



**LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY**

**'Ice' Select Committee**

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# **Breaking the Ice**

***Inquiry into 'ice' use in the Northern Territory***

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## Acronyms and Abbreviations

AADANT	Association of Alcohol and Other Drug Agencies NT
ACC	Australian Crime Commission
ADF	Australian Drug Foundation
AFP	Australian Federal Police
ADIS	Alcohol and Drug Information Service
AIHW	Australian Institute of Health and Welfare
AMT	Alcohol Mandatory Treatment
ANCD	Australian National Council on Drugs
ANSPS	Australian Needle and Syringe Program Survey
AOD	Alcohol and Other Drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
APC	Australian Press Council
ATS	Amphetamine-Type Stimulants
BBV	Blood Borne Virus
COAG	Council of Australian Governments
CEPO	Community Engagement Police Officer
CREDIT NT	Court Referral and Evaluation for Drug Intervention and Treatment Northern Territory
DAISY	Drug and Alcohol Intensive Support for Youth
DAGJ	Department of the Attorney-General and Justice
DCF	Department of Children and Families
DASA	Drug and Alcohol Services Association
DCS	Department of Correctional Services
DoE	Department of Education
DVLS	Domestic Violence Legal Service
GGCCESA	Greater Geelong Collective Community Effort on Substance Abuse
GP	General Practitioner
FDS	Family Drug Support
HIV	Human Immunodeficiency Virus
hYEPP	headspace Youth Early Psychosis Program
IDDI	Illicit Drug Diversion Initiative
IDDR	Illicit Drug Data Report
IDRS	Illicit Drug Reporting System
IGCD	Intergovernmental Committee on Drugs
KE	Key Experts
MCDS	Ministerial Council on Drug Strategy
MDMA	3,4-methylenedioxy-methamphetamine

MMP	Montana Meth Project
NDARC	National Drug and Alcohol Research Centre
NDS	National Drug Strategy
NDSHS	National Drug Strategy Household Survey
NTAHC	Northern Territory AIDS and Hepatitis Council
NTCOSS	Northern Territory Council of Social Services
NT DoH	Northern Territory Department of Health
NTLAC	Northern Territory Legal Aid Commission
NTPS	Northern Territory Police Service
NSP	Needle Syringe Program
OMCG	Outlaw Motorcycle Gang
UNODC	United Nations Office on Drugs and Crime
PGA	Pharmacy Guild of Australia
PWID	People Who Inject Drugs
P2P	Phenyl-2-propanone
SMART Court	Substance Misuse Assessment and Referral for Treatment Court
SVM	Syringe Vending Machine
TADS	Tobacco, Alcohol and Other Drugs Services
WWA	Waste Water Analysis
YEPO	Youth Engagement Police Officer



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## Terms of Reference

On 25 March 2015 the Legislative Assembly resolved that:

A Select Committee on the prevalence, impacts and government responses to illicit use of the drug colloquially known as “Ice” in the Northern Territory, be appointed. The Committee will investigate and report on:

- a. The reliability of government data on Ice use and measures to enhance the collection of data to ensure that the scale of the problem and its impacts on the health, justice, drug and alcohol, and law enforcement efforts of the Northern Territory are understood and measured as accurately as possible;
- b. A comprehensive survey of the various government responses to the abuse of Ice in the Northern Territory and assess their effectiveness or otherwise;
- c. The social and community impacts of Ice in urban, community and remote settings;
- d. Government and community responses to Ice use in other states and some assessment of the effectiveness of these responses in terms of prevention, education, family and individual support and withdrawal and treatment modalities;
- e. The sources of Ice including cross border trafficking, local manufacture and derivation from legal pharmaceuticals and other legal precursors; and
- f. Best practice work place health and safety measures for those in the health system who come into contact with users of Ice.

In consideration of these matters, the Committee should:

- a. Consult widely with Territorians and those organisations and professionals with experience in Ice use;
- b. Consider best practice models for effective early education, prevention, containment, treatment and withdrawal strategies; and
- c. Seek the advice and experience of other jurisdictions regarding the options, costs and effectiveness of government and community approaches.

The committee’s membership shall comprise the Member for Blain, the Member for Arafura, the Member for Casuarina and the Member for Nelson. The Chair will be the Member for Blain.

The Committee may elect a Deputy Chair of the Committee, who may act as the Chair when the Chair is absent from a meeting or there is no Chair of the Committee. A quorum of the Committee shall be two members of the Committee.

The Committee is to report by 17 September 2015.<sup>1</sup>

The provisions of this resolution, insofar as they are inconsistent with the Standing Orders, have effect notwithstanding anything contained in the Standing Orders.

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<sup>1</sup> Amended by the Legislative Assembly to “19 November” on 26 August 2015.

## Executive Summary

Crystal methamphetamine, colloquially known as 'ice', is a particularly insidious drug. The ripple effects of its use impact on the health and welfare of users, their families, community and environment. The Committee found that while 'ice' is certainly an emerging issue of concern, reports of an 'ice' epidemic sweeping across the Northern Territory are misleading. National, and Northern Territory, rates of '*meth/amphetamine use within the past 12 months*' have remained relatively stable since 2010 at approximately 2.1% of the population. Nevertheless, the Committee heard that 'ice', the most potent form of meth/amphetamine, is fast becoming the drug of choice amongst users. In 2010, a third of meth/amphetamine users in the Territory recorded 'ice' as the primary form used, by 2013 this had increased to almost half.

While prevalent in the urban and regional centres of the Territory, there is no evidence of widespread 'ice' use in remote communities. However, accurately determining the prevalence and patterns of 'ice' use in the Territory is hampered by a lack of consistency in the terminology used to record information, and the absence of an efficient means of collating, analysing and sharing data across government and non-government agencies. It is imperative that this be addressed if service provision is to be targeted appropriately and its effectiveness monitored accordingly. *Waste Water Analysis*, a relatively new technology, has proven to be an extremely useful means of accurately assessing the prevalence and geographic distribution of illicit substances. Given its capacity to identify immediate trends in drug use, the Committee is of the view that it would be valuable to undertake a trial of waste water analysis in the Territory.

The adverse effects of 'ice' use vary in type and degree depending on a number of factors including frequency of use, amount used, method of administration, and any pre-existing physical and mental health issues. In the short term, 'ice' use can cause headaches, chest pain, shortness of breath, sleep disorders, loss of appetite, anxiety and paranoia. Physiological impacts of longer term use include weight loss, dermatological problems, neurotoxicity, reduced immunity, elevated blood pressure, damage to teeth and gums, cardiovascular problems and kidney failure. Long term use can also result in psychological, cognitive and neurological issues such as depression, impaired memory and concentration, psychosis, violence and erratic behaviour.

The use of 'ice' can have a devastating impact on family, friends and the community. Problems with interpersonal relationships, domestic violence, child neglect, financial issues, increased reliance on welfare support, and involvement in criminal activity were commonly reported as issues by service providers across a wide range of professions. Given that substance abuse is a factor in many instances of domestic violence, child neglect and abuse, the Committee was particularly concerned to learn that the relationship between child protection services and drug and alcohol agencies is not yet well developed in the Northern Territory. That the Department of Children and Families' *Community Care Information System* lacks the facility to record specific information about parental drug use, or what impact this may have had in a

substantiation of harm, raises serious questions as to the effectiveness of departmental practices and procedures, and the Department's capacity to ensure that children and families are provided with an appropriate level of support. The Committee has, therefore, recommended that an independent review and evaluation be undertaken as soon as practicable and tabled in the Assembly by the end of the first quarter 2016.

There was a considerable level of agreement among service providers, community and industry representatives regarding the need for a strategic framework to coordinate responses to the misuse of *both* licit and illicit substances, as a matter of priority. The Committee has recommended the development and implementation of a *Northern Territory Drug Strategy* based on the National Drug Strategy which espouses a harm minimisation approach, incorporating three central and equally important pillars of demand reduction, supply reduction and harm reduction.

The Committee identified a number of areas the strategy needs to address, including: security of funding for drug services; development of drug specific educational resources; accessibility and currency of information and resources on departmental websites; availability and promotion of family support services; after-hours access to sterile injecting equipment; and responsible reporting guidelines for media outlets. It is further recommended that progress reports on the development, implementation and effectiveness of initiatives under the *Northern Territory Drug Strategy* be published on a six monthly basis and tabled in the Assembly by the Minister for Health.

While there are a wide range of initiatives in place that seek to reduce the demand, supply and harms associated with illicit drug use, evidence received by the Committee led it to make a number of recommendations that it believes will lead to improvements in these areas. For example, it is well recognised that the promotion of healthy lifestyles through school based drug education and positive youth development programs is an effective means of reducing demand by preventing the uptake and delaying the onset of drug use. However, the Committee heard that there is considerable variability in the content, delivery and evaluation of these types of programs across schools. It would be beneficial to review and evaluate drug education and positive youth development initiatives currently offered in government and non-government schools to ensure the currency and accuracy of information provided.

In relation to supply reduction, the Committee notes that mandating the real time, online recording of pseudoephedrine sales, the main precursor used in the manufacture of 'ice', has the capacity to enhance the accuracy and availability of data collected by pharmacies that assists police in identifying clandestine laboratories. It was also evident from the public forums the Committee held, that the Police Service needs to increase its public engagement strategies, including promotion of *Crime Stoppers*, since many members of the community are reticent about informing police about drug users, drug dealers and drug houses.

With regards to harm reduction, the Committee has recommended that additional funding be allocated to increase the availability of detoxification services and relieve the 'bottleneck' in the continuum of care. Ensuring adequate detoxification,

rehabilitation and forensic mental health services are made available in each of the Territory's adult correctional facilities and youth detention centres was also identified as a priority. With regards to increasing incentives within the community for drug users to identify and treat their illicit drug use early and decrease the social impact of illicit drug use, the Committee has suggested that a comprehensive review and evaluation of best practice in drug diversionary programs be undertaken and recommendations developed to enhance access to drug diversion programs in the Northern Territory.

During the course of the inquiry it became evident that frontline workers across a wide range of professions lacked confidence in their ability to identify 'ice' use and respond to 'ice' users given their propensity to experience psychotic episodes and display aggressive or violent behaviour. The clandestine manufacture of 'ice' is also extremely hazardous and poses a serious environmental and public health risk for frontline workers and the wider community. Relevant agencies need to undertake an audit of professional development requirements in relation to 'ice' and ensure all staff likely to come into contact with 'ice' users or contaminated premises are appropriately trained. At a minimum, training should include information on 'ice' and its effects, de-escalation techniques, and appropriate workplace health and safety measures.

While acknowledging that the Northern Territory needs to ensure it is well equipped to manage the impact of 'ice' and other illicit substances as they emerge, witnesses impressed on the Committee the importance of not losing sight of the fact that the abuse of alcohol is a far greater problem in the Territory, and that strategies to address 'ice' should not be implemented at the expense of alcohol-related harm initiatives.

## Recommendations

### Recommendation 1

The Committee recommends that the Government:

- a) allocate additional funding to increase the availability of residential and non-residential detoxification services across the Northern Territory, with a particular emphasis on increasing the availability of services to young people under the age of 18 years; and
- b) monitor access to and availability of residential and non-residential rehabilitation services across the Northern Territory.

### Recommendation 2

The Committee recommends that the Department of Correctional Services in conjunction with the Department of Health:

- a) undertake and publish an audit of drug detoxification, rehabilitation and forensic mental health services, and develop a strategy to ensure adequate services are made available in each of the Northern Territory's adult correctional facilities and youth detention centres; and
- b) the Attorney-General table a copy of the audit and strategy in the Assembly by June 2016.

### Recommendation 3

The Committee recommends that the Department of Health evaluate and update the accuracy and accessibility of information regarding drug services and resources on the Department's website.

### Recommendation 4

The Committee recommends that the NT Police Service and Departments of Health, Education, Correctional Services and Children and Families undertake an audit of professional development requirements in relation to 'ice' use and ensure that, as a minimum, training of frontline staff includes:

- a) information on 'ice' and its effects;
- b) training in de-escalation techniques; and
- c) appropriate workplace health and safety measures for all staff that may come into contact with 'ice' users or premises that may have been used for the manufacture of 'ice'.

### **Recommendation 5**

The Committee recommends that the Government undertake and publish an independent review and evaluation of:

- a) the adequacy, consistency and effectiveness of Department of Children and Families' guidelines, practices and procedures where individuals with parental responsibility are suspected of drug use;
- b) improvements required of the *Community Care Information System* to facilitate the Department's capacity to record details of family drug and alcohol misuse and its impact in the substantiation of harm; and
- c) the Minister for Children and Families table a copy of the review in the Assembly by the end of the first quarter 2016.

### **Recommendation 6**

The Committee recommends that the Government introduce mandatory drug and alcohol testing of individuals arrested for offences involving violence.

### **Recommendation 7**

The Committee recommends that the NT Police Service increase and improve the quantity and quality of its public engagement strategies, including greater promotion of *Crime Stoppers*, to encourage the general public to report information regarding the manufacture, distribution and use of drugs.

### **Recommendation 8**

The Committee recommends that a high level Working Group be established within the Department of Health, with representatives from the Departments of Education, Children and Families, Attorney-General and Justice, Correctional Services, NT Police Service, Australian Government, non-government sector and industry and resourced to:

1. Develop and implement a Northern Territory drug strategy in line with the current *National Drug Strategy* addressing:
  - a) security of funding, continuity and coordination of drug services;
  - b) training and awareness of existing and emerging drugs and related referral options for health, education, children and family services, police, justice, and corrections professionals;
  - c) development of drug specific educational resources for frontline staff, drug users and their families, and the wider community;
  - d) availability and promotion of family support services;
  - e) inclusion of information and links regarding drug use and available services on government and non-government agency websites;
  - f) after-hours access to sterile injecting equipment and authorisation of non-Needle Syringe Program staff to distribute same where required; and

- g) development and implementation of responsible reporting guidelines for media outlets.
2. Develop a strategy for the collection and analysis of data relating to methamphetamine across government and non-government sectors, including guidelines to enhance the consistency of terminology use in recording data; and
3. Publish progress reports on a six monthly basis on the development, implementation and effectiveness of strategies within the *Northern Territory Drug Strategy* to be tabled in the Assembly by the Minister for Health.

### **Recommendation 9**

The Committee recommends that the Department of Education:

1. Undertake and publish a review and evaluation of the adequacy, consistency and effectiveness of:
  - a) positive youth development initiatives, including health and well-being programs, offered in government and non-government schools across the Northern Territory;
  - b) drug education programs offered in government and non-government schools across the Northern Territory;
  - c) the role of Youth Engagement Police Officers in the delivery of these initiatives; and
2. The Minister for Education table a copy of the review in the Assembly by June 2016.

### **Recommendation 10**

The Committee recommends that the Government amend the *Misuse of Drugs Act* to prohibit the display and sale of drug paraphernalia.

### **Recommendation 11**

The Committee recommends that the Government undertake a trial of *Waste Water Analysis* to more accurately assess the prevalence and geographic distribution of 'ice' use across the Northern Territory.

### **Recommendation 12**

The Committee recommends that the Government mandate real time, online recording of pseudoephedrine sales to enhance the accuracy and availability of data collected by pharmacies using *Project STOP*.

### **Recommendation 13**

The Committee recommends that the Department of the Attorney-General and Justice:

- a) undertake and publish a comprehensive review and evaluation of best practice in drug diversionary programs, including police diversions, pre-court diversions

- and drug courts, and develop a strategy to enhance access to drug diversion programs in the Northern Territory; and
- b) the Attorney-General table a copy of the review and strategy in the Assembly by the end of the first quarter 2016.



# 1 Introduction

## Establishment of the Committee

- 1.1 The Legislative Assembly resolved to establish the 'Ice' Select Committee on 25 March 2015. In bringing forward the motion the Chief Minister, Hon Adam Giles, MLA, noted that:

There is a growing threat to our community from the synthetic drug commonly known as ice ... These drugs can cause paranoia and hallucinations, and the user may also become aggressive and violent requiring sedation and physical restraint or police intervention. Using ice also leads to social and financial problems and the risk of family breakdown. Violent crimes and deaths related to the use and supply of ice in the Northern Territory appear to be on the increase and it is of great community concern.<sup>2</sup>

As noted in the terms of reference for the National Ice Taskforce: "combating ice is a priority for the Australian Government and all states and territories."<sup>3</sup>

## Conduct of the Inquiry

- 1.2 At its first meeting on 25 March 2015, the Committee called for submissions to be received by 1 May 2015. The call for submissions was advertised on the Assembly's website, the NT News, regional newspapers throughout the Northern Territory and the Australian. The Committee also directly contacted a number of key stakeholders to advise them of the call for submissions.
- 1.3 The Committee received 37 submissions, listed at Appendix 1. As noted in Appendix 2, the Committee held 4 public hearings in Darwin, Alice Springs and Katherine with a total of 25 organisations appearing. The Committee also held public forums in Katherine and Alice Springs. During the course of the inquiry, the Committee undertook site visits of Banyan House Withdrawal and Rehabilitation Centre in Darwin, Venndale Rehabilitation Centre in Katherine, and BushMob Drug Treatment Centre in Alice Springs.

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<sup>2</sup> Hon Adam Giles, MLA (Chief Minister), *Appointment of Select Committee on the Prevalence, Impacts and Government Responses to 'Ice' in the Northern Territory*, Motion, Full Text Transcript, 25 March 2015, viewed 26 March 2015, <http://notes.nt.gov.au/lant/hansard/hansardd.nsf/WebFullTextTranscript/48C0D127E4ADFDDF69257E13004FF48F?opendocument>.

<sup>3</sup> Department of Prime Minister and Cabinet, *National Ice Taskforce Terms of Reference*, Australian Government, 2015, viewed on 13 October 2015, [http://www.dpmc.gov.au/sites/default/files/files/national\\_ice\\_taskforce\\_terms\\_reference.pdf](http://www.dpmc.gov.au/sites/default/files/files/national_ice_taskforce_terms_reference.pdf).

## 2 Emergence of 'Ice'

### What is 'Ice'?

2.1 Methamphetamine is a synthetic stimulant that is part of the amphetamine group of drugs. Stimulants are drugs that speed up the function of the brain and the central nervous system. As illustrated in Table 1, methamphetamine is available in three distinct forms: 'ice' (crystal methamphetamine), base and speed. 'Ice' is the most potent form of methamphetamine, typically around 80% purity, whereas speed is generally about 10-20% pure.<sup>4</sup> The high purity of 'ice' leads to more intense effects than speed or base; greater strain on the body; longer and worse 'comedown'; and is believed by some to be more addictive than less pure forms of methamphetamine.<sup>5</sup>

**Table 1: Forms of Methamphetamine<sup>6</sup>**

Form	Usual appearance	Also known as	Potency	Mainly used by**
Ice/Crystal Meth	Translucent crystals, sometimes shards	Meth, shabu, Tina, glass	High	Smoking (e.g. with a glass pipe), injecting
Base	Dampish, 'gluggy' substance. Colour varies from white to brown	Pure, point, wax, meth	Medium to high	Swallowing, injecting
Speed*	White or off-white powder	Goey, meth	Low to medium	Snorting, swallowing, injecting

Note: \*May occasionally be amphetamine sulphate.

\*\*All three are also sometimes swallowed (ingested) and injected.

2.2 The Committee notes that a range of terminology is used in the literature and data collection methodologies regarding methamphetamine and 'ice'. Methamphetamine generally encompasses speed, base and 'ice' and is often used interchangeably with methylamphetamine. Some sources refer to crystalline methamphetamine, the technical name for 'ice', while others encompass a number of illicit drugs. For example, the term Amphetamine-Type Stimulants (ATS) is frequently used and generally includes amphetamine, methamphetamine and 3,4-methylenedioxy-methamphetamine (MDMA), commonly known as ecstasy. However, the Australian Crime Commission (ACC) provides statistics on ATS that specifically excludes MDMA; in these instances this is noted in the report. Meth/amphetamine is also used in a number of official data collections and includes both amphetamine and methamphetamine substances.

<sup>4</sup> New South Wales Ministry of Health, *Methamphetamine: Speed and Ice: The Facts*, Sydney, New South Wales Ministry of Health, 2014, p. 1, viewed on 7 October 2015, <http://yourroom.com.au/wp-content/uploads/2013/05/Speed-facts.pdf>.

<sup>5</sup> New South Wales Ministry of Health, *Methamphetamine: Speed and Ice: The Facts*, p. 1.

<sup>6</sup> Australian Government Department of Health, *Methamphetamine: What you need to know about speed, ice, crystal, base and meth*, Canberra, Australian Government Department of Health, p.1, viewed on 7 October 2015, <https://comorbidity.edu.au/sites/default/files/Methamphetamine.pdf>.

- 2.3 Amphetamine and methamphetamine were synthesised in the late 1800s, with the crystallised form of methamphetamine first produced in 1918. From the 1920s, amphetamine was marketed as a decongestant and a treatment for depression and obesity. During World War II, amphetamine was given to soldiers to suppress their appetites and increase energy and alertness. Following the war, surplus stocks of amphetamine and methamphetamine flowed into the recreational drug market resulting in widespread civilian use. Given the potential harms associated with these substances, in 1971 both amphetamine and methamphetamine were listed as controlled substances under the *United Nations Convention on Psychotropic Substances*.<sup>7</sup>

## The Emergence of 'Ice' in Australia

- 2.4 Concerns regarding amphetamine misuse in Australia were largely overshadowed by public concern about heroin and cocaine use until 1991 when the Ministerial Council on Drug Strategy (MCDS) endorsed the *National Action Plan on Problems Associated with Amphetamine Use*. The action plan sought to examine the extent, nature, use and treatment of amphetamine and its related problems. However, despite the development of the action plan:

methamphetamine emerged as a new problem in Australia during the late 1990s and early 2000s with police seizure data suggesting that this form of amphetamine had supplanted amphetamine sulphate as the dominant Australian type.<sup>8</sup>

- 2.5 By the mid-2000s, public concern regarding recreational use of amphetamine and methamphetamine had grown considerably. The ABC's 2006 *Four Corners* investigation 'Ice Age' painted a frightening picture of methamphetamine use in Australia:

graphically depicting the lives of high-risk injecting drug users. A disturbing cycle of dependence was portrayed: 'speed skating', barely eating or sleeping, users rummaging through rubbish, the horrors of 'ice bugs' caused by 'amphetamine psychosis', the impact on children and families and homelessness.<sup>9</sup>

The perception of an 'ice' epidemic sweeping the nation led to a number of government initiated actions including a National Leadership Forum on Ice in 2007 and the MCDS endorsing the development of the *National Amphetamine-Type Stimulant Strategy 2008-2011*.<sup>10</sup>

- 2.6 In 2013, the Victorian Parliament established the *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria* in response to growing concerns and anecdotal reports of the increased use of 'ice' and the detrimental effects it was

<sup>7</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, Victoria, 2014, pp. 39-42. Note: For a more detailed history of amphetamine and methamphetamine see Chapter 3, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*.

<sup>8</sup> N Thomson & D Moore, 'Methamphetamine 'facts': The production of a 'destructive' drug in Australian scientific texts', *Addiction Research and Theory*, December 2014, Vol. 22, Issue 6, p. 453.

<sup>9</sup> K Lancaster et al., 'Problems, policy and politics: making sense of Australia's 'ice epidemic'', *Policy Studies*, Vol. 35, No. 2, 2014, p. 155.

<sup>10</sup> K Lancaster et al., 'Problems, policy and politics: making sense of Australia's 'ice epidemic'', pp. 155-156.

having across the state. Since this time, the notion that Australia is again in the midst of an 'ice' epidemic and the scourge of 'ice' is sweeping across the nation has led to the establishment of number of inquiries and taskforces.<sup>11</sup>

2.7 The Committee notes that there is little written about the emergence of 'ice' in the Northern Territory, or the transition from amphetamine to methamphetamine. A review of the National Drug Strategy Household Survey (NDSHS) data indicates that, while there have been changes in the terminology used in the survey reports over time, amphetamine and meth/amphetamine use has been prevalent in the Territory for many years.<sup>12</sup> Consistent with the national trend, NDSHS data indicates that 'ice' is becoming the most commonly used form of methamphetamine in the Northern Territory.<sup>13</sup> Deputy Commissioner Payne of the Northern Territory Police Service (NTPS) advised the Committee, "it appears that ATS substance users are moving away from other substances such as MDMA and moving towards ice."<sup>14</sup>

2.8 It is clear from data and evidence presented to the Committee that 'ice' is present in the regional centres of the Northern Territory. However, the Committee also heard that the majority of methamphetamine in Alice Springs is not in fact 'ice' but lower purity speed. This perception is based primarily on the reported price that users are paying for the drug. According to the ACC, the average price of 'ice' is higher in the Northern Territory than any other state average.<sup>15</sup> Whereas, prices reported by drug users in Alice Springs are lower than the average price in the Northern Territory and interstate prices.<sup>16</sup>

2.9 The extent to which 'ice' has crept into remote communities in the Northern Territory is a contentious issue and most of the information received by the Committee is anecdotal. Deputy Commissioner Payne (NTPS) noted that:

There is no evidence to suggest that ice use is prevalent in remote communities of the Northern Territory. However, there is some anecdotal evidence that ice has been used in a number of communities but it appears that it is not a drug of choice or taking hold at this stage. I think that it would be naïve to suggest that it would not.<sup>17</sup>

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<sup>11</sup> N Lee, 'Are we in the midst of an ice epidemic? A snapshot of meth use in Australia', *The Conversation*, 8 April 2015, viewed on 7 October 2015, <https://theconversation.com/are-we-in-the-midst-of-an-ice-epidemic-a-snapshot-of-meth-use-in-australia-39697>; J Fitzgerald, 'Don't panic? the 'ice pandemic' is a myth', *The Age*, 18 May 2015, viewed on 7 October 2015, <http://www.theage.com.au/comment/dont-panic-the-ice-pandemic-is-a-myth-20150515-gh2plm.html>. Note: Government inquiries include: Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*; National Ice Taskforce; Parliamentary Joint Committee on Law Enforcement *Inquiry into Crystal Methamphetamine (ice)*; and the Legislative Assembly of the Northern Territory 'ice' Select Committee.

<sup>12</sup> Note: The NDSHS has made changes to the survey terminology over the years from 'amphetamine' to 'meth/amphetamine'. Only data from 2007 distinguishes different forms of methamphetamine such as speed, ice and base.

<sup>13</sup> Australian Institute of Health and Welfare (AIHW), *National Drug Strategy Household Survey 2013 (NDSHS 2013), Supplementary table S7.15*.

<sup>14</sup> Northern Territory Police Service (NTPS) and Australian Federal Police (AFP), Committee Transcript, 19 June 2015, p. 2.

<sup>15</sup> Australian Crime Commission (ACC), *Illicit Drug Data Report 2013-14*, ACC, Canberra, 2015, p. 45.

<sup>16</sup> Ms Taylor, Committee Transcript, Alice Springs Public Forum, 21 July 2015, p. 2.

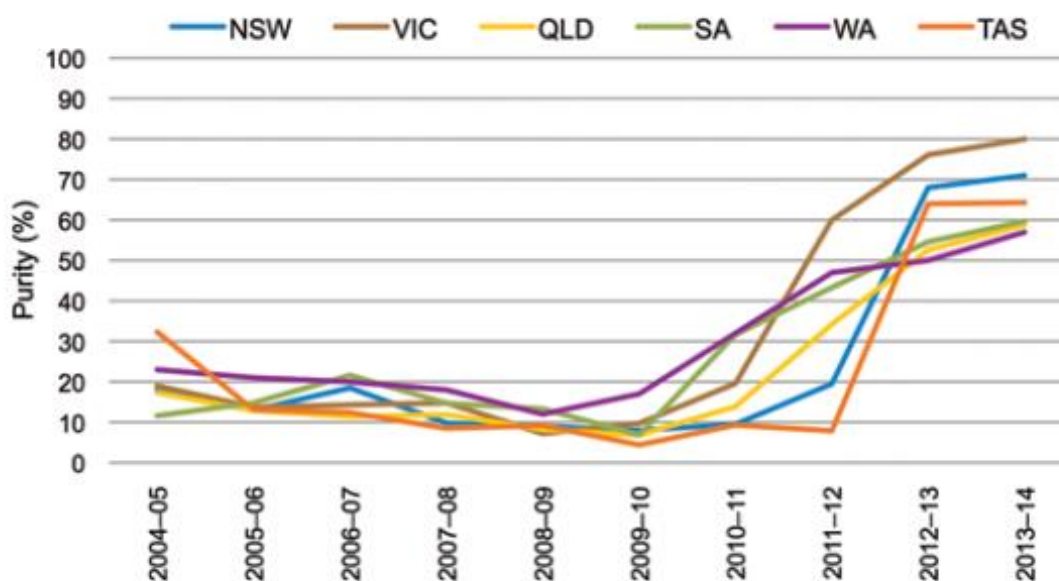
<sup>17</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 2.

2.10 Commander Porter (NTPS) advised the Committee that while there have been incidences of 'ice' use on Groote Eylandt and in Nhulunbuy, they have predominantly involved fly-in, fly-out workers rather than local residents. Commander Porter further noted that:

We have had significant seizures of ice on the main highway, but that is predominantly intercepting vehicles going to Darwin as the major urban centre for distribution. On outer routes into all our communities we have not had any significant seizures of ice going into communities whatsoever... We are not saying it is not in the communities, we are just not detecting it and not getting credible direct information as to who is using it in communities or supplying it to communities.<sup>18</sup>

2.11 It is of particular concern to the Committee that, as illustrated in Figure 1 below, the evidence indicates that the purity of methamphetamine has increased significantly in recent years. This increased purity exacerbates the immediate effects of using 'ice' and is believed to be linked to the longer term harms associated with 'ice' use including drug dependency. While data is not available for the Northern Territory, it is reasonable to assume that a similar trend would have occurred in the Territory.

**Figure 1: Annual median purity of methamphetamine samples 2004-5 to 2013-14<sup>19</sup>**



## Importation, Manufacture and Distribution of 'Ice'

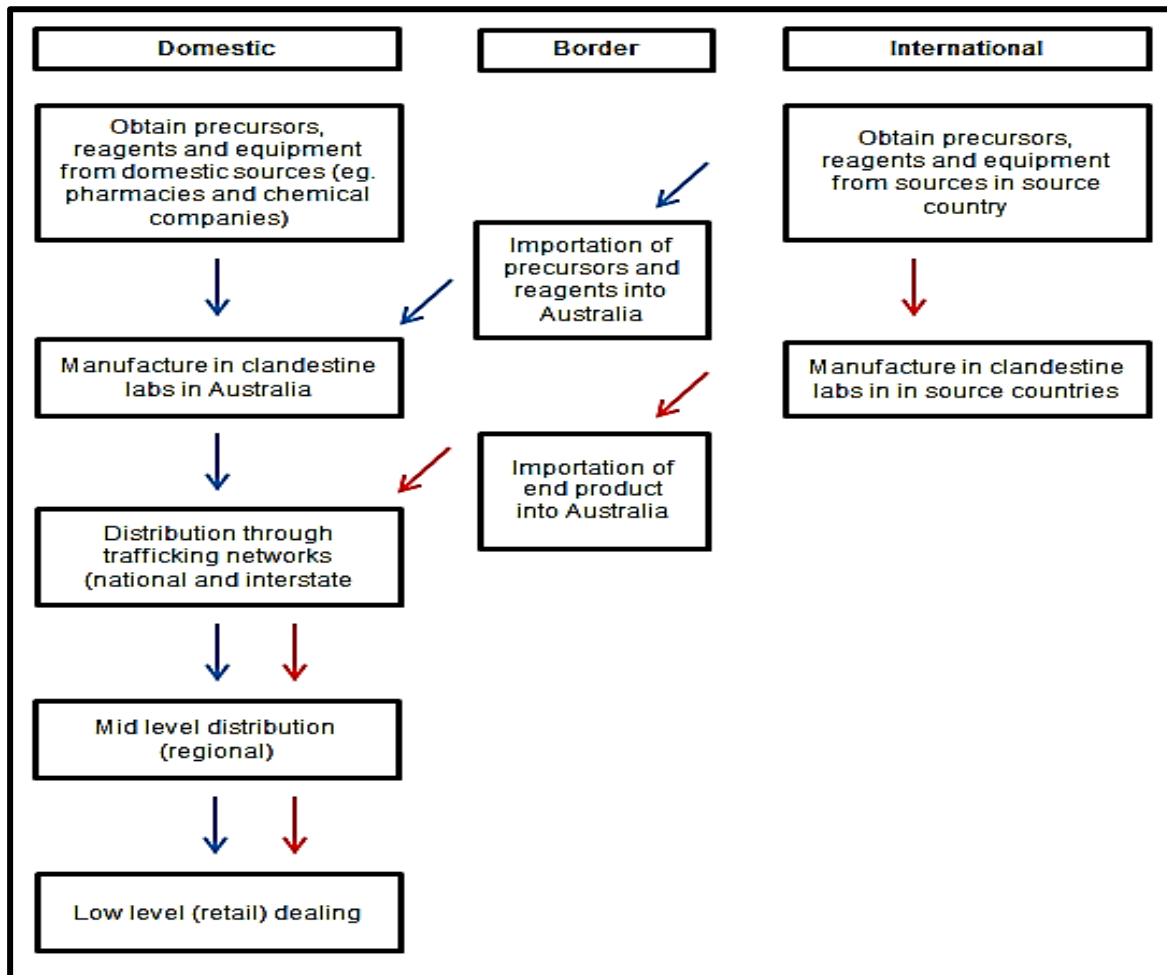
2.12 'Ice' and the precursor chemicals required to manufacture it are illegally imported into Australia via a number of different methods. The Committee heard that there are many players involved in illicit drug markets, both domestically and internationally, ranging from low level drug users and dealers to highly sophisticated crime syndicates, with organised crime networks heavily involved in the

<sup>18</sup> Committee Transcript, Katherine Public Hearing, 14 July, 2015, p. 4.

<sup>19</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 47.

methamphetamine market within Australia.<sup>20</sup> While some groups may only be involved in one specific level of the supply chain, “some criminal networks control the entire supply chain from the sourcing of precursors through to the high and mid distribution of the end product”.<sup>21</sup> Figure 2 below illustrates both the domestic and international supply chains in the Australian methamphetamine market.

**Figure 2: Supply chains in the methamphetamine market<sup>22</sup>**



2.13 In their submission to the Committee, the ACC advised that:

of those organised crime targets recorded on the National Criminal Target List as impacting the Northern Territory, 52 per cent are recorded as being involved in the methylamphetamine market. This involvement includes importation, manufacture and distribution of both methylamphetamine and precursor chemicals.<sup>23</sup>

<sup>20</sup> NTPS, Submission No. 34, 2015, p. 8; Australian Crime Commission (ACC), Submission No. 25, 2015, p. 6.

<sup>21</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, Monograph Series No. 44, Canberra, National Drug Law Enforcement Research Fund, 2012, p. 33.

<sup>22</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 32.

<sup>23</sup> ACC, Submission No. 25, 2015, p. 9.

- 2.14 The involvement of organised crime groups in the methamphetamine market was further emphasised by Mr Hansford, Acting Executive Director of Strategy and Specialist Capability (ACC), who informed the Committee that:

intelligence shows us that serious and organised crime entities are deeply entrenched in the importation, domestic manufacture, supply and distribution of ice to Australians, including in the Northern Territory. We think that 60% of our high-risk crime targets in Australia are involved in the methamphetamine market, which highlights its significance both in illicit profit generation for criminals and the fact it is the key commodity Australian criminals at the top end are seeking to sell in the Australian market.<sup>24</sup>

- 2.15 Mr Hansford further noted that:

the point to note there is one of the reasons we have a national criminal target list is because criminal targets do not operate solely within a jurisdiction, they operate nationally and internationally. Indeed, 70% of our organised crime targets are based or operate largely offshore and impact all of Australia. It is fair to say that organised crime has a footprint in the Northern Territory.<sup>25</sup>

- 2.16 The amount of 'ice' being imported into Australia has increased significantly over the past decade, both in terms of total weight and total number of imports. Mr Jabbour, National Manager, Serious and Organised Crime, Australian Federal Police (AFP), advised the Committee that in 2006 2kg of 'ice' was detected and seized at Australian borders; by 2014 the amount had skyrocketed to 2.6 tonnes.<sup>26</sup> The Committee heard that Australia is a very attractive and lucrative market for transnational 'ice' traffickers due to the high sale price in comparison to the cost to manufacture 'ice' overseas. In China it costs approximately \$6,000 to manufacture 1kg of 'ice' which will sell for between \$160,000 and \$250,000 in Australia.<sup>27</sup>
- 2.17 In 2013-14, 54 countries were identified as embarkation points for amphetamine-type stimulants (ATS) detected at Australian borders. The primary embarkation countries, in terms of the overall weight of ATS detections, were China, Hong Kong, Mexico, the United States and Canada. These five countries accounted for 55.4% of the total number of detections and 86.2% of the total weight of ATS detections.<sup>28</sup>
- 2.18 There are a number of methods that are used to import ATS into Australia. As shown in Figure 3 below, the most frequent detections of ATS are through international mail which accounts for 77.5% of the total number of detections. By comparison, sea cargo accounts for only 0.5% of the total number of detections. However, as illustrated in Figure 4, sea cargo accounted for the largest proportion of ATS importations detected by weight.

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<sup>24</sup> Australian Crime Commission (ACC), Committee Transcript, 19 June 2015, p. 2.

<sup>25</sup> ACC, Committee Transcript, 19 June 2015, p. 5.

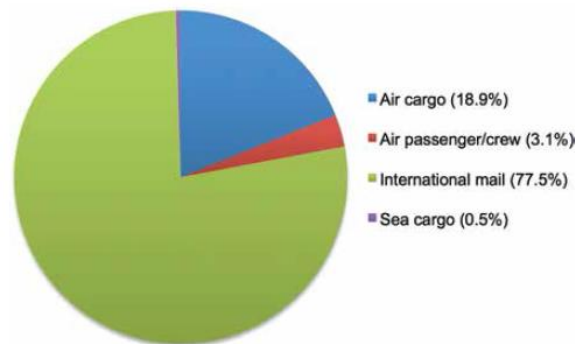
<sup>26</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 4.

<sup>27</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 5.

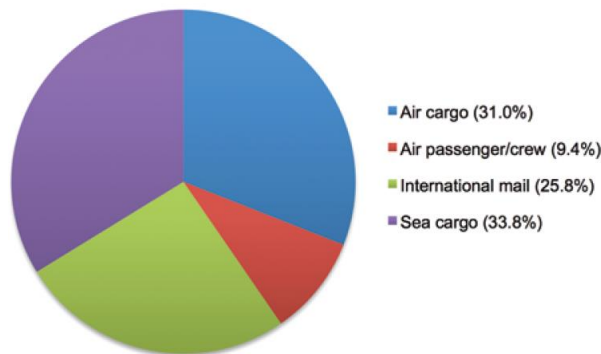
<sup>28</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 32.



**Figure 3: ATS (excluding MDMA) detections at Australian borders as a proportion of total detections, by method of importation 2013-14<sup>29</sup>**



**Figure 4: ATS (excluding MDMA) detections at Australian borders as a proportion of total weight, by method of importation 2013-14<sup>30</sup>**



2.19 Precursor chemicals are illegally imported to circumvent the regulatory restrictions in Australia designed to prevent the manufacture of illicit synthetic drugs including 'ice'. In 2013-14 there were 1,035 detections of ATS precursors at Australian borders totalling 1,505.2kg.<sup>31</sup> China and India are among the largest producers and exporters of chemicals in the world and are "targeted by criminal groups who exploit limited domestic regulatory frameworks and the proximity of manufacturing regions to divert precursor chemicals for illicit drug manufacture."<sup>32</sup> Four of the five largest border detections of precursor chemicals in 2013-14 were for ephedrine which embarked from China and India.<sup>33</sup>

2.20 As illustrated in Figures 5 and 6, international mail was the most commonly detected method of importation for ATS precursors, however air cargo and sea cargo accounted for the largest detections by weight.

<sup>29</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 30.

<sup>30</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 31.

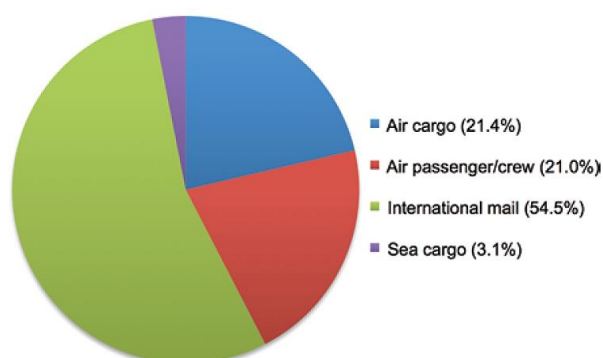
<sup>31</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 159.

<sup>32</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 158.

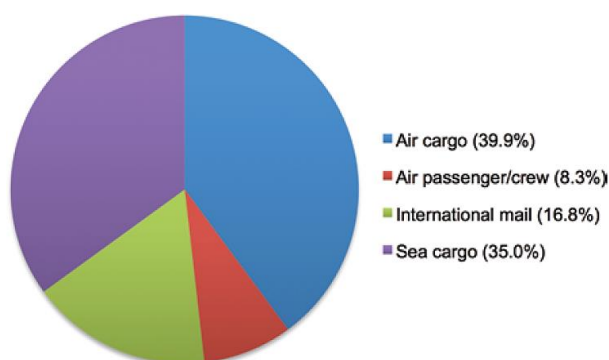
<sup>33</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 160.



**Figure 5: ATS (excluding MDMA) precursor detections at Australian borders as a proportion of total detections, by method of importation 2013-14<sup>34</sup>**



**Figure 6: ATS (excluding MDMA) precursor detections at Australian borders as a proportion of total weight, by method of importation 2013-14<sup>35</sup>**



### **Manufacturing Process**

- 2.21 In addition to the 'ice' that is illegally imported into Australia, 'ice' is also manufactured in clandestine laboratories (clan labs) within Australia for local drug markets. Local manufacturers use a number of commonly available chemical ingredients in conjunction with precursors and pre-precursors that have been sourced both locally and internationally. The precursor chemicals predominantly used in manufacturing 'ice', both nationally and internationally, are pseudoephedrine and ephedrine. Phenyl-2-propanone (P2P also known as phenylacetone), is also used, but to a lesser extent.<sup>36</sup> Between January and June 2014, 70% of methamphetamine border seizures analysed by the AFP were manufactured from pseudoephedrine or ephedrine, while 26.7% were manufactured from P2P.<sup>37</sup>
- 2.22 Many precursor chemicals used in the production of 'ice' have widespread licit use in chemical and pharmaceutical industries. For example, pseudoephedrine and ephedrine are used in the manufacturing of decongestant medications, while P2P is

<sup>34</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 161.

<sup>35</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 162.

<sup>36</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 32 & p.167.

<sup>37</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 36.

used in the manufacture of amphetamine-based medications to treat conditions such as attention deficit hyperactivity disorder. In their submission to the Committee, the ACC noted that precursors are sourced through a number of means:

Diversion has been identified to be occurring from hospitals and other medical settings; the legitimate transport chain; waste destruction facilities; break and enters at pharmacies and chemical companies; exploitation of associates at these businesses; and internet purchases.<sup>38</sup>

2.23 Another method of sourcing pseudoephedrine for methamphetamine production is through 'pseudo runners'. These are people that travel around between pharmacies purchasing pseudoephedrine-based medications to manufacture 'ice'.<sup>39</sup> However, the Committee heard that with regards to the local methamphetamine manufacturing market:

The sourcing of precursor chemicals used in the Northern Territory is an intelligence gap. It is likely they are diverted from local businesses, or ordered from interstate suppliers. It is possible some producers seek to illicitly import precursor chemicals from overseas.<sup>40</sup>

2.24 There are a number of different production methods that can be used to manufacture methamphetamine, some of which are relatively straightforward. While some manufacturers may have a background in chemistry or an understanding of chemical reactions, most small clan lab 'cooks' do not possess a high level of chemistry knowledge and are guided by the proliferation of internet resources that provide instructions on different ways to manufacture methamphetamine. In Australia the different methods of production include:

- Hypophosphorous method – use of hypophosphorous acid and iodine;
- Red phosphorous method – use of hydriodic acid and red phosphorous;
- 'Nazi' method – using lithium or sodium with anhydrous ammonia; and
- P2P or Leuckart method – using phenylacetone or benzyl methyl ketone with formic acid or aluminium amalgam.<sup>41</sup>

2.25 As illustrated in Table 2 below, the hypophosphorous method is the most commonly detected method for manufacturing ATS in clan labs within Australia and the only method detected in the Northern Territory in 2013-14. Nevertheless, the Committee heard that the manufacture and distribution of methamphetamine is in a constant state of flux as "new importation methods are discovered and as novel manufacture processes are invented."<sup>42</sup> Similarly, "methamphetamine markets and supply chains are subject to constant change, largely by endeavours by the criminal networks and individuals to avoid detection by law enforcement."<sup>43</sup> For example, in 2014 the

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<sup>38</sup> ACC, Submission No. 25, 2015, p. 11.

<sup>39</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 60.

<sup>40</sup> ACC, Submission No. 25, 2015, p. 9.

<sup>41</sup> Department of Health and Aging, *National Amphetamine-Type Stimulant Strategy Background Paper*, Monograph Series No. 69, Canberra, Australian Government, 2007, p. 117.

<sup>42</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 30.

<sup>43</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 31.

United Nations Office on Drugs and Crime observed a shift in methamphetamine manufacturing:

from the use of pure ephedrine/pseudoephedrine to the use of pharmaceutical preparations containing these precursor chemicals. This trend follows the pattern of a response by drug traffickers to increased national awareness of and control measures on existing precursors. In recent years, a number of countries have also amended their legislation to more closely monitor pharmaceutical preparations containing ephedrine or pseudoephedrine.<sup>44</sup>

**Table 2: Method of ATS (excluding MDMA) production in clandestine laboratory detections, by state and territory 2013-14<sup>45</sup>**

State/ Territory	Hypophosphorous	Red- phosphorus	Nazi/Birch	Phenyl-2- Propanone (P2P)	Other <sup>a</sup>	Total <sup>b</sup>
NSW	52	8	2	7	9	78
Vic	50	6	5	7	2	70
Qld	144	11	2	5	0	162
SA	21	4	2	1	0	28
WA	3	3	84	0	6	96
Tas	3	0	0	0	0	3
NT	11	0	0	0	0	11
ACT	0	0	0	0	0	0
<b>Total</b>	<b>284</b>	<b>32</b>	<b>95</b>	<b>20</b>	<b>17</b>	<b>448</b>

Notes: a) 'Other' includes the detection of other ATS (excluding MDMA) production methodologies.

b) Total does not equal the total number of ATS (excluding MDMA) clandestine laboratory detections in 2013-14 as the method of production may not be identified. In 2013-14 there were 608 ATS (excluding MDMA) labs detected.

2.26 In the *Illicit Drug Data Report 2013-14* (IDDR), the ACC outlines the complexities involved in reducing the manufacture and supply of synthetic drugs like 'ice' that can be made from precursor chemicals:

Many, but not all, precursor chemicals are controlled by international and domestic regulations. As many industrial chemicals have legitimate application, precursor controls must balance legitimate access with efforts to reduce diversion to the illicit market.<sup>46</sup>

2.27 While precursor regulations have been increased and strengthened, there is still much disparity between international jurisdictions in terms of what chemicals are regulated in an ever changing environment. Mr Jabbour, National Manager, Serious and Organised Crime (AFP), advised the Committee:

the challenge is keeping up with the prescription or listing of these controlled precursors under the Criminal Code Regulations. At present, there are 13 chemicals listed as controlled precursors under the Criminal Code Regulations and this is consistent with the United Nations – they call it a red list – in relation to precursor chemicals that are controlled internationally. In comparison, in

<sup>44</sup> United Nations Office on Drugs and Crime (UNODC), *2014 Global Synthetic Drugs Assessment: Amphetamine-type stimulants and new psychoactive substances*, New York, United Nations, 2014, p. 69.

<sup>45</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 167.

