to transmit safer-use messages over many topics, such as acute/short term hazards, long term hazards, legal risks and harm minimisation strategies (Kriener, et al., 2001). This service type differs from a 'back of house' facility that tests discarded, seized or found substances that does not allow direct contact with consumers (Makkai, et al., 2018).

The results from the trial were encouraging. One hundred and twenty-five people engaged directly with the service, 83 samples were tested, and the quality of psychoactive substances ranged from low to high, while some samples were non-psychoactive (Makkai, et al., 2018). Over half the clients (61%) said they were surprised by the result of the test of their substance. One sample contained N-ethylpentylone,

a cathinone responsible for high numbers of overdoses in New Zealand in 2018 and deaths in the US, while one other substance was given a 'red flag' status because its constituents were indeterminate (Makkai, et al., 2018).

The trial showed that a drug checking intervention is practicable, has the support of police and emergency health staff, and proved the festival audience is willing to use the service and accept the results of the tests.

Recommendation 8: *That the Select Committee recommend the Northern Territory conduct trials of officially approved front-of-house drug checking services at future music and youth festivals in the NT.*

3.1.4 Real-time Monitoring of Prescription Pharmaceutical Drugs

The Northern Territory has the third highest rate of pharmaceutical misuse in Australia as 5.1% of Territorians misused pharmaceuticals, especially analgesics painkillers and opioids. (Northern Territory Government , 2018)

Prescription pharmaceutical drugs are responsible for more deaths in Australia than illicit drugs. In 2016, 663 people died due to benzodiazepines and 550 people died due to prescription analgesic opioids, including oxycodone, morphine and codeine. To underline that point, in the decade between 2006 and 2016, the number of deaths where opioids or benzodiazepines were present rose, respectively, by 127% and 168% (Australian Institute of Health and Welfare, 2017a).

The National Pharmaceutical Strategy Framework for Action 2012-2015 recommended that each state and territory establish a real-time prescription monitoring system as part of a comprehensive response to the problem of misuse of pharmaceutical drugs (National Drug Strategy, 2012). Real time monitoring of prescriptions offers prescribers and pharmacists greater knowledge of and control over their patient's access to controlled, high-risk medications. The main goal is to reduce 'prescription shopping' where an individual attends multiple medical services or prescribers to obtain multiple scripts for one or more pharmaceuticals. (Nicholas, Roche, Dobbin, & Lee, 2013). A patient who covertly receives multiple scripts in that way cannot be supervised responsibly by medical professionals and is at risk of taking an incorrect or excessive dose or taking medications and drugs that interact dangerously with each other (Pilgrim, Yafistham, Gaya, Saar, & Drummer, 2015). Prescription monitoring programs have been successful in reducing prescription shopping in the United States (Ali, Dowd, Classen, Mutter, & Novak, 2017); (Delcher, Wagenaar, Goldberger, Cook, & Maldona-Molina, 2015); (Rutkow, et al., 2015). A second outcome will be the identification of people who are consuming excessive or unsafe amounts of high risk prescriptions, who may be dependent, and will require further attention by health services and possibly drug treatment services.

The value of real time monitoring of prescriptions is recognised by major medical bodies: the Australian Medical Association, the Royal Australasian College of General Practitioners, the Pharmaceutical Society of Australia and the Pharmacy Guild of Australia (Deloitte, 2018). However, as jurisdictions are adopting different monitoring systems (e.g. DORA in Tasmania and SafeScript in Victoria) it is imperative that the systems chosen can be integrated to form a seamless national system and prevent clients evading the system by crossing jurisdictional borders.

Several additional elements are needed to ensure a successful real-time prescription monitoring system: these are, training for prescribers and pharmacists in the appropriate provision of pharmaceutical drugs, and in non-pharmacological treatment of conditions such as pain, insomnia and anxiety; increased access to drug treatment services for persons whose use of pharmaceuticals is excessive; improved preservice education for physicians, pharmacists and other human services workers; improved health literacy within the community so that non pharmaceutical methods of responding to those physical and mental symptoms of distress become more acceptable and more widely utilized (National Drug Strategy, 2012). Social marketing, though not sufficient, can help to inform the public of the value of non-pharmacological treatment of various conditions and of the changes to prescribing and dispensing practices associated with real-time prescription monitoring.

Recommendation 9: *That the Select Committee recommend the Northern Territory Government establish a real-time monitoring system which can intersect with other jurisdictional systems to ensure a nationally comprehensive system.*

Recommendation 10: *That the Select Committee recommend that training be instituted urgently for prescribers and dispensers of pharmaceutical drugs in providing non-pharmacological treatment of physical and mental health conditions and in providing access to such treatments in other services*.

3.3 Adoption of culturally relevant health and education interventions

3.3.1 Alcohol and other drug issues within Aboriginal and Torres Strait Islander populations

Specific and tailored interventions designed and implemented with the support and agency of Aboriginal and Torres Strait Islander peoples are required to prevent and reduce AOD problems and harms among Indigenous population.

Alcohol, tobacco and drug use is higher among Aboriginal and Torres Strait Islander peoples than the non-Indigenous population of Australia. Indigenous Australians are more likely to drink alcohol at risky levels for immediate and long term harm and are 1.8 times more likely to use any illicit drug, 1.9 times more likely to use cannabis, 2.2 times more likely to use meth/amphetamines, and 2.3 times more likely to misuse pharmaceuticals (Australian Institute of Health and Welfare, 2017).

The impact of alcohol upon Aboriginal and Torres Strait Islander populations has been documented many times: excessive consumption of alcohol is directly and indirectly responsible for high rates of mortality and morbidity. It is implicated in a multitude of acute harms such as injury, motor vehicle accidents, and antisocial behaviours including assault, street violence, domestic violence, homicide and suicide and contributes to family breakdown (Intergovernmental Committee on Drugs , 2015). Alcohol is the fifth leading cause of disease among Aboriginal and Torres Strait Islander Australians and the burden of disease that is attributable to alcohol among Aboriginal and Torres Strait Islander people is twice the level of non-Aboriginal and Torres Strait Islander Australians (McRae, et al., 2013).

The high rate of alcohol (and other drug) dependence within Aboriginal and Torres Strait Islander communities is doubly disabling because it prevents people from acting to improve themselves and their community, and to organise themselves politically (Pearson , 2002). Pearson maintains alcohol use is the most pressing issue facing Aboriginal peoples and their communities because the prevalence of alcohol dependence destroys Aboriginal values and stands in the way of their progress. (Pearson , 2002) It is crucial that Aboriginal and Torres Strait Islander people are supported in their efforts to reduce the impact of alcohol and other drug misuse in their communities.

At the same time action to reduce problematic use of legal and illicit substances is unlikely to succeed unless and until the lives of Aboriginal and Torres Strait Islander people are founded more securely. The social and economic determinants of health, including access to employment, education and training, appropriate housing in safe communities (ACT Council of Social Services, 2012) must be addressed simultaneously with action to reduce problematic drinking and other drug use. Notably, young Aboriginal and Torres Strait Islander people who remain in school are less likely to smoke tobacco and drink alcohol, an outcome that improves their health prospects and reduces risk of chronic disease. Policies, programs and measures to improve the health and wellbeing of Aboriginal and Torres Strait Islander people should rest as much responsibility as is possible in Aboriginal and Torres Strait Islander peoples and their appropriate organisations.

Recommendation 11*: That the Select Committee recognise the synergy between the social determinants of health and the prevalence of alcohol and other drug problems in Aboriginal and Torres Strait Islander communities.*

Recommendation 12: *That the Select Committee recommend actions to address alcohol and other drug problems and harms among Aboriginal and Torres Strait Islander populations must include the active participation of Aboriginal and Torres Strait Islander people and organisations at every stage of development and implementation.*

3.3.2 Fetal Alcohol Spectrum Disorders

A health matter of supreme importance to the Northern Territory generally and to Aboriginal and Torres Strait Islander people specifically, is the prevention of Fetal Alcohol Spectrum Disorders (FASD). FASD refers to a range of adverse effects in a pregnant women's unborn baby caused by prenatal alcohol exposure.