<sup>46</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 157.

some foreign jurisdictions there are as many as 100 chemicals, including analogues, listed as controlled precursors.<sup>47</sup>

2.28 Increased regulation of precursor chemicals has led to the use of pre-precursors in illicit drug manufacturing. Pre-precursors are chemicals that can be transformed into precursors through one or more chemical reactions. For example, phenylacetic acid is a direct precursor to P2P, which in turn is used in the manufacture of 'ice'.<sup>48</sup> The Committee notes that the "emergence of production methodologies using unregulated precursors, pre-precursors, solvents and reagents is an ongoing challenge for government and law enforcement."<sup>49</sup> As the ACC pointed out:

The ability of organised crime groups to adapt non-controlled pre-precursors to methylamphetamine manufacture demonstrates a critical vulnerability for domestic diversion. If law enforcement are unaware of a particular chemical's applicability as a pre-precursor, it is likely that chemical sale companies will also be unaware. It is essential that program of ongoing education and liaison between law enforcement agencies and industry is developed for mutual information sharing and identification of suspicious purchases.<sup>50</sup>

2.29 Mr Hansford, Acting Executive Director of Strategy and Specialist Capability (ACC), informed the Committee that to address the emergence of new methods of manufacturing 'ice', the ACC is looking to:

develop a precursor chemical information resource and provide that to all state and territory police and intelligence agencies so we have a national understanding of which chemicals are able to produce methamphetamine. Obviously that is an ongoing challenge, because once you identify a particular set of chemicals and potentially legislate for them then more chemicals can be used in different formulas to make crystal methamphetamine or ice.<sup>51</sup>

2.30 The Committee heard that the size and sophistication of clan labs varies greatly from small addict-based labs to industrial size labs. Most clan labs are located in or adjacent to residential dwellings. Clan labs may also be set up in vehicles, motels, public places and commercial or industrial buildings. Medium and industrial sized labs have been linked to organised crime groups, in particular Outlaw Motorcycle Gangs (OMCG), that have the contacts to acquire the chemicals and equipment for establishing larger clan labs.<sup>52</sup>

2.31 The Committee heard from Mr Jabbour, National Manager, Serious and Organised Crime (AFP), that the involvement of organised crime in the 'ice' market and the high demand for the drug has resulted in:

an increase in the manufacture of methamphetamine and other ATS. We understand that the increase in manufacture is to take advantage of a very lucrative market. We need to understand that ice is a commodity that attracts a very high sell rate across Australia, particularly in the Northern Territory.<sup>53</sup>

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<sup>47</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 4.

<sup>48</sup> UNODC, *2014 Global Synthetic Drugs Assessment: Amphetamine-type stimulants and new psychoactive substances*, p. 71.

<sup>49</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 157.

<sup>50</sup> ACC, Submission No. 25, 2015, p. 13.

<sup>51</sup> ACC, Committee Transcript, 19 June 2015, p. 5.

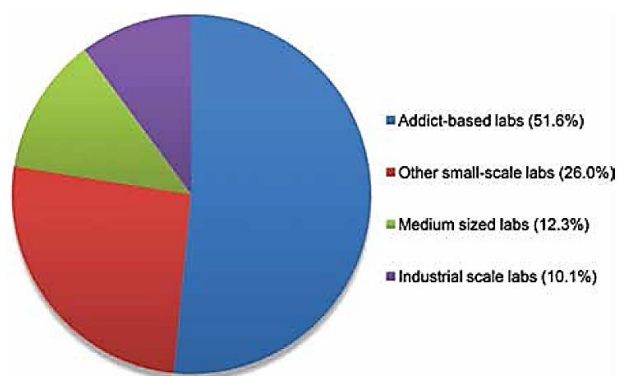
<sup>52</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 35.

<sup>53</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 2.

To be frank, in this country we have a very high demand, an insatiable appetite it would appear, for illicit narcotics, particularly ice, and this results in a highly lucrative methamphetamine market which sustains strong organised crime interest in meeting that demand.<sup>54</sup>

- 2.32 Addict-based labs are established by 'ice' users to manufacture a sufficient quantity for their personal use and generally enough to sell a quantity to cover manufacturing costs.<sup>55</sup> These labs primarily rely on sourcing pseudoephedrine from pharmacies to manufacture 'ice'. As illustrated in Figure 7, the majority of clan labs detected by law enforcement agencies are classified as addict-based labs.

**Figure 7: Category of detected clan labs by size and production capacity 2013-14<sup>56</sup>**



- 2.33 In 2013-14, 608 clan labs manufacturing ATS (excluding MDMA) were detected nationally, an increase of 64 on the total detected in 2012-13. The Committee understands that these clan labs were detected in every jurisdiction with the exception of the Australian Capital Territory. The most recent data available to the Committee indicates that in the 12 months prior to February 2015, 17 clan labs were detected in the Northern Territory.<sup>57</sup> When asked about the extent of local manufacture in the Katherine region, Commander Porter (NTPS) advised the Committee that:

we do not really have much evidence of that at all...most of our information and evidence is that it is being transported in. This stuff can be made dirt cheap overseas and the profit margin is huge in Australia. Our information is that most of it is made overseas and then it is transported here because of the profit margin.<sup>58</sup>

- 2.34 The Committee also heard that 'ice' can be manufactured without needing to set up a laboratory per se. As Commander Warren (NTPS) noted, police in Alice Springs have detected:

A couple of what we call shake-and-bake laboratories, which is slang for a Soda Stream bottle where you put the relevant chemicals in, you do the reaction inside the bottle. People like Soda Stream bottles because they are stronger

<sup>54</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 4.

<sup>55</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 61.

<sup>56</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 165.

<sup>57</sup> Hon Adam Giles, MLA (Chief Minister), *Appointment of Select Committee on the Prevalence, Impacts and Government Responses to 'ice' in the Northern Territory*.

<sup>58</sup> Committee Transcript, Katherine Public Forum, 14 July 2015, p. 10.

than the standard Coke bottle. It allows them to release the pressure by turning the lid on the Soda Stream bottle while the reaction is occurring.<sup>59</sup>

## **Distribution**

2.35 There are a number of distribution methods that exist within the illicit drug market. As previously discussed, international mail is one of the methods used to import 'ice' and this may be sent directly from the dealer to the users or to a 'middleman' dealer who will then on-sell the 'ice' to a user. According to the 2013 National Drug Strategy Household Survey, 57.4% of people who had used meth/amphetamine in the past 12 months sourced it through a friend, while 30.6% obtained meth/amphetamine from a dealer.<sup>60</sup>

2.36 Law enforcement intelligence indicates that ATS are primarily transported into the Northern Territory across state and territory borders. Although there have been a number of international border seizures, it is understood that these drugs were destined for interstate markets after arrival in the Territory.<sup>61</sup>

2.37 As noted previously, there is a strong link between organised crime and OMCG in the supply and distribution of 'ice' within Australia and the Northern Territory. The Committee heard that increased supply of ATS in the Territory has coincided with a rise in the presence of:

OMCG members whose numbers have increased from nine patched members associated with one club in 2011, to currently 31 patched members associated with six clubs.<sup>62</sup>

In addition to the larger organised crime groups and OMCG, the Committee heard that there are a number of smaller syndicates that use joint funds to purchase illicit drugs both locally and interstate for distribution in the Northern Territory.

2.38 The emergence of online drug markets has created new opportunities for suppliers and purchasers in the illicit drug trade and presents complex challenges for law enforcement agencies. The online drug market enables manufacturers and users to source methamphetamine and precursor chemicals from a much broader range of suppliers. Online drug markets generally operate through sites commonly referred to as the 'dark net' and provide sellers and buyers with almost complete anonymity through sophisticated encryption technologies and the use of virtual currencies such as Bitcoin. This level of anonymity poses significant challenges to law enforcement agencies in detecting the flow of illicit substances across borders.<sup>63</sup> The most commonly known online market place for illicit drugs is the *Silk Road*, which emerged in February 2011.<sup>64</sup>

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<sup>59</sup> Committee Transcript, Alice Springs Public Hearing, 21 July 2015, p. 2.

<sup>60</sup> AIHW, *NDSHS 2013, Supplementary table 5.25*.

<sup>61</sup> NTPS, Submission No. 34, p. 9.

<sup>62</sup> NTPS, Submission No. 34, p. 8.

<sup>63</sup> M Barratt et al., 'Use of the Silk Road, the online drug marketplace, in the United Kingdom, Australia and the United States', *Addiction*, May 2014, Vol. 9, Issue 5, p. 774.

<sup>64</sup> J Van Buskirk et al., *Drugs and the Internet, Issue 2*, March 2014, Sydney, National Drug and Alcohol Research Centre, pp. 1-3.

- 2.39 An international study conducted in 2013 surveyed illicit drug users in the United Kingdom, Australia and the United States to explore respondents' awareness of the *Silk Road*; the extent to which purchases were made through the site; and the reasons online purchases may or may not be made. The findings showed that while 53% of Australian respondents had heard of the *Silk Road*, only 14% reported consuming drugs purchased through the site.<sup>65</sup> The primary reasons cited for purchasing illicit drugs from the site were the wider range of drugs available; better quality; convenience of online purchasing; and the seller rating system. The most common reason for Australian respondents not purchasing drugs from the *Silk Road* was adequate access to illicit drugs through existing local networks, followed by fear of being caught by police or customs.<sup>66</sup>
- 2.40 A study by the National Drug and Alcohol Research Centre (NDARC) found that between March and November 2013, there were 178 international retailers advertising methamphetamine for purchase by Australian users on the *Silk Road*. During the same period, there were 75 domestic retailers advertising methamphetamine for purchase in Australia. Among international retailers, methamphetamine was ranked sixth as the most commonly available illicit substance on the *Silk Road*, while among domestic retailers, methamphetamine was ranked fourth.<sup>67</sup> In addition to the trafficking of illicit drugs through the dark net, there is evidence that illicit drugs are being sold through easily accessible websites such as the online classified advertising website 'Craigslist'.<sup>68</sup>
- 2.41 The Committee has reviewed data from national and Northern Territory sources on methamphetamine-related offences. The IDDR produced by the ACC "provides a statistical overview of illicit drug arrests and seizures as well as profiling the current situation; national impact and the emerging trends; and threats of illicit drugs in Australia".<sup>69</sup> The IDDR provides data at state, territory and national levels, however it is important to note the data is based on ATS excluding MDMA and is not specific to methamphetamine or 'ice'.
- 2.42 IDDR data indicates that, in recent years, there has been a steady increase in the number of ATS seizures made by state, territory and federal police. In 2013-14, state and territory police were responsible for 20,218 ATS seizures totalling 685,088 grams. In the same period the AFP made 6,587 ATS seizures with a combined weight of 3,391,296 grams.<sup>70</sup>
- 2.43 With regards to the Northern Territory, in 2012-13 the NTPS seized 2,950 grams of ATS in 344 seizures and the AFP made six seizures in the Northern Territory with a

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<sup>65</sup> M Barratt et al., 'Use of the Silk Road, the online drug marketplace', p. 776.

<sup>66</sup> M Barratt et al., 'Use of the Silk Road, the online drug marketplace', pp. 778-780.

<sup>67</sup> J Van Buskirk et al., *Drugs and the Internet, Issue 2*, p. 6.

<sup>68</sup> ABC News, *Online classified ads allegedly used to sell drug ice, Melbourne man arrested*, 23 July 2015, viewed on 5 August 2015, <http://www.abc.net.au/news/2015-07-23/melbourne-man-arrested-for-allegedly-selling-drug-ice-in-online/6641456> & P Billings, 'Drugs to order on craigslist', *The Mercury*, 29 July 2015, viewed on 5 August 2015 <http://www.themercury.com.au/news/scales-of-justice/drugs-to-order-on-craigslist/story-fnj8cre7-1227462421878>.

<sup>69</sup> ACC Illicit Drug Data Report, viewed on 27 July 2015, <https://www.crimecommission.gov.au/illicit-drug-data-report-2013-14>.

<sup>70</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 210.

combined weight of 4,082 grams.<sup>71</sup> The total number of seizures in 2013-14 increased by 27.7% to 447, while the combined weight of the seizures skyrocketed by 163.6% from 7,032 grams to 18,537 grams.<sup>72</sup> The NTPS were responsible for 442 of the seizures totalling 15,338 grams, while the AFP were responsible for the remaining five seizures weighing 3,119 grams.<sup>73</sup>

2.44 As illustrated in Table 3 below, the number of ATS arrests nationally has almost doubled over the past five years. However, the Committee notes that the total number of ATS related arrests in the Northern Territory dropped from 169 in 2012-13 to 138 in 2013-14.<sup>74</sup> Of these, 74 were 'consumer' arrests for possessing or administering drugs for personal use, of which 54 were male, 18 female and 2 not known. There were also 64 'provider' arrests, for offences such as trafficking and manufacturing, of which there were 44 males and 20 females arrested.<sup>75</sup>

**Table 3: National ATS arrests in total and as a percentage of total drug arrests 2009-10 to 2013-14<sup>76</sup>**

Year	Number of ATS arrests	Percentage of total drug arrests
2009-10	13,982	16.4
2010-11	12,897	15.2
2011-12	16,828	18.1
2012-13	22,189	21.8
2013-14	26,269	23.4

2.45 The Committee also obtained data from the Department of the Attorney-General and Justice on methamphetamine offences charged in the Northern Territory. The Northern Territory criminal justice system databases used by the NTPS, Department of Correctional Services and Department of the Attorney-General and Justice allows methamphetamine-related offences to be recorded through two different methods. Methamphetamine-related offences can be recorded against specific methamphetamine offence codes, enabling them to be easily and directly identified. Alternatively, they can be recorded under generic offence codes, such as the dangerous drugs codes.<sup>77</sup>

2.46 When a methamphetamine-related offence is recorded against a generic code, methamphetamine will generally be recorded in the charge wording text, which allows these offences to be identified through a somewhat more laborious process.<sup>78</sup> However, there is a risk that the specific drug will not be included in the charge wording text, which necessarily impacts on the reliability of the criminal justice system data. Figures 8 and 9 below shows offences charged using methamphetamine codes and offences charged using other codes where text

<sup>71</sup> ACC, *Illicit Drug Data Report 2012-13*, ACC, Canberra, 2014, p. 236.

<sup>72</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 51.

<sup>73</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 210.

<sup>74</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 52.

<sup>75</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 205.

<sup>76</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 209.

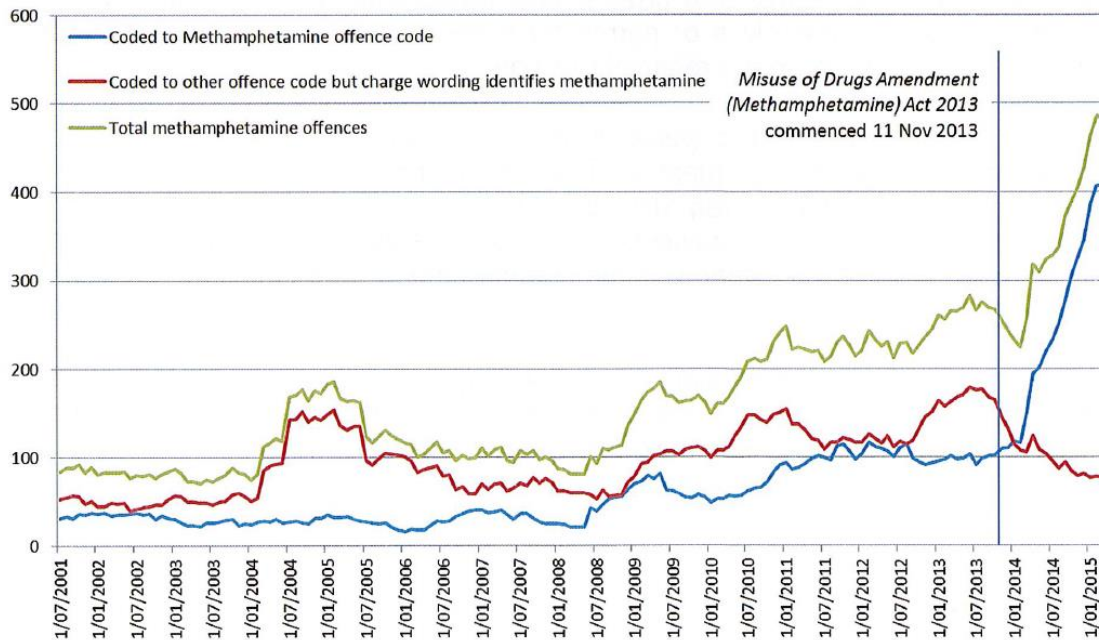
<sup>77</sup> Department of the Attorney-General and Justice (DAGJ), Submission No. 4, 2015, p. 3.

<sup>78</sup> DAGJ, Submission No. 4, 2015, p. 3.

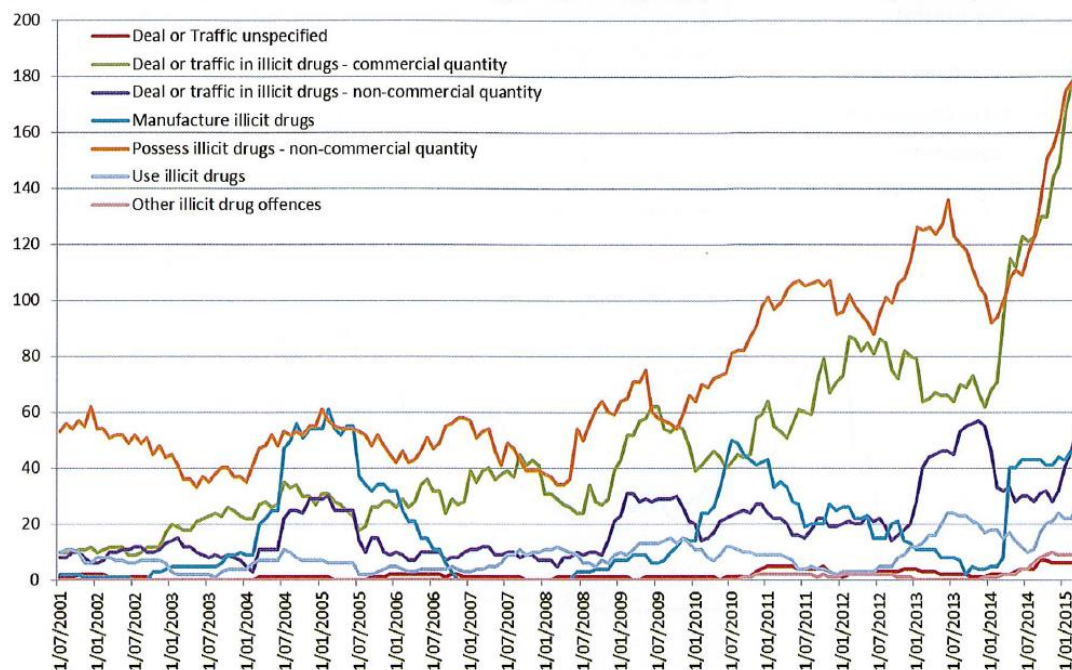


wording identifies methamphetamine, and methamphetamine offences charged by category of offence. The Committee notes the criminal justice data provided is for all forms of methamphetamine, not specifically 'ice'.

**Figure 8: Methamphetamine offences charged, 12 month rolling sums<sup>79</sup>**



**Figure 9: Methamphetamine offences charged by category, 12 month rolling sums<sup>80</sup>**



<sup>79</sup> DAGJ, Submission No. 4, 2015, p. 3.

<sup>80</sup> DAGJ, Submission No. 4, 2015, p. 3.

2.47 It is also noted that these two graphs indicate a significant increase of methamphetamine-related charges following the introduction of the *Misuse of Drugs Amendment (Methamphetamine) Act 2013* which saw the reclassification of methamphetamine from a schedule 2 drug to a schedule 1 drug. As Mr McNeil, Lawyer, Department of the Attorney-General and Justice, pointed out to the Committee :

One of the main issues with the stats is whether our police are focusing on it. It was certainly one of the matters raised with me prior to the methamphetamine legislation coming in 2013 - that police were going to focus a bit more on methamphetamine manufacture and supply. That may explain why the stats have increased as they have.<sup>81</sup>

2.48 Similar observations have been made by Prichard et al., who note:

National data relating to the number and size (weight) of illicit drug seizures provide important indicators of market activity. However, drug seizure and arrest data are influenced by the activities and policies of drug law enforcement agencies; for example, an increase in resources directed at drug seizures will result in an increase in drug seizures. Data on seizures are also difficult to interpret from a law enforcement perspective. For example, a low seizure rate may indicate success because it reflects reduced drug market activity, or it may indicate failure because agencies have not been able to detect drug trafficking.<sup>82</sup>

2.49 Associate Professor Fitzgerald also cautions against relying on crime statistics to establish levels of crime:

Drug crime statistics are inherently problematic because they are discovery crimes. If you put more police out there you are going to find more drug offenders.

When we look at a trend over time and we see many more arrests of drug users, you have to be very careful interpreting it. That increase is not a measure of how much of the drug is around, it's actually a measure of how intensive the policing is.<sup>83</sup>

2.50 Furthermore, Associate Professor Fitzgerald has commented that the increase in methamphetamine arrests, primarily of consumers not providers, due to more intensive policing has inevitably resulted in more people seeking treatment, particularly given that drug diversion initiatives across the country are diverting drug users from the criminal justice system into treatment services.<sup>84</sup>

2.51 The data in Tables 4 and 5 provide a summary of methamphetamine charges by offence, Indigenous status and sex from January 2014 to April 2015.

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<sup>81</sup> DAGJ, Committee Transcript, 19 June 2015, p. 3.

<sup>82</sup> J Prichard et al., 'Measuring drug use patterns in Queensland through wastewater analysis', *Trends and issues in crime and criminal justice*, June 2012, No. 442, Canberra, Australian Institute of Criminology, p. 2.

<sup>83</sup> J McInerney, *ice epidemic claims overstated: drug expert*, ABC Radio National, 17 August 2015, viewed on 18 August 2015, <http://www.abc.net.au/radionational/programs/counterpoint/why-claims-of-an-ice-epidemic-are-overstated/6699080>.

<sup>84</sup> J McInerney, *ice epidemic claims overstated: drug expert*, ABC Radio National.

**Table 4: Charges of methamphetamine offences by month committed and ANZSOC\* classification<sup>85</sup>**

Year	Month	Deal or traffic in illicit drugs unspecified quantity	Deal or traffic in illicit drugs commercial quantity	Deal or traffic in illicit drugs non-commercial quantity	Manufacture illicit drugs	Possess illicit drugs	Use illicit drugs	Other illicit drug offences	Total
2014	1	1	12	1	1	10	2		27
2014	2		4	1		10	1		16
2014	3		27	3	3	11		1	45
2014	4	2	26	3	32**	15	2		80
2014	5	1	4			12	2		19
2014	6	1	14	2	3	10	2	2	34
2014	7		3	1		11			15
2014	8		11	8		18	1	2	40
2014	9	3	10	5		18	6	2	44
2014	10		11	5	2	20	4	1	43
2014	11		22			13	1	1	37
2014	12		7	6	3	16	3		35
2015	1	1	31	8		23			63
2015	2		14	6	3	13	1		37
2015	3		13	11		16	4	1	45
2015	4		12	5		7	1		25

Note: \* ANZSOC refers to the Australian and New Zealand Standard Offence Classification published by the Australian Bureau of Statistics, 2011.

\*\* The 32 offences for 'manufacture illicit drugs' in April 2014 related to ten people, six of whom were each charged with four separate offences related to manufacturing methamphetamine as a result of what appears to be the same incident.

**Table 5: Charges of methamphetamine offences by month committed, Indigenous status and sex<sup>86</sup>**

Year	Month	Non-Indigenous Male	Non-Indigenous Female	Indigenous Male	Indigenous Female	Total
2014	1	18	7	2		27
2014	2	8	6	2		16
2014	3	33	6	6		45
2014	4	57	14	9		80
2014	5	11	3	5		19
2014	6	21	10	3		34
2014	7	11	3	1		15
2014	8	20	12	5	3	40
2014	9	27	10	7		44
2014	10	27	10	5	1	43

<sup>85</sup> DAGJ, Supplementary information provided to the Committee.

<sup>86</sup> DAGJ, Supplementary information provided to the Committee.

<b>Year</b>	<b>Month</b>	<b>Non-Indigenous Male</b>	<b>Non-Indigenous Female</b>	<b>Indigenous Male</b>	<b>Indigenous Female</b>	<b>Total</b>
2014	11	25	3	9		37
2014	12	16	7	12		35
2015	1	33	13	17		63
2015	2	20	13	4		37
2015	3	22	13	7	3	45
2015	4	13	3	9		25

### 3 Prevalence of 'Ice' Use in Australia

#### Data Collection Methodologies

- 3.1 There are a number of data collection sources that provide some level of insight into the prevalence rates of meth/amphetamine and 'ice' use both nationally and within the Northern Territory. Data collection methodologies include population surveys; drug user surveys and interviews; and information collated by Alcohol and Other Drug (AOD) treatment service providers.
- 3.2 The primary data sources include:
- The National Drug Strategy Household Survey (NDSHS) is the principal data collection source on drug use in Australia and is conducted every three years by the Australian Institute of Health and Welfare (AIHW).<sup>87</sup>
  - The Illicit Drug Reporting System (IDRS) is a monitoring system funded by the Australian Government Department of Health and coordinated by the National Drug and Alcohol Research Centre (NDARC). The IDRS reports on price, purity, availability and patterns of drug use among People Who Inject Drugs (PWID).<sup>88</sup>
  - The Ecstasy and Related Drugs Reporting System (EDRS) is a monitoring system for ecstasy and related drugs which is based upon the IDRS and also coordinated by the NDARC.<sup>89</sup>
  - The Australian Needle and Syringe Program Survey (ANSPS) collects data from drug users that use the Needle Syringe Program (NSP). Data in the Northern Territory is collected from the primary NSP sites operated by the Northern Territory AIDS and Hepatitis Council (NTAHC) in Darwin, Palmerston and Alice Springs.<sup>90</sup>
- 3.3 The Northern Territory Department of Health collects data from publically funded government and non-government AOD treatment service providers. The data covers both people seeking treatment for their own drug use as well as people seeking assistance for someone else's drug use. The data identifies drugs used as either the principal drug of concern or additional drugs of concern. A subset of this data is in turn provided to the AIHW to enable the collation of the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS).

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<sup>87</sup> Northern Territory Department of Health (NT DoH), Submission No. 5, 2015, p. 4.

<sup>88</sup> J Stafford & L Burns, *Australian Drug Trends 2014. Findings from the Illicit Drug Reporting System (IDRS)*, Australian Drug Trend Series, No. 127, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015, pp. 2-4.

<sup>89</sup> E Whittaker & L Burns, *Northern Territory Trends in Ecstasy and Related Drug Markets 2014. Findings from the Ecstasy and related Drugs Reporting System (EDRS)*, Australian Drug Trend Series No. 143, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015, pp. 4-5.

<sup>90</sup> J Iverson & L Maher, *Australian NSP Survey: 20 Year National Data Report 1995-2014*, Sydney, Kirkby Institute, UNSW Australia, 2015, p. 101.

3.4 The Committee found that the inconsistency of terminology used in different data sources presents challenges in determining the prevalence rates of illicit drug use and incidence rates of people seeking treatment. While research indicates that methamphetamine is much more common than amphetamine in the current Australian drug climate, some sources capture data for all amphetamine-type stimulants within the one category, making it impossible to distinguish usage and treatment rates by amphetamine, methamphetamine and MDMA.

3.5 The Committee also identified a number of other issues in accurately assessing the prevalence of 'ice' use in the Northern Territory including:

- Currency of the NDSHS data, as the survey is only conducted every three years, and may not reflect current trends in drug use;
- Due to the small sample size of the Northern Territory data in the NDSHS (1079 people), the AIHW has cautioned that some of the data is statistically unreliable;<sup>91</sup>
- NDSHS does not collect data from people who are homeless, institutionalised or living in non-private dwellings;<sup>92</sup>
- AIHW note that due to the low response from people under 35, this group is underrepresented in NDSHS data;<sup>93</sup>
- Sample size in the Northern Territory used for the IDRS, EDRS and ANSPS is only around 100 people;<sup>94</sup> and
- EDRS and IDRS only collect data in Darwin, therefore they do not represent drug use or trends in regional and remote areas.<sup>95</sup>

3.6 The Northern Territory Department of Health advised the Committee that it is considering meeting with NDARC to discuss expanding the scope of the IDRS data collection within the Territory to allow future reports to be more representative of the population base.<sup>96</sup>

3.7 The Committee also understands that population surveys such as the NDSHS are widely believed to underestimate the prevalence of illicit drug use in society.<sup>97</sup> For example, stigmatisation of particular drugs at different times may result in underreporting. This was evidenced in the decrease in lifetime meth/amphetamine use between 2004 and 2007 in the NDSHS. As noted by Dr McKetin:

If you have ever used a drug now, in three years time you will still have used that drug at some point. We actually saw a drop from 9 or 10 per cent of the

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<sup>91</sup> Australian Institute of Health and Welfare (AIHW), Submission No. 12, 2015, p. 3.

<sup>92</sup> AIHW, Submission No. 12, 2015, p. 3.

<sup>93</sup> AIHW, Submission No. 12, 2015, p. 3.

<sup>94</sup> J Stafford & L Burns, *Australian Drug Trends 2014*, p. 2; J Iverson & L Maher, *Australian NSP Survey: 20 Year National Data Report 1995-2014*, p. 101; E Whittaker & L Burns, *Northern Territory Trends in Ecstasy and Related Drug Markets 2014*, p. 4.

<sup>95</sup> NT DoH, Submission No. 5, p. 3; E Whittaker & L Burns, *Northern Territory Trends in Ecstasy and Related Drug Markets 2014*, p. 4.

<sup>96</sup> NT DoH, Submission No. 5, p. 3.

<sup>97</sup> AIHW, *NDSHS 2013*, p. 48; S Dawe et al., *Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do*, Child Abuse Prevention Issues No. 29, Melbourne, Australian Institute of Family Studies, 2008, p. 6.

population saying that they had ever used speed, amphetamine, ice or methamphetamine down to 6 per cent, so 4 per cent of the population suddenly decided that they had not ever tried the drug. So we know that there is underreporting.<sup>98</sup>

3.8 Furthermore, the Committee is aware of discrepancies between the AOD treatment data provided by the Northern Territory Department of Health and the AIHW. The AIHW data covers treatment for clients' own drug use for any type of amphetamine as the principal drug of concern, while the data provided by the Department of Health distinguishes between treatment for methamphetamine and ATS excluding methamphetamine. However, it also includes treatment for another person's drug use, such as parents seeking help for their child's drug use. A small number of records have been excluded from the AIHW data collection as they fail to meet all the AIHW data specification rules. The Committee also notes the AIHW data for the Northern Territory may be incomplete as:

most Australian Government funded Indigenous substance-use services and Aboriginal health services that provide treatment for alcohol and other drug problems do not supply data under the AODTS-NMDS.<sup>99</sup>

## Prevalence Rates

3.9 Data from the 2013 NDSHS indicates that 'lifetime' meth/amphetamine use is recorded for 7% of the population which equates to approximately 1.3 million individuals.<sup>100</sup> On the basis of this data, the Committee understands that:

- National rates of meth/amphetamine use within the past 12 months remained stable for the period 2010 to 2013 at 2.1% of the population (approximately 400,000);<sup>101</sup> Northern Territory rates of meth/amphetamine use within the past 12 months were 2.8% in 2013, a slight increase on the 2010 figure of 2.1%. However, the Committee notes that it is a significant decrease from the rate of 6.3% recorded in 2001;<sup>102</sup>
- Nationally, 'ice' as the primary form of meth/amphetamine used has increased from 21.7% in 2010 to 50.4% in 2013. For the Northern Territory the rate increased from 30.4% in 2010 to 44.6% in 2013;<sup>103</sup>
- Speed powder as the primary form of meth/amphetamine used has decreased nationally from 50.6% in 2010 to 25.5% in 2013. In the Northern Territory it decreased from 63.5% to 29.1%.<sup>104</sup>

<sup>98</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, Committee Transcript, 11 February 2014, p. 4.

<sup>99</sup> Australian Institute of Health and Welfare (AIHW), *Alcohol and other drugs data cubes*, viewed on 16 June 2015, <http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data-cubes/>.

<sup>100</sup> AIHW, *NDSHS 2013*, p. 60.

<sup>101</sup> AIHW, *NDSHS 2013*, p. 60.

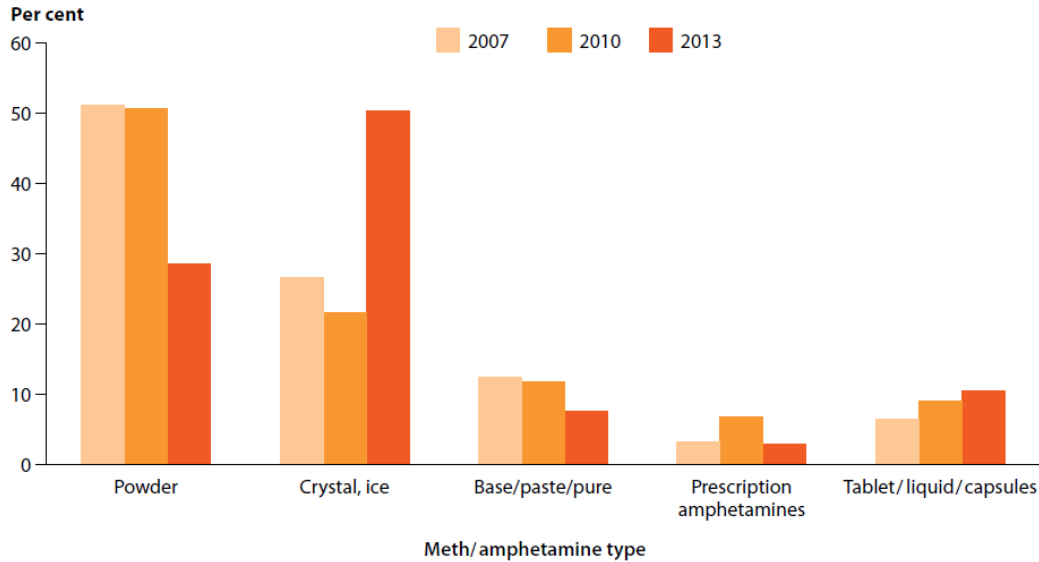
<sup>102</sup> AIHW, *NDSHS 2013, Supplementary table S7.12*; AIHW, Submission No. 12, 2015, p. 3 & Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: State and Territory supplement*, Drug Statistics Series No. 10, Canberra, Australian Institute of Health and Welfare, 2002, p. 8.

<sup>103</sup> AIHW, *NDSHS 2013, Supplementary table S7.15*.

<sup>104</sup> AIHW, *NDSHS 2013, Supplementary table S7.15*.

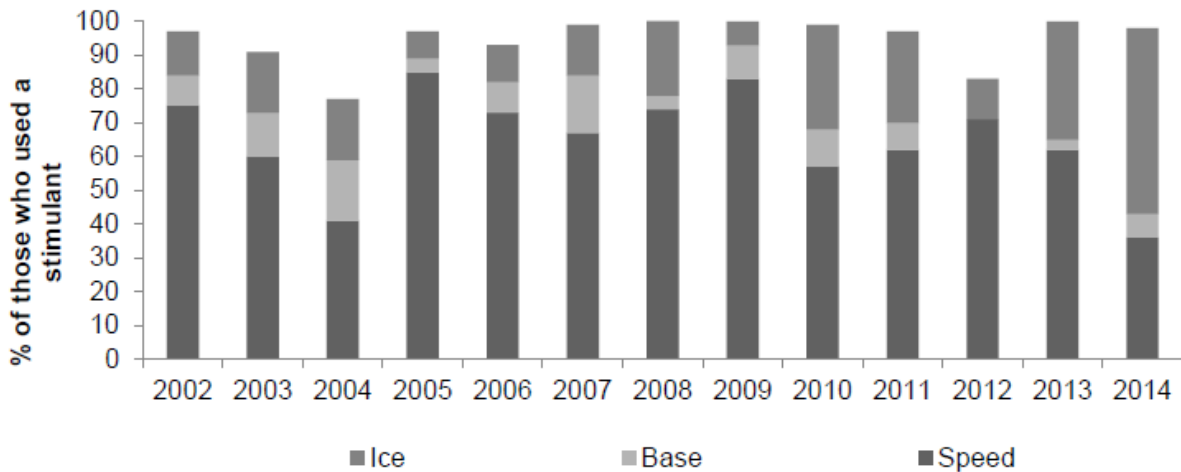
3.10 Figure 10 below illustrates the main form of meth/amphetamine used nationally in the previous 12 months for 2007, 2010 and 2013. The graph also clearly indicates the move away from powder, base, and prescription amphetamines to crystal methamphetamine, 'ice', over this period.

**Figure 10: Main form of meth/amphetamine used nationally in the last 12 months<sup>105</sup>**



3.11 Figure 11 illustrates that among injecting drug users in the Northern Territory that have injected any form of methamphetamine in the past six months, 'ice' is the most commonly injected form.

**Figure 11: Methamphetamine form most used in the preceding six months<sup>106</sup>**



3.12 Data from the 2013 and 2014 IDRS indicates that 'ice' use among PWID is much more prevalent nationally than in the Northern Territory:

<sup>105</sup> AIHW, *NDSHS 2013*, p. 62.

<sup>106</sup> C Moon, *Northern Territory Drug Trends 2014*, p. 15.



- 'Ice' use in the previous six months increased nationally from 55% to 61%. In contrast, it decreased in the Northern Territory from 30% to 26%;<sup>107</sup>
  - Nationally, 'ice' as the drug of first choice increased from 11% to 14%.<sup>108</sup> In the Northern Territory, the rate remained relatively stable at 3% and 4%;<sup>109</sup>
  - 'Ice' as the drug most recently injected increased nationally from 15% to 22%,<sup>110</sup> while Northern Territory rates rose from 4% to 10%;<sup>111</sup> and
  - Nationally, 'ice' as the drug most frequently injected increased from 15% to 22%.<sup>112</sup> In the Northern Territory the rate increased from 3% to 9%.<sup>113</sup>
- 3.13 According to the ANSPS data for the Northern Territory, methamphetamine was the last drug injected by 27% of participants in 2014, 11% in 2013, 18% in 2012 and 23% in 2011, which are higher than the rates reported by IDRS.<sup>114</sup> However, the IDRS specifically relates to 'ice' whereas the ANSPS includes all types of methamphetamine which may account for the disparity between the two data sets.
- 3.14 While morphine as a drug injected did not emerge as a significant issue at public hearings and in submissions, IDRS and ANSPS data indicates that in the Northern Territory, injecting morphine is much more common than injecting 'ice'. Furthermore, the data suggests that morphine injecting is much more prevalent in the Northern Territory than nationally:
- Drug of first choice 48% in the Northern Territory and 10% nationally;
  - Drug last injected 72% in the Northern Territory and 15% nationally; and
  - Drug most often injected 79% in the Northern Territory and 16% nationally.<sup>115</sup>
- 3.15 The Committee notes that this data contradicts the evidence provided to the Committee during public hearings and forums. As Ms Gates, Executive Director of NTAHC, noted, while steroids are the most commonly reported drug last injected by people using the NSP, approximately 40% of people reported methamphetamine as the last drug injected, which equates to 3,088 episodes of needle exchange over a 12 month period.<sup>116</sup> The Committee was also informed by Ms Bettison from the Centre for Disease Control, that historically, clean injecting equipment supplied by emergency departments was used to inject morphine and speed, but around 90% are now used for 'ice'.<sup>117</sup>
- 3.16 AIHW data for 2013-14 reveals that nationally there were 50,825 closed treatment episodes for a client's own amphetamine use, which equated to 30% of all AOD closed treatment episodes. Of this total, 28,886 (17%) were attributed to

<sup>107</sup> J Stafford & L Burns, *Australian Drug Trends 2014*, p. 21.

<sup>108</sup> J Stafford & L Burns, *Australian Drug Trends 2014*, p. 4.

<sup>109</sup> C Moon, *Northern Territory Drug Trends 2014*, p. 8.

<sup>110</sup> J Stafford & L Burns, *Australian Drug Trends 2014*, p. 4.

<sup>111</sup> C Moon, *Northern Territory Drug Trends 2014*, p. 8.

<sup>112</sup> J Stafford & L Burns, *Australian Drug Trends 2014*, p. 4.

<sup>113</sup> C Moon, *Northern Territory Drug Trends 2014*, p. 8.

<sup>114</sup> J Iverson & L Maher, *Australian NSP Survey: 20 Year National Data Report 1995-2014*, p. 96.

<sup>115</sup> J Stafford & L Burns, *Australian Drug Trends 2014*, p. 10.

<sup>116</sup> Northern Territory AIDS and Hepatitis Council (NTAHC), Committee Transcript, 19 June 2015, p. 4.

<sup>117</sup> Committee Transcript, Katherine Public Forum, 14 July 2015, p. 2.

amphetamine as the principal drug of concern, while 21,939 (13%) were for amphetamine as an additional drug of concern.<sup>118</sup> This is higher than 2012-13 when there were a total of 44,028 closed treatment episodes for amphetamine use, 22,265 as the principal drug of concern and 21,763 as an additional drug of concern.<sup>119</sup> AIHW data shows that treatment for a client's own amphetamine use in the Northern Territory rose from 158 closed treatment episodes (4.7%) in 2012-13, to 279 closed treatment episodes (7.1%) in 2013-14.<sup>120</sup>

3.17 The number of closed treatment episodes for methamphetamine and ATS excluding methamphetamine in the Northern Territory are provided in Table 6 below. The figures are higher than the AIHW data, as the Northern Territory includes clients seeking treatment for their own drug use, as well as people seeking treatment for another person's drug use.

**Table 6: Closed treatment episodes for clients seeking treatment for their own drug use and clients seeking treatment for another person's drug use<sup>121</sup>**

Principal drug of concern	2012-13	2013-14	2014-15
ATS excluding methamphetamine	196	211	202
Methamphetamine	4	90	245
<b>Total</b>	<b>200</b>	<b>301</b>	<b>447</b>

3.18 According to the Penington Institute, between 2009-10 and 2012-13 there was an 85% increase in the number of people undergoing treatment in the Northern Territory for meth/amphetamine as their principal drug of concern.<sup>122</sup> It is unclear whether the increase in people seeking treatment is linked to an increase in the number of people using meth/amphetamine.

3.19 The Alcohol and Drug Information Service (ADIS) provides general information and treatment referral options to members of the public and health professionals. The Committee notes that the number of callers identifying meth/amphetamine use as problematic has increased since the beginning of 2013. Of the total calls received by ADIS, meth/amphetamine related calls represented 16.4% in January to June 2013; 30.8% in July to December 2013; 20.3% in January to June 2014; and 25.3% in July to December 2014.<sup>123</sup> The Northern Territory Department of Health noted that while ADIS data does not currently capture what form of meth/amphetamine is being used, future reporting methods will be changed to capture this information as well as the location of the caller.<sup>124</sup>

3.20 The Northern Territory Department of Health also collects data on the number of emergency department presentations where a psychostimulant has been recorded

<sup>118</sup> Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2013-14*. Drug treatment series no. 25. Cat. no. HSE 158. Canberra, Australian Institute of Health and Welfare, 2015, p. 16.

<sup>119</sup> Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2012-13*. Drug treatment series no. 24. Cat. no. HSE 150. Canberra, Australian Institute of Health and Welfare, 2014, p. 12.

<sup>120</sup> AIHW, *Supplementary data provided to the Committee*, p. 1.

<sup>121</sup> NT DoH, *Supplementary data provided to the Committee*, p. 2.

<sup>122</sup> Penington Institute, Submission No. 10, 2015, p. 8.

<sup>123</sup> NT DoH, Submission No. 5, 2015, p. 8.

<sup>124</sup> NT DoH, Submission No. 5, 2015, p. 8.

and the number of hospital separations where a primary or secondary methamphetamine-related diagnosis has been made. As illustrated in Tables 7 and 8, while both have increased over the past three years, they represent a very small proportion of emergency department presentations and hospital separations.

**Table 7: Emergency department presentations with and without psychostimulants<sup>125</sup>**

Year	Without psychostimulant	With psychostimulant	Total
2012	144,138	19	144,157
2013	146,907	31	146,938
2014	142,254	37	142,291

**Table 8: Hospital separations with and without a primary or secondary methamphetamine diagnosis<sup>126</sup>**

Year	Without methamphetamine	With methamphetamine	Total
2012	126,554	46	126,600
2013	132,585	54	132,639
2014	137,303	100	137,403

- 3.21 During the course of the inquiry, the Committee also received substantial anecdotal information on the prevalence of 'ice' use within the Northern Territory. While the veracity of this information cannot be qualified, it provides context around the issues arising from the use of 'ice' and highlights the need for improved data collection methodologies to provide a more robust assessment as to the prevalence and extent of 'ice' use within the Territory.
- 3.22 In considering the prevalence rates and impact of meth/amphetamine and 'ice' use within the Northern Territory, it is important to keep in perspective the prevalence, associated harms and impacts of alcohol and other illicit drugs. For example, the Committee notes that the Territory has the highest rates of alcohol consumption within the country with 9% of people aged over 14 drinking alcohol on a daily basis compared with a national average of 6.5%.<sup>127</sup> The Territory also exceeds the national rates of risky drinking behaviour with 39.7% of drinkers consuming more than four drinks on a single occasion at least monthly compared with 26.4% nationally.<sup>128</sup>
- 3.23 The Committee heard on numerous occasions that while 'ice' is an emerging problem in certain areas of the Northern Territory, the harm caused by alcohol misuse is significantly greater. As St John Ambulance advised the Committee, for the period 1 January 2015 to 18 June 2015, paramedics attended to 230 patients

<sup>125</sup> NT DoH, Submission No. 5, 2015, p. 5.

<sup>126</sup> NT DoH, Submission No. 5, 2015, p. 5.

<sup>127</sup> AIHW, *NDSHS 2013, Supplementary table 7.4.*

<sup>128</sup> AIHW, *NDSHS 2013, Supplementary table 7.8.*

that had a toxidrome consistent with methamphetamine use and 6,682 patients affected by alcohol.<sup>129</sup>

- 3.24 For example, as Ms Morton, Executive Director of the Northern Territory Council of Social Services (NTCOSS) pointed out:

Alcohol is still the number one issue in the Northern Territory and we cannot afford to let resources be taken away from the alcohol area to deal with the ice or methamphetamine issue. We feel very passionate and strong about that. ... Some of the members we have talked to recently have emphasised the fact that those presenting at their service who have a methamphetamine problem also have an alcohol issue and that is still the number one issue and the methamphetamine issue has come secondary to that. So we cannot let our focus be taken away from alcohol; we still have an awful lot more to do in that area.<sup>130</sup>

- 3.25 Mr Goldflam, Barrister and Solicitor with Northern Territory Legal Aid Commission (NTLAC), further noted that:

Although we are alarmed and concerned by the recent very significant upswing in the incidence of ice use by our clients and family members of our clients, we are keenly aware that we must not take our eye off the bigger ball, which is alcohol. Alcohol is still by far the most serious drug problem in the criminal justice system, the family law system and the child protection law system in the Northern Territory. We must not allow ourselves to be distracted from that, and it would be a terrible mistake in our submission to lose sight of the central importance of dealing with alcohol-related harm because that is by far the biggest problem.<sup>131</sup>

- 3.26 Ms Collins, Chief Executive Officer of the Aboriginal Peak Organisation NT, expressed similar views:

In noting what we believe is an increase in ice use in the communities across the Northern Territory, we acknowledge that alcohol still remains the primary health concern for our people and urge that any government's response to ice and other drugs should not detract from the importance of responding in a proportionate evidence based and therapeutic manner to alcohol misuse.<sup>132</sup>

Mr Bishop, Program Manager at Venndale Rehabilitation Centre, also concurred with these opinions, stating "we cannot take our foot off the pedal with alcohol and cannabis, but we need to knock this on the head now before it gets out of hand."<sup>133</sup>

- 3.27 The 2013 NDSHS estimates that 19% of people in the Northern Territory and 12% of the national population over 14 years of age have used some form of illicit drug, excluding the misuse of pharmaceuticals, in the last 12 months. These rates increase to 22% in the Territory and 15% nationally when misuse of pharmaceuticals is included in the estimates.<sup>134</sup> The most commonly used illicit drug used in the Northern Territory is cannabis. The 2013 NDSHS estimates Territory usage rates in the previous 12 months at 17.1% compared with 10.2% nationally.