FASD is associated with irreversible damage to neural development and leads to lifelong consequences for the individual, their family and society. Essentially it is an acquired brain injury caused by exposure to alcohol before birth (Russel, 2016). The risk to the fetus appears to be highest with frequent or high alcohol consumption by an expectant mother, possibly particularly in the first trimester and at other key times during the pregnancy. However, the risk of harm associated with low level exposure is not clear and prospective parents need to be informed about the risk of drinking alcohol prior to conception, during pregnancy and for the term of breastfeeding. The potential for harm is demonstrated by the relatively high proportion of women (44%) who report drinking some level of alcohol while pregnant (Australian Institute for Health and Welfare (AIHW), 2016).

Reports suggest a relatively high prevalence of FAS and FASDs in Aboriginal and Torres Strait Islander populations (Foundation for Alcohol Research and Education, 2013). Aboriginal-inspired research into patterns of drinking in Western Australia reported high risk drinking in pregnancy was common in remote, predominantly Aboriginal communities and that strategies to prevent prenatal consumption was needed urgently (Fitzpatrick, et al., 2015).

In 2011, the Review of Food Labelling Law and Policy recommended mandatory introduction of pregnancy warning labels on alcoholic beverages in Australia and a Parliamentary Inquiry found the voluntary implementation by the alcohol industry is inadequate (House of Representatives Standing Committee on Social Policy and Legal Affairs, 2012) Warning labels legislated by government will provide the highest coverage, comprehension and consistency. Consequently, mandatory pregnancy warning labels should be applied to all alcohol products as part of a larger public education campaign and such labels must include designs that communicate effectively with Aboriginal and Torres Strait Islander populations.

Recommendation 13: *That the Select Committee recommend the Northern Territory Government encourage the Australian Government to implement the National FASD Strategic Action Plan including the commission of a national public awareness campaign over four years to raise awareness about the risks of drinking during pregnancy*

Recommendation 14: *That the Select Committee recommend the Northern Territory Government encourage Food Standards Australia and New Zealand to implement mandatory pregnancy warnings on all alcohol products and include designs that communicate effectively with Aboriginal and Torres Strait Islander people.*

3.4 Police and criminal justice responses to drug related offending

3.4.1 Drug Decriminalisation

Decriminalisation of drugs is a policy option that is adopted to reduce some harms related to drug use under the policy of strict prohibition. Typically, when drugs are decriminalised the production, manufacture, distribution, sale and purchase of drug/s remain outside the law; however, while the producers and distributors are subject to the criminal law, and face criminal penalties, including incarceration, people who (merely) use or consume the drug/s are not charged or convicted of a criminal offence. Instead they face civil administrative penalties or sanctions. 'Decriminalisation' is distinct from 'legalisation'. When drugs are legalised no offences are attached to the production, distribution and consumption of drugs as long as all the agents and agencies comply with the relevant regulations and legislation. This is the case with alcohol in Australia, and cannabis in Colorado, USA.

The theoretical underpinning of much of our criminal law, including our drug law, is deterrence theory which asserts that "undesirable behaviour can be curtailed if punishment is sufficiently certain, swift, and severe" (Andenaes, 1974). Much early criminological research showed that individuals' perceptions of the likelihood of punishment, rather than the severity of punishment, deterred further offending. Where likelihood of detection is low, or hard to estimate, factors other than the law are likely to be more important determinants of behaviour (Lenton, 2005). In mostly private behaviours such as illegal drug use, the likelihood of detection is low. For cannabis, the likelihood of someone being apprehended for using the drug in any one year is between 1 and 3 % (Kilmer, 2002) (Lenton, 2005) It is therefore unsurprising that research shows little relationship between rates of cannabis use and whether strict criminal penalties or civil penalties apply. (Lenton, 2005)

The main argument for reform of Australian drug law, and decriminalisation, as a response is the apparent intractability of illicit drug use. Half a century of concerted action to prevent use of illicit

substances has not succeeded in eliminating drug use and there is no prospect that it will; secondly most drug related arrests are related to the minor offences of personal possession and/or use more than 90,000 of 112,00 drug arrests nationally in 2013-14 related to drug consumer offences and aggregates arrest data from the Australian Crime Commission's annual *Illicit Drug Data Reports* shows that arrests for drug consumer offences represent about two thirds of all drug arrests over the past two decades (Australian Crime Commission, 2015).

The major harm that decriminalisation prevents is the criminal convictions acquired by people who are found guilty of personal possession and use of drugs. Conviction can disrupt their life seriously, including closing off career, employment and travel options and causing problems with personal relationships (Manderson, 1993) Collateral benefits available under decriminalisation include putting people who use drugs in touch with health and welfare services and lessening stigma on illicit drug use that can prevent people from seeking help. (Buchanan, 2015) Another benefit is the reduction of pressure on the legal and judicial systems although that may be balanced by the needs of administering the system and a potential increased commitment to drug treatment and drug prevention.

The concern put forward by those who fear that decriminalisation represents a more liberal policy that will encourage drug use and worsen the drug problem appears to be unfounded. After assessing global drug policy regimes, the UK Home Office reported there was no obvious relationship between levels of drug use in a country and the strictness of its drug laws. (UK Home Office, 2014) Similarly, a review of the South Australian decriminalisation of cannabis possession reported that none of the studies 'found an increase in cannabis use in the South Australian community which is attributable to the introduction of the Cannabis Expiation Notice scheme' (Drug and Alcohol Services Council, 1999).

Decriminalisation can be achieved by *defacto or dejure* means. Under *defacto decriminalisation* all drug related activities remain illegal according to the law, though cases involving defined small quantities are not investigated or prosecuted by police. A weakness of this system is that police have discretion to decide whether to pursue or charge an offender and that can lead to discriminatory enforcement of the law By contrast under d*e jure decriminalization* certain types of drug use and possession are permitted under the statutes as in Portugal (UK Home Office, 2014).

3.4.2 Decriminalisation in Portugal

Drug use has been decriminalised in Portugal since 2001. That means the possession and use of illicit drugs is treated as an administrative matter while the production, manufacture and large scale distribution of illicit drugs has remained a criminal offence. Individuals found in possession of a personal supply of an illicit drug or found to use a drug, are referred to a tribunal known as the Commission for the Dissuasion of Drug Addiction. The role of this body is to make assessments of the individual drug users who are referred to it for appraisal. The Commission can refer drug dependent people to treatment services, while those who are assessed as not drug dependent, or who are not impaired by drug use, are offered other options: these include having their proceedings suspended, being required to attend a police station, being referred for psychological or educational intervention, or paying a fine (Hughes & Stevens, What can we learn from the Portuguese decriminalization of illicit drugs?, 2010). Essentially Portugal's system is the reverse of the Australian schemes of *cautioning or diversion* schemes which limit cautions and diversions to first, second or third offenders. In Portugal, entrenched drug offenders are referred for treatment and the less entrenched receive civil penalties. There are conflicting claims over the effect of Portugal's' system (Hughes & Stevens, A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs, 2012) but available data suggests decriminalisation has not led to a substantial increase in drug use or related harms (Hughes & Stevens, What can we learn from the Portuguese decriminalization of illicit drugs?, 2010).

***Recommendation 15**: That the Select Committee recommend that the Northern Territory Government undertake a formal investigation of the merits of a dejure decriminalisation of illicit drugs, with special reference to the Portugal model.*

3.4.2 Justice Reinvestment

Justice Reinvestment is a comprehensive strategy that employs targeted, evidence based interventions to achieve cost savings in the criminal justice system which can be reinvested into programs that aim to deliver improvements in social and criminal justice outcomes. The object of Justice Reinvestment is to

reduce crime and strengthen communities by enabling local agencies to implement programs designed to prevent and reduce offending. In the NT, similarly to other states and territories, the justice system is heavily burdened by drug related offences. A Justice Reinvestment model may support a community response by offering programs focusing on substance misuse, engagement with school, family support and a reform of the criminal justice system (Australian Institute of Criminology, 2018).