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<sup>129</sup> St John Ambulance, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 1.

<sup>130</sup> Northern Territory Council of Social Services (NTCOSS), Committee Transcript, 7 September 2015, p. 2.

<sup>131</sup> Northern Territory Legal Aid Commission (NTLAC), Committee Transcript, 19 June 2015, p. 3.

<sup>132</sup> Aboriginal Peak Organisation NT and Danila Dilba, Committee Transcript, 19 June 2015, p. 3.

<sup>133</sup> Venndale Rehabilitation Centre, Committee Transcript, 14 July 2015, p. 6.

<sup>134</sup> AIHW, *NDSHS 2013, Supplementary table 7.12*.

The second most common illicit drug used is ecstasy, with estimates of 3.7% and 2.5% respectively.<sup>135</sup>

### **Patterns and Profiles of Drug Use**

3.28 The Committee heard that methamphetamine, including 'ice', is taken by a broad cross-section of the community and is not limited by age, socio-economic or employment status, geographical location, level of education or ethnic background. In the Northern Territory, 'ice' is used across a number of employment sectors including education, legal and medical professions, construction, mining and fly-in fly-out workers, and trades people.<sup>136</sup> 'Ice' use spans across all age ranges and the Committee has heard anecdotal reports of children as young as nine using 'ice' in particular regions.<sup>137</sup>

3.29 Research and available data indicates that the prevalence of meth/amphetamine and 'ice' use is, however, higher among certain groups within society. According to the 2013 NDSHS, the following groups have a higher likelihood of using meth/amphetamine:

- 2.7% of males have used meth/amphetamine compared to 1.5% of females;<sup>138</sup>
- Meth/amphetamine is most commonly used amongst people aged 20-29 (5.7%) and 30-39 (3.1%);<sup>139</sup>
- Unemployed people are 2.4 times more likely to use meth/amphetamine than those in employment;<sup>140</sup>
- Indigenous people are 1.6 times more likely to use meth/amphetamine than the general population;<sup>141</sup>
- 4.4% of people living in remote and very remote areas have used meth/amphetamine compared with 2.1% of those living in major cities;<sup>142</sup>
- 2.2% of people from the lowest socio-economic status report using meth/amphetamine compared with 1.8% of people from the highest socio-economic status;<sup>143</sup> and
- Homosexual and bisexual people are 4.5 times more likely to use meth/amphetamine than heterosexual people.<sup>144</sup>

3.30 In contrast to the national data, Mr Franck, Chief Executive Officer of Banyan House, noted that, "we have seen in our data that there is a definite shift in demographics such as age of people seeking help. The shift is towards younger

<sup>135</sup> AIHW, *NDSHS 2013, Supplementary table 7.12.*

<sup>136</sup> Banyan House, Submission No. 18, 2015, p. 7, Ms Coalter, Committee Transcript, 7 September 2015, p. 3.

<sup>137</sup> Northern Territory Council of Social Services (NTCOSS), Submission No. 13, 2015, p. 7.

<sup>138</sup> AIHW, *NDSHS 2013, Supplementary table 5.18.*

<sup>139</sup> AIHW, *NDSHS 2013, Supplementary table 5.18.*

<sup>140</sup> AIHW, *NDSHS 2013*, p. 84.

<sup>141</sup> AIHW, *NDSHS 2013*, p. 95.

<sup>142</sup> AIHW, *NDSHS 2013*, p. 89.

<sup>143</sup> AIHW, *NDSHS 2013*, p. 90.

<sup>144</sup> AIHW, *NDSHS 2013*, p. 95.

females. In the past we probably would have had 90% males with 10% females. At this point of time we are about 60% to 40%.”<sup>145</sup> While there has been an increase in the overall number of people in the Northern Territory seeking treatment for their meth/amphetamine use, the proportion of people in each age group seeking treatment has remained consistent between 2011-12 and 2013-14:

- 8% aged 10-19 years old;
- 40% aged 20-29 years old;
- 34% aged 30-39 years old; and
- 14% aged 40-49 years old.<sup>146</sup>

3.31 Approximately one quarter of people seeking treatment in the Northern Territory for meth/amphetamine as their principal drug of concern identify as Indigenous in comparison with the national average of around 10%.<sup>147</sup> However, the Committee notes that the higher rates in the Northern Territory may be reflective of the higher proportion of Indigenous people within the Northern Territory demographic.

3.32 There are a number of different methods of categorising methamphetamine users, primarily based on the circumstances in which they use the drug and frequency of use. Figure 12 below shows the type and patterns of methamphetamine use outlined in the *Clinical Treatment Guidelines for Alcohol and Drug Clinicians*.

3.33 Another categorisation method emerged from research commissioned by the Commonwealth Department of Health and Aging into patterns of methamphetamine use. This study identified three specific groups of methamphetamine users: social users, functional users, and dependent users.<sup>148</sup> Social users are “primarily motivated by the drug’s ability to reduce inhibitions”.<sup>149</sup> The feelings of enhanced confidence, energy, stamina and desire to converse with others are motivations to use methamphetamine at social events such as parties, clubs and gatherings. The majority of social users place boundaries around their illicit drug use and do not use methamphetamine outside of a social situation, as they associate this with dependent levels of use.<sup>150</sup>

3.34 Functional users are motivated by the enabling effects of methamphetamine, such as increased confidence, energy, stamina and motivation to undertake a particular task, often related to the users’ employment. There is a justification to using methamphetamine as a ‘means to an end’ and these users perceive that their usage is assisting to achieve a goal, which increases their reluctance to see themselves as illicit drug users. Functional users aiming to increase their work performance may come from a wide range of professions including construction,

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<sup>145</sup> Banyan House, Committee Transcript, 19 June 2015, p. 6.

<sup>146</sup> AIHW, *Supplementary data provided to the Committee*, p. 5.

<sup>147</sup> AIHW, *Supplementary data provided to the Committee*, p. 7.

<sup>148</sup> Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia – Exploratory research*, Canberra, Australian Government, 2008, pp. 8-10.

<sup>149</sup> Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia*, p. 38.

<sup>150</sup> Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia*, pp. 38-39.

transport, hospitality, trades people, management, finance, health and sex workers.<sup>151</sup>

**Figure 12: Types and patterns of methamphetamine use<sup>152</sup>**

<p><b>Experimental use</b></p> <p>Experimental methamphetamine use generally occurs in late adolescence/early adulthood and is typically short lived. Experimental use is motivated by curiosity to experience new feelings/moods or as a result of influence from peers.</p> <p><b>Recreational use</b></p> <p>Recreational methamphetamine use usually occurs in a social setting. The amount and duration of use may vary depending on the occasion. Recreational use is perceived as enjoyable with few negative consequences or effects on social functioning. Methamphetamine is frequently used on a recreational basis, where users limit their use to the weekend or special occasions.</p> <p><b>Circumstantial use</b></p> <p>Circumstantial methamphetamine use occurs when specific tasks have to be performed, which may require special degrees of alertness or endurance. Examples of this include long distance driving or shift work. Circumstantial methamphetamine use may also serve a specific function, such as suppressing appetite and promoting weight loss.</p> <p><b>Intermittent or binge use</b></p> <p>Intermittent or 'binge' use, occurs when methamphetamines are used intensively for a long period of time, anywhere from two to ten days, with significant breaks in between these intense periods of use.</p> <p><b>Regular use</b></p> <p>Regular use is characterised by frequent, habitual use and is often accompanied by a physical and/or psychological dependence syndrome. For regular users, methamphetamine plays a significant role in their day-to-day life and may impair or impact on health, psychological or occupational functioning.</p> <p>Approximately 3% of methamphetamine users will use on a regular basis. This is often in the context of polydrug use, where methamphetamines may be used in combination with other drugs such as alcohol, cannabis or other psychostimulant drugs including ecstasy.</p> <p><b>Polydrug use</b></p> <p>Polydrug use is very common amongst methamphetamine users, with alcohol, cannabis and other psychostimulant drugs (such as ecstasy) being the most frequently used drugs in combination with methamphetamine. Users may do this to enhance or prolong the effects of methamphetamine, or to alleviate unpleasant side effects.</p>
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<sup>151</sup> Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia*, p. 45.

<sup>152</sup> Lee et al., *Methamphetamine dependence and treatment*, p. 4.

- 3.35 Dependent use is defined as “uncontrollable, compulsive drug seeking and use, even in the face of negative health and social consequences”.<sup>153</sup> Motivations for this group of users include feeling ‘normal’ and the ability to get through the day; an escape from mental and lifestyle problems; and the sense of fulfilment experienced when administering the drug. Dependent users are those that use at least weekly and in some instances daily. Methamphetamine users may become dependent as a result of a specific event or trauma in their life which has led them to heavy drug use or, alternatively, a gradual or fast slide from social or functional use into dependent usage.<sup>154</sup> Figure 13 below outlines the sub-groups within these three categorisations of ‘ice’ users based on their attitudes and behaviour towards ‘ice’.
- 3.36 The Committee has reviewed national data on patterns of methamphetamine use to gain an insight into the extent and frequency of use in Australia. Of the people that had used any form of meth/amphetamine in the past 12 months, 15.5% had used at least once per week and 32.1% used at least once per month.<sup>155</sup> Daily/weekly users of meth/amphetamine are generally considered to have developed a drug dependency. The 15.5% of meth/amphetamine users that would be classified as dependent equates to around 62,000 or 0.33% of the population, while those using on at least a monthly basis is around 128,000 or 0.67%.<sup>156</sup> In the three years from 2010 to 2013, the percentage of people using ‘ice’ daily or at least weekly has doubled, from 12.4% to 25.3%, while those using ‘ice’ about once a month rose slightly from 17.5% to 20.2%.<sup>157</sup>
- 3.37 The 'key experts' interviewed as part of the 2014 IDRS noted a number of changes in the methamphetamine market in Darwin from 2013 to 2014:
- more people are now injecting crystal methamphetamine rather than smoking;
  - there has been an increase in the number of younger people, PWID aged under 19 years, using crystal methamphetamine;
  - there are more PWID for whom crystal methamphetamine is the first form of methamphetamine they have used, ie they have not transitioned from speed powder;
  - there appears to be more crystal use amongst regular morphine injectors;
  - there may be two principal patterns of use of crystal methamphetamine:
    - occasional, or "recreational", use among young people who maintain employment, often in a trade and/or the mining industry, and where smoking is more common, and
    - more regular use via injection, where the person is older and unemployed;
  - a number of KE reported that they were aware of an emerging "cohort" of young, often Indigenous, injectors in Palmerston and outer Darwin who were not accessing services and whom services found difficult to access.<sup>158</sup>

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<sup>153</sup> Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia*, p. 50.

<sup>154</sup> Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia*, pp. 50-52.

<sup>155</sup> AIHW, *NDSHS 2013, Supplementary table S7.20*.

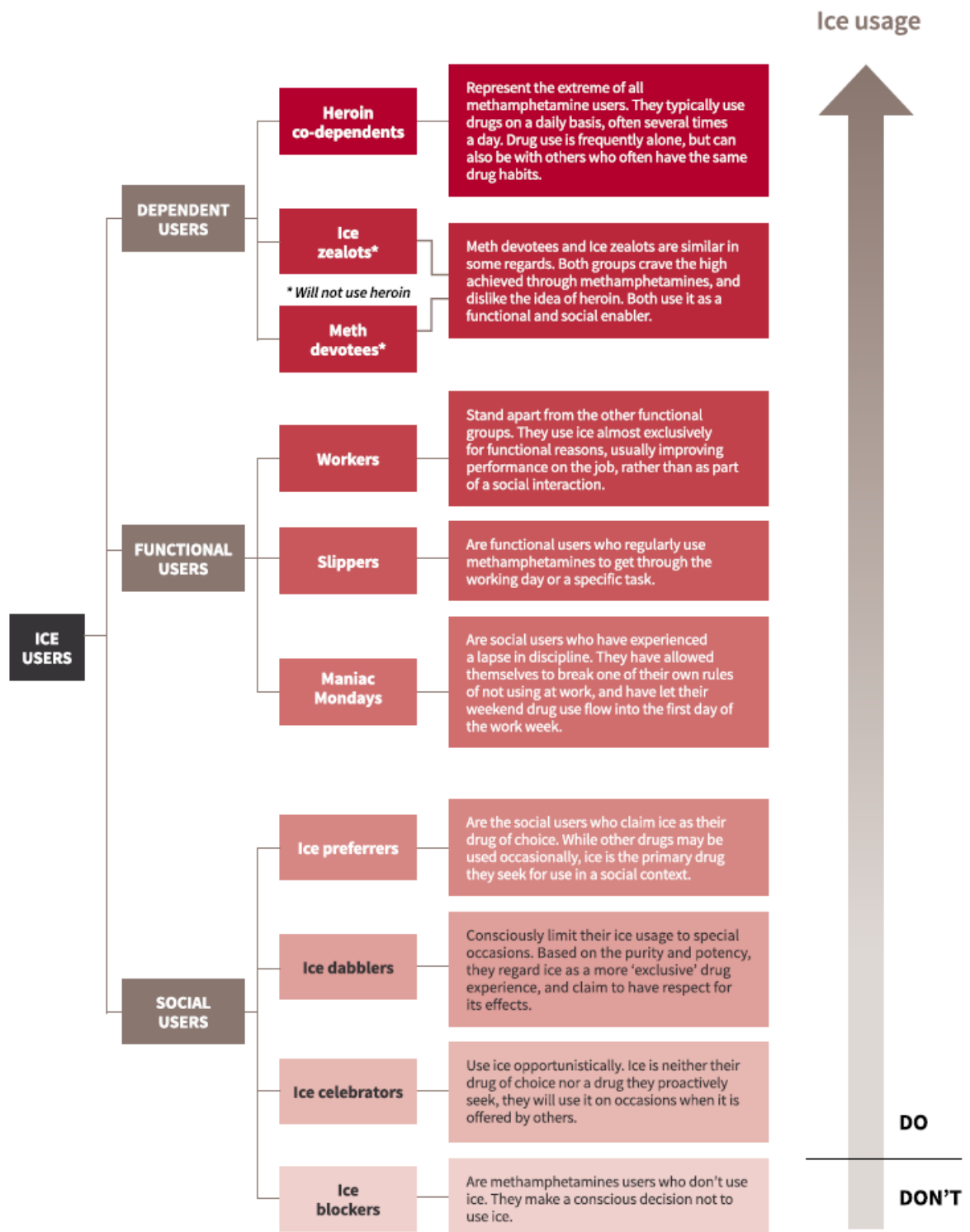
<sup>156</sup> Note: calculation has been based on 2.1% of the population over 14 years of age that have used meth/amphetamine in the past 12 months equating to 400,000 people as stated on page 60 of the *NDSHS 2013 report*.

<sup>157</sup> AIHW, *NDSHS 2013, Supplementary table S7.20*.

<sup>158</sup> C Moon, *Northern Territory Drug Trends 2014*, p. 16.



Figure 13: Specific types of 'ice' users<sup>159</sup>

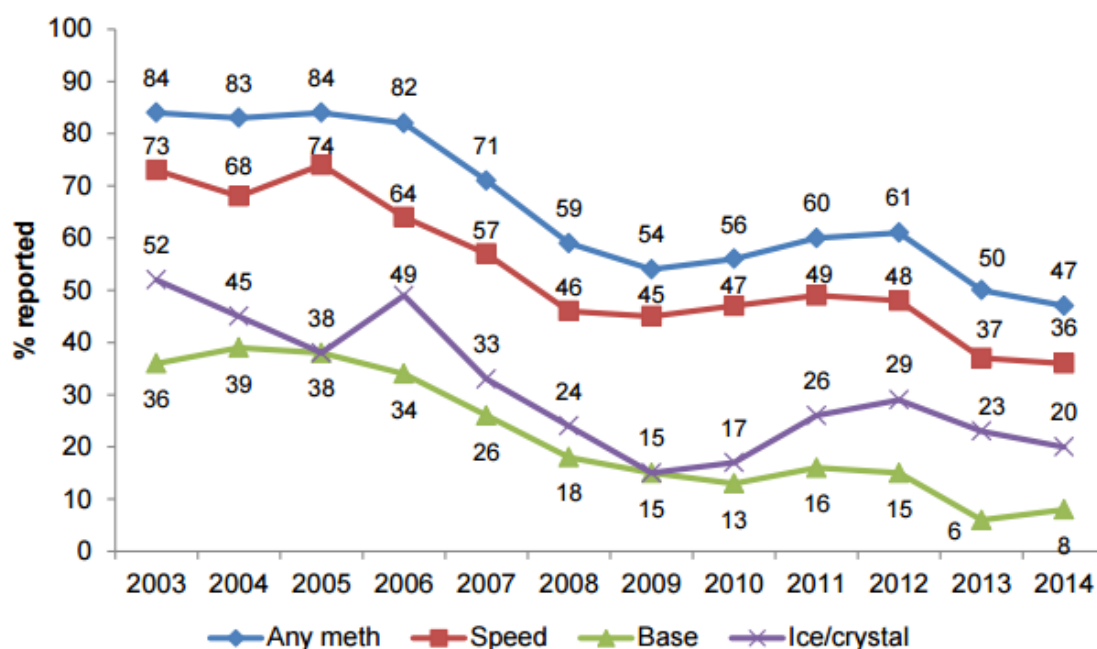


<sup>159</sup> J Coyne et.al., *Special Report Methamphetamine Focusing Australia's National Ice Strategy on the problem, not the symptoms*, Australian Strategic Policy Institute, Barton ACT, October 2015, p. 9.

3.38 The Committee noted that the patterns of 'ice' use among regular ecstasy users in the Northern Territory were similar to those seen nationally:

- Nationally 32% had used 'ice' within their lifetime and 20% within the past six months<sup>160</sup> compared to 39% and 27% respectively in the Northern Territory.<sup>161</sup>
- Methods of administration among this group nationally are smoking 86%, oral ingestion 20%, intranasal 19% and injecting 17%.<sup>162</sup> In the Northern Territory, it is smoking 89%, oral ingestion 15%, intranasal 11% and injecting 4%.<sup>163</sup>
- Nationally, 62% had used powdered speed in their lifetime and 36% had used it within the past six months. Data for the Northern Territory indicates 58% had used powdered speed in their lifetime and 39% within the past six months.<sup>164</sup>

**Figure 14: Methamphetamine use by ecstasy users overall and by type in previous six months, 2003-2014<sup>165</sup>**



3.39 There are a diverse range of opinions about the addictiveness of methamphetamine, and in particular 'ice', which have come to light through a review of academic literature, media reports and views expressed to the Committee through submissions and by witnesses at public hearings. There is a popular perception that trying 'ice' once will result in addiction. However, expert academic opinion and the available data on 'ice' use dispel this view, as the overwhelming majority of people that use 'ice' are infrequent users and not classed as dependent

<sup>160</sup> N Sindicich & L Burns, *Australian Trends in Ecstasy and Related Drug Markets 2014. Findings from the Ecstasy and Related Drugs Reporting System*, Australian Drug Trends Series No. 136, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015, p. 28.

<sup>161</sup> E Whittaker & L Burns, *Northern Territory Trends in Ecstasy and Related Drug Markets 2014*, p. 24.

<sup>162</sup> N Sindicich & L Burns, *Australian Trends in Ecstasy and Related Drug Markets 2014*, p. 29.

<sup>163</sup> E Whittaker & L Burns, *Northern Territory Trends in Ecstasy and Related Drug Markets 2014*, p. 24.

<sup>164</sup> N Sindicich & L Burns, *Australian Trends in Ecstasy and Related Drug Markets 2014*, p. 28.

<sup>165</sup> N Sindicich & L Burns, *Australian Trends in Ecstasy and Related Drug Markets 2014*, p. 26.

users.<sup>166</sup> As the Committee heard from Ms Coalter, Deputy Executive Officer of Amity Counselling Service:

We know that most people most of the time - and the evidence backs up this statement - about 80% of people, manage their drug use and their change process by themselves. Most people take their own hand out of the fire.<sup>167</sup>

3.40 According to research, there are a number of factors that are likely to contribute to whether a person becomes dependent on or addicted to a drug:

Dependence on drugs is influenced by a range of individual, environmental and societal factors, but is also strongly related to patterns of drug use. Drug use patterns that vary with dependence include route of administration, dose, age of initiation into drug use, frequency of drug use, and duration of drug use. Evidence suggests that although some of these use patterns are strongly reinforcing, and can therefore instigate dependence, their occurrence also reflects the natural progression of a drug using career.<sup>168</sup>

3.41 Research suggests that 'ice' is more addictive than other forms of methamphetamine due to its higher purity and therefore potency. A study of methamphetamine users in Sydney undertaken by McKetin et al. found that:

Methamphetamine users who had taken the crystalline form of the drug in the past year were more likely to be dependent on methamphetamine than peers who had not taken the crystalline form of the drug during this time. Current crystalline methamphetamine users were also more likely to smoke or inject the drug, use frequently, and to be longer-term users of the drug...Dependence on crystalline methamphetamine is also likely to be strongly related to the reinforcing effect of the drug. Indeed, crystalline methamphetamine users state that one of the reasons they prefer taking crystalline methamphetamine is because it provides a stronger 'high' than other forms of methamphetamine.<sup>169</sup>

3.42 Mr Bishop, Program Manager at Venndale Rehabilitation Centre, advised the Committee that 'ice' users at the centre have told him that:

'We used speed or ecstasy every weekend or every second weekend. When we were just using speed and ecstasy we were right, we did not need it during the week.' They started doing it with ice to get the bigger high and they have all said, 'But eventually we had to take it every day just to feel normal.'<sup>170</sup>

3.43 In addition to the form of methamphetamine used, the method of administration, in particular injecting and smoking, is also thought to contribute to dependency:

Most problematic use of methamphetamine in Australia involves injection of the drug, but smoking crystalline methamphetamine is a recent trend and has increased markedly since the mid-1990s. Injecting and smoking methamphetamine are both associated with more frequent use patterns, treatment demand, higher levels of risky behaviour and other health and psychiatric consequences.<sup>171</sup>

<sup>166</sup> AIHW, *NDSHS 2013, Supplementary table S7.20* & N Lee, *Ice age: who has used crystal meth and why*, 11 March 2014, viewed on 13 October 2015, <https://theconversation.com/ice-age-who-has-used-crystal-meth-and-why-23031>.

<sup>167</sup> Amity Counselling Services (Amity), Committee Transcript, 7 September 2015, p. 3.

<sup>168</sup> R McKetin, E Kelly & J McLaren, 'The relationship between crystalline methamphetamine use and methamphetamine dependence', *Drug and Alcohol Dependence*, vol. 85, no. 3, 2006, p. 198.

<sup>169</sup> R McKetin, E Kelly & J McLaren, 'The relationship between crystalline methamphetamine use and methamphetamine dependence', pp. 201-202.

<sup>170</sup> Mr Bishop, Katherine Public Forum Transcript, 14 July 2015, p. 12.

<sup>171</sup> A Pennay & N Lee, 'Prevention and early intervention of methamphetamine-related harm', *Prevention Research Quarterly*, No. 6, Australian Drug Foundation, September 2008, p. 4.

- 3.44 The link between the method of administration and dependence has been further explored by Lee et al. who note:

Dependence on methamphetamine is far more common among people who inject the drug, or who smoke crystalline methamphetamine, than among those who prefer oral or intranasal routes of administration. The latter tend to use the drug infrequently, and although dependence can develop with oral or intranasal use, most illicit users progress to more efficient routes of smoking or injecting as their tolerance increases. People who are dependent on these drugs tend to use more than weekly with symptoms of dependence emerging among injecting drug users (IDUs) when they use the drug as little as two to three times a week. Use patterns can escalate to injecting or smoking high doses of the drug several times a day.<sup>172</sup>

- 3.45 The Committee is particularly concerned about the rapid transition from ingestion and intranasal methods of administration to injecting amongst some users. As highlighted in the literature:

A significant proportion of methamphetamine users move relatively quickly from regular use by snorting or swallowing to injecting. Once the transition to injecting has been made, users rarely return to other routes of administration. Advice about the risks of injecting (without over-emphasising the risks of low-dose oral use) may help to reduce the transition to injecting. An early study found that methamphetamine users believed that injecting was more economical and healthier method of use, and more recent anecdotal experience suggests that these misconceptions are still common among this group.<sup>173</sup>

- 3.46 Developing a tolerance to drugs is one of the reasons that users transition from intranasal or ingesting 'ice' to smoking or injecting. However, research suggests there are:

A range of other reasons, besides tolerance, why people progress to using more efficient routes of administration, and related heavy patterns of drug use. The reasons are grounded in the user's perception about the efficacy and social acceptance of particular drug use patterns, the user's own perception of risk, their personal risk factors for becoming dependent on drugs (e.g., psychopathology or a history of trauma) and their social networks.<sup>174</sup>

- 3.47 There is limited data on the preferred method of administration of 'ice' users in the Northern Territory. However, the Committee heard that approximately 40% of injectors that attend needle and syringe exchange locations report methamphetamine as their last drug injected.<sup>175</sup> While there have been anecdotal reports of an increase in 'ice' injectors, there is no hard data to support this. As Table 9 indicates, there has been an increase in the number of people seeking treatment for amphetamine use where smoking is the preferred method of administration and a decrease in the number of injectors seeking treatment. It is not clear whether this reflects a change in the preferred method of administration or simply an increase in the number of 'ice' smokers seeking treatment.

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<sup>172</sup> N Lee et al., 'Everything old is new again: the application of drug treatment to the emerging challenge of methamphetamine use and dependence' in Moore, D & Dietze, P (eds), *Drugs and Public Health: Australian Perspectives on Policy and Practice*, Oxford University Press, Melbourne, 2008, p. 74.

<sup>173</sup> N Lee et al., 'Everything old is new again', p. 77.

<sup>174</sup> R McKetin, E Kelly & J McLaren, 'The relationship between crystalline methamphetamine use and methamphetamine dependence', p. 199.

<sup>175</sup> NTAHC, Committee Transcript, 19 June 2015, p. 4.

**Table 9: Method of administration for clients receiving treatment for their own drug use with amphetamine as the principal drug of concern (percent)**<sup>176</sup>

Method of administration	Northern Territory			National		
	2011-12	2012-13	2013-14	2011-12	2012-13	2013-14
Smokes + inhales	19.3	25.3	41.2	31.3	37.7	41.4
Injects	63.3	63.3	50.9	51.2	45	43.6
Other	14.7	7.6	6.8	13.7	12.2	7.5
Not stated	2.7	3.8	1.1	3.8	5.1	7.6

3.48 Commander Porter of the NTPS noted that in the Katherine region and surrounding communities, the majority of 'ice' users that have come to their attention are not injectors.<sup>177</sup> Commander Porter also commented that there have been a small number of anecdotal reports of 'ice' being used in remote communities in the Top End and in these cases it has been "sprinkled on a cigarette or a joint".<sup>178</sup>

3.49 As highlighted in Table 10 below, polydrug use of both licit and illicit substances is common among methamphetamine users, in particular frequent or dependent users, with alcohol and cannabis most frequently used substances in conjunction with methamphetamine.

**Table 10: Polydrug use among recent drug users aged 14 years or older, Australia, 2013 (percent)**<sup>179</sup>

Recent users of									
Other drugs recently used	Cannabis	Ecstasy	Meth/Amphet Amines	Cocaine	Hallucinogens	Inhalants	Synthetic Cannabinoids	New & emerging psycho-active substances	Pharmaceuticals
Cannabis	n.a.	76.8	72.7	69.7	87.1	58.4	91.4	87.2	29.5
Ecstasy <sup>(b)</sup>	20.0	n.a.	53.0	55.8	63.7	46.8	33.8	72.9	13.7
Meth/amphetamines <sup>(c)</sup>	15.4	42.0	n.a.	38.6	43.2	36.6	37.3	60.4	15.6
Cocaine	15.1	44.9	39.5	n.a.	37.8	30.9	19.3	46.8	12.3
Hallucinogens	11.1	31.5	26.4	21.4	n.a.	32.5	25.5	49.4	9.2
Inhalants	4.6	14.6	13.9	11.3	20.0	n.a.	*10.0	38.2	5.7
Synthetic Cannabinoids	11.1	16.1	22.2	10.9	24.5	*15.6	n.a.	40.7	7.5
New and emerging psychoactive substances	3.5	11.3	11.8	8.5	15.6	*19.6	13.5	n.a.	4.0
Pharmaceuticals <sup>(c)</sup>	13.4	24.9	34.7	25.8	33.5	33.7	27.9	44.2	n.a.
Did not use any other illicit	54.7	8.3	8.2	13.1	*2.2	27.5	*4.5	—	62.1

Notes: a) Used at least once in the previous 12 months b) Included 'designer drugs' before 2004 c) For non-medical purposes

<sup>176</sup> AIHW, *Supplementary data provided to the Committee*, p. 13.

<sup>177</sup> Commander Porter, Katherine Public Forum Transcript, 14 July 2015, p. 3.

<sup>178</sup> Commander Porter, Katherine Public Forum Transcript, 14 July 2015, p. 4.

<sup>179</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, Victoria, 2014, p. 215.

3.50 According to the 2013 NDSHS, 66.5% of meth/amphetamine users consume alcohol while they are using the drug and 51% smoke tobacco on a daily basis.<sup>180</sup> There are a number of reasons for polydrug use among illicit drug users, however a common reason among methamphetamine users is to:

alleviate withdrawal not only by continued use of stimulant drugs, but also by smoking cannabis or taking sedatives, because these drugs help them to sleep and relieve psychological distress.<sup>181</sup>

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<sup>180</sup> AIHW, *NDSHS 2013*, pp. 9-15.

<sup>181</sup> N Lee et al., 'Everything old is new again', p. 75.

## 4 Effects of 'Ice' and Treatment Options

### Physical and Psychological Harms

- 4.1 There are a broad range of physical and psychological effects that are associated with taking methamphetamine and more specifically 'ice'. The effects and harms of 'ice' vary among users and are dependent on a number of factors including the dose level, which is influenced by the purity of the drug; the frequency of use; the person's weight; tolerance to the drug; general physical health; general mental health and any pre-existing mental illness; method of administration; and polydrug use.<sup>182</sup> Some effects are primarily experienced while the 'ice' remains within a person's body and will disappear once the drug has been metabolised. However, other effects, generally psychological, can remain for an indeterminate period of time even after the drug has been metabolised.<sup>183</sup>
- 4.2 Consuming methamphetamine causes changes to neurotransmitters, which are the brain's chemical messengers. The three main neurotransmitters affected by 'ice' are dopamine, noradrenaline (also called norepinephrine) and serotonin.
- *Dopamine* controls movement, attention and memory, and purposeful behaviour. It is the main neurotransmitter involved in feelings of pleasure and euphoria when a person engages in activities that are essential for human survival, such as eating, drinking, and sexual activity. Dopamine encourages these behaviours by making people feel good so they are motivated to repeat them. This system is referred to as the 'reward pathway' and, because dopamine is also linked to cravings to use all drugs, it is thought to be involved in the development and maintenance of drug dependence in general.
  - *Noradrenaline* is involved primarily in preparing individuals to either run away from, or stand and fight against, perceived threats ('fight or flight' response): it stimulates the central nervous system, and is involved in heart function and blood circulation, concentration, attention, learning and memory.
  - *Serotonin* is involved in a variety of important activities including control of mood; appetite; sleep; thinking and perception; physical movement; regulation of temperature, blood pressure and pain; and sexual behaviour.<sup>184</sup>
- 4.3 Methamphetamine primarily affects the dopamine neurotransmitters by flooding the brain's chemical pathways with dopamine. The amount of dopamine released by the brain after administering 'ice' is up to a 1,000 times higher than normal levels.<sup>185</sup> Along with the euphoric feeling, 'ice' users will usually experience increased confidence, excitement, alertness and energy. These effects are one of the primary

<sup>182</sup> New South Wales Ministry of Health, *Methamphetamine: Speed and Ice: The Facts*, p. 1.

<sup>183</sup> Australian Government Department of Health, *Methamphetamine: What you need to know about speed, ice, crystal, base and meth*, p. 3.

<sup>184</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine: A Practical Guide for Frontline Workers*, Canberra, Australian Government Department of Health and Aging, 2008, p. 15.

<sup>185</sup> N Lee, *Ice age: who has used crystal meth and why*.

reasons that people find 'ice' so attractive.<sup>186</sup> The increased amount of noradrenaline released by the brain triggers the 'fight or flight' response and can make people anxious, suspicious, paranoid and jumpy, as well as increasing the risk of aggressive and violent behaviour.<sup>187</sup>

4.4 As the effects of the 'ice' wear off, the brain is depleted of dopamine and serotonin. The euphoric feeling dissipates and may lead to cravings for more of the drug to stimulate the dopamine neurotransmitters and regain the euphoric feeling. As part of the 'comedown', users may feel depressed, lethargic, increased appetite, lack of motivation and fatigued. This 'comedown' period may last from a couple of days to a week.<sup>188</sup> As highlighted in Table 11 below, the short term effects of 'ice' are dependent, in part, on both the dose and method of administration. Injecting or smoking 'ice' results in almost instantaneous effects, while intranasal or ingestion methods will delay the onset and the intensity of the effects.

**Table 11: Short term dose related effects of methamphetamine<sup>189</sup>**

	Low dose	High dose
<b>Physical</b>	<ul style="list-style-type: none"> <li>• Increases in systolic and diastolic blood pressure</li> <li>• Sweating</li> <li>• Palpitations</li> <li>• Chest pain</li> <li>• Shortness of breath</li> <li>• Headache</li> <li>• Tremor</li> <li>• Hot and cold flushes</li> <li>• Increases in body temperature</li> <li>• Reduced appetite</li> </ul>	<ul style="list-style-type: none"> <li>• High blood pressure</li> <li>• Rapid or abnormal heart action</li> <li>• Seizures</li> <li>• Cerebral haemorrhage</li> <li>• Jaw clenching and teeth-grinding</li> <li>• Nausea, vomiting</li> </ul>
<b>Psychological</b>	<ul style="list-style-type: none"> <li>• Euphoria</li> <li>• Elevated mood</li> <li>• Sense of wellbeing</li> <li>• Increased alertness and concentration</li> <li>• Reduced fatigue</li> <li>• Increased talkativeness</li> <li>• Improved physical performance</li> </ul>	<ul style="list-style-type: none"> <li>• Confusion</li> <li>• Anxiety and agitation</li> <li>• Performance of repetitive motor activity</li> <li>• Impaired cognitive and motor performance</li> <li>• Aggressiveness, hostility and violent behaviour</li> <li>• Paranoia including paranoid hallucinations</li> <li>• Common delusions including being monitored with a hidden electrical device, and preoccupation with 'bugs' on the skin</li> </ul>

<sup>186</sup> Australian Government Department of Health, *Methamphetamine; What you need to know about speed, ice, crystal, base and meth*, p. 2.

<sup>187</sup> The Sydney Morning Herald, 'Ice: The drug that's hard on the head – and hard on families', *The Sydney Morning Herald*, 21 July 2014, viewed on 13 October 2015, <http://www.smh.com.au/lifestyle/diet-and-fitness/chew-on-this/ice-the-drug-thats-hard-on-the-head--and-hard-on-families-20140720-3c8ou.html>.

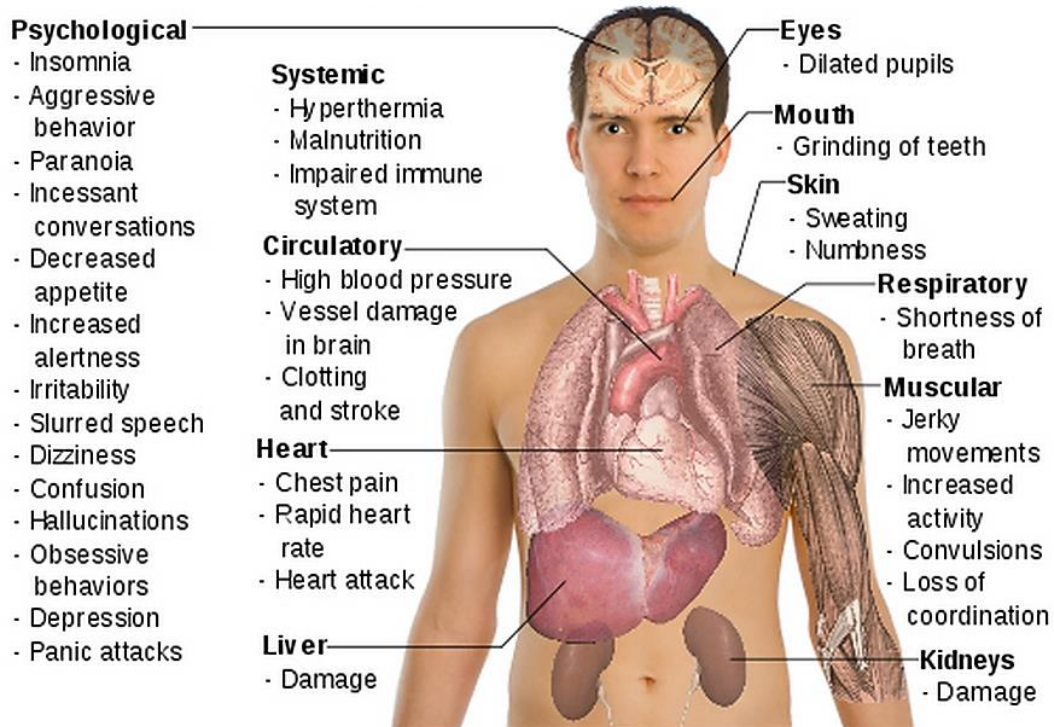
<sup>188</sup> Australian Government Department of Health, *Methamphetamine; What you need to know about speed, ice, crystal, base and meth*, p. 2.

<sup>189</sup> N Lee et al., *Methamphetamine dependence and treatment*, p. 2.



4.5 As highlighted in Figure 15, consumption of methamphetamine can affect the normal functioning of a number of organs within the body and may physically damage parts of the body.

**Figure 15: Effects of Methamphetamine<sup>190</sup>**



4.6 Physical effects and harms that can be caused by 'ice' use include:

- Cardiovascular problems such as irregular heartbeat; weakened heart muscle (cardiomyopathy); bacterial infections of the heart lining (endocarditis); and heart attack (myocardial infarction);
- Burst blood vessels in the brain (stroke, ruptured aneurysm and brain haemorrhage);
- Increased blood pressure;
- Oral hygiene disorders often referred to as 'meth mouth' including: gum inflammation (gingivitis); tooth decay and cavities resulting from methamphetamine induced dry mouth; teeth grinding, jaw clenching and general poor dental hygiene;
- Blood borne viruses (BBV) such as hepatitis B, hepatitis C and human immunodeficiency virus (HIV) contracted through the sharing of injecting equipment;
- Septicaemia, skin abscesses, infections and damage to veins through injecting practices;

<sup>190</sup> E Freye, *Pharmacology and Abuse of Cocaine, Amphetamines, Ecstasy and Related Designer Drugs*, Springer, Netherlands, 2010, p. 120.

- Sexually transmitted diseases such as HIV and syphilis due to risky sexual behaviour;
- Nosebleeds, sinus problems and damage to the inside of the nose through intranasal administration;
- Malnutrition and significant weight loss;
- Obsessive skin picking and scratching, often due to the feeling of bugs crawling under the skin, leading to possible infections; and
- Shortness of breath in 'ice' pipe smokers.<sup>191</sup>

4.7 While the increased risks of contracting BBV through sharing injecting equipment are widely acknowledged, the risks associated with the sharing of glass 'ice' pipes are less well known. The Northern Territory Centre for Disease Control advised the Committee that:

Sharing glass pipes and other non-sterile smoking equipment can facilitate blood borne virus and other communicable disease transmission, especially when burns, cuts, and other injuries on the lips, mouth, hands, or face are present.<sup>192</sup>

**Table 12: Major psychological harms associated with methamphetamine use<sup>193</sup>**

Variable	Comment
Psychosis	
General	Unlike opioids, methamphetamine can induce psychosis. Usually transient, with delusions and hallucinations
Comparisons	Psychostimulant users have higher levels of psychosis than users of opioids, benzodiazepines, barbiturates
Dependence	Most likely among chronic, dependent users. Longer periods of psychostimulant use, and heavier use, increase risk
Pre-existing pathology	High risk of psychotic symptoms if pre-existing schizophrenia, mania or other psychotic disorders
Route of administration	Injection associated with increased risk
Depression rates	
Suicide	Rates of major depression substantially higher than general population
Risk factors	Rates of attempted suicide substantially higher than general population Higher levels of depression and suicide associated with longer use careers, more frequent use, dependence and injecting
Anxiety rates	
Risk factors	Rates of anxiety disorders substantially higher than general population Anxiety disorders associated with longer use careers, more frequent use, dependence and injecting
Violent behaviours	
Rates	Violent behaviours appear common
Reasons	Experimental evidence that chronic use can increase aggressive behaviour. Acute intoxication may enhance or augment aggressive response when threatened or provoked Psychosis may be accompanied by violent behaviours
Neurotoxicity	
Animals	Neurotoxic effects in rodents, other mammalian non-primate species and non-human primates. Degeneration of dopamine and serotonin in frontostriatal region
Humans	Neurochemical abnormalities found in chronic methamphetamine users. Primarily involve monoamine function

<sup>191</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, p. 20; S Darke et al., 'Major physical and psychological harms of methamphetamine use' *Drug and Alcohol Review*, vol. 27, issue 3, May 2008, p. 254; New South Wales Ministry of Health, *Methamphetamine: Speed and Ice, The Facts*, p. 2.

<sup>192</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 6.

<sup>193</sup> S Darke et al., 'Major physical and psychological harms of methamphetamine use', p. 258.

4.8 In addition to the physical effects and harms that can occur from 'ice' use, there are a number of psychological effects associated with 'ice' use. Research indicates that long-term chronic methamphetamine use, particularly of high purity 'ice', leads to:

both short-term neurotransmitter depletion and changes in brain structure and function. To reduce overexposure to neurotransmitters, particularly dopamine, the body responds by reducing both the number of receptors (receivers) and transporters (carriers) of these neurotransmitters in certain parts of the brain. In addition, brain cells themselves can be killed (neurotoxicity) as they struggle to break down excess dopamine. The result is chronic dopamine *underactivity*, resulting in damage to memory, concentration, decision-making, impulse control, and emotional balance.

The recovery period after long-term use, during which complete avoidance of methamphetamine should be maintained, can take many months or even years. Some researchers believe that certain individuals, particularly long-term regular users who began using methamphetamine at an early age, may never recover completely.<sup>194</sup>

4.9 The Committee heard that 'ice' users can experience a number of mental health problems, which may occur in people with no prior history of mental illness. For people that may have an underlying mental health condition, 'ice' use may exacerbate psychotic symptoms. Research indicates psychotic symptoms that may be experienced as a result of 'ice' use include:

- Hallucinations – the person experiences sensations that have no basis in reality such as hearing 'voices' (auditory hallucinations), 'feeling' things on the skin or in the body (tactile hallucinations), or seeing things that others cannot (visual hallucinations). Other hallucinations involve taste (gustatory hallucinations) and smell (olfactory hallucinations);
- Delusions — the person holds fixed, false beliefs that do not shift even when faced with logical evidence to the contrary. For example, a person might believe that he or she is being spied upon by a secret agency, or that his or her thoughts are being controlled by external forces. Beliefs that are part of a person's religion or culture are not considered to be delusions unless those beliefs are not upheld by others in the person's same religious or cultural group;
- Thought disorder — a person's thinking becomes confused, concentration becomes difficult, thoughts may speed up or slow down, or the person will jump from one topic to another with no obvious logical connections; and
- Disorganised or bizarre behaviour — a person will respond to strange thoughts or unusual sensory experiences by changing their behaviour to adapt to their beliefs or perceptions. To others, their behaviour may seem disorganised or bizarre, but to the person they make sense. For example, those who fear surveillance might pull down blinds; speak in whispers; disconnect the phone; appear generally anxious, jumpy or afraid; and may even keep a weapon for protection.<sup>195</sup>

4.10 The link between methamphetamine use and psychosis is well established. A study of methamphetamine users conducted by Hall et al. in the mid 1990s found that around half of the participants reported experiencing hallucinations or persecutory ideation that began after they started to use methamphetamine. A more recent

<sup>194</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, p. 16.

<sup>195</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, pp. 29-30.

study conducted by McKetin et al. found that dependent methamphetamine users were three times more likely to experience psychotic symptoms than non-dependent users. Furthermore, the rate of psychosis among methamphetamine users was 11 times higher than among the general Australian population.<sup>196</sup>

- 4.11 For many people, psychotic symptoms will resolve themselves spontaneously when the effects of 'ice' wear off or when they cut down their level of use. However, for some people, methamphetamine psychosis may continue for days, weeks or months after 'ice' is last used. Research suggests that it is likely that this latter group of people "were already at risk for developing a psychotic disorder and the methamphetamine use triggered it".<sup>197</sup> Since methamphetamine psychosis may present with similar symptoms to schizophrenia, it is extremely difficult to distinguish between the two, and diagnosis must be made by a psychiatrist.<sup>198</sup>
- 4.12 The Committee notes that depression is particularly common among 'ice' users.<sup>199</sup> People may feel depressed in the hours or days that they experience the 'comedown'. While some people may use 'ice' to self-medicate existing depression, chronic 'ice' use can lead to longer term depression as a result of damage to the brain's neurotransmitters.<sup>200</sup>
- 4.13 Research also indicates that the risk of suicidal ideation is higher among 'ice' users. In a 2008 study undertaken by Torok et al., 33% of participants that had used methamphetamine at least weekly in the preceding 12 months had attempted suicide in their lifetime, while 9% had attempted suicide in the previous 12 months. Among those that had attempted suicide, a proportion had made multiple attempts throughout their lifetime. The study also found that 33% of the participants had a history of self-harm, with 12% self-harming in the previous 12 months.<sup>201</sup>
- 4.14 The Committee notes that there has been limited research undertaken into the effects of methamphetamine use during pregnancy. There are some difficulties in determining the underlying cause of issues affecting foetal development as pregnant methamphetamine users are often polydrug users; specifically using alcohol and tobacco. Nevertheless, the Northern Territory Legal Aid Commission noted that:

There is evidence that maternal drug use is associated with general psychosocial risk factors that may compromise child outcomes apart from substance dependence issues. Regardless of the form of drug use, this research shows a number of these factors may be more pronounced in drug using populations and include poverty, chaotic and dangerous lifestyles, symptoms of psychopathology, history of childhood sexual abuse, and involvement in difficult or abusive relationships ... These are all factors that we

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<sup>196</sup> R McKetin et al., 'The prevalence of psychotic symptoms among methamphetamine users', *Addiction*, vol. 101, issue 10, 2006, pp. 1474-1476.

<sup>197</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, p. 30.

<sup>198</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, p. 31.

<sup>199</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, p. 36.

<sup>200</sup> Australian Government Department of Health, *Methamphetamine: What you need to know about speed, ice, crystal, base and meth*, p. 3.