Policy responses in Justice Reinvestment may include options such as the 'problem-solving court' or 'drug-court'. In this case a magistrate may have a range of sentencing options that recognises an offender has a substance misuse or mental health problem that affects their behaviour (Australian Institute of Criminology, 2018). The introduction of diversion programs for drug offences can maximise cost effectiveness to the justice system and improve offender outcomes (Hughes & Ritter, A Summary of Diversion Programs for Drug and Drug Related Offenders in Australia, 2008). Responsibility for Justice Reinvestment in Indigenous communities should at least be shared by relevant Aboriginal and Torres Strait Islander organisations and bodies.

Currently, the North Australian Aboriginal Justice Authority and the NT Council of Social Services are conducting a Justice Reinvestment project in Katherine via funding from the NT Law Society. (NTCOSS, 2018) Justice Reinvestment is thought to have potential in containing escalating rates of Indigenous incarceration, particularly through its focus on building local community capacity to tackle underlying causes of offending. At this stage the program is consulting with the Katherine community to assess the possibility of developing and introducing initiatives to tackle offending by young Indigenous people. These initiatives might focus (for example) on substance abuse, engagement with school, family support and/or reform of the criminal justice system (NTCOSS, 2018).

Recommendation 16: *That the Select Committee recommend the continuing implementation of Justice Reinvention programs throughout the Northern Territory to address drug related offending and where appropriate include Aboriginal and Torres Strait Islander bodies in the design and implementation of the programs.*

3.5 POLICE AND COURT DIVERSION PROGRAMS

3.5.1 Drug Courts

The ADF believes it is imperative for a Drug Court to be established in the NT to reduce preventable, long-term drug related harm. Drug Courts are shown to facilitate clients' recovery from drug dependence, prevent future offending and improve employment prospects. Evaluations of Drug courts in Victoria and New South Wales have provided evidence that the Drug Court system is an effective alternative to traditional sanctions, such as imprisonment (Taplin, 2002), (Lind, et al., 2002) (Victorian Association of Alcohol and Drug Agencies, 2013). These evaluations show that the Drug Courts are meeting their aim of reducing recidivism, reducing AOD use, increasing full-time employment, and reducing unemployment among participants. KPMG reported a 31% lower rate of reoffending in the first 12 months, and 34% lower rate of reoffending within 24 months for offenders who had undertaken the Drug Court Program (KPMG, 2014), and another study found participants were significantly less likely to commit any further offence (Weatherburn, Jones, Snowball, & Hua, 2008). Participants in the program reported that it was helpful in stopping or reducing AOD use (Taplin, 2002) and Freeman confirmed that drug use by participants reduced significantly, despite access to illicit substances remaining unchanged (Freeman, 2002). Furthermore, a 2006 review found that full-time employment among participants doubled upon the completion of the program, while there was a 32% reduction in unemployment (Victorian Association of Alcohol and Drug Agencies, 2013). The structure of the program means that as the offenders are not separated from society, the period of readjustment upon completion is far less than with imprisonment (Freeman, 2002).

Two evaluations of Drug Courts have recommended that the system be extended with the addition of more specialised courts for suitable drug offenders (Weatherburn, Jones, Snowball, & Hua, 2008) (Victorian Association of Alcohol and Drug Agencies, 2013). A further need is to extend the Drug Court program to rural areas, and this will require the addition of appropriate support services. Data collection has been also raised as an issue deserving improvement, with particular concern related to the number of referrals received to drug Courts compared to the number of participants accepted in order to gauge demand. Other data that should be recorded includes individual-level cost reports, trends in non-compliance, and data pertaining to the health, well-being and reoffending of former participants (Lind, et al., 2002) (KPMG, 2014).

Recommendation 17: *That the Select Committee recommend the establishment of Drug Courts in the Northern Territory as a matter of urgency.*

3.6 PUBLIC AWARENESS CAMPAIGNS, INCLUDING SCHOOL BASED EDUCATION

3.6.1 Public awareness campaigns

The improving of public knowledge of alcohol and other drugs is a crucial feature of a drug strategy and action plan. To protect their health and wellbeing, people need accessible, accurate information about alcohol and drug issues, the effects of drugs, and how they can avoid drug problems and harms. Misinformation may increase health problems if people misunderstand the relative risk associated with specific drugs, especially the risk posed by licit substances. Despite the larger contribution of alcohol and pharmaceuticals to the burden of disease, illicit drug use is popularly regarded as the biggest drug problem and its impact on mortality is exaggerated (Australian Institute of Health and Welfare, 2017). Such misunderstanding can also result in pressure for governments to direct resources away from major drug problems to lesser problems. A dedicated drug information service is required to provide accurate, up to date information on topics that are often misunderstood or misrepresented in other information sources, such as media reporting. A responsive information service requires an online service, an email service and a phone information service.

The ADF supports social marketing campaigns to improve public awareness of AOD related issues but is aware that while they can be useful in drawing public attention to an issue and can help to create a social climate that is conducive to policy change, in themselves they are unlikely to create substantial behaviour change. Therefore, it is important that social marketing campaigns are integrated with other strategies in campaigns that are employed to address alcohol and other drug issues and change behaviour.

Recommendation 18: *That the Select Committee place the provision of publicly accessible and accurate information on drug related matters at the heart of the advice it provides to the Northern Territory government.*

3.6.2 School based education

> "Extensive research has been conducted into the efficacy of drug education programs. The results are mixed. Some programs have made a discernible difference in reducing the incidence of risky use of alcohol, cigarettes, and cannabis, while others have been associated with an increased use of drugs or increased delinquency among the target participants. It is therefore important that, rather than relying entirely on intuitive approaches, the drug educator is informed by the evidence base about effective drug education." (Cahill, 2006)

The above quotation emphasises the need for schools to act on the best available evidence when delivering drug education and their practice must be informed by the guidelines published by the Australian Government (Meyer & Cahill, Principles of School Drug Education, 2004) and the latest research findings. The 12 principles enunciated in that document are as follows: (1) drug education practice must be based on evidence; (2) be informed by a whole school approach; (3) bear clear educational outcomes; (4) be delivered within a positive school climate; (5) sit within a safe and supportive environment; (6) be culturally appropriate and targeted (7) be informed by relevant risk and protective factors (8) have consistency with policy and practice (9) delivered in a timely fashion(10) be delivered by classroom teachers (11) employ interactive strategies and skill development (12) and use credible and meaningful activities for learning (Meyer & Cahill, Principles for School Drug Education, 2002). The *Principles* elaborates on each of these aspects in detail and a satisfactory school drug education program will accord with each of them.

The *Principles* is augmented by the review of alcohol education by the National Centre for Education and Training in Addictions (Lee, 2014), and the Positive Choices website at the National Alcohol and Drug Research Centre (NDARC), which includes internet access to various resources (University of NSW, 2017).

Schools promote protective factors and reduce risk factors for young people through their educational, health promotion and pastoral care programs. Effective drug education programs provide accurate information about drugs, have a focus on social norms, and take an interactive approach which assists students in the development of interpersonal skills. A Cochrane Review found the most effective

programs teach social and coping skills to deal with drug taking issues and have substantial duration - between 10– 20 sessions with follow up sessions (Faggiano, 2005). It is important that teachers are trained in health education because programs that simply provide information on drugs have no impact (Faggiano, 2005) and presentations to children by ex-drug users may even be counterproductive (Ashton, 2005).

Australian programs such as the School Health and Alcohol Harm Reduction Project (SHAHRP) and the CLIMATE program have reported reducing drug use and related harm. Students who participated in SHAHRP were 23 per cent less likely to experience alcohol-related harm (McBride, Farrington, Midford, Meulners, & Phillips, 2004). The Climate Schools program reduced student weekly drinking and cannabis use after 12 months (Teeson, Newton, & Barrett, 2012) (Lee, 2014). All schools have access to on-line training and resources via the internet through the Positive Choices website directed by the National Drug and Alcohol Research Centre (NDARC). In addition, schools can download the CLIMATE drug education program on the Positive Choices website.