<sup>201</sup> M Torok et al., *Comparative rates of violent crime amongst methamphetamine and opioid users: Victimisation and offending*, Monograph Series No. 32, Hobart, National Drug Law Enforcement Research Fund, 2008, pp. 12-13.

see as common with our clients who have contact with the family law and child protection jurisdictions.<sup>202</sup>

- 4.15 With regards to the impact of maternal 'ice' use on the neonate, research indicates that:

The use of amphetamines during pregnancy is associated with low rates of prenatal care, low birth weight, increased frequency of hospitalization for pregnancy complications, perinatal mortality, preterm deliveries, maternal anaemia, premature membrane rupture, pre-eclampsia, meconium-stained amniotic fluid, post-partum haemorrhage, unplanned caesarean delivery, vacuum extraction with forceps, and neonatal infection. ... Cases of neonatal birth defects associated with prenatal methamphetamine exposure include atresia, hydrocephalus, cardiac defects, epidermolysis bullosa and Down's syndrome. However, congenital anomalies occur at low frequency (~2–4% of cases) and there are insufficient data to determine whether these defects occur at higher than normal rates.<sup>203</sup>

## Treatment of 'Ice' Use and Dependence

- 4.16 While dependence rates are relatively low among 'ice' users, the broad range of associated physical and mental health problems require treatment services to focus on more than just the treatment of drug dependence to fully meet the needs of clients. To provide effective treatment it is necessary for services to provide holistic treatment to clients or have well developed referral pathways to ensure that clients have access to services that will address the full facet of problems associated with methamphetamine use.<sup>204</sup>
- 4.17 There is a diverse range of treatment options and interventions available for 'ice' users that vary in the level of intensity depending on the needs of the user. 'Ice' users access treatment from a variety of sources including general practitioners (GP), specialist AOD providers, emergency departments, mental health workers, psychologists and addiction specialists.<sup>205</sup> For example, when an 'ice' user is in a crisis situation and experiencing psychotic symptoms or acute behavioural disturbances resulting from methamphetamine toxicity, they may present to an emergency department. On the other hand, 'ice' users seeking treatment to address their dependence are more inclined to seek assistance from their GP or an AOD service.<sup>206</sup>
- 4.18 The Committee heard evidence from a number of witnesses that once an 'ice' user has undergone detoxification, treatment options do not differ greatly to those used in other instances of drug addiction. Ms Taylor, Chief Executive Officer of the Drug and Alcohol Services Association (DASA) informed the Committee that:

after people are detoxed there is not a lot of difference. There has been a lot of talk about a difference and they are different when they are healing. We have not found that. We have found that once each group is detoxed they are much the same. They can mix with the others in a rehab environment quite

<sup>202</sup> Northern Territory Legal Aid Commission (NTLAC), Submission No. 26, 2015, p. 5.

<sup>203</sup> C Cruickshank & K Dyer, 'A review of the clinical pharmacology of methamphetamine', *Addiction*, vol. 104, no. 3, p. 1093.

<sup>204</sup> Lee et al., 'Everything old is new again', p. 75.

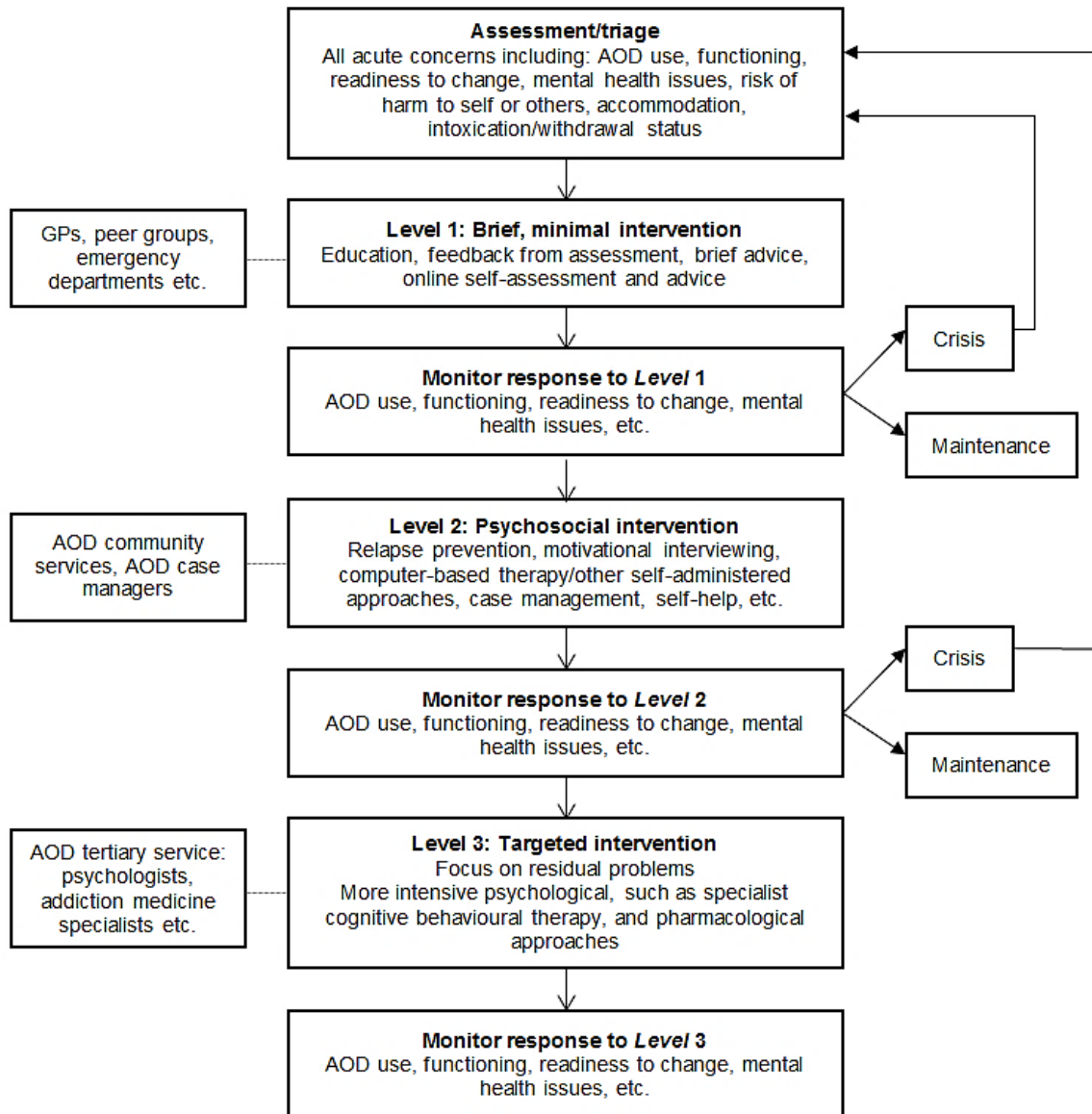
<sup>205</sup> NT DoH, Submission No. 5, 2015, p. 8.

<sup>206</sup> N Lee et al., 'Everything old is new again', p. 75.

comfortably, and we have not found people going berserk a long time afterwards.<sup>207</sup>

4.19 Research suggests that the stepped care treatment model, outlined in Figure 16, is a best practice framework based on starting with the lower intensity treatment options, monitoring the effectiveness of the intervention and then either 'stepping up' or 'stepping down' the intensity of the interventions according to the person's needs.<sup>208</sup>

**Figure 16: Stepped Care Treatment Model<sup>209</sup>**



4.20 Changes in the level of intervention can be achieved by:

- Altering the frequency of treatment sessions;
- Reintroducing strategies that were previously successful;

<sup>207</sup> Drug and Alcohol Services Association, (DASA), Committee Transcript, 7 September 2015, p. 3.

<sup>208</sup> Lee et al., 'Everything old is new again', p. 82.

<sup>209</sup> Lee et al., 'Everything old is new again', p. 82.

- Introducing new strategies, for example, motivational interviewing, contingency management, detoxification, medication and pharmacotherapy;
- Altering the way the intervention is delivered, for example, face-to-face sessions, computer-based programs, self-help material; and
- Modifying the intervention to focus on a single issue or an integrated approach that addresses multiple issues simultaneously, for example, focussing on just methamphetamine use or looking at drug use and mental health and the links between symptoms.<sup>210</sup>

4.21 The benefit of the stepped care treatment model is that it allows interventions to be specifically tailored to the needs of the individual client at the particular time they are seeking treatment. This targeted approach improves client engagement and retention, thereby increasing the likelihood that they will complete the course of treatment. As Ms Coalter, Deputy Executive Officer of Amity Counselling Service, explained to the Committee:

It is a continuum of care.... not all shoes fit all people. It depends on what I might need because of what is going on. For example, if I am a construction employee and can hold down a job but want to change, coming to somewhere like Amity might be really useful for me. However, if I do not have a job or a home I may choose residential rehab to support me through those processes.<sup>211</sup>

4.22 Mr Dwyer, Chief Executive Officer of Amity Counselling Services, further noted that:

there is a lot of information of the effectiveness of different services. If you are looking at effective and cheaper, quite often there is a group that will suit the counselling mode and then you have a group that will need residential rehabilitation and detox within that environment. It is not that all need to go to one, it depends on their circumstances ... We may all have experienced various things in our life and at different times are more vulnerable to drug use or a particular behaviour, but quite often if we are given the resources and support we make our own changes or make changes in the environment we are in. Not everybody needs to go to residential rehab.<sup>212</sup>

4.23 By starting with the least intensive intervention that is likely to meet the client's needs, service providers may be able to offer treatment to a larger number of people. In addition, a clear understanding of what is involved in 'stepping up' the treatment should assist service providers to refer clients to other services for more specialised and higher intensity interventions if required.<sup>213</sup>

4.24 As highlighted in the literature, it is critical that an assessment is undertaken when an 'ice' user first seeks treatment, regardless of the entry point into treatment. The assessment is designed to ascertain frequency and quantity of drug use; polydrug use; method of administration; dependency; impact of the drug use on health and wellbeing; existing mental health issues; previous AOD treatment; readiness to change; current status in terms of intoxication or withdrawal; and the goals of the

<sup>210</sup> Australian Drug Foundation, *The stepped care model: a useful intervention strategy for people who use methamphetamine*, Melbourne, Australian Drug Foundation, September 2008, p. 2.

<sup>211</sup> Amity, Committee Transcript, 7 September 2015, p. 6.

<sup>212</sup> Amity, Committee Transcript, 7 September 2015, pp. 5-6.

<sup>213</sup> Australian Drug Foundation, *The stepped care model: a useful intervention strategy for people who use methamphetamine*, p. 2.

client – are they seeking to cease using drugs completely or do they wish to reduce their drug use or harms associated.<sup>214</sup>

4.25 It is also important that the assessor gains an understanding of other personal and social factors that may be impacting on the client. For example, are they going through a family/relationship breakdown; facing criminal or civil court proceedings; experiencing severe financial stress; and unemployed or homeless. By understanding the context in which the client is seeking treatment, the assessor will be better able to develop a treatment plan that is most appropriate to the client's needs and this is likely to increase their engagement.<sup>215</sup>

4.26 Brief interventions are generally most suitable for people that use 'ice' intermittently, have not developed a drug dependency and have not yet come to the attention of the AOD sector. Brief interventions are, by their very name, short in duration and may be provided by a variety of primary health care workers such as GPs, emergency department staff, paramedics, mental health professionals, youth workers and needle exchange workers. These interventions can include harm reduction advice such as safe injecting practices; providing verbal or written education on the harms of 'ice' use; and referrals to counselling and AOD treatment providers.<sup>216</sup>

4.27 Counselling is the most extensively used treatment option within the AOD sector and may include motivational interviewing, cognitive behavioural therapy, relapse prevention, and acceptance and commitment therapy. These psychological interventions can be delivered face-to-face through residential rehabilitation or outpatient settings, over the telephone and online. The availability of internet-based counselling services may be a more attractive and less confronting entry point into seeking treatment for users that are reluctant to do so.<sup>217</sup> The broad range of delivery options alleviates a number of the barriers that 'ice' users face in seeking treatment such as opening hours of counselling services and location.<sup>218</sup>

4.28 In the case of dependent drug users, the Committee heard that they may need to undergo detoxification prior to participating in counselling. Detoxification is the process whereby a dependent drug user withdraws from the effects of the drug. While detoxification can be undertaken in a number of settings including hospitals, residential rehabilitation and at home, the Committee heard that unlike withdrawal from alcohol or other drugs such as heroin:

ice users need a low-stimuli environment to detox – no harsh lights, no loud music or voices. So straightaway accident and emergency is not suitable.<sup>219</sup>

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<sup>214</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, pp. 54-58.

<sup>215</sup> Lee et al., 'Everything old is new again', p. 82; L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, pp. 55-55; Australian Drug Foundation, *The stepped care model: a useful intervention strategy for people who use methamphetamine*, p. 1.

<sup>216</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, p. 54

<sup>217</sup> N Lee et al., 'Everything old is new again', p. 80.

<sup>218</sup> L Jenner & N Lee, *Treatment Approaches for Users of Methamphetamine*, pp. 58-60 & Lee et al., *Methamphetamine dependence and treatment*, pp. 11-12.

<sup>219</sup> Amity, Committee Transcript, 7 September 2015, p. 4.



- 4.29 The level of medical supervision and risk associated with detoxification also determines the most suitable venue for detoxification and is dependent on a number of factors. If the person has a concomitant significant medical or psychiatric illness, medically supervised detoxification in hospital or residential rehabilitation may be the most appropriate option to ensure that any complications associated with the detoxification can be managed.<sup>220</sup> Residential rehabilitation services that do not have onsite medical staff are only appropriate for mild to moderate risk detoxification.<sup>221</sup>
- 4.30 People that choose to undertake detoxification at home may do so with a family member or friend caring for them, while others may have access to a nurse or GP that will make daily home visits to monitor their condition. The descriptor for the Tobacco, Alcohol and Other Drugs Service (TADS) outpatient and withdrawal service on the Northern Territory Department of Health's website notes that "withdrawal may take place at the Royal Darwin Hospital (for high risk clients), in supported accommodation (e.g. Banyan House or the Salvation Army) or include home visits."<sup>222</sup>
- 4.31 The Committee notes that at-home detoxification under the supervision of a GP does not appear to be common practice in the Northern Territory. Associate Professor Parker, President of the Australian Medical Association NT, advised the Committee that detoxification:
- requires a certain level of expertise by the GP and also requires availability. Someone in detox requires a GP who is pretty available. They just cannot see someone in two weeks' time, they have to probably be monitoring people on pretty much a daily, two-day basis to check how they are travelling, because someone who is going through detox will probably have high levels of arousal or agitation and need a fair amount of physical/psychological support.<sup>223</sup>
- 4.32 As Ms Rombouts, Counselling Service Coordinator of Amity Community Services, pointed out to the Committee, while it is well documented that detox by itself does not work:
- most people who are drug users have detoxed by themselves many times. I have known people who have booked themselves into a hotel room with a 'Do not disturb' sign and detox there. Most ice users have detoxed by themselves. That is where the problem starts; they only fall back into the habit because it so hard to keep on going because motivation is really tested ... Clients need follow-up for a long period of time.<sup>224</sup>
- 4.33 The Committee notes that conflicting evidence was received regarding the timeframe for detoxification from 'ice'. Academic research on 'ice' dependence and withdrawal notes that withdrawal symptoms generally last "7-10 days and a return

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<sup>220</sup> A Baker, N Lee & L Jenner (eds.), *Models of intervention and care for psychostimulant users*, 2<sup>nd</sup> Edition, National Drug Strategy Monograph Series No. 51, Canberra, Australian Government Department of Health and Aging, 2004, pp. 111-114.

<sup>221</sup> Banyan House, Committee Transcript, 19 June 2015, p. 6 & DASA, Committee Transcript, 7 September 2015, p. 3.

<sup>222</sup> Northern Territory Department of Health, *Withdrawal Services*, viewed 13 October 2015, [http://www.health.nt.gov.au/service\\_locator/withdrawal\\_services/index.aspx](http://www.health.nt.gov.au/service_locator/withdrawal_services/index.aspx).

<sup>223</sup> Australian Medical Association (AMA) NT, Committee Transcript, 7 September 2015, p. 5.

<sup>224</sup> Amity, Committee Transcript, 7 September 2015, p. 4; see also A Baker, N Lee & L Jenner (eds.), *Models of intervention and care for psychostimulant users*, p. 111.

to normalcy can be expected within several weeks of ceasing methamphetamine use."<sup>225</sup> However, Ms Rombouts, Counselling Service Coordinator of Amity Community Services, noted that:

Detox for alcohol and heroin takes about five to seven days, while for ice users this is 10 to 14 days. What happens for ice users is they crash for the first three days, then they often have no capacity to engage or even reach a simple goal of having a shower.<sup>226</sup>

4.34 Mr Franck, Chief Executive Officer of Banyan House, noted that:

The more traditional drugs, including alcohol withdrawal generally requires a 10 to 14 days withdrawal window before the person is ready to effectively enter a rehabilitation program. International research informs that ice withdrawal can take up to 70 days, and that is a totally different picture. If one's resources are geared for a 14-day cycle, a significant increase in ice withdrawal ... will place us in a difficult position. Our resources would not be able to cope with a significant increase in numbers and duration of withdrawals.<sup>227</sup>

4.35 Associate Professor Parker, President of the Australian Medical Association NT provided a possible explanation for the differing views regarding detox timeframes for 'ice':

My impression is the addictive quality of methamphetamine - because of its short half-life the addictive quality is fairly short, and I suspect they are talking about anxiety issues that are probably more psychologically based. ... The psychosis, which is the excess level of dopamine in their brain caused by the use of the methamphetamine, is usually out of their system in a couple of days. They turn up at the mental health unit where we give them medication and usually discharge them about four or five days after they come in.

I suspect what has been described by some people as a detox is actually high levels of arousal which people normally have and which have been used to self-medicate. The methamphetamine has been used to self-medicate. I am not convinced there is, necessarily, a physical detox requiring three weeks. It is much more a psychological issue where the person has a pre-existing vulnerability and as soon as they stop using the substance that comes up again. ... The key factor for people and rehab is that psychological issue, because you can go through a physical detox but if you have not dealt with the psychological issues of whatever the substance is medicating you will still be using it. That is the key factor of rehab. Often it can take three, six, nine months for people to come to terms with that because the psychological issues are probably much more damaging than the physical issues.<sup>228</sup>

4.36 Ms Kudell, Executive Director of the Association of Alcohol and Other Drug Agencies NT (AADANT), also noted that while the timeframe for detoxification is usually around three to seven days, it is necessarily related to:

how dependent the user is, how long they have been using and the dosage they are using. It might be that they are very frequent users, and then you will see that it takes a little longer for them to detox.<sup>229</sup>

4.37 The Committee heard that pharmacotherapy is also commonly used in the detoxification process for drug addiction and is designed to ease the symptoms of

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<sup>225</sup> Lee et al., 'Everything new is old again', p. 75.

<sup>226</sup> Amity, Committee Transcript, 7 September 2015, p. 4.

<sup>227</sup> Banyan House, Committee Transcript, 19 June 2015, p. 3.

<sup>228</sup> AMA NT, Committee Transcript, 7 September 2015, pp. 3-4.

<sup>229</sup> Association of Alcohol and Other Drug Agencies NT (AADANT), Committee Transcript, 14 July 2015, pp. 2-3.

withdrawal and assist clients to stop using a drug. While there are currently no broadly accepted pharmacotherapies for treating methamphetamine addiction, there are trials in other jurisdictions using lisdexamphetamine and modafinil.<sup>230</sup> However, Dr Arya, Chief Medical Officer of the Northern Territory Department of Health, advised the Committee that “the evidence is not that convincing and there are pros and cons for using both these medicines in treatment of addiction.”<sup>231</sup> The Committee understands that naltrexone, a drug used as a pharmacotherapy for heroin addiction, is also being trialled in Western Australia.<sup>232</sup> The Committee was also advised that:

There is some evidence that a chemical substitute such as Ritalin and other forms of dexamphetamine have some success. However there needs to be more ongoing research.<sup>233</sup>

- 4.38 Residential rehabilitation is a longer term treatment option that may be appropriate for ‘ice’ users that require a more intensive intervention. As the Committee heard during its site visits to Banyan House, Venndale Rehabilitation Centre and BushMob, residential rehabilitation allows clients to detox and then take part in psychological interventions, such as cognitive behavioural therapy and acceptance and commitment therapy, while removed from their normal environment. Many residential rehabilitation centres, such as Banyan House, operate through a therapeutic community framework, where clients are expected to abstain from drugs and alcohol, undertake group and individual therapy, and participate in the operations of the community – for example, cooking meals and maintaining the gardens.
- 4.39 While residential rehabilitation may be appropriate for some, particularly dependent ‘ice’ users where other interventions have been unsuccessful, it is not necessarily the best option for everyone. As the Committee heard:

not everybody needs to go to rehab. Traditionally it has been one of the methods of dealing with any drug use, but it is only one area and does not suit everybody. It also depends on the individual and the environment they are in. If people are homeless, have poor social connections, financially difficult issues then rehab may be appropriate. For others they may be in work. ... from first use to time of problematic use can be 10 years. If we think back to the industries where people are working, and usually shift workers, people can manage their drug use and manage their employment. It might be an indication that they do not need rehab and certainly do not need detox, but might want to change over a period of time.<sup>234</sup>

### **Barriers to accessing treatment**

- 4.40 Research indicates that attracting ‘ice’ users to treatment services is problematic, as unlike users of other licit and illicit drugs, they are generally:

<sup>230</sup> NT DoH, Submission No. 5, 2015, p. 8.

<sup>231</sup> NT DoH, Committee Transcript, 19 June 2015, p. 3.

<sup>232</sup> ABC 7.30 Report, *This is the ice controversial treatment former addicts swear by*, 13 October 2015, viewed 26 October 2015, <http://www.abc.net.au/7.30/content/2015/s4331084.htm>.

<sup>233</sup> Amity, Committee Transcript, 7 September 2015, p. 4.

<sup>234</sup> Amity, Committee Transcript, 7 September 2015, p. 5.

reluctant to attend alcohol and other drug (AOD) services because they see these services as being orientated towards alcohol and heroin use and, therefore, as unable to provide appropriate treatments for methamphetamine use. Clinical services and staff also report a high level of uncertainty about treating methamphetamine use.<sup>235</sup>

4.41 A review of academic literature and evidence presented to the Committee indicates that there are a number of barriers when it comes to accessing treatment including:

- Low levels of confidence in AOD staff and treatment services;
- General practitioners may be ineffective as a first point of call due to a lack of understanding about 'ice' use and associated issues;
- Lack of clear referral pathways between service providers and difficulty in navigating these pathways;
- Stigmatisation of 'ice' users in the media resulting in reluctance to acknowledge a use or dependence problem and seek help;
- Organisational barriers such as opening hours and location;
- Lack of suitable pharmacotherapies for treating 'ice' dependence;
- Waiting lists for treatment options such as residential rehabilitation and detoxification preventing users from receiving an immediate placement in a treatment facility; and
- Concerns about confidentiality, particularly for those seeking assistance for the first time.<sup>236</sup>

4.42 With regards to the latter point, the Committee heard that, in order to maintain a certain level of anonymity, and to remove themselves from any potential peer pressure, 'ice' users will often seek treatment, particularly residential rehabilitation, in a town other than where they normally reside. For example, Darwin 'ice' users have attended Venndale, while Katherine 'ice' users have travelled to Darwin for treatment at Banyan House.<sup>237</sup>

4.43 Ms Kudell, Executive Director of AADANT, also noted that the age of 'ice' users also represents a barrier to accessing treatment:

Some of the challenges when you are looking at crystal meth, is that the research is showing a much younger demographic. Quite often those younger people have not had exposure to AOD treatment services before. This creates an access issue there in that they are unfamiliar with what it means to (a) ask for treatment and (b) engage in and remain in treatment. So that becomes an access issue.<sup>238</sup>

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<sup>235</sup> N Lee et al., 'Everything old is new again', p. 73.

<sup>236</sup> Lee et al., *Methamphetamine dependence and treatment*, pp. 9-10 & Australian Drug Foundation, *The stepped care model: a useful intervention strategy for people who use methamphetamine*, p. 1.

<sup>237</sup> Venndale Rehabilitation Centre, Committee Transcript, 14 July 2015, pp. 2-3.

<sup>238</sup> AADANT, Committee Transcript, 14 July 2015, p. 3.

## Treatment Options in the Northern Territory

4.44 The Committee understands that there are a number of national telephone and online counselling services that provide information, support and referrals for drug users and their families. As noted on the Northern Territory Department of Health's website, the Alcohol and Drug Information Service provides:

24-hour 7-day telephone counselling, information and referral for people with an alcohol or drug problem. People can access immediate counselling and support including crisis intervention, support in dealing with the impact of drug use on the family, information on how to reduce the harm associated with drug use and information and referral to treatment and support services across the NT.<sup>239</sup>

4.45 Turning Point Alcohol and Drug Centre, which focuses on treatment, education and research, has developed a number of interactive web-based initiatives to assist clients, professionals, GPs and families. Turning Point also provides *Counselling Online*; a 24 hour confidential online counselling service provided through real time web chats, email communication and videoconferencing. *Counselling Online* can also provide immediate telephone support through its associated 24 hour drug and alcohol telephone service *DirectLine*.<sup>240</sup>

4.46 The Australian Drug Foundation (ADF) website provides a number of resources for both individuals and families dealing with drug use. The website lists phone numbers and provides links to national, state and territory organisations that provide 24 hour support and counselling for drug users and their families, as well as a number of mental health help lines. In addition to factsheets on illicit and licit substances, the ADF publishes factsheets specifically for parents and grandparents dealing with drug use in the family. The ADF has published the *Ice: family and friends support guide* which includes information on the immediate effects of using 'ice'; the potential effects that may occur in the days or weeks after using 'ice'; how to assist a user to seek help or treatment; and details of organisations that can provide online or telephone counselling and referrals.<sup>241</sup>

4.47 Family Drug Support (FDS) is a non-government organisation that provides support to families and friends of substance users. FDS also provides a national 24 hour support line where people can seek advice and referral information for the substance use of a loved one. While FDS run support groups in a number of states, it is noted that there are no FDS support groups currently operating in the Northern Territory. FDS is primarily staffed by volunteers that have experienced the difficulties caused by a family member's substance use and addiction.

4.48 FDS has also developed resources and education programs for family members which aim to teach strategies for coping with another person's drug use, setting boundaries and dealing with conflict. At the time of writing, none of these programs were scheduled to be facilitated in the Territory. A number of free publications are

<sup>239</sup> Northern Territory Department of Health, *Alcohol and Other Drug Related Links*, viewed 13 October 2015, [http://www.health.nt.gov.au/Alcohol\\_and\\_Other\\_Drugs/Related\\_Links/index.aspx](http://www.health.nt.gov.au/Alcohol_and_Other_Drugs/Related_Links/index.aspx).

<sup>240</sup> Counselling Online, viewed on 13 October 2015, <<https://www.counsellingonline.org.au/>>.

<sup>241</sup> Australian Drug Foundation, *Ice: family and friends support guide*, viewed on 1 September 2015, [http://www.druginfo.adf.org.au/images/documents/AU\\_Ice\\_Brochure-Web.pdf](http://www.druginfo.adf.org.au/images/documents/AU_Ice_Brochure-Web.pdf).

available on the FDS website including a fact sheet on 'ice' and *Walking a Tightrope - Alcohol and other drug use and violence: A guide for families*.<sup>242</sup>

4.49 In addition to the five regional hospitals, the Northern Territory Department of Health's website lists 22 government and non-government AOD services across the Territory that provide a range of treatment options from counselling to withdrawal/detoxification and rehabilitation. However, the Committee notes that some of these services are specific to alcohol, while others, as discussed below, do not necessarily have the appropriate experience, resources or facilities to cater for 'ice' users. The following discussion provides an overview of those services that made submissions to the inquiry or appeared as witnesses before the Committee.

4.50 Amity Community Services (Amity) is a not for profit organisation that provides counselling, information, education and training to the Darwin and broader Northern Territory community in relation to "behaviours of habit".<sup>243</sup> The Committee heard that Amity's drug related programs are reliant upon a mix of Territory and Commonwealth funding. The main counselling service is funded by the Northern Territory Department of Health. The illicit drug counselling and referral project, which focuses on building referral networks with GPs and other organisations throughout the more remote communities, is funded by the Australian Government Department of Health.<sup>244</sup> Noting that this latter program is only funded on a 12 monthly basis, security of funding over the longer term was highlighted as an ongoing issue of concern for non-government service providers.<sup>245</sup>

4.51 Data provided for the first quarter (January, February and March) of the last three years shows an increase in new clients presenting at Amity with methamphetamine as their primary drug of concern. In 2013, methamphetamine use accounted for 8% of new clients, this rose to 10% in 2014 and 19% in 2015.<sup>246</sup> It was further noted that:

In the six month period 1 July to 31 December 2014 the two highest primary substances of concern for Amity clients was: methamphetamine 39% and cannabis 22%, for the six months prior to that data showed cannabis at 44% and methamphetamine at 23%, demonstrating a shift in primary substance of concern for our service.<sup>247</sup>

As Amity point out, it is unclear whether the increase in the number of people seeking treatment for methamphetamine use is due to an increase in the number of people using methamphetamine, lack of availability of other illicit drugs, or increased public awareness about methamphetamine treatment.<sup>248</sup>

4.52 The Drug and Alcohol Intensive Support for Youth (DAISY) program, developed and run by CatholicCare NT, is funded to June 2016 by the Australian Government Department of Health through the *Substance Misuse Service Delivery Grant Fund*.

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<sup>242</sup> Family Drug Support, viewed on 1 September 2015, <http://www.fds.org.au/>.

<sup>243</sup> Amity, Submission No. 17, 2015, p. 2.

<sup>244</sup> Amity, Submission No. 17, 2015, p. 10.

<sup>245</sup> Amity, Committee Transcript, 7 September 2015, pp. 9-10.

<sup>246</sup> Amity, Submission No. 17, 2015, p. 8.

<sup>247</sup> Amity, Submission No. 17, 2015, p. 8.

<sup>248</sup> Amity, Submission No. 17, 2015, p. 8.

Servicing Darwin, Palmerston and the rural area, the program provides an intensive support service based on the harm minimisation model for young people aged between 12 and 19 and their families. The three-tiered service uses casework, group work and family therapy to reduce the incidence and uptake of substance use and the harms associated with substance use.<sup>249</sup>

- 4.53 In their submission to the Committee, CatholicCare NT advised there has been a significant increase in the number of clients presenting to the DAISY program for their 'ice' use. Of particular concern to the Committee, is that the program:

is currently supporting young women who have been introduced to ICE by older men and then sexually abused, and increasingly young people identify that if they have not already tried ICE that they intend to do so in the future. .. The experience of CatholicCare NT's AOD workers to date is that ICE users appear to have minimal awareness of the numerous negative effects the drug can have.<sup>250</sup>

Given that the DAISY program is one of the few youth specific AOD programs operating within the greater Darwin area, the lack of security regarding ongoing funding is cause for concern.

- 4.54 Anglicare NT delivers the headspace Darwin program which provides a number of youth services for people aged between 12 and 25. Funded by the Australian Government Department of Health, the headspace program provides:

a range of early intervention youth mental health responses including clinical, counselling and support services as well as community engagement, education and youth participation activities.<sup>251</sup>

- 4.55 At present the Northern Territory Department of Health provides a Tobacco, Alcohol and Drug Counsellor for one session per week to counsel up to four young people. However, the Committee heard that in the future it is anticipated that clients will have on-site access to GPs and a "multi-disciplinary team including psychiatrists for the headspace Youth Early Psychosis Program (hYEPP). The Committee understands that the hYEPP was established by the Australian Government in 2013 and is designed to provide early intervention, responsive and recovery focused care for young people at risk of or experiencing their first psychotic episode.<sup>252</sup>

- 4.56 Ms Cook, Executive Manager Primary and Early Psychosis Services of Anglicare NT, advised the Committee that the:

early psychosis program which commenced in April this year in an initial service model, has currently been put on hold by the federal government - we cannot expand it but we have an initial service operating - about 50% of the young people would have been assessed with a first episode of psychosis and accepted into treatment also have or are still using crystal methamphetamine, which is interesting.<sup>253</sup>

- 4.57 Ms Cook further noted that:

<sup>249</sup> CatholicCare NT, Supplementary information provided to the Committee, DAISY Program Guidelines, p. 2.

<sup>250</sup> CatholicCare NT, Submission No. 16, 2015, p. 3.

<sup>251</sup> Anglicare NT, Submission No. 24, 2015, p. 1.

<sup>252</sup> Anglicare NT, Submission No. 24, 2015, p. 1.

<sup>253</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 3.



Based on the population model we should only be seeing about 20 young people a year and we have seen 70. If they do not fit the criteria for the early psychosis program it does not mean we are not seeing them, we just might be seeing them in the primary headspace platform and/or doing referrals to other more suitable services. We are not trying to have a 'wrong door' approach, but it might be that for this program they have not met the threshold for an early psychosis, which is positive but it still means we can do some early intervention work. So 19 in that short space in time with limited services is quite a significant number in the Northern Territory. About 56% of those young people are Aboriginal or Torres Strait Islander.<sup>254</sup>

4.58 Tables 13 and 14 below provide a snapshot of the residential rehabilitation services provided in the Northern Territory. As noted previously, given that some of these services are specific to alcohol withdrawal, the data does not include beds that have been specifically funded for Alcohol Mandatory Treatment. In addition, the Northern Territory Department of Health notes that the figures relating to waiting lists may include Correctional Services referrals for clients that have not yet been released from prison, and therefore do not necessarily imply that the service is at full capacity.

4.59 Of particular concern to the Committee, is that the submission from AADANT points out that:

Of the 9 key AOD rehabilitation - residential or day - services in the NT, most report the inability to provide specialized ICE treatment such as withdrawal services for a number of reasons including infrastructure deficit in terms of appropriate treatment protocols, exclusionary parameters that protect the nature of current services (i.e. families) and non specialized staff. Of the remaining AOD sector services there is limited specialized capacity to treat the harmful use of ICE.<sup>255</sup>

**Table 13: Services funded by the Northern Territory Government<sup>256</sup>**

Service Name	Location	No of NTG funded residential rehabilitation beds	No of people on waiting list as at 06/07/2015
Barkly Region Alcohol and Drug Abuse Advisory Group ( <b>BRADAAG</b> )	Tennant Creek	20	6
Foster Foundation ( <b>Banyan House</b> )	Darwin	18	3
<b>Bushmob</b>	Alice Springs	20 (young people)	0
Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties ( <b>FORWAARD</b> )	Darwin	16	14
Central Australian Aboriginal Alcohol Program Unit ( <b>CAAAPU</b> )	Alice Springs	15	2
	<b>Total</b>	<b>89</b>	<b>25</b>

<sup>254</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 5.

<sup>255</sup> AADANT Submission No.15, 2015, p. 1.

<sup>256</sup> NT DoH, Answer to Questions on Notice, p. 1.



**Table 14: Services jointly funded by the Northern Territory Government and Australian Government<sup>257</sup>**

Service Name	Location	No of jointly funded residential rehabilitation beds	No of people on waiting list as at 06/07/2015
Council for Aboriginal Alcohol Program Services Inc ( <b>CAAPS</b> )	Darwin	8 NTG funded for young people VSA 30 AG funded for adults	0 NTG 7 AG
Drug and Alcohol Services Association ( <b>DASA</b> )	Alice Springs	20	0
Kalano Community Association ( <b>Venndale</b> )	Katherine	20	62
Salvation Army ( <b>Sunrise</b> )	Darwin	21 (plus three beds for withdrawal and day service)	10
	<b>Total</b>	<b>69</b>	<b>72</b>

Note: VSA – Volatile Substance Abuse

4.60 Operated by the Forster Foundation, Banyan House is a 26 bed, residential rehabilitation service located in Darwin for individuals (18 years and over) and families struggling with alcohol and drug issues. Banyan House receives 75% of its funding through the Northern Territory Department of Health, with the remaining 25% provided by the Australian Government Department of Health.<sup>258</sup> Operated as a 'Therapeutic Community', treatment is based on the stepped care model discussed previously:

Banyan House has traditionally offered a 12 - 52 week residential multidimensional program using withdrawal, group therapy, education, therapy/counselling, participation in activities (working groups/social and sport) and values and skills development. Residents are expected to develop the capacity to be positive role models as they progress through the program.<sup>259</sup>

The Committee understands that as of 1 July 2015, Banyan House will also deliver an outpatient/day AOD program that will be provided over 10 half days or 5 full days.<sup>260</sup>

4.61 As highlighted in their submission to the inquiry, Banyan House has experienced a definable increase in 'ice' users seeking treatment in the Northern Territory. Five years ago the facility only had one resident seeking treatment for methamphetamine addiction. However, in January 2015 Banyan House accommodated three people seeking treatment for 'ice', this rose to 11 in March and 14 in April.<sup>261</sup> The Committee heard that these numbers have increased further with instances of up to 17 of the 26 beds accommodating 'ice' users.<sup>262</sup> Of the 26 beds, six are funded as detoxification beds and Banyan House receives referrals for these beds from the Royal Darwin Hospital through TADS. In the absence of the

<sup>257</sup> NT DoH, Answer to Questions on Notice, p. 2.

<sup>258</sup> Banyan House, Submission No. 18, 2015, p. 4.

<sup>259</sup> Banyan House, Submission No. 18, 2015, p. 4.

<sup>260</sup> Banyan House, Submission No. 18, 2015, pp. 4-5.

<sup>261</sup> Banyan House, Submission No. 18, 2015, p. 6.

<sup>262</sup> Banyan House, Committee Transcript, 19 June 2015, p. 4.

necessary clinical staff, detoxification (withdrawal) services are limited to those assessed as a mild to moderate risk level. As Mr Franck, Chief Executive Officer of Banyan House explained to the Committee:

Withdrawal beds that 'belong' to TADS. They allocate medical resources that come in and monitor them daily or as often as required. We monitor care for them 24/7, but TADS medical staff (nurses) attend to their requirements from a medical perspective. We cannot take clients in for withdrawal without support from TADS AOD/Withdrawal nurses - because we do not have the medical staff. There is too much risk involved in withdrawals to admit clients without medical supervision and backing.<sup>263</sup>

4.62 In the 2014-15 financial year, referral sources to Banyan House included voluntary self-referral 38%; forensic 21%; TADS 18%; police diversion 11%; and mental health services 4%.<sup>264</sup> Mr Franck, Chief Executive Officer of Banyan House, informed the Committee that under the current funding arrangements, they do not receive any funding to accommodate referrals from the Department of Correctional Services:

The Department of Health is quite explicit in that it funds us as a health facility to accommodate alcohol-mandated, volatile substance abuse and voluntary clients and explicitly not to accommodate forensic and corrections clients. Our funding model is geared not to accommodate the latter, but there is significant pressure from that source to accommodate them. We do our utmost to accommodate them, but ... the Department of Health's perspective is that clients referred from the Corrections facilities have had a period of treatment within the Corrections facilities while voluntary clients have not had that opportunity. It has been clearly stated that we can accommodate clients from Corrections IF the Department of Corrections funds those beds/places. We currently receive no funding / financial support from the Department of Corrections.<sup>265</sup>

4.63 Mr Franck also commented on the challenges of providing detoxification services under the existing arrangements:

The government services is perceived to struggle with resourcing and that has a flow-on effect on us because they buy the withdrawal beds from us – six withdrawal beds are dedicated to TADS and we cannot fill those beds from our own referral base. If there is a blockage in the Department's assessment and allocation system/process, we sit with six empty beds. We have, over the past two months, experienced five of the six beds being vacant for a six-week period – while we are aware of people in need and who could have been accommodated if we had access to the beds AND the medical staff to manage those clients.<sup>266</sup>

4.64 In Katherine, the Kalano Community Association operates Venndale Rehabilitation Centre, a 40 bed residential rehabilitation centre for alcohol and drugs. Funded to provide rehabilitation services for voluntary referrals as well as people referred for Alcohol Mandatory Treatment (AMT), the Committee heard that Venndale does not currently have the capacity to provide detoxification services. Historically, clients have sought treatment at Venndale for alcohol and drugs such as cannabis. However, in the first half of 2015, Venndale received over 15 referrals for people

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<sup>263</sup> Banyan House, Committee Transcript, 19 June 2015, p. 6.

<sup>264</sup> Banyan House, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 2.

<sup>265</sup> Banyan House, Committee Transcript, 19 June 2015, pp. 4-5.

<sup>266</sup> Banyan House, Committee Transcript, 19 June 2015, pp. 5-6.

using 'ice'; generally in combination with alcohol. During a site visit to Venndale, the Committee was informed that the 20 rehabilitation beds funded specifically for AMT referrals must be available for AMT clients. Nevertheless, as highlighted in the case of Banyan House, the beds are at times left vacant despite there being voluntary referrals waiting for treatment at Venndale.<sup>267</sup>

4.65 BushMob, is a 20 bed residential rehabilitation service located in Alice Springs that provides a "residential treatment service, Bush Adventure Therapy and Outreach programs for young people aged 12 - 25 experiencing significant harms from Volatile Substance Abuse, Alcohol and Other Drugs Abuse."<sup>268</sup> The service is funded by the Northern Territory Department of Health and the Commonwealth Department of Prime Minister and Cabinet through its Indigenous Advancement Strategy, Safety and Wellbeing Program Stream. BushMob accepts voluntary, court and Department of Children and Families referrals for young people from across the Northern Territory. In addition, they also receive referrals from other Australian jurisdictions in a fee for service capacity.<sup>269</sup>

4.66 The Committee notes that BushMob is the only residential rehabilitation service that caters to young people under the age of 18 currently operating in the Northern Territory. At the time of appearing before the Committee in July 2015, five young people were undergoing treatment for 'ice' use aged between 13 and 16.<sup>270</sup> At this time, BushMob was at capacity and had a waiting list. BushMob has access to medical clinical services and has an on-site volunteer doctor to provide pharmacotherapy-assisted detoxification. However, the Committee was informed that it is not ideally set up to provide this service as there is no separate area free of noise for young people to be located while they undergo their withdrawal.<sup>271</sup>

4.67 With regards to referrals, Chief Executive Officer Mr MacGregor advised the Committee that under the current funding arrangements:

We are obligated to provide 20 beds to the Northern Territory government volatile substance abuse and alcohol and other drugs so if it is coming through the system we are obligated to take that referral first and then a self-referral when we can.<sup>272</sup>

4.68 The Committee also heard from the Alice Springs based Drug and Alcohol Services Association (DASA) which operates a 20 bed 'Therapeutic Community' at Aranda House:

We have a sobering-up shelter. We have the rehab services with associated low-level detox. We have transitional care units following rehab so people can go for a lot longer than the traditional 12 weeks, and we have independent living. We also have an outreach service that follows people as they come through that journey and beyond.<sup>273</sup>

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<sup>267</sup> Venndale Rehabilitation Centre, Committee Transcript, 14 July, pp. 2-3.

<sup>268</sup> BushMob, Submission No. 3, 2015, p. 1.

<sup>269</sup> BushMob, Committee Transcript, 21 July 2015, p. 2.

<sup>270</sup> BushMob, Committee Transcript, 21 July 2015, p. 2-5.

<sup>271</sup> BushMob, Committee Transcript, 21 July 2015, p. 2-3.

<sup>272</sup> BushMob, Committee Transcript, 21 July 2015, p. 5.

<sup>273</sup> DASA, Committee Transcript, 7 September 2015, p. 2.

4.69 DASA Chief Executive Officer, Ms Taylor, reiterated the challenges non-government providers face in the absence of long term funding.<sup>274</sup> Ms Taylor also acknowledged that the lack of detox services was causing a 'bottleneck' in the system and the continuum of care model:

I see that as the bottleneck of fear. There are many people who are very afraid to even go in the detox space with people who are on meth or on ice, depending on what level of addiction they have. I suggest ... that we need to look at how we detox people from this drug or set of drugs in general, because they are different. They are a lot more aggressive, a lot more paranoid, a lot more difficult to deal with. So there is a bottleneck. ... Hospitals traditionally only take someone who is detoxing for two to three days. That is all they have the space and the time to do. After that, they would normally come to us.<sup>275</sup>

### **Recommendation 1**

#### **The Committee recommends that the Government:**

- a) allocate additional funding to increase the availability of residential and non-residential detoxification services across the Northern Territory, with a particular emphasis on increasing the availability of services to young people under the age of 18 years; and**
- b) monitor access to and availability of residential and non-residential rehabilitation services across the Northern Territory.**

4.70 As noted above, the Committee heard evidence from a number of non-government organisations in the AOD treatment sector that security of funding poses challenges in delivering services. In particular, 12 month funding cycles have presented difficulties in recruiting and retaining staff, as well as planning and delivering treatment services.<sup>276</sup>

4.71 A number of witnesses to the inquiry questioned the adequacy of detoxification and rehabilitation services in adult and youth correctional facilities in the Northern Territory. While the Committee was advised that there are no onsite rehabilitation facilities currently available, the Department of Correctional Services noted that:

There has been discussion around establishing a Meth Clinic in the Complex Behaviour Unit at the Darwin Correctional Centre however this is in its infancy stage and there needs to be robust calculations around the cost and implementation of such a clinic.<sup>277</sup>

4.72 The Committee heard that, at present, the Northern Territory Department of Health TADS staff deliver AOD treatment at the adult and youth correctional facilities in Darwin. Counselling and AOD education is provided through the Prison In-Reach Program which is available to prisoners on remand and those sentenced to prison terms of less than six months. Through this program, referrals to external AOD organisations are made for prisoners that wish to continue AOD treatment after their release. Where required, detoxification is managed by the Primary Health

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<sup>274</sup> DASA, Committee Transcript, 7 September 2015, pp. 7-8.

<sup>275</sup> DASA, Committee Transcript, 7 September 2015, pp. 2-3.

<sup>276</sup> AADANT, Committee Transcript, 14 July 2015, p. 4.

<sup>277</sup> Department of Correctional Services (DCS), Submission No. 23, p. 4.

Care Clinic at the Darwin adult correctional facility, who liaise with TADS and the hospital if detoxification complications arise.<sup>278</sup>

- 4.73 However, the Committee was informed on a number of occasions that there are no AOD services operating in the adult or youth correctional facilities in Alice Springs.<sup>279</sup> It is understood that where AOD treatment is required, detainees are transferred to Darwin. The Committee has concerns about the lack of treatment services in correctional facilities, particularly in light of the number of young people entering detention that are self-reporting using 'ice'. While there is no drug testing regime upon admission to youth detention centres in the Northern Territory, the Department of Correctional Services noted that 90-100% of young people are self-reporting using 'ice' or exhibiting behaviours associated with 'ice' addiction. The age of young people self-reporting has also decreased from the typical age group 16 to 18 to people as young as 13 and 14.<sup>280</sup>
- 4.74 According to the Northern Territory Department of Health, self-reporting is encouraged and from a treatment perspective, drug testing is not critical as it will not change the treatment provided and may in fact delay treatment.<sup>281</sup> However, as discussed previously, for a number of reasons, reliance on self-reporting is not necessarily a very accurate gauge of drug use. As the Committee heard, it is not possible to qualify if the level 'ice' use self-reported is a true reflection of the prevalence amongst this demographic or whether this is in fact over-reporting to increase their 'street cred' in the detention centre.<sup>282</sup>
- 4.75 Ms Cohen, Executive Director of Youth Justice, highlighted a number of challenges associated with managing young people entering detention that have been using 'ice':

young people coming into our system with what appears to be withdrawal from ice - we cannot forget they are often exposed to using and abusing a number of substances of which ice is but one. That is another complex layer on a range of challenging behavioural issues, cognitive disorders, and foetal alcohol syndrome spectrum disorder...ice is critical for us. It is very concerning but we are managing it a complex environment...Those people who come to us - this is predominantly in the youth justice system or those brought into our care - undergo significant, highly violent, highly concerning, highly psychotic episodes of withdrawal for about the first two weeks. We see the ongoing trauma that is left behind from ice. We see it as long-term damage.<sup>283</sup>

- 4.76 With regards to the effective delivery of AOD treatment in youth detention centres, Ms Cohen noted that:

one of the greatest challenges we have is the majority of our population in detention centres are on remand...we have 40-odd kids in detention, only a

<sup>278</sup> Hon John Elferink (Attorney-General, Minister for Justice and Minister for Health), Letter to Chair of the 'Ice' Select Committee, Mr Nathan Barrett MLA, regarding *detox withdrawal and drug rehabilitation services currently available to adults and young offenders in each of the Territory's correctional facilities provided by the Department of Health*, 20 August 2015.

<sup>279</sup> DASA, Committee Transcript, 7 September 2015, p. 6 & Ms Wilks, Alice Springs Public Forum, 21 July 2015, p. 7.

<sup>280</sup> DCS, Submission No. 23, 2015, p. 3.

<sup>281</sup> NT DoH, Committee Transcript, 19 June 2015, p. 7.

<sup>282</sup> DCS, Committee Transcript, 19 June 2015, p. 6.

<sup>283</sup> DCS, Committee Transcript, 19 June 2015, p. 2.

handful of those will be sentenced. I think we are travelling at eight or 10 at the moment, which is high. The majority of kids are on remand. They will come in and out. We are limited in what we can do in services and limited in what we can do in services during the length of their remand period. You have somebody coming in who might have been on a charge of X, but they have also been using ice. They are with us for two weeks and there is only so much you can do and I think we need to handle that better.<sup>284</sup>

4.77 Ms Swan, forensic psychologist, Youth Justice, outlined to the Committee what is required to improve AOD treatment in youth correctional facilities:

specialised substance use treatment programs are imperative. At present in Don Dale Youth Detention Centre, CatholicCare is providing the DAISY program. They do that through our educational program, so it targets a range of substances and a range of young people as well. A lot of our young people who have reported methamphetamine use have also reported they do not want to change that behaviour. It is difficult to provide high level services at this point in time when those young people are not in a position to change.

The best we can do at the moment is programs like DAISY, which targets all the young people and can motivate them to start thinking about their drug use behaviour and provide them with more of a platform to see the positives and negatives of what is going on and decide they want to make changes. At that time it would be more appropriate to have more one-on-one specialist treatment with the young people and work with them on their goals around drug use.<sup>285</sup>

4.78 As highlighted in the Department of Correctional Services submission to the inquiry, the legislative parameters of the *Youth Justice Act* and associated Regulations do not provide for appropriate intervention:

working within the current legal parameters makes establishing a comprehensive response for managing the overall complexities associated with any drug use (including ice) challenging. Youth Justice suggest an imperative need for the following:

- Legislative review
- Centre-based AOD staff or access to a facility where detainees can be placed on a supported withdrawal regime prior to transferring to a youth detention centre
- Training for staff
- Ice education and awareness training for detainees, their families and staff
- Access to appropriate intervention and programs

Youth Justice is very concerned with the long-term offending trajectory in addition to the long-term health outcomes for this cohort of young people given the high levels of risk involved in managing them, and the lack of access to appropriate services available to adequately address the issues and the escalating numbers self-reporting using ice.<sup>286</sup>

4.79 In order to assist correctional staff ascertain whether a person has recently used drugs and determine whether they may suffer from withdrawal symptoms, the Committee was advised that the Department of Correctional Services recently purchased three drug detection machines that use a number of methods to detect traces of drugs. However, given the timeframe between being arrested and presenting at a correctional facility, the Department noted that it would be far more

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<sup>284</sup> DCS, Committee Transcript, 19 June 2015, p. 6.

<sup>285</sup> DCS, Committee Transcript, 19 June 2015, pp. 5-6.

<sup>286</sup> DCS, Submission No. 23, 2015, p. 3.

beneficial if drug testing was undertaken while people are in police custody. Nevertheless, Mr Ferguson, Director of Professional Standards, Department of Correctional Services informed the Committee:

These machines are capable of testing mucus from the mouth. It is a very quick system and gives you a result in approximately one minute if a drug is active in the system. That is particularly useful for when someone initially comes into custody, either juvenile or adult. ... However, the machine is also used for trace testing, which is what we believe is the most useful thing to do. For example, if you were to take a trace off someone's hands who had used ice or any other drug within up to the last three days it will show on the machine. That gives you an idea, an intel-perspective that this person has had contact with that drug within that last time frame and you can plan for that. You can put them into programs accordingly. ... It is very useful for us, for intel, to detect what drugs are coming into the system and what people have used before they come in.<sup>287</sup>

## **Recommendation 2**

**The Committee recommends that the Department of Correctional Services in conjunction with the Department of Health:**

- a) undertake and publish an audit of drug detoxification, rehabilitation and forensic mental health services, and develop a strategy to ensure adequate services are made available in each of the Northern Territory's adult correctional facilities and youth detention centres; and**
- b) the Attorney-General table a copy of the audit and strategy in the Assembly by June 2016.**

4.80 With regards to barriers to accessing treatment in the Northern Territory, the Committee is particularly concerned to note that the Northern Territory Department of Health's website regarding AOD service providers and related links has not been reviewed since 2009. The Committee notes that minimal information is provided on the AOD services listed; despite many of the services listed having their own websites, links are not generally provided; many of the links on the 'related links' page are no longer current; and the website does not include any resources or fact sheets on the misuse of drugs or alcohol, let alone anything specific to 'ice' use.

## **Recommendation 3**

**The Committee recommends that the Department of Health evaluate and update the accuracy and accessibility of information regarding drug services and resources on the Department's website.**

### ***Training and Safety of Frontline Workers***

4.81 A consistent theme throughout the submissions and evidence received by the Committee related to the need for professional development and training specific to the management and treatment of 'ice' users. The majority of witnesses advised the Committee that frontline workers are not sufficiently trained in recognising 'ice' use;

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<sup>287</sup> DCS, Committee Transcript, 19 June 2015, p. 3.

understanding the associated behaviours of users; and managing interactions with 'ice' users. The Pennington Institute, which has a high level of expertise regarding 'ice' use and facilitating community forums and frontline worker training in Victoria, advised the Committee that:

presentations, particularly the more acute presentations from those using ice, are significantly different to those which the drug and alcohol services and the frontline workers have typically been exposed to. Even for people who have worked in the system for quite some time, these new presentations can be quite confronting. There are responses that can be introduced, taught and learnt that provide greater capacity for the people working at the front line to be able to respond. ... A lot of our training has been going into the frontline worker sector to give them the skills to recognise problematic ice use early, and to teach them techniques around early interventions designed to direct them into treatment, if necessary, and also to get them thinking about the need to question their drug use.<sup>288</sup>

4.82 The Committee heard that the need for additional training is not limited to AOD workers but extends to a wide range of professionals that may be required to deal with 'ice' users in the course of their work, including police, paramedics, GPs, correctional services, AOD, child protection, mental health, legal practitioners, youth and housing workers. As Ms Morton, Executive Director of NTCOSS, pointed out:

The broader sector is often the first to see the problem of people using ice before they go on to access alcohol and other drug services. Whatever we put in place...around training it needs to be going across the broader sector and not just targeted to drug and alcohol services. There is a lack of understanding coming from some of those broader sector services around whether people are using methamphetamine - presenting with that or other drug issues.<sup>289</sup>

4.83 Ms Buxton, Deputy Chief Executive Officer of Anglicare NT, noted that they had identified a need for training that focussed on:

general awareness raising, capacity to identify, knowledge about the referral points for additional information and assistance, whether a generic support service needs extra information or help in the needs assessment they will be undertaking with clients. We are also looking at building up the awareness of services in what the treatment options are. If you have youth workers working with young people, it is really critical that they know what the treatment options are and the referral points.<sup>290</sup>

4.84 The Committee also heard evidence from a number of witnesses about the need for training in specific occupational areas. For example, the submission from the Department of Children and Families noted that while child protection workers receive regular training on substance abuse, it:

does not provide workers with practical advice on supporting/managing ice users; information on worker safety, particularly on the risks of coming into contact with 'meth labs'; or guidance on determining ice use and addiction.<sup>291</sup>

4.85 The Committee notes that the Department has since delivered some training targeted at "the child protection area and services working in child protection where

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<sup>288</sup> Pennington Institute, Committee Transcript, 7 September 2015, p. 4.

<sup>289</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 2.

<sup>290</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 7.

<sup>291</sup> Department of Children and Families (DCF), Submission No. 33, 2015, p. 11.



'ice' was present within families that had been referred."<sup>292</sup> Ms Buxton, Deputy Chief Executive Officer of Anglicare NT, noted that it was "the first specific training that we had seen our staff being able to access over the last year or so. It was in demand and it was well received."<sup>293</sup> The Committee was advised that the resources being developed by the Northern Territory Department of Health for health clinicians working with 'ice' users will be adapted by the Department of Children and Families for use in the child protection context.<sup>294</sup>

4.86 Mr Davies, Chief Executive Officer of the Department of Education, noted that:

Whilst the Department of Education has no responsibility for those employed within the health system, best practice workplace measures should be applied at all times to staff with the potential to interact with students or parents affected by ice. At some schools, anecdotal evidence indicates that staff in contact with students or parents affected by ice may be increasing, and as a consequence, appropriate workplace health and safety measures and professional development must be in place. ... Principal feedback reflects a need for skill development to:

- recognise situations that have the potential to escalate
- de-escalate situations
- self protection
- what to look for and what to expect to identify if students are affected by substance misuse and ice in particular
- how to help students and families impacted by substance misuse and ice in particular
- regular opportunities for debriefing/counselling, especially after critical incidents.<sup>295</sup>

4.87 The Committee heard that staff working in youth detention centres do not receive the necessary training to respond to the challenging behaviours, some which may be attributable to 'ice' use, presented by young people in detention. Noting that training for youth justice officers was scheduled to be introduced in August 2015, Ms Cohen, Executive Director of Youth Justice advised the Committee that:

our colleagues in the adult system have what I call the luxury of 11 weeks training, and then they go on the job for the remainder of a full year shadowing senior staff - people who have had a lot of experience. Our staff have had very limited *ad hoc* training. This is not tongue-in-cheek. Sometimes it might be as little as three days and they are given a set of keys and 'fill your boots'. We are rolling out a Certificate III in Correctional Practices Youth Justice as of August, but as Mr Ferguson said, there are units within that, for example Indigenous Mental Health First Aid. That will provide our staff with an understanding and ability to recognise certain behaviours, certain actions or certain responses. It certainly does not train them in how to respond. I think their response would be, 'I need to get on the blower'.<sup>296</sup>

4.88 Reflecting the views of the Penington Institute, the Committee notes that a number of AOD service providers did not believe that the Certificate IV AOD training provided workers with the necessary skills to treat and manage 'ice' use.<sup>297</sup> A recent

<sup>292</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 7.

<sup>293</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 7.

<sup>294</sup> DCF, Submission No. 33, 2015, p. 12.

<sup>295</sup> Department of Education (DoE), Submission No. 8, 2015, p. 11.

<sup>296</sup> DCS, Committee Transcript, 7 September 2015, p. 5.

<sup>297</sup> BushMob, Submission No. 3, 2015, p. 2.

survey of the AOD sector regarding 'ice', identified training and support as an area that requires urgent attention. In particular the sector called for:

- Case management training
- ICE specific training
- Trauma training
- Clinical and non-clinical training
- Upgrading and upskilling of all AOD treatment services.<sup>298</sup>

4.89 However, the Committee notes that this view was not shared by all AOD providers. Ms Taylor, Chief Executive Officer of DASA pointed out that:

What a couple of my staff, not all of them, would benefit from is something that makes them realise they have the capacity. The people with AOD Certificate IV have the capacity to deal with this, and our people have been in the system for quite some time. A lot of our people have dual mental health and AOD diplomas. As I said, there is a lot of fear around this drug ... It is a matter of confidence. If we are going to up skill people we should maybe upskill them a little about the effects of the drug. But the major issue is to look at dealing with one's own capacity. People need to understand that they can do this ... one of the things we are doing now is putting people who are confident in dealing with such people with people who are not so confident, so they get the capacity off each other.<sup>299</sup>

4.90 Given that 'ice' users are prone to unpredictable and often aggressive behaviour, a number of witnesses raised concerns regarding the safety of frontline workers. For example, St John Ambulance commented on the challenges and risks associated with managing patients experiencing methamphetamine-related psychosis, in particular those exhibiting signs of paranoia and hallucinations:

This group of patients poses a significant risk to paramedics as they are generally agitated and can become, and frequently do become aggressive and combative. These patients frequently require sedation and restraint in the form of protecting the patient from injuring themselves or others.<sup>300</sup>

4.91 Mr McKay, Director of Operations, St John Ambulance, advised the Committee that:

since 1 January this year we have attended 230 patients who have had a toxidrome consistent with potentially methamphetamine use, so substance abuse... of those 230 people we attended, 85 needed sedation because of their paranoia, hallucinatory state and their aggressiveness. Of those 85, 22 required police assistance to restrain as well as drugs to calm them down. That is significant. Recently a paramedic had a serious head injury attending a case where it is believed ice was involved.

It is a big problem to our workforce and my peers. These people are very difficult people to restrain and protect from themselves. One thing we are doing is working closer with the police and having a better approach to how we deal with these people. ... We will not send our crews into volatile situations. We do not want to take more patients to the scene so we will hold off, wait for police to arrive then we will enter the scene.<sup>301</sup>

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<sup>298</sup> AADANT, Submission No. 15, 2015, p. 11.

<sup>299</sup> DASA, Committee Transcript, 7 September 2015, pp. 4-5.

<sup>300</sup> St John Ambulance, Submission No. 11, 2015, p. 2.

<sup>301</sup> St John Ambulance, Committee Transcript, 19 June 2015, pp. 2-3.

- 4.92 Ms Bradford, Chief Executive Officer of the Department of Children and Families informed the Committee about the safety concerns for child protection workers and the protocols currently in place:

there are some particular features of ice use which make the role of the child protection worker challenging ... safety risks to child protection workers visiting or entering homes where ice may be manufactured or regularly used; paranoia, or potentially violent or highly reactive behaviours, that may be exhibited by parents ... In these instances, the personal safety of the worker and the child or children is our imperative. Child protection workers therefore operate in pairs and will always seek additional information from the Northern Territory police if they have concerns about visiting a residence. In some instances, where there are concerns about a situation escalating a police officer may attend. Child protection workers will also seek family or other service involvement to verify and help mediate some of the potential paranoia and reactionary behaviours.<sup>302</sup>

- 4.93 Mr MacGregor, Chief Executive Officer of BushMob, also advised the Committee that a particular issue for AOD workers is that, unlike paramedics or police,

We are not legally allowed to touch anyone, restrain anyone, secure anyone, so it makes it really difficult. It is a massive grey area across all service systems.<sup>303</sup>

As highlighted in the literature, in the case of acute toxicity, clinicians and service providers may need to initially manage agitated or aggressive behaviours and psychotic symptoms being exhibited by the users. It is vital that frontline workers exposed to these users are able to recognise these signs and are experienced in de-escalation techniques to employ where necessary. It is also critical that workers understand safety procedures relevant to their work environment to ensure the safety of themselves and other people within the vicinity.<sup>304</sup>

- 4.94 As discussed in more detail in Chapter 5, the Committee notes that premises that are being, or have been, used for the manufacture of 'ice' present additional safety concerns for frontline workers, which agencies need to take into consideration when developing workplace health and safety measures. The Committee also acknowledges the recommendation from the NTPS that:

Where practicable protocols are established and information shared to ensure that all Government and Non-Government agencies who come into contact with Ice users, are operating in an environment where the highest possible work health safety standards are maintained and the risks to individuals are minimised.<sup>305</sup>

#### **Recommendation 4**

**The Committee recommends that the NT Police Service and Departments of Health, Education, Correctional Services and Children and Families undertake an audit of professional development requirements in relation to 'ice' use and ensure that, as a minimum, training of frontline staff includes:**

- a) information on 'ice' and its effects;**

<sup>302</sup> DCF, Committee Transcript, 19 June 2015, p. 3.

<sup>303</sup> BushMob, Committee Transcript, 21 July 2015, p. 5.

<sup>304</sup> N Lee et al., 'Everything old is new again, pp. 75-76.

<sup>305</sup> NTPS, Submission No. 34, 2015, p. 5.

- b) training in de-escalation techniques; and**
- c) appropriate workplace health and safety measures for all staff that may come into contact with 'ice' users or premises that may have been used for the manufacture of 'ice'.**

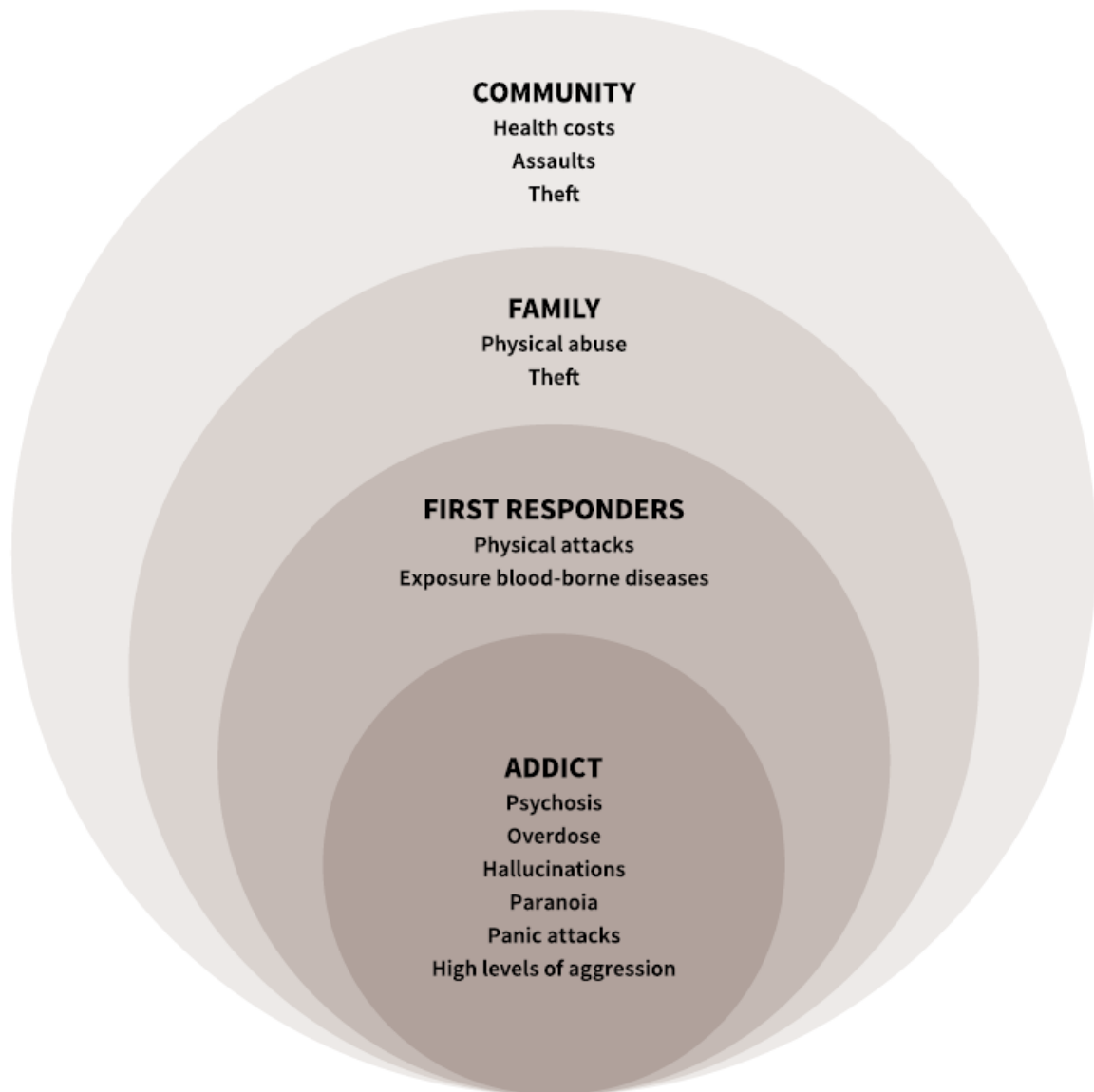
## 5 Social, Community and Environmental Impacts of 'Ice'

### Effects of 'Ice' Use on Families and Children

5.1 As illustrated in Figure 17, the impacts of 'ice' use go well beyond the physical and psychological effects experienced by the 'ice' user. Moreover, as noted in the Australian Strategic Policy Institute's recently released report on methamphetamine:

as ice use rises, the ripple effects of its use increase markedly. Among multiple other issues, psychosis, violence and erratic behaviour due to ice use are becoming more common in large cities and small communities across the nation.<sup>306</sup>

**Figure 17: The Ripple Effects of 'Ice' Use<sup>307</sup>**



<sup>306</sup> J Coyne et.al., *Special Report Methamphetamine Focusing Australia's National Ice Strategy*, p. 8.

<sup>307</sup> J Coyne et.al., *Special Report Methamphetamine Focusing Australia's National Ice Strategy*, p. 10.

5.2 The Committee heard that the effects of 'ice' use on families and children can be quite devastating. As Ms Coalter, Deputy Executive Officer of Amity Counselling Service noted, people with methamphetamine issues commonly report:

problems with relationships, relationship breakdown, domestic and family violence, increased aggression, mental health concerns, anxiety, paranoia, depression, physical health issues, employment issues or unemployment, child welfare and protection problems, housing, financial and legal issues.<sup>308</sup>

5.3 While acknowledging that the effects of 'ice' may vary greatly between families, based on the experience of AOD workers, AADANT noted that there is no doubt that 'ice' has the potential to and is "tearing families apart".<sup>309</sup> Apart from the emotional strain 'ice' use can place on familial relationships, the cost of maintaining a regular or dependent 'ice' habit may result in users and their families experiencing significant financial difficulties; the Committee notes that one gram of 'ice' in the Northern Territory costs between \$1,200 and \$1,600 per gram.<sup>310</sup>

5.4 The Northern Territory Legal Aid Commission noted in their submission that:

Ice usage is now a common factor arising in both care and protection and family law proceedings. The highly addictive nature of the substance, coupled with the lack of insight available to users presents serious challenges to clients understanding the link between the usage and parenting/contact with children.<sup>311</sup>

### **Domestic Violence**

5.5 The Committee heard from a number of organisations and witnesses that 'ice' use is becoming more common in cases of domestic/family violence. The Domestic Violence Legal Service (DVLS) observed that the prevalence of 'ice' as a factor in domestic violence orders has increased significantly in recent times:

Several years ago, ice was rarely mentioned by our clients. In the last 12-18 months, clients have increasingly cited the use of ice to our service and/or in their application for domestic violence orders. Prior to this, we would have averaged one ice related application every three months. It is now not uncommon to have one or two matters a week at court where ice is cited as a major factor for the need for protection.

The increasing prevalence of ice is of such concern due to the level and ferocity of the violence that accompanies its use. We often see cases where the ice user goes on a rampage over a period of three to four days, where the victim is often held against their will and subjected to serious physical and sexual violence.<sup>312</sup>

5.6 The DVLS also noted that:

When a domestic violence order is taken out, they are often in the form of a full non-contact order. This is mainly due to the defendant being unable to have insight into their behaviour and the impact it has on the family ... Often the

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<sup>308</sup> Amity, Committee Transcript, 7 September 2015, p. 3.

<sup>309</sup> AADANT, Submission No. 15, 2015, p. 13.

<sup>310</sup> ACC, *Illicit Drug Data Report 2013-14*, p. 45.

<sup>311</sup> NTLAC, Submission No. 26, 2015, p. 5.

<sup>312</sup> Domestic Violence Legal Service (DVLS), Submission No. 27, 2015, p. 2.

people seeking protection do not wish to press charges. They simply want the violence to stop and for the defendant to seek treatment for their addiction.<sup>313</sup>

- 5.7 In a survey of legal practitioners undertaken by the NTLAC, the following comment was made in relation to 'ice' users and domestic violence:

While alcohol and cannabis remain serious and intractable problems, what makes the increasing prevalence of Ice of such concern is the level and ferocity of the violence that accompanies its use ... their violence is often predicated on delusional thinking, making their actions unpredictable and uncontrollable and causing tremendous grief and distress to family members. Because users are extremely irrational, children and other family members are at greater risk.<sup>314</sup>

The Committee notes that media reports also indicate that women in violent family relationships are in fact starting to use 'ice' or are increasing their level of use to help cope with or provide an escape from their situation.<sup>315</sup>

- 5.8 In 2008, a comparative study into rates of violent crime amongst methamphetamine and opioid users, found that:

Domestic violence is a major concern, and psychostimulant use clearly engenders a proportion of violence. Domestic violence also raises issues about the risk to children of methamphetamine users. It would appear appropriate for treatment agencies admitting methamphetamine users, whether through diversion schemes or otherwise, to conduct a risk assessment of children living in families where the parents are active methamphetamine users.<sup>316</sup>

### ***Neglect of Children***

- 5.9 The effect of drug use on a parent or carer's ability to raise their children is a matter of serious concern to the Committee. Research indicates there are a multitude of risks that children may be exposed to as a result of parental 'ice' use including:

- Being deprived of basic essentials such as food, clothing and medication due to financial mismanagement and money being spent on drugs;
- Lack of supervision or responsiveness to a child's needs while the parent is intoxicated or during the 'comedown' period where they may sleep for several days after a binge;
- Parents' heightened levels of suspiciousness, hostility and delusional beliefs of persecution;
- Exposure to injecting equipment and other drug paraphernalia;
- Exposure to drug use, drug overdose, drug dealing and other criminal behaviour;
- Witnessing violent behaviour;

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<sup>313</sup> DVLS, Submission No. 27, 2015, p. 3.

<sup>314</sup> NTLAC, Submission No. 26, 2015, p. 6.

<sup>315</sup> L Burke, *The unspoken role of ice in Australia's domestic violence*, 29 July 2015, viewed on 5 August 2015, <http://www.news.com.au/lifestyle/real-life/the-unspoken-role-of-ice-in-australias-domestic-violence-problem/story-fnu2q5nu-1227461150488>.

<sup>316</sup> M Torok et al., *Comparative rates of violent crime amongst methamphetamine and opioid users*, p. 27; see also S Dawe et al., *Improving outcomes for children living in families with parental substance misuse*, p. 2.

- Physical and emotional abuse, particularly during intoxication or withdrawal;
- Parental or extra-familial sexual abuse; and
- Children being required to take on a parental role to assume care for themselves, siblings or their parents.<sup>317</sup>

5.10 As Ms Bradford, Chief Executive Officer of the Department of Children and Families, advised the Committee:

Children growing up in families where ice is used are more likely to come into contact with the child protection system because ice-affected parents may not be aware of, or ignore their child's basic needs, either as a result of being affected by ice or as a result of the prolonged coming down period reported by ice users. Ice users report being sexually stimulated when high, thereby increasing risks of sexual exploitation and sexual abuse. Children may witness, or be subject to, violence or punitive or reactionary behaviours if a parent is affected by ice or its after-effects.

Ice using families are often highly chaotic, and over time can affect a child's development and psychological health and wellbeing. Older children may be 'parentified' when they are expected to take on the parenting role for younger children due to parent neglect, and household income is spent on ice rather than on essential household items. There are also immediate and long-term safety risks if children are exposed to the chemicals or manufacturing process involved in ice production in the home.<sup>318</sup>

5.11 The Department of Education's submission to the inquiry noted that while statistics from the Cancer Council's 2011 *Australian secondary school students' use of tobacco, alcohol, and over-the counter and illicit substances* report indicates that amphetamine use by children aged 12 to 17 is 3.2%, "a greater impact on Northern Territory students appears to be caused by family or community use and the resultant dysfunction, abuse and neglect preventing students from adequately participating in education."<sup>319</sup>

5.12 Ms Bradford, Chief Executive Officer of the Department of Children and Families, advised the Committee that the extent of 'ice' use in families referred to the Department is unclear:

First and foremost understanding the prevalence of ice use in the Northern Territory and its impact on the child protection system is quite difficult to quantify. Those using ice or any illicit drug for that matter do not freely admit their use of drugs and under reporting is common. It is certainly not a disclosure that is readily made by parents to child protection workers undertaking investigations or family support work.<sup>320</sup>

5.13 Furthermore, the Committee understands that the Department of Children and Families' database, *Community Care Information System*, has serious limitations as it:

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<sup>317</sup> S Dawe et al., *Improving outcomes for children living in families with parental substance misuse*, pp. 2-4; see also L Bromfield et al., *Issues for the safety and wellbeing of children in families with multiple complex problems*, National Child Protection Clearinghouse Issues No. 33, Melbourne, Australian Institute of Family Studies, 2010, pp. 3-4.

<sup>318</sup> DCF, Committee Transcript, 19 June 2015, pp. 2-3.

<sup>319</sup> DoE, Submission No. 8, 2015, p. 8.

<sup>320</sup> DCF, Committee Transcript, 19 June 2015, p. 2.



does not allow for the recording of information about the use of specific drugs in relation to child abuse and neglect concerns. The 'Substantiated Harm' data that can be reported is the broad measure of 'Alcohol/Drug Abuse'. While this measure indicates that alcohol or other drugs may be a contributing factor to the substantiated investigation, it is not possible to specify which drug or drugs are of concern or what impact the drug use has had in the substantiation of harm. In addition CCIS is a client information system where the child is the client, recording that a child's parent/other person uses a particular substance, (regardless of the type), is not possible and cannot be reported.<sup>321</sup>

The Department of Children and Families advised that it is in the process of reviewing the limitations of the database with the view to moving to a more contemporary database that better meets its needs, subject to available funding.<sup>322</sup>

- 5.14 Consequently, the Committee was unable to obtain statistical data on the number and frequency of child protection investigations involving 'ice' use. However, Ms Bradford informed the Committee that:

anecdotally, there is an increase in notifications and therefore child protection investigations relating to ice. Increases have been noted by my central intake team from December 2013, and are currently reported as predominately evident in Darwin and Alice Springs, but are currently featuring in notifications relating to children in Katherine.

It should be noted that in all instances where ice was reported to central intake, other drug and alcohol use was also reported. Notifications relate to young people using ice with the central intake team estimating around two to three notifications per month. There are approximately four to five notifications about parents using ice each month. The central intake team receives approximately 1200 reports each month, and while the figures for ice-related reports are comparably low, they indicate an emerging trend which is of concern to us.<sup>323</sup>

- 5.15 In instances where child protection workers are concerned that a parent has a problem with substance abuse, the Committee was advised that:

it is common practice in Darwin to request the parent to partake in a drug test. This practice is not commonly used elsewhere however, it would be built into case work practice if the impacts of Ice use increased substantially in other regions. In cases where parental Ice abuse is confirmed, child protection workers may apply to the Court for a Protection Order with a supervision direction requiring the parent to attend sessions at an alcohol and other drugs service and/or family support service to address addiction and to increase parenting capacity.<sup>324</sup>

- 5.16 As noted previously, given that the training provided to child protection workers on substance abuse does not provide practical advice or guidance on determining 'ice' use or addiction, the Committee sought further clarification from the Department on this point and was subsequently advised that:

The Department of Children and Families does not rely on confirmation or otherwise of drug use to assess the safety or risks to a child. The Department of Children and Families can ask an individual to attend a medical diagnostic service for a drug test, but this practice is not consistent across the Northern Territory. Increased cooperation between medical services, police and the

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<sup>321</sup> DCF, Submission No. 33, 2015, pp. 9-10.

<sup>322</sup> DCF, Committee Transcript, 19 June 2015, pp. 4-5.

<sup>323</sup> DCF, Committee Transcript, 19 June 2015, p. 2.

<sup>324</sup> DCF, Submission No. 33, 2015, pp. 10-11.

Department of Children and Families is necessary to respond effectively to families affected by ice.<sup>325</sup>

5.17 The Committee heard from a number of sources, including submissions, discussions at public forums and media reports, that there has been an increase in the number of grandparents looking after their grandchildren due to parental use of 'ice' which, in some instances, results in parents being incarcerated for crimes associated with their drug use. The Committee understands that a support group, *Families Crying out for Help*, recently formed in Darwin to assist family members affected by an 'ice' user.<sup>326</sup> The Department of Education also advised that some principals have noted an increase in the number of students who are being cared for by family members due to their parents being incarcerated or incapacitated as a result of the misuse of 'ice'.<sup>327</sup>

5.18 As noted in the submission from the Department of Children and Families, anecdotal reports indicate:

an increased trend in child protection investigations where contact is being made by grandparents who are assuming protective roles of their grandchildren due to parental methamphetamine or ice use. These extended family members report frustration in having to take on this role due to parental use and lack of service delivery to support the parents and address methamphetamine use. It is considered likely in these circumstances that the actions of the grandparents are affording the children safety thereby not necessitating statutory intervention to ensure the children's protective needs. This has been particularly clear in the Katherine region.<sup>328</sup>

5.19 As Ms Bradford, Chief Executive Officer of the Department of Children and Families, pointed out, better coordination between government departments and the AOD sector would certainly improve support for 'ice' users and their families:

The relationship between child protection services and drug and alcohol agencies is not yet well developed in the Northern Territory, and there are limited illicit drug treatment options available. Better coordination of support for parents and for young people affected by ice and improving the Department of Children and Families referral protocols is warranted. This will become increasingly important if services for ice users develop in the Northern Territory in response to an increasing prevalence.<sup>329</sup>

5.20 Given the above comments, the Committee has concerns about the effectiveness of departmental child protection policies and procedures in place to guide frontline workers in the identification and management of 'ice' use as a factor in potential and substantiated cases of child abuse and neglect.

## **Recommendation 5**

**The Committee recommends that the Government undertake and publish an independent review and evaluation of:**

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<sup>325</sup> DCF, Answer to Question Taken on Notice, Public Hearing, 19 June 2015, p. 1.

<sup>326</sup> DoE, Submission No. 8, 2015, p. 9; R Jones, 'Grandparents call for support as NT fights scourge of ice', *ABC News*, 19 January 2015, viewed on 4 August 2015, <http://www.abc.net.au/news/2015-01-19/grandparents-call-for-support-as-nt-fights-scourge-of-ice/6024524>.

<sup>327</sup> DoE, Submission No. 8, 2015, p. 8.

<sup>328</sup> DCF, Submission No. 33, 2015, p. 11.

<sup>329</sup> DCF, Committee Transcript, 19 June 2015, p. 3.

- a) the adequacy, consistency and effectiveness of Department of Children and Families' guidelines, practices and procedures where individuals with parental responsibility are suspected of drug use;
- b) improvements required of the *Community Care Information System* to facilitate the Department's capacity to record details of family drug and alcohol misuse and its impact in the substantiation of harm; and
- c) the Minister for Children and Families table a copy of the review in the Assembly by the end of the first quarter 2016.

## The Impact of 'Ice' on Communities

5.21 There have been numerous media reports of late, both in the Northern Territory and nationally, regarding the impact of 'ice' on communities. During the course of the inquiry it became evident that, given the nature of 'ice', many people were concerned about their personal safety and criminal offending related to 'ice'; in particular property related offences and crimes involving violence. The submission from the Penington Institute also noted that:

A strong relationship between health issues in the workplace and overall community wellbeing and functioning exists, in terms of both economic and social impact on businesses, families, communities. Where health issues arising from drug use are present in the workplace, the effect is felt throughout the Australian economy and community.<sup>330</sup>

### *Criminal Offending Related to 'Ice' Use*

5.22 Deputy Commissioner Payne (NTPS) noted that the police have observed:

an increase in the connection between the use of ice and other offending. Predominantly that was in property offending associated with being able to afford your habit essentially...We also have seen that of the offences investigated by Serious and Major Crimes Squads in the Territory a significant number are either directly or indirectly associated with ATS use including ice, and we have seen an increase in the number of information reports submitted over a three-year period relating to ATS including ice.<sup>331</sup>

5.23 The Committee notes that research indicates that "involvement in illicit drug markets, and other situational factors associated with a dependent drug-using lifestyle, universally increase the risk of being exposed to violence."<sup>332</sup> Moreover, given the nature of 'ice', it is acknowledged that:

Police perceptions that methamphetamine use is associated with higher levels of aggressive behaviour and violence appear to be well founded. ... Methamphetamine users are unpredictable, high proportions have psychotic symptoms, and are liable to an agitated delirium that evokes violent behaviours. It should also be born in mind that psychostimulants are one of the most commonly detected classes of illicit substances found amongst homicide offenders and victims. In dealing with methamphetamine users, police need to

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<sup>330</sup> Penington Institute, Submission No. 10, 2015, p. 19.

<sup>331</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 3.

<sup>332</sup> M Torok et al., *Comparative rates of violent crime amongst methamphetamine and opioid users*, p. 23.

be aware of the high potential for pharmaceutically induced violence, even amongst street-level users not involved in dealing networks.<sup>333</sup>

5.24 As Deputy Commissioner Payne (NTPS) informed the Committee:

we have also seen a growth in the number of violent crimes associated with ice. It is less so with someone being ice affected and then committing an assault per se, but more so violence that is associated with the dealing and the transaction elements surrounding ice, that is dealers upon dealers.<sup>334</sup>

Ms Cohen, Executive Director of Youth Justice, also noted that:

We are seeing a change in offence type, especially in youth justice, where their offences are becoming far more violent than what we once typically called a youth offence. The severity of offences linked to drugs is increasing, and we have seen that over the last three years.<sup>335</sup>

5.25 The Department of Correctional Services further advised that young people admitted to youth detention centres have self-reported using large amounts of 'ice' prior to incarceration and have freely admitted to committing crimes to fund their illicit drug use.<sup>336</sup> As Mr Mitchell, Clinical Services Manager of Banyan House pointed out:

You just have to go back to a lot of the discussions around the economics of methamphetamine in the Northern Territory - it is a lot more expensive. If you become dependent on methamphetamine in the Northern Territory you will have to find sources of funding, which will usually be involved in criminality unless you have a high paying job.<sup>337</sup>

5.26 The Committee is also aware that there are situations in which 'ice' is being used as a form of currency and that some people will go to extreme lengths to fund their addiction. The Committee heard disturbing reports that "young boys are being groomed to commit crimes and be paid for in ice, and young girls are being sexually groomed and asked to perform sexual acts to be paid for in ice".<sup>338</sup> In a recent case before the Northern Territory Supreme Court, a man was convicted of 50 property-related offences that were committed to maintain his 'ice' addiction. During the trial, the Court was told that the man, who was running a business that was financially struggling, paid a teenage employee in 'ice', which resulted in the teenager also becoming addicted.<sup>339</sup>

5.27 The Northern Territory criminal justice system database does not have the capacity to identify offences that are committed by individuals under the influence of 'ice' at the time of the offence. The involvement of drugs or alcohol during an apprehension can be recorded in the database however the information is not specific to the drug involved. While it is possible to identify if a number of offences have been committed at the time of apprehension, such as drug and property offences, this

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<sup>333</sup> M Torok et al., *Comparative rates of violent crime amongst methamphetamine and opioid users*, p. 27.

<sup>334</sup> NTPS and AFP, Committee Transcript, 19 June 2015, p. 3.

<sup>335</sup> DCS, Committee Transcript, 19 June 2015, p. 3.

<sup>336</sup> DCS, Submission No. 23, 2015, pp. 2-3.

<sup>337</sup> Banyan House, Committee Transcript, 19 June 2015, p. 6.

<sup>338</sup> DCS, Committee Transcript, 19 June 2015, p. 2.

<sup>339</sup> C McGrath, 'Darwin man Ricky-Lee Jones paid teenage for work with drug ice, jailed for six years', *ABC News*, 2 October 2015, viewed 14 October 2015, <http://www.abc.net.au/news/2015-10-02/ricky-lee-jones-jailed-after-teen-paid-for-work-with-ice/6823676>.

does not indicate whether the offender was under the influence of 'ice' at the time of the offending.<sup>340</sup>

- 5.28 To more accurately assess the incidence and prevalence of 'ice' use, or other illicit substances, in crimes involving violence, the Australian Hotel Association suggested that people arrested for offences involving violence should undergo mandatory drug testing:

Currently anyone involved in violent crimes in and around licensed premises are presumed and perceived to be under the influence of alcohol. While this may be correct in some cases and is often confirmed by a breath analyses by Police, there is no way to know if the violent offender was under the influence of illicit substances. With current data suggesting 20% of people attending late night entertainment precincts have consumed illicit substances, by not mandating drug tests, it is unknown what percentage of illicit drug users then go on to commit violent acts in and around licensed premises.<sup>341</sup>

As previously discussed, correctional services staff also indicated that in order to determine the most appropriate treatment regime, individuals suspected of being under the influence of drugs should be tested when first apprehended by police.

### **Recommendation 6**

**The Committee recommends that the Government introduce mandatory drug and alcohol testing of individuals arrested for offences involving violence.**

### **Crime Stoppers**

- 5.29 During the course of the inquiry, the Committee heard on a number of occasions that one of the challenges for law enforcement agencies is obtaining intelligence from members of the public. Given that the correlation between methamphetamine use and violent offending is well established, the Committee found that there was a significant level of reluctance on the part of the general public when it came to informing police of drug related activities.<sup>342</sup> As Mr Blaney, an AOD worker with Wurli Wurlinjang Health Service pointed out to the Committee:

I have a client I work with whose neighbour is dealing and he knows this guy has done gaol for significant violent offences and he is terrified. ... He is terrified to say anything, and I am trying to encourage him to put it forward but he will not because he says if the police rock up there ... this bloke would kill him. ... Overcoming that is an issue – the fear – because as you know, people who use ice can become physically violent in most cases so these people are too terrified to report it.<sup>343</sup>

- 5.30 The issue of anonymity was also raised at both the Katherine and Alice Springs public forums, with participants acknowledging that relationships and proximity to incidents relating to drugs resulted in under reporting. However, as Commander Warren (NTPS) noted:

<sup>340</sup> DAGJ, Submission No. 4, 2015, p. 4

<sup>341</sup> Australian Hotel Association (AHA), Submission No. 29, 2015, p. 2.

<sup>342</sup> M Torok et al., *Comparative rates of violent crime amongst methamphetamine and opioid users*, p. 25.

<sup>343</sup> Committee Transcript, Katherine Public Forum, 14 July 2015, p. 5.

I think it is really important to put the reporting issue in a broader context, especially in Central Australia. I imagine the people you spoke to in Katherine – it would be quite a similar scenario. The issues around reporting are not restricted to this category of drug; they are related to being in a small community. We find with domestic violence enforcement in a more remote community, say Papunya or Yuendumu, people feel if you say something about an issue, everyone in the community will know about it. It is not an issue restricted to drugs, but it is a very real issue in small communities in the Northern Territory.<sup>344</sup>

- 5.31 While Commander Warren pointed out that, in close knit communities or where individuals might be concerned about retribution, information could be passed on to police via the free call *Crime Stoppers* number, it was evident that it was not generally understood that information could be provided anonymously:

Police respect the right to stay anonymous and, in relation to drug information, we are legally bound to keep that information confidential. We do not share that information. ... Sometimes we get information about criminal behaviour, and because we know that if we act on it at that time we will give up the person who told us the information, we might tend to just hold that information until we can verify it in a different way. It is important to protect sources of information. ... I think Crime Stoppers is the best way to stay anonymous and remote from police and still share information. ... We could probably do more around advertising the anonymous aspect of Crime Stoppers.<sup>345</sup>

- 5.32 Commander Warren also noted that where the threat of retribution was of concern, people could always request a third party to contact police on their behalf:

If you came to us and said, "I have information that has been passed on by someone I cannot identify", we would categorise that in our database as information that is not as valuable as knowing the source, but it still forms a picture. So it is still useful to us. ... Maybe we could do more work around advertising that as an alternative.<sup>346</sup>

## **Recommendation 7**

**The Committee recommends that the NT Police Service increase and improve the quantity and quality of its public engagement strategies, including greater promotion of *Crime Stoppers*, to encourage the general public to report information regarding the manufacture, distribution and use of drugs.**

## ***Drug Use in the Workplace***

- 5.33 The impact of drug use in the workplace, in particular 'ice', has attracted considerable media attention of late, and for very good reasons. The Committee heard that:

Currently, methamphetamine and other drug use may result in lateness and absenteeism, lost time and reduced production and work quality as a result of incidents and injuries. There may also be losses associated with inefficiency and damage to plant, equipment and other property.<sup>347</sup>

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<sup>344</sup> Committee Transcript, Alice Springs Public Forum, 21 July 2015, p. 3.

<sup>345</sup> Committee Transcript, Alice Springs Public Forum, 21 July 2015, p. 4.

<sup>346</sup> Committee Transcript, Alice Springs Public Forum, 21 July 2015, p. 4.

<sup>347</sup> Penington Institute, Submission No. 10, 2015, p. 19.

5.34 As illustrated in Table 15, given the prevalence of drug use amongst the working population, the Penington Institute noted that:

A comprehensive strategy is required that includes policies and programs directed towards AOD use in, or associated with, employment and workplaces. Resources should be directed towards assisting employers to establish AOD policies and programs to ensure that misuse of alcohol or drugs in a workplace context can be dealt with ethically, legally and to the benefit of both the company and the employee. However, punitive approaches, such as drug testing for methamphetamine use, and dismissal upon positive results, are not beneficial. Workers have a better chance of recovery from illicit drug use if they are still working. Delivering early intervention and harm reduction strategies to these industries is a challenge, but an area worthy of action. The workplace is an ideal place to run effective drug and alcohol prevention programs because the peer support network in a workplace can be used to shape behaviour.<sup>348</sup>

**Table 15: Percentage of workforce that used a drug at least once for non-medical purposes<sup>349</sup>**

Industry	Use last 12mths months	Use last month	Occupation	Use last 12mths months	Use last month
Hospitality	31.8%	21.5%	Tradespersons	26.5%	16.5%
Construction	24.2%	14.4%	Skilled worker	21.7%	10.5%
Retail	20.7%	11.9%	Unskilled worker	17.4%	13.5%
Transport	18.3%	11.1%	Managers	14.5%	7.7%
Finance	17.4%	9.8%	Professionals	13.7%	9.8%
Manufacturing	17.2%	10.1%			
Wholesale	16.4%	8.1%			
Agriculture	15.8%	9.6%			
Services	15.1%	9.2%			
Admin/defence	12.4%	8.6%			
Mining	12%	5.6%			
Education	9.2%	5.4%			

5.35 The Committee notes that an increasing number of industries are implementing, or are required to implement, workplace drug testing regimes to ensure that they comply with workplace health and safety requirements relating to the mitigation of risks. As Mr Malone, Executive Director of Master Builders Association NT, pointed out:

The model occupational health and safety legislation today makes employers and managers responsible for foreseeable risks. If a risk was foreseeable and something occurred they are personally liable, not just as a corporation, which might have been the case some time ago. In parallel, of course, individuals are now responsible for their own colleagues as well... We have been saying to our membership if we think intoxication is a foreseeable risk, that by not implementing a program of their own they are leaving themselves personally exposed to potential sanctions of one kind or another if they do not do

<sup>348</sup> Penington Institute, Submission No. 10, 2015, p. 19.

<sup>349</sup> K Pidd & A Roche, *Workplace Drug Testing: Evidence and Issues*, National Centre for Education and Training on Addiction, Flinders University, Adelaide, 2011, p. 6.

something about it. ... there has to be zero tolerance to intoxicated people onsite.<sup>350</sup>

5.36 The Committee notes that recent amendments to the *Building Code 2013* now require that principal contractors on Commonwealth Government funded projects implement workplace drug testing.<sup>351</sup> Drug tests may be conducted through urinalysis and saliva testing, and must comply with the following minimum testing requirements:

- Where there are less than 30 workers on site – at least 10% of the workforce;
- Where there are 30 to 100 workers on site – a minimum of 5 workers per month; and
- Where there are greater than 100 workers on site – a minimum of 10 workers per month.<sup>352</sup>

5.37 In many industries, such as the mining, transport, oil and gas sectors, pre-employment drug testing and random drug testing of the workforce is commonplace. Mr Townsend, General Manager External Affairs and Joint Venture, INPEX, advised the Committee that:

Employment offers are contingent on a negative alcohol and other drugs, or AOD, result. Secondly, a fitness for work procedure provides for regular AOD testing of personnel which can either be blanket or randomly applied. ... Testing is also implemented following certain work-related incidents or where personnel may be thought to be affected by AOD. ... Third is training and awareness programs ... Fourth is an employee counselling and assistance program.<sup>353</sup>

Mr Townsend further advised that to date JKC has undertaken 425,000 breath alcohol tests with 232 (.05%) returning a positive result. In addition 17,855 drug saliva tests have been conducted with 11 (.06%) returning a positive result.<sup>354</sup>

5.38 Ms Bilato, Executive Officer of the NT Road Transport Association, noted that transport drivers expect to undergo workplace drug testing:

any company that has contracts that go out onto any of the mine sites, that go onto the port, that go to the rail yard in Alice Springs, that deliver fuel to the airport, for example, all have stringent drug and alcohol testing regimes in place. That also is a clear indicator to those drivers that if they are not being tested today they could be tested tomorrow. People will invariably be aware that that is a very high likelihood. Probably in excess of 10 of the 15 companies that I spoke said their drivers had been tested three and four times this year by various companies that they do work with, which is quite significant when you look at the broader population.<sup>355</sup>

5.39 Nevertheless, workplace drug testing remains a controversial issue and has resulted in a number of challenges to State and Commonwealth Industrial Relations

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<sup>350</sup> Master Builders Association NT, Committee Transcript, 7 September 2015, p. 4.

<sup>351</sup> Fair Work and Building Construction, *Drug and Alcohol Testing under the Building Code 2013*, Australian Government, viewed on 14 October 2015, <http://www.fwbc.gov.au/drug-and-alcohol-testing-under-building-code-2013>.