School ethos is also an important protective factor. Schools actively involved in health promotion can diminish the effect of personal and social risk factors that encourage substance use, and at the same time, promote protective factors that lower the likelihood of drug use (Bond, 2004). Key protective factors include feeling connected to and enjoying school; having harmonious relationships with peers and teachers; and having multiple opportunities to contribute and participate in the school's activities (Bond, 2004).

Recommendation 19: *That the Select Committee recommend that schools conduct alcohol and other drug education according to the national drug education guidelines published by the Australian Government.*

Recommendation 20: *That the Select Committee advise the Northern Territory Government that the national drug education guidelines indicate school teachers are best placed to provide students with drug education and that they require appropriate support and professional development to do so effectively.*

3.7 Support for affected families and communities

3.7.1 Provision of Naloxone

The ADF believes that a wide distribution of naloxone within the community is important to reduce preventable disability and fatalities due to opioid overdose. Naloxone is an opioid antagonist that can reverse the effects of opioids and its application for a person who has overdosed will often resuscitate them quickly and prevent the risks of permanent disability and death. Naloxone is equally effective for overdose of prescribed pharmaceutical opioids as for illicit opioids sourced on the street; it does not have capacity for misuse and there are few serious side effects (Pricolo & Nielsen, 2018).

As many opioid overdoses are witnessed by another individual, the distribution of naloxone among people who inject drugs (PWID) and their peers (friends and family) has the potential to reduce much opioid related harm. Naloxone can be administered via injection with a prefilled syringe by a lay person and this mode of application has reversed tens of thousands of overdoses worldwide (Olsen, Dwyer, & Lenton, Take home naloxone in Australia and beyond, 2018). However, it is preferable that recipients of naloxone receive some formal training in opioid overdose management and the use of naloxone (Olsen, Dwyer, & Lenton, Take home naloxone in Australia and beyond, 2018). Take-home naloxone was pioneered in Australia by the ACT in 2011 (Olsen, McDonald, Lenton, & Dietze, 2018) although awareness, availability and distribution varies among PWID and their peers (Dietze, et al., 2018).

Take home naloxone programs are yet to target regular and high risk consumers of pharmaceutical opioids (Dwyer, et al., 2018) though national mortality trends indicate that is an urgent need as deaths due to pharmaceutical opioids outnumber deaths due to 'street' opioids (Australian Institute of Health and Welfare, 2017a). An investigation is required into how members of this cohort who may not identify with PWID can gain access to a supply of naloxone. This issue may become more pressing with the introduction of real time monitoring of prescription pharmaceuticals in 2019 as vulnerable people may lose access to 'legal opioids' and seek an illicit alternative substance.

The cost of naloxone is a problem for many PWID whose disposable income is low, due to their marginalised circumstances (Pricolo & Nielsen, 2018). Naloxone is prescribed at a cost of $6.00 for a person with a (low income) concession card, or for $38.80 as a subsidised medicine on the

Pharmaceutical Benefits Scheme (PBS); it is also available over-the-counter for $73.52, a charge that can be problematic for people who inject drugs regularly (Olsen, Dwyer, & Lenton, Take home naloxone in Australia and beyond, 2018).

The widest coverage of naloxone supply to the key stakeholders of PWID, peers and support groups will be achieved through multiple channels and health settings (Pricolo & Nielsen, 2018). Unless legislative changes are made to allow for its supply outside prescribers and pharmacists, which, for example, could allow needle and syringe services to provide naloxone direct to hard-to-reach PWID, partnerships could be formed between community pharmacies and organisations that are unable to authorise supply but have close links to PWID; another option is a Scottish model in which trained peer workers are granted an exemption to enable them to supply naloxone (Dwyer, et al., 2018) (Pricolo & Nielsen, 2018).

Recommendation 21: *That the Select Committee recommend the Northern Territory Government take account of emerging and innovative models of naloxone distribution to ensure ready access to people at risk of opioid overdose.*

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