<sup>352</sup> Fair Work and Building Construction, *Drug and Alcohol Testing under the Building Code 2013*.

<sup>353</sup> INPEX & JKC Australia LNG Pty Ltd, Committee Transcript, 7 September 2015, p. 3.

<sup>354</sup> INPEX & JKC Australia LNG Pty Ltd, Committee Transcript, 7 September 2015, pp. 3-4.

<sup>355</sup> NT Road Transport Association, Committee Transcript, 7 September 2015, p. 2.



Commissions by workplace union organisations.<sup>356</sup> As noted above, the most common methods of workplace drug testing are urinalysis and saliva testing. Table 16 outlines the advantages and disadvantages of each method.

**Table 16: Advantages and disadvantages of urinalysis and saliva testing<sup>357</sup>**

<i>Urinalysis</i> involves the employee producing a urine sample into a sterile tamper-proof container.		<i>Saliva testing</i> involves collection of a sample of saliva from inside the mouth using a swab or pipette.	
Advantages	Disadvantages	Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Inexpensive</li> <li>• Fully developed methodology</li> <li>• More reliable for detecting past use</li> <li>• Fewer sample storage issues</li> </ul>	<ul style="list-style-type: none"> <li>• Intrusive</li> <li>• Wide window of detection for cannabis (days/wks)</li> <li>• May not detect very recent use of some drugs</li> <li>• Requires appropriate collection facilities</li> <li>• Time consuming</li> <li>• Donor may not be able to readily provide a specimen</li> <li>• Dilution, adulteration, or substitution of urine easier compared to other methods</li> </ul>	<ul style="list-style-type: none"> <li>• Relatively un-intrusive</li> <li>• Swab wipe only</li> <li>• Narrow window of detection</li> <li>• Can detect current/recent use</li> <li>• Specimen available immediately</li> <li>• Less opportunity for substitution, dilution, or adulteration</li> </ul>	<ul style="list-style-type: none"> <li>• Can be difficult to collect sufficient quantities for confirmatory analysis</li> <li>• Oral contamination can adulterate or dilute the sample</li> <li>• Can be time consuming</li> <li>• Donors need to be supervised for up to 30 mins prior to sample collection to minimise oral contamination</li> <li>• Cannot detect intoxication or impairment</li> <li>• Ability to reliably detect cannabis use questioned</li> </ul>

5.40 While workplace drug testing may play a role in improving workplace safety and reducing the level drug use, the Committee notes that the:

evidence is inconclusive regarding the efficacy of drug testing in reducing workplace accidents and injuries. While there is some limited evidence that testing can reduce injury and accident rates, more rigorous studies indicate testing has only a small effect or no effect at all. Evidence of any deterrent effect of workplace testing is also inconclusive. The few studies that have utilised rigorous methodologies indicate that workplace testing has either no deterrent effect, or only a very small deterrent effect.<sup>358</sup>

## Environmental Impacts of 'Ice'

5.41 As previously discussed, clan labs can be set up virtually anywhere including private residences, motel rooms, vehicles, public places and commercial buildings. In addition to the precursors, a broad range of chemicals are used in the manufacturing process, many of which have toxic side effects that will contaminate the clan lab site, including:

- Solvents (e.g., acetone, ether/starter fluid, methanol, white gas, xylene), which have been linked to irritation to skin, eyes, nose and throat; headaches; dizziness; depression; nausea; vomiting; visual disturbance and cancer;

<sup>356</sup> Australian Drug Foundation, *Policy Talk: Workplace drug testing*, Australian Drug Foundation, November 2012, viewed on 14 October 2015, <http://www.adf.org.au/policy-advocacy/policy-talk-november-2012>.

<sup>357</sup> K Pidd, A Roche & M White, *Workplace Drug and Alcohol Testing*, National Centre for Education and Training on Addiction, Flinders University, Adelaide, October 2011, p. 2.

<sup>358</sup> K Pidd & A Roche, *Workplace Drug Testing: Evidence and Issues*, p. vi.

- Corrosives/irritants (e.g., anhydrous ammonia, hydriodic acid, hydrochloric acid, phosphine, sodium hydroxide, sulphuric acid), which have been linked to coughing; eye, skin and respiratory irritation; burns and inflammation; gastrointestinal disturbances; thirst; chest tightness; muscle pain; dizziness; and convulsions; and
- Metals/salts (e.g., iodine, lithium metal, red phosphorous, yellow phosphorous, sodium metal), which have been linked with eye, skin, nose and respiratory irritation; chest tightness; headaches; stomach pain; birth defects; and jaundice/kidney damage.<sup>359</sup>

5.42 Mr Hansford, Acting Executive Director of Strategy and Specialist Capability (ACC), advised the Committee that:

There is a whole range of different types of domestic manufacture ranging from an addict-based clandestine laboratory, which is done primarily to support addict-based people and that is high risk because people set it up potentially in hotel rooms or car boots and there is a lot of potential to go wrong, right up to an industrial organised crime-based meth lab ... All of them have a chance to go wrong, and some of the houses you might have seen in pictures of houses raided by police - the detrimental impact to the house and the surrounding environment is not just for the next month, it is for years and years ahead. The remediation of clandestine laboratories is a particular issue, and those living next to clandestine laboratories are particularly at risk. We have seen them in a whole range of different places and it only takes a child to walk into a clandestine laboratory and there will be catastrophic impacts.<sup>360</sup>

5.43 The Committee understands that contamination from clan labs may be transient or residual. A number of gas by-products, including ammonia and phosphine, are transient and are likely to only remain present in the air for a short period of time after active drug production. Residual contaminants include vapours from liquids that can be retained in soft furnishings such as carpets, furniture and bedding, or on hard surfaces after the drug production has ceased. Residual contaminants may also be in the form of surface deposits such as salts or liquids that absorb into porous surfaces such as plasterboard. Many of the residual contaminants produced during methamphetamine production are of a highly hazardous nature and include heavy metals and carcinogens. It is important to note that while the by-products of methamphetamine production are a cause for concern, the residual methamphetamine that remains in a clan lab is one of the key contaminants of concern in terms of public health risk and remediation.<sup>361</sup>

5.44 In clan labs, contaminants are commonly inhaled, absorbed through the skin or ingested. The effects of exposure depend on the level of contamination and the length of exposure. Acute exposure to high levels of toxic chemicals, some of which are highly corrosive, generally occurs during the manufacturing process and will mainly affect the eyes and respiratory system. Chronic effects may also occur from exposure to lower contaminant levels over an extended period of time. Acute and chronic effects may also result from the dumping of the toxic waste by-products left over from the manufacturing process. Exposure to residual methamphetamine,

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<sup>359</sup> Department of Health and Aging, *National Amphetamine-Type Stimulant Strategy Background Paper*, p. 54.

<sup>360</sup> ACC, Committee Transcript, 19 June 2015, p. 5.

<sup>361</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, p. 7.

whether acute or chronic, causes the same physical and psychological effects that result from intentionally consuming methamphetamine.<sup>362</sup>

- 5.45 The Committee notes that contaminants that are present in clan labs pose a health risk to everyone exposed to them. People that are present in a clan lab during production, generally the 'cooks', will be exposed to the transient contaminants. However, there are often other occupants within a clan lab dwelling, children and family members, who may also be exposed, albeit at a lower level. In the case of children, it is estimated that around one third of methamphetamine lab detections have children associated with them.<sup>363</sup>
- 5.46 Children are highly susceptible to the risk of exposure to clan lab contaminants for a number of reasons. Young children are likely to come into contact with contaminants on the floor through crawling or playing on the floor and are also likely to put objects that may be contaminated into their mouths. Data from the United States illustrates the detrimental health effects for children exposed to methamphetamine clan labs:
- 2028 children were present at seized methamphetamine laboratory sites and 35% of those tested positive for toxic levels of chemicals. Health effects for children exposed to these chemicals include gastrointestinal problems, chemical burns, brain damage, headaches, skin and eye irritations, tachycardia, agitation, irritability and vomiting.<sup>364</sup>
- 5.47 The risk of exposure to residual contaminants in a clan lab extends to a much larger group of people who may unknowingly come into contact with the contaminants. This may include family and children who are not present during the manufacturing process; future tenants in residential dwellings where a clan lab has not been detected and remediated; tradesmen working in confined contaminated spaces; friends and visitors; and police or other authorities that are involved in the discovery of a clan lab.<sup>365</sup> The Committee understands that it is not uncommon for fires and explosions to occur in clan labs which can result in immediate health risks from exposure to toxic chemicals, and may cause long term disabilities or even death. It is estimated that up to 20% of residential clan labs are identified as a result of fire or explosion.<sup>366</sup>
- 5.48 Environmental contamination of soil and water can occur when contaminants and toxic by-products are dumped after methamphetamine production. In small residential dwelling clan labs, this is likely to occur within the surrounds of the property such as in the garden or down drains. However, in the case of larger scale production:

It is estimated that a clandestine laboratory manufacturing methylamphetamine generates up to 10 kilograms of hazardous and toxic waste for each kilogram of pure methylamphetamine produced. Toxic chemicals and residues have been

<sup>362</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, pp. 12-15.

<sup>363</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, p. 11.

<sup>364</sup> Department of Health and Aging, *National Amphetamine-Type Stimulant Strategy Background Paper*, p. 54.

<sup>365</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, p. 12.

<sup>366</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, p. 14.

found dumped into drains, rivers, public parks, on roadsides and in sewerage systems, posing immediate and long-term environmental health risks.<sup>367</sup>

5.49 The Australian Government has developed the *Clandestine Drug Laboratory Remediation Guidelines* for regulatory authorities to undertake investigations and remediation of sites contaminated from the operation of clan labs. The Guidelines are designed to:

assist appropriate authorities in administering their respective environmental acts and regulations in addressing contamination arising from clandestine laboratories adequately and in a nationally consistent manner, and in this way provide protection to their local community and the environment. Further, the Guidelines will provide assistance for environmental professionals and landowners to meet appropriate assessment, remediation and reporting criteria.<sup>368</sup>

As illustrated in Figure 18 below, the Guidelines outline the four phases of clan lab site remediation and the appropriate course of action for each.

5.50 In their submission to the Committee, the NTPS noted that:

By their very nature these labs create an extremely dangerous environment for the community and police officers. To ensure best practice and officer safety, standard operating procedures for NT Police are that the response to any suspected clan lab is undertaken by a team who have had specialised training.<sup>369</sup>

5.51 The NTPS provided further information to the Committee on the workplace health and safety measures they have developed in recognition of the dangers posed to frontline workers and third parties that come into contact with clan labs:

All personnel who respond to and process illicit clandestine laboratories are appropriately trained in the various methods of manufacture, stages of production, likely hazards and utilisation of breathing apparatus. These personnel are also issued with personal protective equipment and clothing specifically purchased for these duties. The response that personnel take at the scene of a clandestine laboratory and the level of the safety equipment that they must wear is dictated by the forensic chemist who first enters the scene with an 'initial entry team' to make this assessment. An 'initial entry team' is comprised of a police officer, a forensic chemist and a NT Fire and Rescue officer.

On a case-by-case basis if any first responders or third parties have been exposed to clandestine laboratories then they are provided with necessary advice by the forensic chemist and police at the time of conducting an investigation into the laboratory that has been discovered. The NTPF is currently in the process of producing an information pamphlet that will provide health and safety information to those persons who may have come into contact with a clandestine laboratory or may have to remediate a scene after its dismantlement and removal. The most hazardous phase for a clandestine laboratory is where apparatus and chemicals are present prior to police response. In these circumstances the environment is potentially contaminated with lethal toxic fumes and potentially highly vulnerable to explosion.<sup>370</sup>

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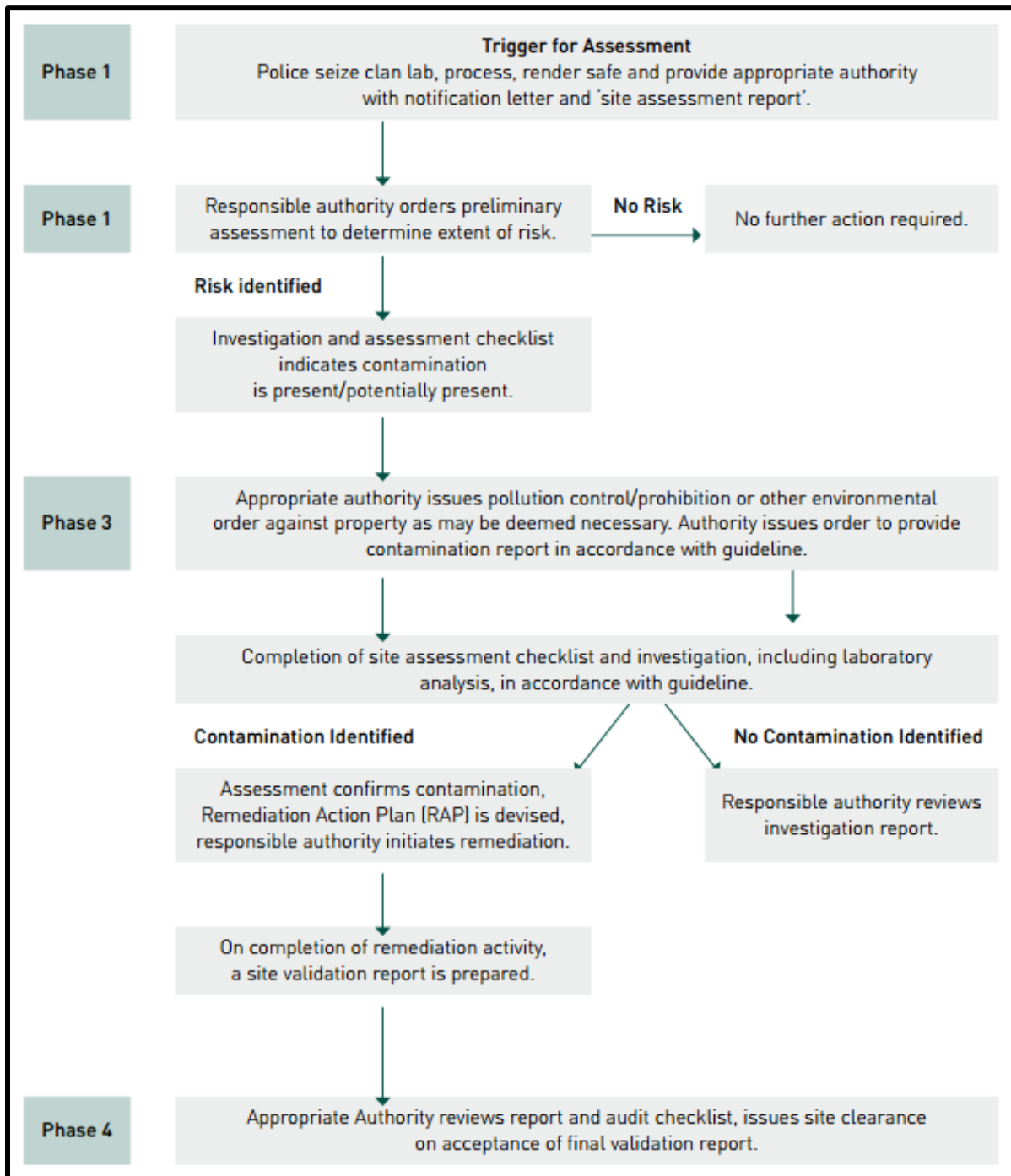
<sup>367</sup> Australian Crime Commission (ACC), *The Australian Methylamphetamine Market – The National Picture*, Canberra, Commonwealth of Australia, 2015, p. 20.

<sup>368</sup> Attorney-General's Department (AGD), *Clandestine Drug Laboratory Remediation Guidelines*, Canberra, AGD, 2011, p. 2.

<sup>369</sup> NTPS, Submission No. 34, 2015, p. 21.

<sup>370</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 9.

Figure 18: General Process for Site Investigation and Reporting<sup>371</sup>



5.52 The Northern Territory Department of Health advised the Committee that it is currently working on the development of local Environmental Health Guidelines and public information for clan lab remediation, in collaboration with Northern Territory Police, Fire and Emergency Department and the Northern Territory Environmental

<sup>371</sup> AGD, *Clandestine Drug Laboratory Remediation Guidelines*, p. 4.

Protection Authority.<sup>372</sup> The Department informed the Committee that in the Northern Territory, the Environmental Health Branch is responsible for:

issuing warnings and remediation information to residents and landowners on the risks to human health and safety arising from the residual contamination from illicit drug manufacture and use. At the time of preparing this submission, DoH has dealt with four reported clandestine drug laboratory detections since November 2014 (three in Alice Springs and one in Darwin). ... currently in the Northern Territory there are no clandestine drug laboratory remediation and assessment services, while waste management of residual contaminants of chemical waste is currently transported and disposed at interstate depots.<sup>373</sup>

5.53 The Department of the Attorney-General and Justice noted that while it has not been requested to consider legislative reforms regarding the remediation of premises used as clan labs, the *Sentencing Act*, the *Criminal Property Forfeiture Act* and the *Misuse of Drugs Act* contain provisions that may be used by NTPS and other agencies to recover costs incurred as a result of remediation:

Section 89 of the *Sentencing Act* contains powers for a court to “order an offender to pay the reasonable costs incurred by the Territory arising out of the commission of the offence including the costs of removing, disposing, dispersing, destroying, rehabilitating and cleaning up a thing used in or associated with the commission of the offence” Section 88(c) ... may also be applicable where the offence occurs in or on public housing. Section 88(c) notes that a court may order an offender to: “pay compensation for the loss or destruction or damage to property that occurs in the course of or in connection with the commission of an offence.”

[T]here are provisions in the *Criminal Property Forfeiture Act* relating to the forfeiture of crime-used property and crime-used property substitution provisions are applicable where the property used is not owned by the offender. The *Misuse of Drugs Act* also contains ‘declared drug trafficker’ provisions that allow a court to forfeit all property owned by a qualifying offender, regardless of whether the property was used or derived from the commission of an offence.<sup>374</sup>

5.54 The Committee notes that it has been estimated that only 1 in 10 clan labs are detected in Australia.<sup>375</sup> Assuming this is the case, methamphetamine production represents a serious public health risk given the toxic residual contaminants that remain in buildings and the likelihood that people will be unknowingly exposed to them. This is particularly the case in high traffic areas such as motel rooms and rental properties, given that the property owners may be unaware of the contamination or may not seek to remediate the property due to the high cost involved.<sup>376</sup>

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<sup>372</sup> NT DoH, Submission No. 5, 2015, p. 11.

<sup>373</sup> NT DoH, Submission No. 5, 2015, p. 11.

<sup>374</sup> Department of Attorney-General and Justice, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 3

<sup>375</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, p. 6.

<sup>376</sup> enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, p. 12 & R Puddy, ‘Former meth labs ‘toxic death traps’’, *The Australian*, 13 October 2015.

## 6 Government and Community Responses to 'Ice'

### National Drug Strategy

6.1 Australia's National Drug Strategy (NDS) 2010-2015 is the overarching policy framework for the formulation of national, state and territory drug, alcohol and tobacco policies. The NDS was first developed in 1985 to establish a coordinated policy approach towards substance misuse utilising the harm minimisation approach. The NDS is built upon the three central and equally important pillars of demand reduction, supply reduction and harm reduction, which combined aim to minimise the harms caused through substance use and misuse as outlined below:

- **Demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol, tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community.
- **Supply reduction** to prevent, stop, disrupt or otherwise reduce the production of illegal drugs; and control, manage and/or regulate the availability of legal drugs.
- **Harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.<sup>377</sup>

6.2 Demand reduction recognises that preventing drug use is more cost effective than treating drug related problems. The following objectives and actions, while not exhaustive, form the basis of the demand reduction pillar:

- **Prevent the uptake and delay the onset of drug use:** promotion of healthy lifestyles; school based education and public awareness campaigns using the internet and other media; reducing exposure to tobacco and alcohol advertising; encouraging responsible and accurate media portrayal of alcohol, tobacco and illicit drug use; and developing treatment and family support approaches to prevent and break patterns of drug use including intergenerational patterns.
- **Reduce use of drugs in the community:** increasing awareness of and accessibility to appropriate treatment and support services for both drug users and their families; promotion of available telephone and internet counselling and support services; targeted screening and interventions for at-risk groups; implementing early intervention programs including brief interventions by primary health care workers; and increased diversion from the criminal justice system into drug assessment and treatment programs.
- **Support people to recover from dependence and reconnect with the community:** improving referral pathways to drug treatment services and communication between service providers; developing clinical standards for treatment services; improved communication and links between treatment,

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<sup>377</sup> Ministerial Council on Drug Strategy (MCDS), *National Drug Strategy 2010-2015*, Canberra, Commonwealth of Australia, 2011, p. ii. Note: The Intergovernmental Committee on Drugs (previously the MICDS) released its draft National Drug Strategy 2016-2025 for public consultation in October 2015.

welfare and community services such as housing, education and employment; and reducing the stigma associated with drug use and treatment.

- **Support efforts to promote social inclusion and resilient individuals, families and communities:** developing children's resilience particularly through drug prevention education through schools; engaging at-risk groups in community life; and developing support programs targeting life transition points.<sup>378</sup>

6.3 Supply reduction focuses on eliminating illicit drugs by targeting all levels of the supply chain to dismantle drug networks; regulate access to legal drugs including alcohol, tobacco and pharmaceuticals; and controlling precursor chemicals used in the manufacture of illicit drugs. The following objectives and actions related to the supply reduction pillar are:

- **Reduce the supply of illegal drugs:** improved detection of illicit drug and precursor chemical trafficking; increased collaboration and exchange of information between different tiers of law enforcement agencies; improving relationships with international counterparts; and ensuring the currency of legislation so that it reflects changes within the illicit drug market.
- **Control and manage the supply of alcohol, tobacco and other legal drugs:** enforcing the regulation of legitimate supply markets and disrupting illegal markets by improving regulatory frameworks; and providing training to suppliers of pharmaceutical drugs on inappropriate supply and misuse of these substances to prevent diversion of these to the black market.<sup>379</sup>

6.4 The harm reduction pillar acknowledges that some members of society will inevitably use alcohol, tobacco and illicit drugs and aims to reduce the adverse consequences of substance use and abuse to individuals, families and the community. The following objectives and actions are included within the harm reduction pillar:

- **Reduce harms to community safety and amenity:** improving safety in public places where there are high levels of drug and alcohol use; legislation relating to driving under the influence of alcohol and illicit drugs; training and support for frontline workers interacting with people under the influence of illicit drugs and alcohol displaying aggressive and violent behaviours; provision of safe needle and syringe disposal units; and improved awareness of the health and environmental dangers of clandestine laboratories and remediation procedures.
- **Reduce harms to families:** enhancing child and family sensitive practices in treatment services; community education focusing on prevention; improved coordination and referral pathways between treatment, community

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<sup>378</sup> MCDS, *National Drug Strategy 2010-2015*, pp. 9-13.

<sup>379</sup> MCDS, *National Drug Strategy 2010-2015*, pp. 13-16.



and child welfare services; and developing measures to reduce substance use by pregnant women.

- **Reduce harms to individuals:** encouraging safe injecting practices through the provision of needle and syringe programs; raising awareness of the harms associated with drug use; promoting available treatment services and encouraging users to seek treatment; diversion from the criminal justice system into treatment programs; and efforts to prevent drug overdose through withdrawal and pharmacotherapies.<sup>380</sup>

6.5 The Committee notes that in October 2015 the Intergovernmental Committee on Drugs (IGCD previously the MCDS) released its draft *National Drug Strategy 2016-2025* (the Strategy) for public consultation. In proposing a ten year timeframe for the strategy, IGCD notes that:

this reflects the consistent and ongoing commitment to the harm minimisation approach over the National Drug Strategy's 30 year history. The flexible structure of the Strategy allows for responses to be developed to emerging issues and changing policy environments within this framework. The overarching harm-minimisation approach that has proved so successful in previous iterations of the Strategy remains the direction for 2016-2025. The National Drug Strategy 2016-2025 continues to build on the successful collaboration of health and law enforcement agencies in leading the implementation of the three pillars of harm minimisation.<sup>381</sup>

6.6 As illustrated in Figure 20 below, and detailed in Appendix 3, the Strategy is underpinned by four key principles: partnerships; coordination and collaboration; evidence informed responses; and national direction, jurisdictional implementation. The priorities detailed in the Strategy that are considered to be vital in reducing drug-related harm over the next ten years can be summarised as follows:

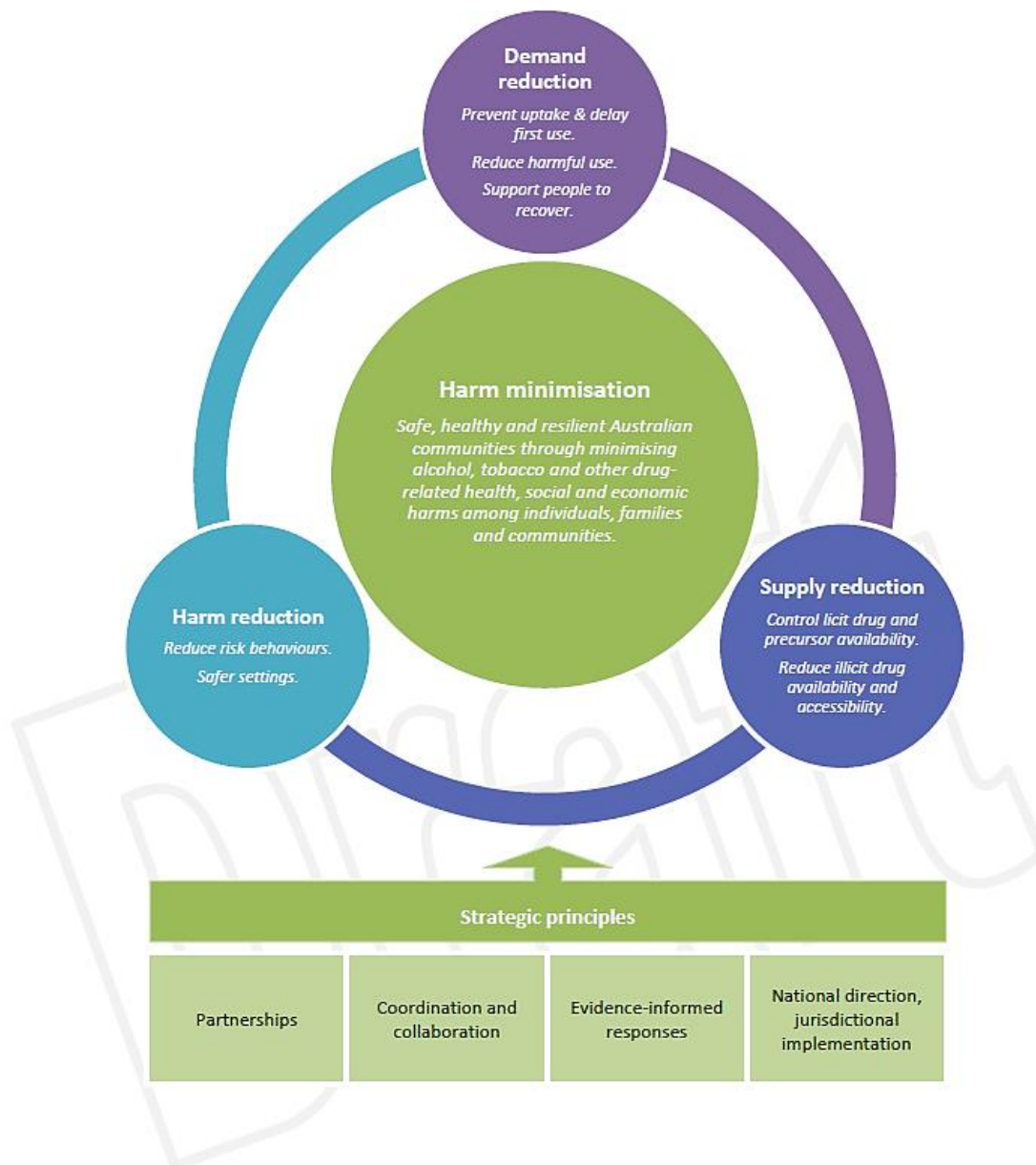
- Increasing processes for community to identify and respond to key alcohol, tobacco and other drug issues;
- Improving national coordination;
- Developing and sharing data and research that supports evidence-informed approaches;
- Developing innovative responses to prevent uptake, delay the first use and reduce harmful levels of alcohol, tobacco and other drug use;
- Restricting or regulating the availability of alcohol, tobacco and other drugs; and
- Enhancing harm reduction approaches.<sup>382</sup>

<sup>380</sup> MCDS, *National Drug Strategy 2010-2015*, pp. 16-19.

<sup>381</sup> Intergovernmental Committee on Drugs, *National Drug Strategy 2016-2025, Draft: for public Consultation*, Australian Government, Canberra, October 2015, p. 3.

<sup>382</sup> Intergovernmental Committee on Drugs, *National Drug Strategy 2016-2025*, p. 3.

Figure 19: National Drug Strategy 2016-2025<sup>383</sup>



6.7 The Committee notes that the extent of the 'ice' problem in some areas of the country has resulted in a re-emergence of drug specific action plans. As detailed in Appendix 4, in April 2015 the National Ice Taskforce was established to work with states and territories with the aim of developing a *National Ice Action Strategy*.<sup>384</sup> The Taskforce presented an interim report to the Council of Australian Governments (COAG) in July 2015 which identified six key action areas where more work needs to be done by all levels of government:

- Targeted primary prevention;
- Improving access to early intervention, treatment and support services;
- Supporting local communities to respond;

<sup>383</sup> Intergovernmental Committee on Drugs, *National Drug Strategy 2016-2025*, p. 8.

<sup>384</sup> Department of Prime Minister and Cabinet, *National Ice Taskforce*, Australian Government viewed on 12 August 2015, <http://www.dpmc.gov.au/taskforces/national-ice-taskforce>.

- Improving tools for frontline workers;
- Focussing law enforcement actions; and
- Improving and consolidating research and data.<sup>385</sup>

The Committee understands that a final report will be provided to the Prime Minister with a final strategy to be considered by COAG before the end of 2015.

### ***Jurisdictional Drug Strategies and Action Plans***

- 6.8 Drug and alcohol strategies vary greatly between the states and territories, both in their currency and specificity regarding different types of illicit drugs. At the time of writing, the drug and alcohol strategies in New South Wales and the Australian Capital Territory had both lapsed and Victoria was the only jurisdiction with a methamphetamine/‘ice’ specific action plan. Although Western Australia’s *Mental Health, Alcohol and Other Drug Services Plan* is current through to 2025,<sup>386</sup> Opposition Leader Mark McGowan has advocated for a specific Methamphetamine Action Plan given that NDSHS data indicates WA has the highest rate of methamphetamine use in the country at 3.8% of the population.<sup>387</sup>
- 6.9 In 2013 the Parliament of Victoria established its *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria* to be undertaken by the Law Reform, Drugs and Crime Prevention Committee in response to the heightened concern by the government and community about the level of ‘ice’ use within the state and the impacts it was having on individuals, families and the community. The Committee tabled its report in September 2014 which contained 54 recommendations including:
- Strategies to address the manufacture, supply and distribution of ice;
  - Prevention and early intervention responses;
  - Support for frontline workers;
  - Issues in treatment and support for ice users and their families;
  - Harm reduction strategies;
  - Strategies to address drug related crime; and
  - Research priorities.<sup>388</sup>
- 6.10 The Law Reform, Drug and Crime Prevention Committee recommended the establishment of a Ministerial Council on Methamphetamine comprised of the Premier, particular ‘lead’ Ministers and their senior executive staff to be tasked with the development and implementation of a state wide methamphetamine action plan. The Law Reform Committee acknowledged that:

While in recent years there has been a move away from specific drug strategies to relying on a single overarching alcohol and other drug strategy, the Committee believes that when it comes to methamphetamine, in particular

<sup>385</sup> Department of Prime Minister and Cabinet, *National Ice Taskforce*.

<sup>386</sup> Government of Western Australia Mental Health Commission, *The Western Australia Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, viewed 27 October 2015, <http://www.mentalhealth.wa.gov.au/ThePlan.aspx>.

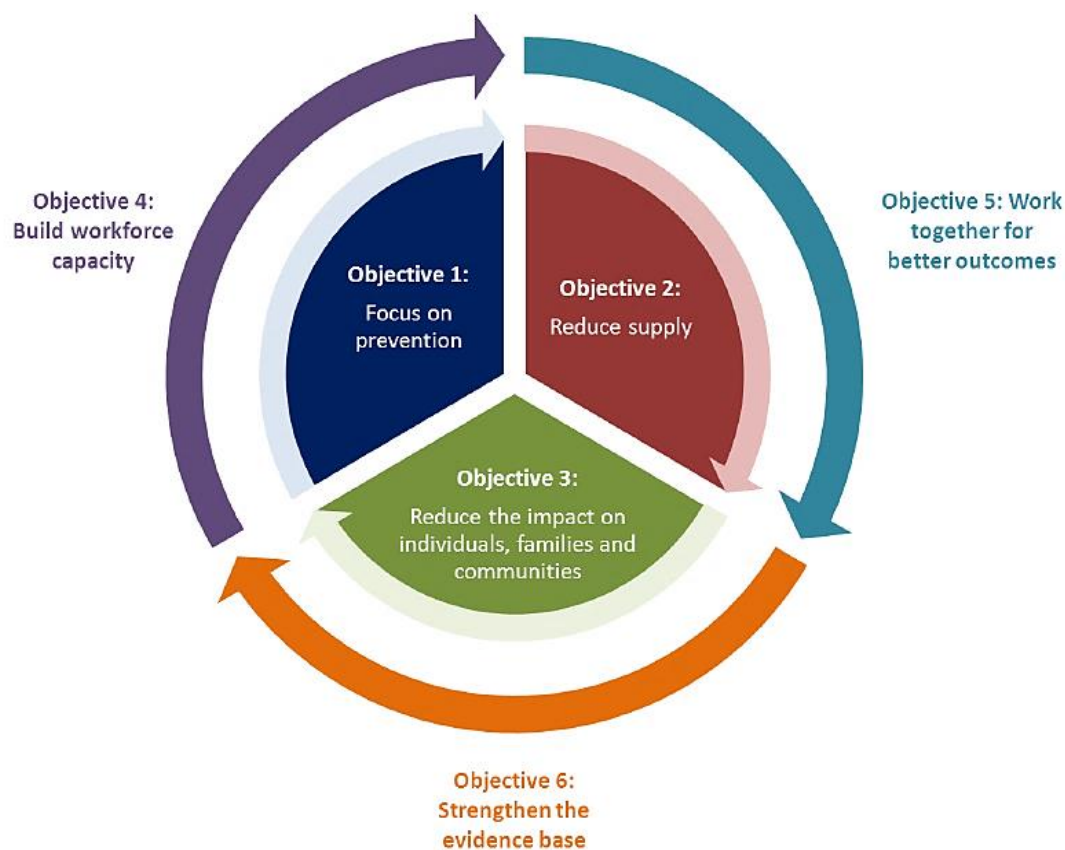
<sup>387</sup> Mark McGowan, *Methamphetamine Action Plan Fact Sheet*, viewed on 11 August 2015, [http://www.markmcgowan.com.au/files/Methamphetamine\\_Action\\_Plan\\_Fact\\_Sheet.pdf](http://www.markmcgowan.com.au/files/Methamphetamine_Action_Plan_Fact_Sheet.pdf).

<sup>388</sup> Victorian Ice Action Taskforce 2015, *Ice Action Framework*, Victorian Government, p. 7, viewed on 12 August 2015, [http://www.dpc.vic.gov.au/images/documents/Ice\\_Action\\_Plan\\_-\\_Framework\\_document\\_-\\_Final\\_4\\_Mar\\_2015.pdf](http://www.dpc.vic.gov.au/images/documents/Ice_Action_Plan_-_Framework_document_-_Final_4_Mar_2015.pdf).

crystal methamphetamine, a generalist alcohol and other drug strategy may not be able to address the complex and wide-ranging issues associated with this drug. Such an approach reflects the evidence the Committee received with regard to the lack of coordination and ad hoc responses to addressing methamphetamine use, in particular the development of policy and programs in 'silos' across and between government departments. There is currently no single document that assists health, justice and other sectors to implement policy with respect to methamphetamine (or other drugs).<sup>389</sup>

6.11 Victoria's *Ice Action Plan* was subsequently released in March 2015. The plan is complemented by the *Ice Action Framework* which is underpinned by the harm minimisation philosophy espoused by the NDS. Figure 21 illustrates the six primary objectives of the *Ice Action Framework*.

**Figure 20: Victoria's Ice Action Framework**<sup>390</sup>



6.12 The Victorian Government committed \$45.5 million for the implementation of the *Ice Action Plan* which outlines six key areas based on the harm minimisation approach to combat 'ice' use and the associated harms across Victoria. Figure 22 identifies these six areas and provides details of the funding allocation for specific actions.

<sup>389</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, p. xvi.

<sup>390</sup> Victorian Ice Action Taskforce 2015, *Ice Action Framework*, p. 8.

Figure 21: Victoria's Ice Action Plan<sup>391</sup>

<b>01</b> Helping Families	<ul style="list-style-type: none"> <li>&gt; \$4.7 million in additional support for families and communities to prevent and address ice use</li> <li>&gt; New dedicated Ice Help Line – a one-stop shop that directs families and health professionals to the support they need</li> </ul>
<b>02</b> Supporting Frontline Workers	<ul style="list-style-type: none"> <li>&gt; \$1 million for training courses to give frontline workers the skills they need to deal with users, and expand clinical supervision training</li> </ul>
<b>03</b> More Support, Where It's Needed	<ul style="list-style-type: none"> <li>&gt; \$18 million to expand drug treatment, focusing on rehabilitation for users in rural and regional areas</li> <li>&gt; \$1.8 million for Needle and Syringe Programs (NSPs) to make harm reduction more effective</li> </ul>
<b>04</b> Prevention is Better than a Cure	<ul style="list-style-type: none"> <li>&gt; Supporting skills and creating more jobs</li> <li>&gt; Education campaigns that target people who are most at risk</li> <li>&gt; Smarter use of technology</li> </ul>
<b>05</b> Reducing Supply on Our Streets	<ul style="list-style-type: none"> <li>&gt; \$4.5 million to expand Victoria Police's forensic analysis capability to shut down clandestine laboratories</li> </ul>
<b>06</b> Safer, Stronger Communities	<ul style="list-style-type: none"> <li>&gt; \$15 million for new drug and booze buses to get ice users off the road</li> <li>&gt; \$500,000 to support the work of people who know their communities best</li> </ul>

6.13 The Victorian Government also launched the 'Taking Action, Stopping Ice' website which contains details of the *Ice Action Plan* as well as information, resources and referral details to support services. The dedicated help line, 1800 ICE ACTION has been established as a 24 hour advice line run by Turning Point to provide information, referrals and brief interventions to 'ice' users and their families. As the implementation of the *Ice Action Plan* is still in its infancy, it is not possible to evaluate the effectiveness of the strategies in terms of prevention, education, family and individual support and withdrawal and treatment modalities.

6.14 In terms of funding allocation across the three pillars of the harm minimisation framework, the Committee notes that Australian governments at the federal, state

<sup>391</sup> Victorian Ice Action Taskforce 2015, *Ice Action Plan*, Victorian Government, viewed on 12 August 2015, <https://4a5b508b5f92124e39ff-ccd8d0b92a93a9c1ab1bc91ad6c9b9fdb.ssl.cf4.rackcdn.com/2015/03/Ice-Action-Plan-Final-Summary-Document-Web-Version.pdf>.

and territory levels have historically allocated significant resources to law enforcement strategies to combat the use of illicit drugs in society, while only a small proportion of expenditure has been used for treatment and prevention. In 2009-10, Australian governments spent approximately \$1.7 billion on illicit drugs: 66% on law enforcement; 9% on prevention; 21% on treatment; and 2% on harm reduction. Of the \$1.7 billion, 69% was made up of state and territory government spending, while the remainder was federal expenditure. The imbalance in expenditure allocations regarding illicit drugs has been publically discussed in light of the focus on 'ice' use nationally and the acknowledgement by a number of senior law enforcement officials that governments cannot arrest or police their way out of the 'ice' problem.<sup>392</sup>

- 6.15 While Australian jurisdictions have only recently begun developing action plans to address methamphetamine use, the Committee notes that the New Zealand Government established the *Tackling Methamphetamine: an Action Plan* (the Action Plan) in 2009. National drug surveys indicate that meth/amphetamine use in New Zealand peaked in 2001 with 5% of the population aged between 16 and 64 reporting using meth/amphetamine in the previous year; a significant increase from 2.9% in 1998. The use of crystal methamphetamine, colloquially known as P in New Zealand (short for Pure Methamphetamine), also grew from 0.1% to 0.9% of the population.<sup>393</sup>
- 6.16 The Action Plan is founded on the New Zealand National Drug Strategy which provides an overarching harm minimisation framework for alcohol and other drug policy, similar to that of Australia. The three pillars of the National Drug Strategy are supply control, demand reduction and problem limitation. Supply control is aimed at reducing the importation of illicit drugs and precursor chemicals across New Zealand's borders along with disrupting the domestic growing and manufacture of illicit drugs. Demand reduction focuses on preventing or delaying the uptake of alcohol and illicit drugs; increasing the awareness of risks; and promoting healthier lifestyle choice. Problem limitation focuses on reducing the harms associated with drug and alcohol use; assisting people to recover from dependence; and reintegrating drug users into the community.<sup>394</sup>
- 6.17 As outlined in Figure 23 below, the Action Plan focuses on five key areas with 22 specific actions that aim to reduce the supply and demand of methamphetamine in New Zealand.

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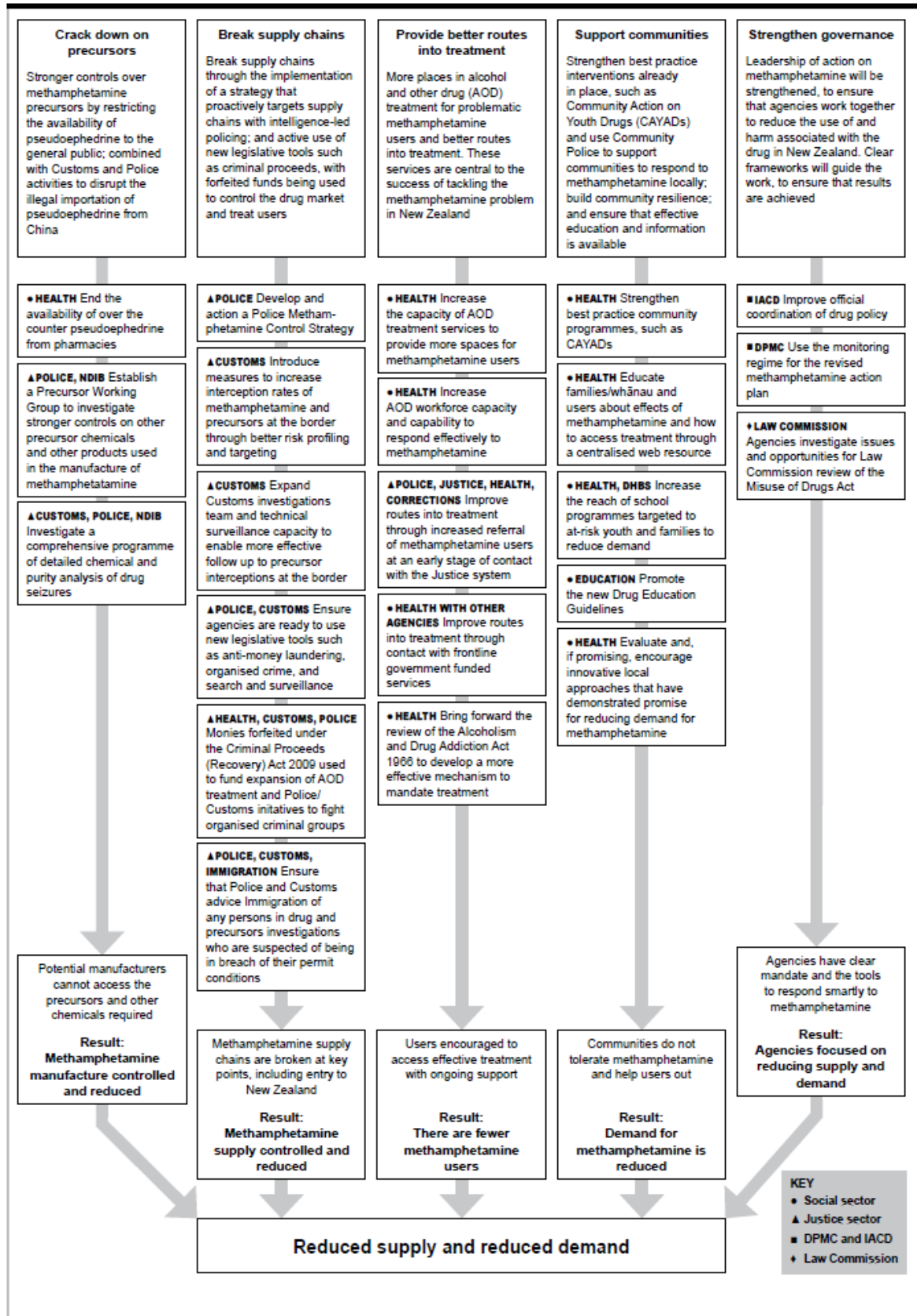
<sup>392</sup> NTLAC, Submission No. 26, 2015, p. 6.

<sup>393</sup> Department of the Prime Minister and Cabinet (NZ), *Tackling Methamphetamine: an Action Plan*, Department of the Prime Minister and Cabinet, Wellington, 2009, p. 7.

<sup>394</sup> Department of the Prime Minister and Cabinet (NZ), *Tackling Methamphetamine*, pp. 1-2.



Figure 22: New Zealand Tackling Methamphetamine Action Plan<sup>395</sup>



<sup>395</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, p. 731.

6.18 The Action Plan is a whole of government approach that is coordinated by the Department of Prime Minister and Cabinet. As a cross-agency strategy, chief executives of relevant departments are required to provide six monthly updates to the Prime Minister and Ministerial Committee on Drug Policy on the implementation of the 22 specific actions contained within the plan.<sup>396</sup> The *Indicators and Progress Reports* outline progress on cross-agency actions by each department; control of the supply of methamphetamine with details of price, purity, availability and seizures; and demand reduction in terms of prevalence, frequency of use and treatment services accessed by methamphetamine users.<sup>397</sup>

### **Northern Territory Drug Strategy**

6.19 It is of particular concern to the Committee that the Northern Territory has not had a drug strategy or action plan in place since 2012. The Committee reviewed the *Strategic Priorities 2009-12* on the Northern Territory Department of Health's website which contained information on *Priority Action Area 3: Targeting Smoking, Alcohol and Substance Abuse*. While there are some elements within this document that relate to harm reduction and demand reduction, its primary focus is on tobacco and alcohol.<sup>398</sup> As highlighted in the final report of the Northern Territory Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, in the absence of a clearly defined drug strategy, "the extent to which NT policy links in with the goals and objectives of national policy cannot be readily assessed."<sup>399</sup>

6.20 From a law enforcement perspective, the Committee was advised that:

All law enforcement agencies at a national and federal level have developed or are in the process of developing strategies to combat the prevalence and impact of Ice on their communities. These strategies are consistent with the three 'pillars' of the National Drug Strategy.<sup>400</sup>

To this end, the Committee heard that the NTPS has drafted a Methylamphetamine Action Plan with the following key objectives:

- To understand the scope and impact of the ATS problem through research and information gathering;
- Reduce the Harm that ATS use has on the community;
- Work with external agencies to reduce the demand for ATS within the community;
- Reduce the supply of ATS to the community through targeting suppliers, traffickers and distribution networks;

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<sup>396</sup> Department of the Prime Minister and Cabinet (NZ), *Tackling Methamphetamine*, pp. 3-4.

<sup>397</sup> Department of the Prime Minister and Cabinet (NZ), *Methamphetamine – Indicators and Progress Reports*, viewed 27 October 2015, <http://www.dpmc.govt.nz/dpmc/publications/methamphetamine>.

<sup>398</sup> Northern Territory Department of Health, *Priority Action Area 3: Targeting Smoking, Alcohol and Substance Abuse*, viewed on 11 August 2015, [http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/40/41.pdf&siteID=1&str\\_title=Priority%20Action%20Area%20%20-%20Targeting%20Smoking,%20Alcohol%20and%20Substance%20Abuse.pdf](http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/40/41.pdf&siteID=1&str_title=Priority%20Action%20Area%20%20-%20Targeting%20Smoking,%20Alcohol%20and%20Substance%20Abuse.pdf).

<sup>399</sup> Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *The Preventable Disability*, Northern Territory Legislative Assembly, Darwin, February 2015, p. 106.

<sup>400</sup> NTPS, Submission No. 34, 2015, p. 19.



- The hosting of a NT Drug Summit to provide key stakeholders the opportunity to assist in identifying the scope and impact of the problem in the Northern Territory and to assist in developing whole of community solutions to the problem.<sup>401</sup>

6.21 Acknowledging the need for an overarching drug strategy, the NTPS submission recommends that:

an holistic approach is adopted to address the social and community impacts of ice use, incorporating integration and multi-faceted approaches which bring together the various Government and Non-Government Agencies who have an inevitable role to play in the provision of Demand Reduction, Harm Reduction, and Supply Reduction services.<sup>402</sup>

In the absence of a whole of government drug strategy, the Committee heard that a number of interagency working groups have been established to address growing concerns regarding 'ice' use in the Territory.

6.22 For example, the NTPS advised that they are currently involved in two interagency groups related to the impact of methamphetamine. The first is focussed on the development of educational resources in partnership with the Northern Territory Department of Health, Amity Community Services, Danila Dilba, the Central Australian Aboriginal Congress and the Aboriginal Medical Services Alliance NT.<sup>403</sup>

6.23 The second working group consists of representatives from the NTPS and the Northern Territory Department of Health. Given the high incidence of polydrug use, this working group is concerned with all illicit drugs. However, it is noted that "there is a particular focus on methamphetamine supply, use, harm, and treatment."<sup>404</sup> The Committee understands that this group meets quarterly to share information and discuss strategies related to:

- arrest and seizure rates;
- patterns of drug use including drug type, volume and length of use;
- national strategies and approaches;
- availability and type of treatment options;
- community based efforts to address impact of illicit drug use; and
- increases in usage in particular urban, regional and/or remote areas.<sup>405</sup>

6.24 Ms Morton, Executive Director of NTCOSS, also informed the Committee that:

at a recent meeting the Chief Minister held with representatives of the NGO sector ... NTCOSS agreed ... to bring NGOs together to look at the issue of ice and how, as a sector, we might be able to share information and work together better. Government is doing it internally between departments, but it became clear the NGO sector was seeking something similar. At that meeting we agreed with the Chief Minister to take the lead and we expect to do that in the next of month or two.<sup>406</sup>

6.25 While the Committee applauds these initiatives, as this report illustrates, the misuse of drugs whether licit or illicit is a complex, multi-dimensional issue that requires a

<sup>401</sup> NTPS, Submission No. 34, 2015, p. 17.

<sup>402</sup> NTPS, Submission No. 34, 2015, p. 5.

<sup>403</sup> NTPS, Submission No. 34, 2015, p. 15.

<sup>404</sup> NTPS, Submission No. 34, 2015, p. 15.

<sup>405</sup> NTPS, Submission No. 34, 2015, p. 15.

<sup>406</sup> NTCOSS, Committee Transcript, 7 September 2015, p. 3.

coordinated, whole of government response through the development of a comprehensive drug strategy that provides the appropriate level of focus on each of the three pillars of the national harm minimisation framework.

### **Recommendation 8**

**The Committee recommends that a high level Working Group be established within the Department of Health, with representatives from the Departments of Education, Children and Families, Attorney-General and Justice, Correctional Services, NT Police Service, Australian Government, non-government sector and industry and resourced to:**

- 1. Develop and implement a Northern Territory drug strategy in line with the current *National Drug Strategy* addressing:**
  - a) security of funding, continuity and coordination of drug services;**
  - b) training and awareness of existing and emerging drugs and related referral options for health, education, children and family services, police, justice, and corrections professionals;**
  - c) development of drug specific educational resources for frontline staff, drug users and their families, and the wider community;**
  - d) availability and promotion of family support services;**
  - e) inclusion of information and links regarding drug use and available services on government and non-government agency websites;**
  - f) after-hours access to sterile injecting equipment and authorisation of non-Needle Syringe Program staff to distribute same where required; and**
  - g) development and implementation of responsible reporting guidelines for media outlets.**
- 2. Develop a strategy for the collection and analysis of data relating to methamphetamine across government and non-government sectors, including guidelines to enhance the consistency of terminology use in recording data; and**
- 3. Publish progress reports on a six monthly basis on the development, implementation and effectiveness of strategies within the *Northern Territory Drug Strategy* to be tabled in the Assembly by the Minister for Health.**

### **Media Campaigns**

6.26 Over the decades there have been a number of media campaigns both nationally and internationally on the harms associated with both licit and illicit drug use. With regards to the use of methamphetamine, the Montana Meth Project (MMP) is one of the more well-known advertising campaigns. Established in 2005 as a privately

funded non-government organisation, the MMP media campaign had a simple message: 'Meth: not even once'. Intentionally graphic and hard hitting:

methamphetamine users are portrayed in advertisements as unhygienic, dangerous, untrustworthy, and exploitative. Users are shown threatening to kill their parents, being raped, and prostituting themselves to fund their drug habit.<sup>407</sup>

- 6.27 The MMP has been promoted as a resounding success by the organisation, politicians and the media with regards to changing attitudes towards 'ice' and reducing 'ice' use in Montana. Due to its apparent success, the MMP campaign has been rolled out across the United States and no longer relies upon private funding. However, the MMP campaign is not without its critics. There have been claims that the campaign is not viewed as credible and exaggerates the effects and experiences associated with 'ice' use.
- 6.28 In a review of the MMP, Erceg-Hurn asserts that claims as to the campaign's effectiveness are not supported by empirical evidence. Indeed, the campaign was found to have been associated with increases in the acceptability of using methamphetamine and decreases in the perceived danger of using drugs. Moreover, Erceg-Hurn notes these and other negative findings from the surveys conducted by the MMP were ignored and misrepresented.<sup>408</sup> As discussed below, similar views were expressed to the Committee regarding the current 'ice' media campaign in Australia.
- 6.29 In May 2015, the Australian Government Department of Health launched the \$11 million advertising campaign 'Ice destroys lives'. The television advertisements portray graphic images of 'ice'-related psychosis and violence, users taking money from family members and scratching at imaginary bugs under their skin. The advertisements provide a link to the Australian Government Department of Health website which provides information on 'ice', contact details for the Alcohol and Drug Information Service in each state/territory and links to other support services.<sup>409</sup>
- 6.30 The media campaign has received criticism for a number of reasons. Firstly, the 2015 advertisements are almost identical to the Australian Government's 2007 media campaign 'Don't let ice destroy you'. The Australian Government defended the decision to remake the advertisements on the basis of internal research by the Health Department that demonstrated that the 2007 campaign had been highly effective.<sup>410</sup> However, there have been contrary reports which indicate that the Health Department had been advised against running shock and fear campaigns, since the 'drugs are bad' message does not account for the fact that some people will inevitably use illicit drugs and has no credibility with younger people.

<sup>407</sup> D Erceg-Hurn, 'Drugs, Money, and Graphic Ads: A Critical Review of the Montana Meth Project', *Prevention Science*, Vol. 9, Issue 4, December 2008, pp. 256-257.

<sup>408</sup> D Erceg-Hurn, 'Drugs, Money, and Graphic Ads: A Critical Review of the Montana Meth Project', pp. 256-263.

<sup>409</sup> Australian Government Department of Health, *Ice Destroys Lives*, Australian Government, viewed on 23 July 2015, <http://www.drugs.health.gov.au/internet/drugs/publishingcp.nsf/content/home>.

<sup>410</sup> A Meade, 'Abbott government defends almost identical anti-ice TV ads', *The Guardian*, 20 May 2015, viewed on 17 August 2015, <http://www.theguardian.com/australia-news/2015/may/20/abbott-government-defends-almost-identical-anti-ice-tv-ads>.

Furthermore, the 'Ice destroys lives' campaign may be perceived as 'over the top' and 'scaremongering', and therefore may have less of an impact.<sup>411</sup>

- 6.31 Professor Dietze, Head of Alcohol and Other Drug Research at the Centre for Population Health, has raised concerns about the effectiveness of graphic, fear-based campaigns, noting that research indicates that these type of campaigns can create stigma around 'ice' use and may in fact drive users away from treatment instead of encouraging them to seek treatment.<sup>412</sup> Mr Ryan, Chief Executive Officer of the Penington Institute commented that remaking the fear-based campaign was counter-productive as:

audience research confirms that the consequences of ice are already well known and quite frightening. Drug users, and people who don't use illicit drugs, are well aware of the most frightening consequences, including the possibility of psychosis and violence. Our research shows that there is already a strong perception that ice can ruin lives.<sup>413</sup>

- 6.32 Associate Professor Parker, President of the Australian Medical Association NT, questioned the effectiveness of the campaign as it doesn't consider the reasons why people are using 'ice':

The whole current federal government advertising is totally wasted money. Someone has identified two groups of people who take ice. There are the ones who are out for a good night on a Friday... then there are those who have issues with low self-esteem, anxiety or whatever and are self-medicating so it gives them a bit of a hit. None of those people take it to have a psychotic episode or to go out and whack some copper or nurse in ED. There is no intent to do that. The current advertising misses the point. To my mind, I would have a 'do the math' type advertising where some guy is offering you speed with all these images of you becoming superman or doing this or that, followed by you sitting in ED with a couple of broken limbs or sitting in a prison cell. You have to look at why people are using it, and the advertising totally misses that point.<sup>414</sup>

- 6.33 Ms Gates, Executive Director of NTAHC noted that the 'ice' campaign was being viewed as ineffective amongst needle and syringe workers and clients:

I do not believe scare tactics work in campaigns, in health promotion campaigns anyway, but around the country the feedback on the campaign is it is being compared to the Grim Reaper campaign, and although everyone remembers it the Grim Reaper campaign did nothing to reduce HIV in the community at that point in time. It is a campaign people will remember, but will it make a difference? Probably not. It is not encouraging people to access treatment.<sup>415</sup>

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<sup>411</sup> R Baker & N McKenzie, 'Shock and awe ice campaign a turn off: research', *The Age*, 23 May 2015, viewed on 17 August 2015, <http://www.theage.com.au/victoria/shock-and-awe-ice-campaigns-a-turn-off-research-20150522-gh7as2.html>.

<sup>412</sup> B Quinn & P Dietze, 'Awareness campaigns need to target the real victims of ice', *The Conversation*, 13 May 2015, viewed on 17 August 2015, <https://theconversation.com/awareness-campaigns-need-to-target-the-real-victims-of-ice-40631>.

<sup>413</sup> R Baker & N McKenzie, 'Shock and awe ice campaign a turn off: research', *The Age*, 23 May 2015, viewed on 17 August 2015, <http://www.theage.com.au/victoria/shock-and-awe-ice-campaigns-a-turn-off-research-20150522-gh7as2.html>.

<sup>414</sup> AMA NT, Committee Transcript, 7 September 2015, p. 6.

<sup>415</sup> NTAHC, Committee Transcript, 19 June 2015, p. 6; see also AADANT, Committee Transcript, 14 July 2015, p. 9.

Moreover, as Ms Kudell, Executive Director of AADANT, pointed out scare tactics do not generally work for those that use 'ice' primarily as a party drug, as they are unlikely to relate to images that they perceive to be associated with drug addicts.<sup>416</sup>

- 6.34 Nevertheless, the Committee notes that a recent evaluation of the 'Ice destroys lives' campaign based on questionnaires of 2,126 young people aged 14 to 25 years and 1,679 parents found that:

The Campaign was effective in delivering clear messages related to the harms of ice and/or discouraging ice use, and these messages were felt to be believable and effective by both youth and parents.<sup>417</sup>

However, it was also noted that, as is generally the case with such campaigns, "fewer find them personally relevant."<sup>418</sup>

- 6.35 In contrast to the national media campaign, in September 2014 the Victorian Government launched the 'What are you doing on ice' advertising campaign. Developed in conjunction with the Pennington Institute, the campaign was aimed at young people aged 18 to 25 and included television, social media, radio and billboard advertisements. The primary theme in the advertisements was centred on the highly addictive nature of 'ice' and:

aimed to provide information on the harms of ice while avoiding the scare tactics and a 'just say no' mentality. The advertisements also provided the viewer with a 'next step', inviting them to go the website. The website then provided users with links to agencies that provided support and assistance to people using ice.<sup>419</sup>

- 6.36 According to Mr Ryan, Chief Executive Officer of the Pennington Institute:

This was an evidence-based campaign. We knew from the beginning that young people were only going to listen if we presented a realistic picture of ice use and addiction. And the initial campaign results show that it has been received really well by those most at risk.

A survey of 150 young people showed that 75 percent of those who had taken drugs before had thought about their attitudes towards ice or spoken to family and friends about the issue since seeing the campaign.<sup>420</sup>

- 6.37 In May 2015, South Australia launched its 'Keep your hands off our Ambos' social media campaign highlighting the violence and aggression that paramedics are exposed to, as a consequence of alcohol and drug abuse, through the course of their work. The campaign is designed to promote awareness of the high risk environment that paramedics work within and aims to get people to reconsider their actions and behaviour towards paramedics, with the message "I can't fight for your mate's life if I'm fighting for mine." Preliminary findings indicate that the campaign is having a positive effect with the number of violent incidents against South

<sup>416</sup> Committee Transcript, Katherine Public Forum, 14 July 2015, p. 11.

<sup>417</sup> Stancombe Research + Planning, *National Drugs Campaign 2015 Evaluation Research*, Stancombe Research + Planning, Sydney, August 2015, p. 6.

<sup>418</sup> Stancombe Research + Planning, *National Drugs Campaign 2015*, p. 38.

<sup>419</sup> Pennington Institute, Submission No. 10, 2015, p. 14.

<sup>420</sup> Pennington Institute, *Ice campaign hits home with those most at risk*, viewed on 17 August 2015, <http://www.penington.org.au/ice-campaign-hits-home-with-those-most-at-risk/>.

Australian ambulance officers dropping quite markedly in the two months following commencement of the campaign.<sup>421</sup>

6.38 During the course of the inquiry, numerous comments were made regarding what the Australian National Council on Drugs (ANCD) refers to as the “misrepresentation and overly sensational reporting that reinforces stigma and detracts from informed public debate.”<sup>422</sup> As noted previously, stigmatising ‘ice’ through inappropriate reporting is counterproductive since it is likely to deter some users from accessing services:

Therein lies a massive issue with people who are abusing crystal methamphetamine and not wanting to access services for fear of the stigma attached to the use of ice.<sup>423</sup>

6.39 Based on a review of prominent news stories in metropolitan and regional press and broadcast media during 2014, the ANCD concluded that there is little recognition within the media or the AOD sector of the Australian Press Council’s (APC) 2001 guidelines on Drugs and Drug Addiction. Noting that the print media, in particular newspapers, are bound to comply with the reporting standards reflected in the APC guidelines, ANCD point out that they are “an excellent premise for reporting AOD issues.”<sup>424</sup> Endorsed by the ANCD as the standard by which all media reporting should be measured, the APC’s reporting guidelines state:

- Responsibly report public debate about drug use and addiction;
- The harmful effects of any particular drug should not be exaggerated or minimised;
- Avoid detailed accounts of consumption methods, even though many young people are generally familiar with them;
- Outlining the chemical composition of a drug may be justified in some reports, but avoid providing any details which could assist its manufacture;
- Do not quote the lethal dose of any particular drug;
- Guard against any reporting which might encourage readers’ experimentation with a drug, for example highlighting the ‘glamour’ of the dangers involved;
- Highlight elements of a story which convey the message that preventive measures against drug abuse do exist, and that people can be protected from the harmful consequences of their addictive behaviours; and
- Bear in mind the arguments of those who point out that tobacco and alcohol use and addiction are another major aspect of the drug story.<sup>425</sup>

6.40 The Government of Western Australia’s Drug and Alcohol Office further suggests that, as is the case with reports associated with mental illness or suicide, media

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<sup>421</sup> ABC News, *Violence facing ambulance paramedics prompts SA safety awareness campaign*, 27 May 2015, viewed 19 October 2015, <http://www.abc.net.au/news/2015-05-27/violence-ambulance-paramedics-awareness-campaign-sa-health/6501006>.

<sup>422</sup> Australian National Council on Drugs (ANCD), *Summary report of the Australian National Council on Dugs’ media project*, pp. 2-3, viewed 28 October 2015, <http://www.atoda.org.au/wp-content/uploads/Summary-report-of-the-Australian-National-Council-on-Drugs%E2%80%99-media-project.pdf>.

<sup>423</sup> AADANT, Committee Transcript, 14 July 2015, p. 9.

<sup>424</sup> ANCD, *Summary report of the Australian National Council on Dugs’ media project*, p. 2.

<sup>425</sup> ANCD, *Summary report of the Australian National Council on Dugs’ media project*, p. 2.

outlets should be encouraged to provide contact details for counselling, referral and further information such as the ADIS 24 hour telephone counselling service.<sup>426</sup> Given the above, the Committee is of the view that the *Northern Territory Drug Strategy*, as provided for in Recommendation 8 above, should incorporate the development and implementation of responsible reporting guidelines for local media outlets.

## Task Force Nemesis

- 6.41 Earlier this year the NTPS established Task Force Nemesis, a joint agency operation with the Australian Federal Police, Australian Crime Commission and the Australian Customs and Border Protection Service. With a focus on 'ice' and other amphetamine-type stimulants, Task Force Nemesis is part of a concerted national effort "to identify, disrupt and dismantle criminal networks who import drugs, firearms and crime enabling commodities into Australia and the NT."<sup>427</sup>
- 6.42 As noted in the NTPS submission to the inquiry, the Committee understands that the introduction of Task Force Nemesis will also incorporate:
- the development of local communication strategies to raise public awareness of harms associated with the use of 'ice'; with "specific strategies to communicate with regional and remote communities."<sup>428</sup>; and
  - proposals for legislative reforms to support operational priorities relating to the "disruption and dismantling of drug supply, supply routes [and] distribution networks."<sup>429</sup>
- 6.43 With regards to the latter point the Committee notes that, to date, the NTPS has proposed amendments to the following legislative provisions:
- **Firearms Act:** to remedy existing offence and penalty deficiencies, and develop Firearm Prohibition Orders;
  - **Misuse of Drugs Act:** to capture aggravation offences including manufacture with child present; dangerous drug offences where firearm/weapons are involved or used; to provide for declared drug detection areas – see section below; to reclassify amphetamine, ketamine and other phenethylamine based compounds from Schedule 2 to Schedule 1 of the Act – the Committee is advised that the regulations to achieve this move from Schedule 2 to Schedule 1 are currently being drafted;<sup>430</sup>
  - **Serious Crime Control Act:** to increase responses available to NTPS when dealing with organisations or entities that incorporate criminal offending in their activities;

<sup>426</sup> Government of Western Australia, Drug and Alcohol Office, *Media*, viewed 28 October 2015, <http://www.dao.health.wa.gov.au/vsu/pages/Media.htm>.

<sup>427</sup> NTPS, Submission No. 34, 2015, p. 17.

<sup>428</sup> NTPS, Submission No. 34, 2015, p. 17.

<sup>429</sup> NTPS, Submission No. 34, 2015, p. 5.

<sup>430</sup> Department of Attorney-General and Justice, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 2.



- **Criminal Code Act:** to capture aggravation offences, as noted above, and remedy existing consorting legislation; and
- **Traffic Act:** to enable police to conduct random driver drug testing on Northern Territory roads – see below.<sup>431</sup>

### **Declared Drug Detection Areas**

6.44 On 16 September 2015, the Northern Territory Attorney-General, Hon John Elferink MLA, introduced the *Misuse of Dangerous Drugs Amendment Bill 2015* which proposes to introduce the power for police to declare drug detection areas in the Northern Territory. In the explanatory statement introducing the Bill, the Attorney-General stated that the amendment was necessary as:

Recent seizures in the Northern Territory and police intelligence from around Australia has highlighted major drug suppliers are attempting to evade detection by packaging drugs and secreting them in fuel tanks, vacuum sealed devices, and by otherwise masking the smell of the drugs through various and increasingly elaborate means...The *Police Administration Act* contains wide-ranging powers for the police to search for and seize dangerous drugs as well as their precursors. However, the use of their powers is dependent on police reasonably suspecting an offence has been, or is likely to be, committed and is, therefore, reactionary and reliant upon either a tip-off from interstate law enforcement agencies or the use of other forms of criminal intelligence.<sup>432</sup>

6.45 The proposed amendments provide for a police officer at the rank of commander or above to authorise an area to be declared a drug detection area, if they suspect the area to be used to transport dangerous drugs or precursors, in accordance with the following stipulations:

- The declared area must be at least 30 kilometres from the Darwin general post office;
- The total size of the declared area cannot exceed three square kilometres;
- The total length of the declared area cannot exceed three kilometres;
- The authorisation of the declared areas cannot exceed 14 days;
- No more than three authorised drug detection areas may be in place at any one time;
- Police officers are authorised to carry out drug detection inside and outside of a vehicle and person or property in or out of the vehicle using a detection dog or electronic drug detection system;
- Seize any items believed to be connected with an offence against the Act; and

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<sup>431</sup> NTPS, Submission No. 34 2015, pp. 18 and Annexure F: Draft Methamphetamine Action Plan; Department of Attorney-General and Justice, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, pp.1-2.

<sup>432</sup> Hon John Elferink, MLA, (Attorney-General), *Misuse of Dangerous Drugs Amendment Bill (Serial 136)*, Explanatory Statement, Full Text Transcript. 16 September 2015, viewed on 23 September 2015, <http://notes.nt.gov.au/lant/hansard/hansardd.nsf/WebFullTextTranscript/D0DF13E6AF3DFF5C69257EC20053010D?opendocument>.



- Reports containing details of drug detection areas and resulting seizures are to be tabled annually in the Legislative Assembly by the Attorney-General.<sup>433</sup>

6.46 The Committee notes that similar legislation was introduced in South Australia in 2008 through the *Controlled Substances (Drug Detection) Amendment Act*. More recently, the 2014 Victorian Parliamentary *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria* also recommended that:

the Victorian Government introduce legislation allowing for the declaration of 'drug transit routes' to assist in cross-border detection and seizure of illicit drugs on intrastate and interstate roads.<sup>434</sup>

6.47 In addition to the above, the Committee notes that the *Misuse of Dangerous Drugs Amendment Bill* proposes changes to s40 of the Act, which relates to evidentiary matters that need to be satisfied to prove a person was in possession of a dangerous drug. As the Attorney-General explained, s40(c) as it currently stands requires:

prosecuting authorities to prove beyond reasonable doubt that the person knew or suspected that the drugs or precursors found in or on a workplace to which the person was an occupier or was concerned in the management or control of were in their possession. In the absence of admissions or surveillance evidence in this matter, it is difficult to prove and it is being successfully utilised to an offender's advantage where they are intercepted either entering or preparing to enter the Northern Territory or Indigenous communities with drugs in their luggage or in their vehicles. The Northern Territory police have noted that the use of the defence is being actively promoted.<sup>435</sup>

To ensure that this evidentiary provision cannot be used as a blanket defence in instances where possession is alleged, a 'reverse onus' provision has been proposed whereby the accused must prove a "lack of knowledge of possession".<sup>436</sup>

### **Drug Driving Legislation**

6.48 On 17 September 2015, the Minister for Transport, Hon Peter Chandler MLA, introduced the *Traffic Act and Other Legislation Amendment Bill 2015* to expand the powers of police to conduct random drug testing of drivers on Northern Territory. As the Minister pointed out:

recent evidence indicates that drug driving is now becoming more prevalent than drunk driving, with up to 13% of fatal road crashes being caused by drivers under the influence of prohibited drugs. This risk becomes even higher where the drug ice is involved.<sup>437</sup>

<sup>433</sup> Hon John Elferink, MLA, (Attorney-General), *Misuse of Dangerous Drugs Amendment Bill*.

<sup>434</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, p. xxxi.

<sup>435</sup> Hon John Elferink, MLA, (Attorney-General), *Misuse of Dangerous Drugs Amendment Bill*,

<sup>436</sup> Hon John Elferink, MLA, (Attorney-General), *Misuse of Dangerous Drugs Amendment Bill*.

<sup>437</sup> Hon Peter Chandler, MLA, (Minister for Transport), *Traffic Act and Other Legislation Amendment Bill 2015 (Serial 138)*, Explanatory Statement, Full Text Transcript, 17 September 2015, viewed on 23 September 2015, <http://notes.nt.gov.au/lant/hansard/hansardd.nsf/WebFullTextTranscript/E648882891323AAE69257EC30039E92D?opendocument>.

With the exception of Tasmania, all other jurisdictions in Australia now have legislation in place that provide for random roadside drug testing.<sup>438</sup>

- 6.49 The Committee notes that there is significant concern nationally regarding the number of people driving under the influence of illicit drugs. According to the *Weekend Australian*:

Across NSW this year, one in every 15 drivers tested positive for drugs such as cannabis, methamphetamine or MDMA, the drug class that includes ecstasy. Similar figures have been reported by South Australia and Victoria in recent years. In the ACT, almost one in six drivers tested positive for drugs last year. These are much higher rates than for drink driving which, after years of campaigns, ranges across the country from one in every 76 drivers to one in 567.<sup>439</sup>

- 6.50 As part of the Victorian *Ice Action Plan*, the Government has committed \$15 million to deliver 10 new drug and alcohol roadside testing buses and increase the number of drivers tested for drugs to 100,000 per year. In addition, amendments to the Victorian *Road Safety Act 1986*, have introduced a new offence of driving under the influence of a combination of alcohol and illicit drugs.<sup>440</sup> In 2015, the NSW Government announced their commitment to triple the number of roadside drug tests to over 97,000 by 2016-17.<sup>441</sup>

- 6.51 The Northern Territory *Traffic Act* currently provides for two drug driving offences. Under s28, the offence of 'driving with drug in blood' is established where a person drives a motor vehicle while there is a prohibited drug in their blood. There is no requirement for the person's ability to drive a motor vehicle to be impaired to establish this offence.<sup>442</sup> Section 29AAA, provides for 'driving under the influence of alcohol or drug'. In this instance, a person must be under the influence of a drug to such an extent as to be incapable of having proper control of the vehicle to establish an offence.<sup>443</sup>

- 6.52 At present, a police officer may only pull over a driver for random a drug test if they are driving a vehicle with a gross vehicle mass of 4.5 tonnes or greater. Drivers of vehicles with a gross vehicle mass of less than 4.5 tonnes, can only be required to submit a saliva sample where a police officer has reasonable cause to suspect the person of committing an offence of 'driving with drug in blood'; 'driving under the influence of alcohol or drug'; or where the driver was involved in an accident on a road, road-related area or public place.<sup>444</sup>

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<sup>438</sup> Hon Peter Chandler, MLA, (Minister for Transport), *Traffic Act and Other Legislation Amendment Bill 2015* (Serial 138).

<sup>439</sup> Weekend Australian, 'Ice: the drug that shatters lives', *Weekend Australian*, 26 September 2015, viewed on 1 October 2015, <http://www.theaustralian.com.au/opinion/editorials/ice-the-drug-that-shatters-lives/story-e6frg71x-1227544300232>.

<sup>440</sup> Victorian Government, *Cracking Down on Drunk, Drugged Drivers*, media release, 12 July 2015, viewed on 25 August 2015, <http://www.premier.vic.gov.au/cracking-down-on-drunk-drugged-drivers>.

<sup>441</sup> New South Wales Ministry of Health, *Crystal Methamphetamine Background Paper – NSW Data*, August 2015, NSW Government, viewed on 25 August 2015, <http://www.health.nsw.gov.au/crystallinemethamphetamine/Publications/background-paper.pdf>.

<sup>442</sup> *Traffic Act* (NT), s. 28.

<sup>443</sup> *Traffic Act* (NT), s. 29AAA.

<sup>444</sup> *Traffic Act* (NT), s. 29AB & s. 29AAF.

- 6.53 The current regime in the Northern Territory is to confirm the presence of a prohibited drug through a blood test. However, as is the case in some other jurisdictions, the Committee understands that the *Traffic Act and Other Legislation Amendment Bill* proposes to allow saliva testing to be used for the secondary test, as opposed to requiring a blood sample. The Bill also removes the limitations on the circumstances under which police may conduct drug driver testing by empowering police to:

direct any driver to pull over and submit to random drug testing, similar to random breath testing, to detect drunk drivers. With these amendments, police will be able to randomly test any driver, motorcycle rider or driving instructor for the presence of prohibited drugs in their saliva.<sup>445</sup>

- 6.54 The Minister for Transport further advised that the Bill includes minor amendments to sections of the *Motor Vehicles Act* relating to drivers who have had their licences suspended following conviction for certain offences:

Similar to drink drivers, convicted drug drivers will now need to complete a drug driver education course before being able to re-apply for their license to drive. This course will aim to deter drivers from future offences by educating them about the risks associated with driving under the influence of drugs.<sup>446</sup>

## Community Responses to 'Ice'

- 6.55 As mentioned previously, in the Northern Territory, the *Families Crying Out for Help* support group was established earlier this year by a local grandmother caring for her three grandsons following the incarceration of her daughter for crimes committed while on 'ice'.<sup>447</sup> The Committee understands that a number of local community action initiatives have been established elsewhere in the country, in particular Victoria, in response to growing concerns about 'ice' use within particular communities.
- 6.56 For example, *Project Ice Mildura* was established by the Northern Mallee Community Partnership as a proactive prevention and education campaign aiming to reduce the demand for 'ice' within the region. The executive committee is made up of community members from a diverse range of sectors including health, education, justice and welfare organisations. *Project Ice* has hosted a large number of community forums to provide information on 'ice' use, engage community members and promote treatment and support services. In addition, the group has developed television and radio advertisements, flyers and information pamphlets and mobile billboards to promote their prevention messages and provide referrals to treatment services.<sup>448</sup>
- 6.57 'Our Town's ICE Fight' is a grassroots campaign established by the Greater Geelong Collective Community Effort on Substance Abuse (GGCCESA) to tackle

<sup>445</sup> Hon Peter Chandler (Minister for Transport), *Traffic Act and Other Legislation Amendment Bill 2015*.

<sup>446</sup> Hon Peter Chandler (Minister for Transport), *Traffic Act and Other Legislation Amendment Bill 2015*.

<sup>447</sup> ABC News, *Grandparents call for support as Northern Territory fights scourge of ice*, viewed 26 October 2015, <http://www.abc.net.au/news/2015-01-19/grandparents-call-for-support-as-nt-fights-scourge-of-ice/6024524>.

<sup>448</sup> Northern Mallee Community Partnership, *Project Ice Mildura*, viewed on 31 August 2015, <http://www.nmcp.org.au/project-ice-mildura>.

the rising level of 'ice' use in the Geelong area. The GGCCESA is a partnership of government departments, non-government organisations and local businesses which have committed more than \$300,000 in cash and in-kind support toward 'Our Town's ICE Fight'.<sup>449</sup> In August 2014, the group held an IDEAS Summit which was attended by a cross section of community members from police, sporting, youth, health, education, business and employment sectors to develop ideas and plans to raise awareness of the harms of 'ice' use and promote prevention messages. In November 2014, the group held the Geelong Declaration Day to launch the 12 community action projects developed through the Summit.<sup>450</sup>

- 6.58 The GGCCESA has created 'Ice Fight Information Kits' specifically for employers and employees, teachers and students, sporting coaches and players. The 'Our Town's ICE Fight' website provides links to the information kits available for purchase, general information on 'ice' use and its effects, as well as referral details to treatment providers. The group has delivered information sessions to construction workers on the dangers of using 'ice', particularly in the workplace. It has also developed a smartphone interactive application for workplace inductions on AOD use in the workplace which is currently being trialled in the construction industry.<sup>451</sup>
- 6.59 The Committee notes that the Victorian *Ice Action Plan* allocated \$500,000 in funding for 'Safer, Stronger Communities'. This funding pool provides grants of up to \$10,000 to community groups in rural and regional Victoria to develop community action initiatives and local solutions to combat 'ice' use within their area. To date, \$130,000 has been allocated to 13 projects to assist community groups tackle issues associated with the 'ice', with additional projects to be funded each year over the next three years.<sup>452</sup>
- 6.60 During discussions at the Committee's public forums in Katherine and Alice Springs, it was evident that many members of the community acknowledge that local community action has the capacity to assist in addressing a range of issues associated with the use of 'ice'. However, it was also clear that most did not know how to go about bringing the community together to develop and implement strategies to address issues that might be quite specific to their local area such as those cited above.
- 6.61 In the case of Victoria, the Committee heard that the Penington Institute has been working with the Government to support 'ice' affected communities across the state; providing community information forums on methamphetamine, community capacity building workshops, and training seminars for frontline workers from a diverse range of workforces.<sup>453</sup> As Mr Boag, Acting Operations Manager of the Penington

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<sup>449</sup> Committee for Geelong, *ICE Declaration Day*, media release 21 November 2014, viewed on 31 August 2015, <http://www.committeeforgeelong.com.au/news-updates/committee-for-geelongs-weekly-addy-opinion-piece-ice-declaration-day/>.

<sup>450</sup> Committee for Geelong, *ICE Declaration Day*.

<sup>451</sup> Greater Geelong Collective Community Effort on Substance Abuse, *Our Town's ICE Fight*, viewed on 31 August 2015, <http://www.icefight.com.au/latest-news>.

<sup>452</sup> Victoria, *Ice Action Plan*, viewed 28 October 2015, <http://www.vic.gov.au/news/ice-action-plan-b.html>.

<sup>453</sup> Penington Institute, Submission No. 10, 2015, p. 7.

Institute, pointed out to the Committee it is important to "recognise that the response to this drug goes beyond simply responding to the needs of the user themselves."<sup>454</sup>

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<sup>454</sup> Penington Institute, Committee Transcript, 7 September 2015, p. 3.

## 7 Enhancing the NT's Response to 'Ice'

### Strategies to Combat 'Ice'

7.1 As indicated in the preceding chapters, by and large strategies to combat 'ice' are not dissimilar to those employed in the fight against the misuse of alcohol and other licit and illicit drugs. Consequently, the Committee's recommendations thus far have focussed primarily on strengthening the Territory's capacity to respond to both existing and emerging drugs. While not wishing to pre-empt the types of strategies that may be developed and implemented under a *Northern Territory Drug Strategy*, this chapter considers specific issues that were raised during the course of the inquiry in relation to demand reduction, supply reduction and harm reduction strategies.

#### ***Demand Reduction Strategies***

7.2 As previously outlined, demand reduction strategies are aimed at preventing the uptake and/or delaying the onset of drug use; reducing the misuse of drugs within the community; and supporting drug users to recover from dependence and reintegrate with the community.

#### **Drug Education and Positive Youth Development in Schools**

7.3 The Committee is concerned about the level of drug use within Northern Territory schools given the latest data from the Department of Education on the number of suspensions as a result of substance use and possession. Divided into 'dangerous drug related suspensions' and 'all other substance use/possession related suspensions' the Committee understands that the Department is unable to specifically identify meth/amphetamine related suspensions.

7.4 Nevertheless, the Committee notes that in 2013 there were a total of 110 drug related suspensions of which 36 (32%) were classified as 'dangerous drugs'. In 2014, the total number of suspensions increased to 192 with 74 (38%) for 'dangerous drugs', representing a significant increase in use/possession of dangerous drugs. The Department also advised that "suspensions due to drug use or possession have predominantly occurred in the Darwin and Palmerston regions, with relatively few incidents outside urban areas."<sup>455</sup>

7.5 School based education, incorporating positive youth development and drug education programs, is widely acknowledged as a key strategy in the early intervention and prevention of drug use. With regards to demand reduction, the *Victorian Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria* found that, "programs and policies that help build resilience, especially in

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<sup>455</sup> DoE, Submission No. 8, 2015, p. 5.

young people, reduce risk factors and augment protective factors" are particularly important.<sup>456</sup>

- 7.6 The Committee notes that drug education in schools is a controversial topic, with differing views between academics, educators and the community as to the content of drug education programs, and their effectiveness in preventing or delaying the uptake of licit and illicit drugs. As Professor Midford, Health in Education, Charles Darwin University, pointed out to the Victorian *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*:

I think that drug education is a really important component in prevention. It has a bad rap, and certainly a lot of people in academia who work in the drug area do not feel that it is a particularly effective strategy, but my sense is that it is an effective strategy if it is done properly. I think harm minimisation is the way to go, particularly with the more prevalent drugs, because if people are using, giving an abstinence message is not going to be particularly effective. The harm minimisation message about keeping oneself safe and being aware of how to negotiate and navigate the dangers of drug use will keep them safe. I feel that a skills-based, realistic, harm minimisation drug education program is probably the best thing you can do for kids of that age who are on the cusp of making decisions about drug use.<sup>457</sup>

- 7.7 With reference to drug education in the Northern Territory, the Committee was advised that the Department employs a strengths based approach, with a focus on "positive teachings related to building resilience and harm-minimisation."<sup>458</sup> While education about specific drugs is not generally included until the middle school curriculum for years 7-9, Mr Davies, Chief Executive Officer Department of Education, pointed out that

The opinions of NT school-based staff, as expressed in the department's frontline officers' survey, indicate that many Northern Territory students need support and guidance in understanding what is happening when others around them are using ice, how to deal with the situation, including assistance in where to go for help, and understanding how to minimise harm in their home environments. This support should address the contrast between messages relayed in school drug education and those students receive outside school with continued exposure to adult substance misuse.<sup>459</sup>

- 7.8 In the case of senior secondary students, the Department advised that the:

Northern Territory Certificate of Education and Training (NTCET) subject *Stage 1 Health* includes one relevant option for study: *'The effects of alcohol, tobacco and other drugs on health'*. This option provides teachers with an opportunity to assess students on their understanding of the impacts of drugs such as Methamphetamine. In *Stage 2 Health*, one of two core concepts is *'The Social and Economic determinants of Health'*, which may involve ways of analysing a health issue, such as the use of Methamphetamine, and exploring its possible determinants, costs and risks to society. Currently across the NT, *Stage 1 Health* is taught in eight senior secondary schools with 128 enrolees and *Stage 2* is taught in ten secondary schools with 218 enrolees.<sup>460</sup>

<sup>456</sup> DoE, Submission No. 8, 2015, p. 5.

<sup>457</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, Committee Transcript, 3 February 2014, p. 7.

<sup>458</sup> DoE, Submission No. 8, 2015, p.7; Appendix C.

<sup>459</sup> DoE, Committee Transcript, 19 June 2015, p. 3.

<sup>460</sup> DoE, Submission No. 8, 2015, p. 7.

7.9 On the basis of the aforementioned survey, it is evident that a wide range of student wellbeing programs are presently being delivered in government schools; the most common being the *School-Wide Positive Behaviour Support Program*, *KidsMatter* and *You Can Do It* programs. However, while all 68 respondents indicated that they had student wellbeing programs in place, only 58 had drug education programs in place. As with student wellbeing programs, the Committee notes that there are a variety of drug education programs on offer in government schools; the overwhelming majority of which do not currently include information specifically addressing 'ice'. In some schools drug education is delivered by internal staff, while in others it is provided by external organisations and specialists, or Youth Engagement Police Officers (YEPOs).<sup>461</sup>

7.10 With regards to the latter, a number of witnesses to the inquiry noted that schools had insufficient access to YEPOs. As Mr Davies, Chief Executive Officer of the Department of Education, commented:

There is no doubt that once you throw in operational duties, sometimes their attention in schools can be spread so widely that the impact you would have in getting information about what was going on in the community and dealing with particular families is not as good as it could be at the school level. ...You will recall the old school-based police program and the drug and alcohol resistance education program. It is with some regret in our schools that the program has, over the years, become watered down. I understand there is a need for the police to have an operational role, but that program played a big role in drug education in schools and in resistance to the issues that were in the broader community.<sup>462</sup>

7.11 The NTPS advised the Committee that there are currently 16 YEPOs, three in Darwin, Palmerston and Alice Springs, two in Katherine and five in Casuarina:

The YEPOs are responsible for carrying out a proactive policing role through the establishment of positive relationships with students, parents and teaching staff to promote a supportive learning environment and safer school communities. ... they perform operational duties associated with their positions including regular patrols of residential areas, shopping complexes and bus interchanges. They operate both proactively and in response to reports of antisocial or criminal behaviour involving students.

The YEPOs are also involved in identifying youth at risk within the school system and working with the Department of Education to ensure that appropriate programs are in place to assist these students. The YEPOs work with schools in relation to drug and alcohol awareness programs. While they do not deliver formal programs, they are involved on an informal basis at times assisting in the delivery of certain aspects of programs the schools may run. They also deliver localised responses in accordance with local school needs and emerging issues.<sup>463</sup>

7.12 A further eight Community Engagement Police Officers (CEPOs) undertake duties similar to YEPOs in remote schools.<sup>464</sup> However, as indicated in Tables 16 and 17 below, given the size of the area CEPOs are responsible, their capacity to engage effectively with students and support schools is necessarily limited. Ms Taylor, Chief

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<sup>461</sup> DoE, Submission No. 8, 2015; Appendix B.

<sup>462</sup> DoE, Committee Transcript, 19 June 2015, pp. 5-6.

<sup>463</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 8.

<sup>464</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, pp. 7-8.



Executive Officer of DASA, suggested that local role models could be effective in delivering drug education in schools, particularly in regional and remote areas in the Northern Territory:

There is a fairly big group of Aboriginal and non-Aboriginal people in their early 20s, particularly in Alice Springs, who would be very good at this who are not being utilised and would have a huge impact. They are football coaches, football players, people of note in the community, and people in Aboriginal communities who have gone through law, and therefore have some respect. They would be a very good group of people to use to teach the younger kids about the use of alcohol and drugs. Bringing in people and systems from interstate is an absolute waste of time.<sup>465</sup>

**Table 17: Community Engagement Police Officers - Northern Command<sup>466</sup>**

Northern Command	
CEPO – 'Western' (based from Darwin)	CEPO – 'Arafura' (based from Darwin)
Lajamanu (Hooker Creek)	Maningrida
Timber Creek	Ramingining
Yarralin	Milingimbi
Kalkaringi (Wave Hill)	Galiwinku (Elcho Island)
Bulman	Gapuwiyak (Lake Evalla)
Beswick	Warruwi (Goulbourn Island)
Maranboy	Minjilang (Croker Island)
Mataranka / Jilkminggan (Duck Creek)	Jabiru
Manyallaluk (Eva Valley)	Gunbalanya (Oenpelli)
CEPO – 'Bonaparte' (based from Darwin)	CEPO – 'Carpentaria' (based from Darwin)
Wadeye (Port Keats)	Alyangula (Groote Eylandt)
Peppimenarti	Angurugu (Groote Eylandt)
Palumpa	Umbakumba (Groote Eylandt)
Daly River	Milyakburra (Bickerton Island)
Pine Creek	Numbulwar
Adelaide River	Ngukurr
Batchelor	Minyerri (Hodgson Downs)
	Borroloola
	Nhulunbuy / Yirrkala

**Table 18: Community Engagement Police Officers - Southern Command<sup>467</sup>**

Southern Command	
CEPO – 'Central' (based from Alice Springs)	CEPO – 'Barkly' (based from Alice Springs) Vacant
Ntaria (Hermannsburg)	Elliott
Ltyenty Apurte (Santa Teresa)	Avon Downs
Ti Tree	Arlparra (Utopia)
Willowra	Amplilawatja (Ammaroo)
Laramba	Alpurrurulam
Harts Range	Ali Curung (Warrabri)
CEPO – 'Ghan' Vacant	CEPO – 'Capricorn' (based from Alice Springs)
Yulara	Walungurru (Kintore)
Mutitjulu	Papunya
Docker River	Ikuntji (Haasts Bluff)
Imanpa	Mount Liebig
Kulgera	Yuendumu
Finke	Yuelamu (Mount Allen)
Titjikala	Nyirripi

<sup>465</sup> DASA, Committee Transcript, 7 September 2015, p. 2.

<sup>466</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 8.

<sup>467</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 7.

7.13 Given the above, the Committee has concerns regarding the consistency and effectiveness of drug education and positive youth development programs in both government and non-government schools, across the Territory. Reflecting the need for a whole of government, coordinated response to address the impacts of drugs such as 'ice', the Department of Education noted that:

A collaborative strategy provides greater opportunities to mitigate the risk of increased methamphetamine abuse and is particularly able to provide:

- stronger partnerships with Northern Territory Police, Department of Health and non-government organisations to deliver effective drug education, including wherever possible, developing strategies to improve access to Youth Engagement Police Officers
- improved referral options to support students impacted by substance abuse
- increased information sharing to better inform and prioritise departmental efforts
- providing parental access to drug education through School Councils
- access to relevant training for staff, including:
  - improving recognition of ice-related incidents
  - providing strategies that support staff to deal safely with users.<sup>468</sup>

#### **Recommendation 9**

**The Committee recommends that the Department of Education:**

- 1. Undertake and publish a review and evaluation of the adequacy, consistency and effectiveness of:**
  - a) positive youth development initiatives, including health and well-being programs, offered in government and non-government schools across the Northern Territory;**
  - b) drug education programs offered in government and non-government schools across the Northern Territory;**
  - c) the role of Youth Engagement Police Officers in the delivery of these initiatives; and**
- 2. The Minister for Education table a copy of the review in the Assembly by June 2016.**

#### **Sale of Drug Paraphernalia**

7.14 In July 2015, the Attorney-General referred an enquiry from a concerned member of the public regarding the sale of drug paraphernalia in local shops to the Committee for its consideration. The Committee notes that, in contrast to most other jurisdictions, the *Misuse of Drugs Act* (NT) does not currently incorporate any provisions specifically relating to the display and sale of drug paraphernalia. As is the case in Tasmania, s12 of the *Misuse of Drugs Act* simply prohibits the unlawful

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<sup>468</sup> DoE, Submission No. 8, 2015, p. 12.

possession of “a thing (other than a hypodermic syringe or needle) for use in the administration of a dangerous drug.”<sup>469</sup>

- 7.15 The Committee acknowledges that drugs can be administered in many different ways and that a range of everyday items can be modified to administer drugs. However, the Committee is of the view that the display and sale of drug paraphernalia sends mixed messages to young people and may encourage experimentation.
- 7.16 The Committee notes that legislative provisions relating to the display and sale of drug paraphernalia vary across jurisdictions. For example, the *Misuse of Drugs Act 1981* (WA) is quite broad and prohibits the display and sale of anything that can be made or modified to be used in the manufacture or preparation of a prohibited drug or a prohibited plant for administration or use by a person for smoking, inhaling or ingesting.<sup>470</sup> Whereas in Victoria, the *Drugs, Poisons and Controlled Substances Act 1981* is specific to cocaine kits and ‘ice’ pipes, and in NSW the *Drug Misuse and Trafficking Act 1985* relates to the sale, supply and display of waterpipes and ‘ice’ pipes.<sup>471</sup>
- 7.17 Subsequent advice received from the Attorney-General indicates that there are no foreseeable impediments to amending the Territory’s legislation to prohibit the display and sale of drug paraphernalia. As the Attorney-General pointed out:
- Business may state that it will unduly affect their business as they display and sell the items for ornamental purposes. This may be the case, but the items are recognised for and made for administering drugs, not acting as vases or decorative pieces.<sup>472</sup>

## Recommendation 10

**The Committee recommends that the Government amend the *Misuse of Drugs Act* to prohibit the display and sale of drug paraphernalia.**

### ***Supply Reduction Strategies***

- 7.18 The primary objective of supply reduction strategies is to prevent, stop, disrupt or otherwise reduce the production of illegal drugs; and control, manage and/or regulate the availability of legal drugs. Improving detection methodologies and strengthening regulatory controls to inhibit access to precursor chemicals are primary supply reduction strategies.

### **Waste Water Analysis**

- 7.19 As highlighted in Chapter 3, access to up to date, valid data regarding the prevalence of ‘ice’ use, is problematic for a range of reasons. While the majority of

<sup>469</sup> *Misuse of Drugs Act* (NT), s. 12.

<sup>470</sup> *Misuse of Drugs Act* (WA), s. 7B.

<sup>471</sup> *Drugs, Poisons and Controlled Substances Act 1981* (Vic), s. 80; *Drug Misuse and Trafficking Act 1985* (NSW), s. 11.

<sup>472</sup> Correspondence from the Attorney-General, Hon John Elferink, to the Chair of the ‘Ice’ Select Committee, Mr Nathan Barrett, MLA, regarding the display and sale of drug paraphernalia, 16 September 2015, p. 2.

the drug monitoring and data collection methodologies within Australia, such as the NDSHS, IDRS and EDRS, are reliant on self-reporting, it is acknowledged that the prevalence estimates produced through these methodologies are likely to under represent actual rates of illicit drug use due to under reporting. The Committee heard that waste water analysis (WWA) has been undertaken in a number of Australian and overseas jurisdictions to more accurately determine the prevalence of illicit drug usage.<sup>473</sup>

7.20 As the ACC pointed out, WWA has the potential to supplement data and information derived from self-reporting surveys to provide a more comprehensive picture of methamphetamine use in specific regions:

Once you combine all that data with something like waste water, you start to get a good idea of the prevalence of ice use within particular communities. You will have potentially seen the work done in Queensland, South Australia and Australia on waste water analysis. They are starting to get a picture of methamphetamine use by using waste water, equally so in Europe. Some of the numbers they are identifying are substantially more than what we would have expected. Once you add waste water, in comparison to other data, you start to get a true and accurate picture or the threat to different communities.<sup>474</sup>

7.21 The ACC also highlighted this in their submission to the inquiry:

Analysis of illicit drug metabolites in sewage (wastewater) provides an estimate of the consumption of drugs in the catchment area. Analysis of waste water accurately maps drug prevalence trends in the area being serviced by the treatment facility, and establishes an evidence base to inform response options. The data obtained from waste water analysis would provide law enforcement, policy, regulatory and health agencies with additional and more objective data in relation to usage of methylamphetamine and other drugs. The data could also be used to assess the effect of supply and demand and harm reduction strategies implemented by these agencies.<sup>475</sup>

7.22 The Committee notes that the results of trials in South Australia, Queensland, and Europe indicate a much higher incidence of methamphetamine use than has previously been identified by user surveys.<sup>476</sup> In addition to not relying on the veracity of self-reporting, WWA provides a more accurate estimation of the type of illicit drugs that are being consumed:

Deceptive trade practices in the illicit drug market mean that methamphetamine or other substances are substituted in tablets purporting to contain MDMA. Whereas self-report studies reflect users' belief regarding substance use, WWA ... provides objective data that accurately differentiates between drugs such as methamphetamine and MDMA.<sup>477</sup>

7.23 Mr Jabbour, National Manager Serious and Organised Crime (AFP), advised the Committee that while WWA is a relatively new concept, the strategy has been recommended and is currently being considered by the Serious Organised Crime

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<sup>473</sup> ACC, Committee Transcript, 19 June 2015, p. 2.

<sup>474</sup> ACC, Committee Transcript, 19 June 2015, p. 2.

<sup>475</sup> ACC, Submission No. 25, 2015, pp. 7-8.

<sup>476</sup> ACC, Submission No. 25, 2015, p. 8.

<sup>477</sup> J Prichard et al., 'Measuring drug use patterns in Queensland through wastewater analysis', p. 3.

Committee.<sup>478</sup> Mr Hansford, Acting Executive Director of Strategy and Specialist Capabilities (ACC), noted that:

I think it would also be viable in the Northern Territory. There are, as your question alluded to, differences between a city and a regional and remote area. It is much easier to get a more accurate reading in a city where there is a larger number of people compared to regional and remote communities. However, it is a good analysis to undertake and one we are supportive of from the Australian Crime Commission's point of view.<sup>479</sup>

7.24 As Deputy Commissioner Payne (NTPS) advised the Committee:

it is certainly something we are quite interested in. Waste water analysis gives us some very strong indicators of overall population use pure amphetamine, particularly substances such as methamphetamine. How it works is that waste water is captured and analysed for the trace elements parts per million. It gives indicators not only in an overall sense, but particularly waste water that is trapped and analysed from specific areas such as central business district areas or certain areas that may be presenting as problematic in ice or other drug usage. It provides not only an indicator of the amount of use, but can help identify what cohorts are using more often.<sup>480</sup>

### Recommendation 11

**The Committee recommends that the Government undertake a trial of *Waste Water Analysis* to more accurately assess the prevalence and geographic distribution of 'ice' use across the Northern Territory.**

### **Project STOP**

7.25 As noted in Chapter 2, one of the most common precursor chemicals used in 'ice' manufacturing is pseudoephedrine, which is contained in a number of decongestant medications available without a prescription from pharmacies. Research indicates that low level methamphetamine manufacturers rely primarily on pseudoephedrine sourced from pharmacies. However, 'pseudo runners' are also used by high level illicit drug manufacturing organisations. Organised crime groups have been known to arrange for 'pseudo runners' to travel to country towns or across state borders to purchase large quantities of pseudoephedrine-based products to be used to manufacture methamphetamine. Furthermore, organised crime groups are known to maintain lists of pharmacies not participating in *Project STOP* and therefore unable to check a customer's history of purchasing pseudoephedrine-based products when making a sale.<sup>481</sup>

7.26 *Project STOP* is one of the key strategies aimed at reducing the diversion of legal pseudoephedrine-based medications into the illicit drug manufacturing market. Developed by the Queensland branch of the Pharmacy Guild of Australia in 2005, *Project STOP* is a national, real time, online dispensary recording software program which "records all requests for products containing pseudoephedrine within a

<sup>478</sup> NTPS & AFP, Committee Transcript, 19 June 2015, p. 3.

<sup>479</sup> ACC, Committee Transcript, 19 June 2015, p. 2.

<sup>480</sup> NTPS & AFP, Committee Transcript, 19 June 2015, p. 3.

<sup>481</sup> A Ritter, D Bright & W Gong, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, p. 61.

pharmacy, and alerts law enforcement authorities to suspicious transactions."<sup>482</sup> When the customer's identification details are entered into *Project STOP* there are two possible results:

A 'no match result' means the customer's identification has not been entered into Project STOP within the threshold or therapeutic period, that is, no suspicious activity. If there is a 'match result' then the customer's identification number has been associated with either (1) recent transaction activity where the threshold has been breached; or (2) the customer has purchased at least one other pseudoephedrine-based medication within the recommended therapeutic period.<sup>483</sup>

7.27 Where there is a match result, the pharmacist can view all purchases made by the customer, known as a 'person of interest' over a 100 day period. The parameters that will trigger a match for a person of interest is based on a particular number of transactions within a specific period; which is determined by police in each jurisdiction. After viewing a 'match result' or 'no match result', the pharmacist has three choices: to make the sale; to refuse the sale due to concerns about the legitimacy of the customer's request; or to make the sale but record it in the database as a 'safety sale', that is, the sale was made under duress.<sup>484</sup>

7.28 The Pharmacy Guild further advised that:

In every state and territory in Australia the police have real-time online access to the Project STOP database. Project STOP sends alerts to the police by email and even by SMS if there is evidence of 'pseudo-runners' moving between pharmacies in a particular area or if particular suspects purchase pseudoephedrine products. The information and notification service provided by Project STOP is currently provided at no cost to the police.<sup>485</sup>

7.29 While approximately 80% of pharmacies nationally are using *Project STOP*, regulations relating to the recording of pseudoephedrine sales are not uniform. In Queensland, South Australia and Western Australia, pharmacists are required to view identification for customers wishing to purchase products containing pseudoephedrine, and real time online recording of all sales is mandatory.<sup>486</sup> While other jurisdictions may require pharmacists to view identification and record pseudoephedrine sales, there is not necessarily any requirement for them to be recorded in real time or electronically.<sup>487</sup>

7.30 In the case of the Northern Territory, the Committee was advised that:

In April 2008 the Northern Territory government regulated the recording of pseudoephedrine sales under paragraph 28(1)(b) of the *Poisons and Dangerous Drugs Act*. However, while the regulation includes identification document requirement for the consumer and mandatory recording of the sale, electronic recording or real time online recording are not specified.<sup>488</sup>

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<sup>482</sup> Pharmacy Guild Of Australia NT Branch (PGA), Submission No.21, 2015, p.1.

<sup>483</sup> M Devaney, J Ferris & L Mazerolle, 'Online reporting of pseudoephedrine pharmacy sales: does Australia require a mandatory system?', *International Journal of Pharmacy Practice*, Vol. 23, Issue 4, 2015, p. 249.

<sup>484</sup> M Devaney, J Ferris & L Mazerolle, 'Online reporting of pseudoephedrine pharmacy sales: does Australia require a mandatory system?', p. 249.

<sup>485</sup> Pharmacy Guild of Australia NT Branch, Answers to Questions Taken on Notice, 14 September 2015, p.1.

<sup>486</sup> PGA, Submission No. 21, 2015, pp. 1-2.

<sup>487</sup> PGA, Submission No. 21, 2015, pp. 1-2.

<sup>488</sup> PGA, Submission No. 21, 2015, p. 2.

However, as the Pharmacy Guild points out, paper-based recording withholds information from law enforcement officials as the information is only accessible to police if they physically enter a pharmacy and request to see the record. Furthermore, paper-based records prevent pharmacists from viewing a customer's purchase history.<sup>489</sup>

7.31 In their submission to the Committee, the ACC stated that *Project STOP*:

has had a genuine effect in most markets in reducing sales of over-the-counter pseudoephedrine preparations intended for diversion, despite jurisdictional differences in its use. Despite the implementation of Project STOP, pseudo-shopping remains an issue, albeit at significantly reduced levels. Pseudo-shopping appears primarily to be undertaken for use in addiction labs, as is evidenced by the lack of pseudoephedrine product packaging found at larger labs. Project STOP has proven to be a useful tool in identifying those likely diverting pharmaceutical drugs to addiction labs. Its continued existence is an important component of law enforcement's response to the methylamphetamine market.<sup>490</sup>

7.32 The Committee notes that the cooperation between pharmacies and the NTPS, particularly in Alice Springs, has assisted police in identifying and arresting people in relation to the manufacture of 'ice' using pseudoephedrine-based medications. Detective Sergeant Bedwell (NTPS) stated that this relationship had "formed part of the information or intelligence package that has led to arrests this year".<sup>491</sup> In their submission to the Committee, the NTPS also noted that it "had been successful in the NT in identifying a number of illicit laboratories."<sup>492</sup>

### **Recommendation 12**

**The Committee recommends that the Government mandate real time, online recording of pseudoephedrine sales to enhance the accuracy and availability of data collected by pharmacies using *Project STOP*.**

### ***Harm Reduction Strategies***

7.33 Harm reduction strategies aim to reduce the adverse health, social and economic consequences of the use of drugs. As noted in the National Drug Strategy, encouraging safe injecting practices through the provision of needle and syringe programs and diversion of users from the criminal justice system into treatment programs are two of the primary strategies associated with reducing harms to individuals.

### ***Needle and Syringe Programs***

7.34 As discussed in Chapter 4, there are significant harms associated with injecting drugs including contracting blood borne viruses and vein damage. The 2014 *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria* found

<sup>489</sup> PGA, Answers to Questions Taken on Notice, 14 September 2015, p. 3.

<sup>490</sup> ACC, Submission No. 25, 2015, p. 13.

<sup>491</sup> NT News, 'Chemists give leads on ice baking', *NT News*, 13 October 2015, p. 8.

<sup>492</sup> NTPS, Submission No. 34, 2015, p. 16.

“probably the most proven harm reduction measure thus far to reduce or prevent harms associated with ‘ice’ use is the provision of needle and syringe exchange programs”.<sup>493</sup>

7.35 Needle and syringe programs (NSP) are run in every jurisdiction in Australia. While their primary role is to provide sterile injecting equipment to injecting drug users, NSP also provide education on safe injecting practices and provide the opportunity for brief interventions. As Ms Gates, Executive Director of NTAHC explained to the Committee:

We provide education about the harms of drug use. We are not funded to do alcohol and other drug work; we are there to provide the needle/syringe program. We do not, as you said, force it down people’s throat. The information is there, it is available in our NSPs for people to see and read. We send messages around the harms of drug use all the time through our health promotion messaging, but we do not stand there saying, ‘You should get help’....We have a no judgment policy. Ours is a health-based approach about blood-borne viruses and to reduce the harms related to drug use. If we started judging people who walk through our doors they would stop walking through our doors.<sup>494</sup>

7.36 The NSP in the Territory was established in 1989 and is overseen by the Northern Territory Department of Health’s Sexual Health and Blood Borne Virus Unit within the Northern Territory Centre for Disease Control.<sup>495</sup> The NTAHC manages three primary NSP outlets located in Darwin, Palmerston and Alice Springs that provide a broad range of injecting equipment, facilities for the safe disposal of used injecting equipment, information, support and referral services for injecting drug users.<sup>496</sup>

7.37 Ten secondary outlets are located at Clinic 34s (sexual health service overseen by the Department of Health) in Darwin, Katherine, Tennant Creek, Alice Springs and Nhulunbuy; hospital emergency departments in Katherine, Tennant Creek, Alice Springs and Nhulunbuy; and the Yulara Medical Centre in Uluru-Kata Tjuta National Park, the only NSP located in a remote area. Of the 35 pharmacies in the Northern Territory, there are 15 pharmacy-based outlets across Darwin, Katherine, Alice Springs and Nhulunbuy.<sup>497</sup>

7.38 The Committee understands that “secondary and pharmacy-based outlets typically provide a limited range of sterile injecting equipment and disposal facilities.”<sup>498</sup> With the exception of the four NSP located in hospital emergency departments, at present there are no other facilities that offer after-hours access to sterile injecting equipment. The Committee was advised that in 2014, hospital emergency departments distributed 4,420 units of sterile injecting equipment. Notably, there is nowhere in Darwin to obtain sterile equipment after-hours as the Royal Darwin Hospital is not an NSP outlet.<sup>499</sup>

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<sup>493</sup> Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, p. 605.

<sup>494</sup> NTAHC, Committee Transcript, 19 June 2015, pp. 3-5.

<sup>495</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 2.

<sup>496</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 2.

<sup>497</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 2.

<sup>498</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 2.

<sup>499</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 4.



- 7.39 An evaluation of the cost effectiveness of NSP in Australia was conducted in 2009 by the National Centre in HIV Epidemiology and Clinical Research at the University of New South Wales. Between 2000-09, Australian governments spent \$243 million funding the delivery of NSP services nationally. The evaluation suggests that in this period, 32,050 new HIV infections and 96,667 new hepatitis C infections were prevented which equated to an economic saving of \$1.28 billion in direct healthcare costs.<sup>500</sup> It is estimated that for the same period the saving in direct healthcare costs in the Northern Territory equated to approximately \$4.2 million.<sup>501</sup>
- 7.40 The Committee received submissions from a number of organisations, including the Penington Institute, NTAHC and the Aboriginal Peak Organisation, advocating for the introduction of Syringe Vending Machines (SVMs) in the Northern Territory. As the Penington Institute pointed out, given that intravenous drug use is an 'around the clock' activity, "it is essential that users have 24-hour access to NSPs through strategies such as syringe Secure Dispensing Units."<sup>502</sup> In 1992, the first trial of SVMs was undertaken in New South Wales. Since then, all jurisdictions with the exception of the Northern Territory have introduced SVMs as part of their needle and syringe programs. The Committee was advised that SVMs are:
- self-contained units that dispense injecting equipment mostly for a small fee. There are several styles and models that are usually nondescript stand-alone or wall-mounted metallic units. Unlike snack, beverage or cigarette vending machines they do not advertise their contents. SVMs may operate after NSP service hours or provide 24-hour access to injecting equipment.<sup>503</sup>
- 7.41 Another challenge when it comes to supplying sterile injecting equipment in the Northern Territory, particularly in remote locations, is the regulatory framework of the *Misuse of Drugs Act*. Section 12(2) of the Act states that:
- a person, other than a medical practitioner, a nurse practitioner, a pharmacist or a member of a class of persons authorized so to do by the Minister who supplies a hypodermic syringe or needle to another person, whether or not the other person is in the Territory, for use in the administration of a dangerous drug to that or another person is guilty of an offence.<sup>504</sup>
- 7.42 The Northern Territory Department of Health further advised that the Attorney-General and Minister for Justice is responsible for authorising:
- NSP staff to supply sterile injecting equipment in a document called the *Authorisation of Classes of Persons to Supply Hypodermic Syringes and Needles*. There is nothing in the Act to prevent the Minister from authorising non-NSP staff (for example, remote health professionals) to supply equipment ... With the exception of staff at the Yulara Medical Centre, there are presently no remote health professionals authorised to distribute sterile injecting equipment in the Northern Territory.<sup>505</sup>

<sup>500</sup> National Centre in HIV Epidemiology and Clinical Research, *Return on investment 2: Evaluation the cost-effectiveness of needle and syringe programs in Australia*, Sydney, UNSW, 2009, p. 8.

<sup>501</sup> National Centre in HIV Epidemiology and Clinical Research, *Return on investment 2: Evaluation the cost-effectiveness of needle and syringe programs in Australia*, p. 69.

<sup>502</sup> Penington Institute, Submission No. 10, 2015, p. 4.

<sup>503</sup> Australian Government Department of Health, *Needle and Syringe Programs*, viewed on 20 August 2015, <http://health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-needle-frame-toc~illicit-pubs-needle-frame-nee>.

<sup>504</sup> *Misuse of Drugs Act* (NT), s. 12(2).

<sup>505</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 5.

- 7.43 Despite the lack of access to sterile injecting equipment, the Committee notes that anecdotal evidence indicates that intravenous drug use occurs in some remote areas of the Territory:

For example, one remote health centre completed a Needs Assessment in relation to injecting drug use in May 2014 and stated: *Clinical staff have treated one case of illicit intravenous drug use relating in an overdose, two incidences of patients attempting to remove needles and syringes from the clinic, and there is one patient who openly admits to injecting illicit drugs.*<sup>506</sup>

However, in the absence of appropriate authorisation from the Minister, in instances such as this it is an offence for health centre staff to distribute sterile injecting equipment to clients.

- 7.44 In 2014, 30.8% of NSP clients in the Northern Territory reported they were collecting injecting equipment for another person.<sup>507</sup> The Committee understands that there are a number of reasons why people collect injecting equipment on behalf of someone else:

Anecdotal evidence suggests some people are unable to access NSP outlets during business hours due to work or family commitments, while others do not feel comfortable accessing these services. Transport issues and the spontaneous nature of some drug use may also present barriers to service access. Accordingly, some NSP clients collect equipment for their partners, friends or family members.<sup>508</sup>

- 7.45 The Committee was advised that international best practice suggests that 'peer distribution' is "an effective method of increasing access to sterile injecting equipment, in the same way that peer distribution of condoms (between friends, for example) increases access to safer sex commodities."<sup>509</sup> However, under section 12(2) of the *Misuse of Drugs Act*, this practice is currently illegal in the Territory. In July 2015, Tasmania introduced legislative amendments to become the first jurisdiction in Australia to legalise peer distribution and advocacy groups have called for other jurisdictions to follow suit.<sup>510</sup>

- 7.46 In 2011, a review of the Northern Territory Needle and Syringe Program found that "44% of NSP clients had been unable to access sterile injecting equipment when they needed it. Of these, roughly half indicated it was because an NSP outlet was closed."<sup>511</sup> Accordingly, the review recommended:

The Department of Health improve coverage of the NT NSP through the expansion of service delivery modalities including the introduction of syringe vending machines to improve afterhours access to sterile injecting equipment.<sup>512</sup>

The NTAHC subsequently submitted a proposal to the Northern Territory Government to trial SVMs in Darwin, Palmerston and Alice Springs. The cost of the 12 month trial, including initial outlay to purchase the three machines, was

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<sup>506</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 4.

<sup>507</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 5.

<sup>508</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 5.

<sup>509</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 5.

<sup>510</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 5.

<sup>511</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 4.

<sup>512</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 4.

estimated to be \$54,000. It is noted that the proposal was endorsed by both the Northern Territory Harm Reduction Steering Committee and the Northern Territory Sexual Health Advisory Group.<sup>513</sup>

- 7.47 In light of the findings of the 2011 review and the evidence presented during the inquiry, the Committee has recommended that, as part of the development and implementation of the *Northern Territory Drug Strategy*, the Government undertake a review of after-hours access to sterile injecting equipment. The Committee has also noted that the register of authorised classes of person to supply hypodermic needles should be reviewed in consultation with urban and remote stakeholders to enable the Minister for Health to consider expanding the register to include health professionals in remote areas.

### **Diversiory Programs**

- 7.48 In recognition of the fact that traditional law enforcement approaches of punishment and imprisonment are ineffective when it comes to reducing recidivism or addressing the underlying causes of the criminal behaviours of low level drug offenders, in 1999 the Council of Australian Governments (COAG) developed the Illicit Drug Diversion Initiative (IDDI). All state and territory governments subsequently committed to drug diversion programs under the IDDI with federal funding provided for a number of diversionary programs across Australia.<sup>514</sup> As noted on the Northern Territory Department of Health's website:

The primary objective of the IDDI is to increase incentives within the community for drug users to identify and treat their illicit drug use early. It also aims to decrease the social impact of illicit drug use and to prevent a new generation of drug users from committing drug related crime, thereby leading to safer communities across Australia.<sup>515</sup>

- 7.49 As illustrated in Figure 24 and summarised below, diversion programs can be classified as pre-arrest; pre-trial; pre-sentence; and post-sentence. A number of diversionary programs are embedded in legislation and must be offered to offenders, while other diversion options are at the discretion of police and magistrates. These programs are primarily reliant on the offender agreeing to undertake a diversion program. Some programs require an admission of guilt by the offender to be eligible, while others do not.
- 7.50 **Pre-arrest:** This form of diversion occurs when police first detect an offence may have been committed and prior to charging the offender. The diversionary options available to police generally include: taking no action; informal warnings; formal cautions; infringement notices which include a fine; and formal cautions plus

<sup>513</sup> NT DoH, Supplementary Submission No. 36, 2015, p. 4.

<sup>514</sup> C Hughes and A Ritter, *A summary of diversion programs for drug and drug-related offenders in Australia*, Monograph No. 16, DPMP Monograph Series, National Drug and Alcohol Research Centre, Sydney, 2008, p.4.

<sup>515</sup> Northern Territory Department of Health, *Other Substances: Illicit Drug Diversion Initiative*, viewed 30 October 2015, [http://www.health.nt.gov.au/Alcohol and Other Drugs/Other Substances/index.aspx](http://www.health.nt.gov.au/Alcohol%20and%20Other%20Substances/index.aspx).

intervention such as referral to assessment, education or treatment.<sup>516</sup> Examples of pre-arrest drug diversion programs include:

- Cannabis caution/expiation/infringement notice schemes exist in all jurisdictions in Australia. The number of times that an offender may be eligible for the diversion varies across jurisdictions, as does the nature of the program, from the issuing of fines to a requirement to complete an education and treatment program.
- Police Early Diversion Program (ACT) allows police to divert offenders that have been apprehended for the possession of a small quantity of illicit drugs for personal use under the *Drugs of Dependence Act 1989* (ACT) to attend drug assessment and treatment sessions. To be eligible for a diversion, the offender must have no prior involvement with the courts, have not participated in drug diversion programs on more than two occasions and violence must not have been involved in committing the offence.<sup>517</sup>

7.51 **Pre-trial:** Diversionary measures occur after a charge has been laid but prior to the matter being heard in court. In most instances, an admission of guilt is required by the offender. Pre-trial diversionary programs may include: treatment as a bail condition – if treatment is completed successfully generally no conviction will be recorded, however non-compliance may lead to prosecution; conferencing or mediation between the victims of crime and other community members or experts which aims to encourage offenders to take responsibility for their actions and reintegrate into the community; and prosecutor discretion, where the prosecutor may offer the offender treatment as opposed to proceeding to court.<sup>518</sup> Examples of pre-trial drug diversion programs include:

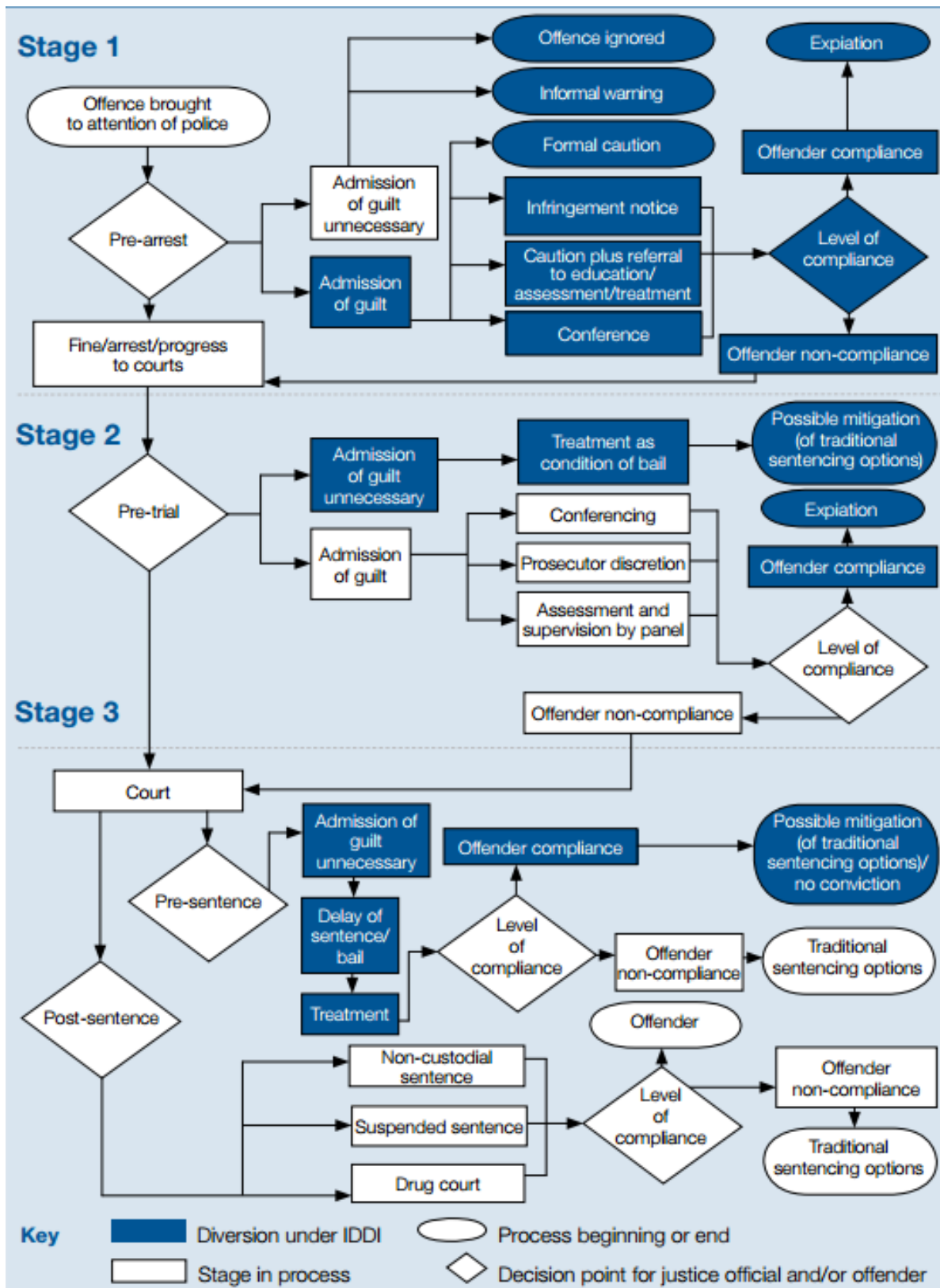
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<sup>516</sup> J Joudo, *Responding to substance abuse and offending in Indigenous communities: review of diversion programs*, Research and Policy Series No. 88, Australian Institute of Criminology, 2008, p. 17.

<sup>517</sup> Australian Federal Police, *AFP Practical Guide on Drug Diversions (ACT Policing)*, viewed on 26 August 2015, <http://www.afp.gov.au/~media/afp/pdf/ips-foi-documents/ips/publication-list/pr10076%20drug%20diversions%20act%20policing.pdf>.

<sup>518</sup> J Joudo, *Responding to substance abuse and offending in Indigenous communities*, p. 17.

Figure 23: Drug diversion processes in Australia<sup>519</sup>



<sup>519</sup> J Joudo, *Responding to substance abuse and offending in Indigenous communities*, p. 16.

- Court Referral and Evaluation for Drug Intervention Treatment Program (CREDIT)/Bail Support Program (Victoria) is an amalgamation of two former programs and is available to any defendant that is eligible for bail irrespective of whether a plea has been entered or whether the defendant intends to plead guilty or not. The offence for which a person has been charged does not need to be drug related, however it must be a non-violent offence. Participants in this program are provided with a range of services while on bail including referrals for drug assessment and treatment, case management for up to four months and support and monitoring of their drug use.<sup>520</sup>
- Magistrates Early Referral Into Treatment (MERIT) (NSW) is a program for defendants charged with drug related offences to seek treatment for their drug use problem while on bail. The MERIT treatment plan is generally an intensive treatment plan that operates over a minimum of 12 weeks which may include detoxification, pharmacotherapy, urinalysis, residential rehabilitation, community outpatient services and case management. The defendant must attend court to provide progress updates during the treatment plan. Non-compliance with the treatment plan may result in cessation of the MERIT plan or withdrawal of bail with the defendant being incarcerated on remand.<sup>521</sup>

7.52 **Pre-sentence:** This involves the delay of sentencing following a conviction to allow the offender to complete a diversionary program such as drug treatment where the conviction may not be recorded if the program is completed successfully, while non-compliance sanctions may apply. An example of pre-sentence drug diversion program is:

- Pre-Sentence Opportunity Program (WA) is available for low level drug offenders that plead guilty to an offence and would normally receive a fine or community-based order and may be referred to the program at a magistrate's discretion. The offender's case is remanded for about eight weeks while they seek treatment for their drug use after which time the offender returns to court for sentencing.<sup>522</sup>

7.53 **Post-sentence:** The diversionary programs that fall into this category include: suspended sentencing where a term of incarceration is handed down and its suspension is conditional on factors such as participation and completion of a treatment program; abstinence from drugs or avoiding contact with specific associates; non-custodial sentences involving probation, supervised orders or participation and completion of a treatment program. These types of programs are generally associated with drug courts.<sup>523</sup>

- Drug courts currently operate in all jurisdictions with the exception of the ACT, Tasmania and the Northern Territory. While the formation, process and

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<sup>520</sup> Magistrates' Court of Victoria, *CREDIT Bail Support Program*, viewed on 26 August 2015, <https://www.magistratescourt.vic.gov.au/court-support-services/credit-bail-support-program>.

<sup>521</sup> J Linden, *Magistrates Early Referral Into Treatment Program (MERIT)*, Judicial Commission of New South Wales, viewed on 26 August 2015, [http://www.judcom.nsw.gov.au/publications/selected\\_papers/merit](http://www.judcom.nsw.gov.au/publications/selected_papers/merit).

<sup>522</sup> J Joudo, *Responding to substance abuse and offending in Indigenous communities*, p. 17.

<sup>523</sup> J Joudo, *Responding to substance abuse and offending in Indigenous communities*, p. 18.



procedures applying to drug courts differ across jurisdictions, the main aim of these courts is to “divert illicit drug users from incarceration into treatment programs for their addiction.”<sup>524</sup>

### **Diversion Programs in the Northern Territory**

7.54 The NT Illicit Drug Pre-Court Diversion Program was introduced in the Northern Territory in 2002 and allows police to refer adult and juvenile first time offenders for use and possession of illicit drugs into drug treatment services, as opposed to entering the formal criminal justice system. The program is funded by the Australian Government Department of Health and jointly managed by the NTPS and Northern Territory Department of Health. The objectives of the program are to:

- Provide early drug education, counselling and/or treatment to offenders by making treatment available immediately;
- Offer an alternative to the criminal justice system for persons apprehended for use and possession of less than a trafficable quantity of illicit drugs; and
- Develop a commitment on the part of drug users to education, counselling and treatment by capitalising on the impact of being apprehended by police.<sup>525</sup>

7.55 The NTPS informed the Committee that, to date, the pre-court diversion program has not been widely used in the apprehension of offenders for ‘ice’ use and possession:

Cannabis is the main substance used by program referrals and at present ice referrals are very low. There has been one current offender for ice, one for LSD and 30 referrals for cannabis. The number of referrals has increased in the past 12 months.<sup>526</sup>

7.56 The Pre-Court Youth Diversion Scheme (previously Juvenile Pre-Court Diversion) is provided for under s39 of the *Youth Justice Act*. The diversion scheme allows police to elect to not charge a juvenile offender suspected of committing an offence and instead issue them with a verbal or written warning; require the youth to participate in a Youth Justice Conference; or refer them to a formal diversion program. A young offender is not eligible for pre-court diversion if they have committed a serious offence or have been offered diversion in the form of a Youth Justice Conference or a formal diversion program on two previous occasions. The Committee notes that the Pre-Court Youth Diversion Scheme is not specific to drug offences. The Act also provides for the Youth Justice Court to divert offenders prior to a finding of guilt to be assessed for inclusion in a youth diversion program.<sup>527</sup>

7.57 The Committee understands that the funding agreement for the Pre-Court Youth Diversion Scheme expired in 2013. However, the NTPS has continued to operate

<sup>524</sup> Australian Crime Commission (ACC), *Australian responses to illicit drugs: Drug courts*, viewed 30 October 2015, [http://www.aic.gov.au/criminal\\_justice\\_system/courts/specialist/drugcourts.html](http://www.aic.gov.au/criminal_justice_system/courts/specialist/drugcourts.html).

<sup>525</sup> Australian Institute of Health and Welfare, *The effectiveness of the Illicit Drug Diversion Initiative in rural and remote Australia*, Drug statistics series no. 19, Cat. No. PHE 96, Canberra, Australian Institute of Health and Welfare, 2008, p. 181.

<sup>526</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 6.

<sup>527</sup> *Youth Justice Act* (NT), s. 39 & s. 64.

the drug diversion scheme and the Northern Territory Department of Health continues to fund referrals to treatment and counselling that are made by the NTPS.<sup>528</sup> The Committee was informed during a site inspection of Banyan House that youth offenders have been diverted by police to Banyan House for counselling on their drug use.

7.58 Contrary to the information provided on the Northern Territory Department of Health's website, there is currently no drug court in operation in the Northern Territory, however there have previously been court diversion programs operating in the Territory. In 2003, the Court Referral and Evaluation for Drug Intervention and Treatment Northern Territory (CREDIT NT) was established as a voluntary pre-sentence bail program for offenders with a substance use problem charged with a criminal offence. The aims of the CREDIT NT program included:

- Reducing the likelihood of a sentence involving incarceration;
- Delaying or further reducing offending behaviour;
- Reducing the cost to the health system;
- Assisting participants to become more productive members of the community; and
- Improving the quality of life for participants.<sup>529</sup>

7.59 The CREDIT NT program was replaced in 2011 by the Substance Misuse Assessment and Referral for Treatment (SMART) Court. The aims of the SMART Court included:

- Reducing offending and antisocial behaviour associated with substance misuse;
- Increasing rehabilitation; and
- Reducing the risks and harms associated with substance misuse through improved health and social outcomes for people whose offending is related to substance abuse.<sup>530</sup>

7.60 The Committee understands that offenders with a substance use problem could be referred to the SMART Court from the Court of Summary Jurisdiction or the Youth Justice Court. The offender would be assessed by a court clinician to determine appropriate drug treatment options to be included within a SMART order. In addition to undertaking drug treatment, the SMART order could also contain requirements for monitoring the offender's progress in drug treatment; future court attendances; and random urinalysis drug testing. The SMART Court operated on a reward and sanction or 'carrot and stick' premise. Rewards for offender compliance with a SMART order included decreased supervision; reduction in frequency of drug testing; and a change in the type and frequency of treatment. Sanctions for non-

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<sup>528</sup> NTPS, Answers to Questions Taken on Notice, Public Hearing, 19 June 2015, p. 6.

<sup>529</sup> Australian Institute of Health and Welfare, *The effectiveness of the Illicit Drug Diversion Initiative in rural and remote Australia*, p. 183.

<sup>530</sup> W Yee Tan & M Johnson, *A Report into the Effectiveness of Civil Commitment in the Treatment of Alcoholism, and its Sustainability for Implementation in the Northern Territory*, Aurora Project, Summer 2013, viewed on 17 September 2015, p. 22, <http://www.naccho.org.au/download/aboriginal-health/NACCHO%20resources%20-Full%20Report%20on%20NT%20Mandatory%20Rehabilitation-1.pdf>.



compliance included increased supervision; increased frequency of drug testing; changes to the treatment services to be attended; more frequent attendances at court; and imprisonment or detention of up to 14 days.<sup>531</sup>

7.61 Under the *Alcohol Reform (Substance Misuse Assessment and Referral for Treatment Court) Act*, the SMART Court could either:

- Defer the sentencing of the offender for a period of between six and 12 months, grant the offender bail and make a SMART order with the offender's progress to be monitored. The offender was then sentenced upon the completion of the SMART order, taking into account the extent to which the offender complied with such, and any sanctions imposed during this period; or
- Sentence the offender to a period of imprisonment, suspend the execution of the sentence for a period of between six and 12 months and make a SMART order with the offender's progress to be monitored. Following the completion the SMART order, the Court must reconsider the sentence imposed and either confirm the original sentence or set it aside and impose a new sentence with a period of imprisonment not exceeding the original sentence. In reconsidering the original sentence, the Court must take into account the extent to which the offender complied with the SMART order and any sanctions imposed during this period.<sup>532</sup>

The Committee notes that the legislation establishing the SMART Court, the *Alcohol Reform (Substance Misuse Assessment and Referral for Treatment Court) Act*, was repealed in 2013 through the introduction of the *Alcohol Mandatory Treatment Act 2013*.

7.62 During the course of the inquiry, a number of witnesses called for more in the way of diversionary programs and/or the re-introduction of the SMART Court. As Mr Goldflam, Barrister and Solicitor with the NTLAC advised the Committee, "in the criminal justice system, the most pressing need is more therapeutic justice."<sup>533</sup> Noting the benefits of therapeutic jurisprudence at the 2013 AIJA Indigenous Justice Conference, Hillary Hannam, former Chief Magistrate of the Northern Territory stated that:

the fundamental issue remains that imprisonment does not operate as a deterrent to potential offenders, and generally does not appear to result in rehabilitation, particularly for those with mental illness or drug or alcohol issues. This is of course demonstrated by the number of repeat offenders and the difficulty many offenders have in reintegrating into their community after imprisonment. ...It is well recognised that Drug Courts and related Court-based programs make social as well as fiscal sense. Over 20 years of research has shown that drug treatment courts not only reduce crime by as much as 35 per cent but cost less than traditional court processes as well. A report from the National Indigenous Drug and Alcohol Committee, found that, in addition to being more successful at reducing recidivism, diversion from the prison system could save tax payers \$111,458 per offender. That is in addition to more than

<sup>531</sup> *Alcohol Reform (Substance Misuse Assessment and Referral for Treatment Court) Act* (NT), s. 25, (repealed).

<sup>532</sup> *Alcohol Reform (Substance Misuse Assessment and Referral for Treatment Court) Act* (NT), (repealed).

<sup>533</sup> NTLAC, Committee Transcript, 19 June 2015, p. 2.

\$92,000 per offender saved in the long term due to lower mortality and a better health regime through rehabilitation programs rather than prison.<sup>534</sup>

7.63 Moreover, the Committee notes that the United Nations Office on Drugs and Crime points out that:

In response to the growing number of drug offenders cycling in and out of the criminal justice system without treatment for underlying drug problems, the judicial systems in a number of countries have adopted drug courts to divert offenders from incarceration to supervised drug treatment. This form of treatment as an alternative to criminal justice sanctions has been found to be effective. Results of 23 program evaluations confirmed that drug courts significantly reduced drug use and crime and saved money. Treatment as an alternative to criminal justice sanctions is specifically encouraged in the international drug control conventions and it has been found to be more effective than imprisonment in encouraging recovery from drug dependence and reducing drug related crime. It can be provided in ways that do not violate the rights of the patients, provided that the decision to refuse treatment remains in the hands of the drug user and the patient's autonomy and human rights are respected.<sup>535</sup>

### **Recommendation 13**

**The Committee recommends that the Department of the Attorney-General and Justice:**

- a) undertake and publish a comprehensive review and evaluation of best practice in drug diversionary programs, including police diversions, pre-court diversions and drug courts, and develop a strategy to enhance access to drug diversion programs in the Northern Territory; and**
- b) the Attorney-General table a copy of the review and strategy in the Assembly by the end of the first quarter 2016.**

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<sup>534</sup> H Hannam, *Current Issues in Delivering Indigenous Justice: Challenges for the Courts*, AIJA Indigenous Justice Conference, viewed on 17 September 2015, p. 6, <http://www.aija.org.au/Ind%20Courts%20Conf%2013/Papers/Hannam.pdf>.

<sup>535</sup> United Nations Office on Drugs and Crime, *From coercion to cohesion: Treating drug dependence through health care, not punishment*, United Nations, New York, 2010 pp. 8-9.

## Appendix 1: Submissions Received

1. Australian Medical Association of the Northern Territory
2. National Drug Research Institute
3. BushMob
4. NT Department of the Attorney-General and Justice
5. NT Department of Health
6. Venndale Rehabilitation Centre
7. Australian Drug Foundation
8. NT Department of Education
9. INPEX
10. Penington Institute
11. St John Ambulance Australia (NT) Inc
12. Australian Institute of Health and Welfare
13. NT Council of Social Service
14. National Drug and Alcohol Research Centre
15. Association of Alcohol and Other Drug Agencies NT
16. CatholicCare NT
17. Amity Community Service
18. Banyan House
19. Danila Dilba Health Service
20. Northern Territory AIDS and Hepatitis Council
21. Pharmacy Guild of Australia
22. Prison In-Reach Program – Darwin Correctional Centre Clinic (Confidential)
23. NT Department of Correctional Services
24. Headspace Darwin and Anglicare NT
25. Australian Crime Commission
26. Northern Territory Legal Aid Commission
27. Domestic Violence Legal Service
28. Central Australian Aboriginal Alcohol Programmes Unit
29. Australian Hotels Association (NT Branch)
30. TEAMHealth
31. Taminmin College Council
32. NT Department of Children and Families
33. Darwin Region Indigenous Suicide Prevention Network
34. NT Police Service
35. Aboriginal Peak Organisations NT
36. NT Department of Health - Supplementary Information on NT Needle and Syringe Program
37. Tangentyere Council

**Note:** Copies of submissions are available at:

<http://www.nt.gov.au/lant/parliamentary-business/committees/ice/Submissions.shtml>

## **Appendix 2: Public Hearings, Private Briefings, Public Forums and Site Visits**

### **Public Hearings**

#### ***Darwin: 19 June 2015***

- NT Police Service and Australian Federal Police
- NT Department of Health
- NT Department of the Attorney-General and Justice
- NT Department of Correctional Services
- NT Department of Children and Families
- NT Department of Education
- NT Legal Aid Commission
- NT AIDS and Hepatitis Council
- Aboriginal Peak Organisations NT and Danila Dilba
- St John Ambulance (NT) Inc.
- Australian Crime Commission
- Banyan House

#### ***Katherine: 14 July 2015***

- Venndale Rehabilitation Centre
- Association of Alcohol and Other Drug Agencies NT

#### ***Alice Springs: 21 July 2015***

- BushMob
- Central Australia Aboriginal Alcohol Programmes Unit

#### ***Darwin: 7 September 2015***

- NT Road Transport Association
- Australian Hotels Association NT Branch
- INPEX and JKC Australia LNG Pty Ltd
- Master Builders Association NT
- Australian Medical Association NT
- Amity Community Services Inc.
- NT Council of Social Service Inc.
- Penington Institute
- Drug and Alcohol Services Association Inc.

### **Private Briefings**

#### ***Darwin: 15 May and 27 August***

- National Ice Task Force

### **Public Forums**

#### ***Katherine: 14 July 2015***

- Charmaine Briant: CatholicCare NT
- Corinna Pope: CatholicCare NT
- Donna Fraser: CatholicCare NT
- Resham Pachai: CatholicCare NT
- Casey Bishop: Venndale Rehabilitation Centre
- Commander Bruce Porter: NT Police Service
- Andy Blaney: Wurlu Wurlinjang Health Service
- Eric Thomas: Wurlu Wurlinjang Health Service
- Stuart Duncan: Victoria Daly Regional Council
- Jill Kelly: Community Member
- Douglas Kelly: Alcohol and Other Drugs Service
- Brad Dyson: Good Beginnings Australia
- Angela Nish: Good Beginnings Australia
- Fay Miller: Katherine Town Council
- Robert Jennings: Katherine Town Council
- Steven Rose: Katherine Town Council
- Peter Gazey: Katherine Town Council
- Jo Allan: Anglicare NT
- Karyn Cook: Anglicare NT
- Rachel Morris: Anglicare NT
- Miranda Halliday: AADANT
- Michelle Kudell: AADANT
- Natalie Ellis: CDU Katherine
- Cheryl Govan: NT Department of Housing
- Eileen Pugh: NT Department of Housing
- Willem Westra Van Holthe MLA: Deputy Chief Minister and Member for Katherine
- Jane Quinlan: Community Member
- Nicole Stoburt: Community Member
- David Forder: Somerville Community Services
- Kerry Bettison: Centre for Disease Control
- Emily Ball: Community Member

***Alice Springs: 21 July 2015***

- Commander Brent Warren: NT Police Service
- Skye Mitchell: NT Corrections
- Mandy Taylor: Community Member
- Christine Donnellan: CAAPU
- Merle Thomas: CAAPU
- Ron Miliado: CAAPU
- Delores Furber: CAAPU
- Eileen Hoosan: CAAPU
- Theodora Nelson: CAAPU
- Christobel Swan: CAAPU
- Paul Schluter: NT Corrections
- Bridget Davey: NT Corrections
- Mark Nixon: NT Corrections

- Suzanne Wilks: NT Corrections
- Dorinda Block: NT Corrections
- Darren Nesbit: NT Corrections
- Carole Taylor: Drug & Alcohol Services Association Inc.
- Matt Garrick: Centralian Advocate
- Robyn Lambley MLA: Member for Araluen
- Mr Turner: Community Member
- Blair McFarland: Central Australian Youth Link Up Service
- Andrew Walder: Tangentyere Council
- Jenny McFarland: Central Australian Youth Link Up Service

## **Site Visits**

### ***Darwin: 26 June 2015***

- Banyan House Residential Therapeutic Community

### ***Katherine: 14 July 2015***

- Venndale Rehabilitation Centre

### ***Alice Springs: 21 July 2015***

- BushMob Drug Addiction Treatment Centre

**Note:** Copies of hearing transcripts, tabled papers and answers to questions taken on notice are available at:

<http://www.nt.gov.au/lant/parliamentary-business/committees/ice/Inquiries.shtml>

## **Appendix 3: Key Principles – National Drug Strategy 2016-2025**

### **Partnerships**

The core partnership between health and law enforcement is central to the harm minimisation approach. This is reflected in membership of the Intergovernmental Committee on Drugs (IGCD), which has oversight of the Strategy on behalf of respective government ministers. However, a wide range of effective partnerships are critical components of the harm minimisation approach.

This includes partnerships between both government and non-government agencies in areas such as education, treatment and services, justice, child protection, social welfare, fiscal policy, trade, consumer policy, road safety and employment. It also includes partnerships with researchers and communities, affected communities such as drug user organisations, Aboriginal and Torres Strait Islander communities, and other priority populations.

### **Coordination and collaboration**

Coordination and collaboration at the international level, nationally and within jurisdictions leads to improved outcomes, innovative responses and better use of resources. The Strategy coordinates the national response to alcohol, tobacco and other drugs by establishing the harm minimisation approach. The Strategy also facilitates collaboration by describing the wide variety of responsibilities within the harm minimisation approach and their interdependence, as well as through the Strategy's governance structure.

### **Evidence informed responses**

Funding, resource allocation and implementation of strategies should be informed by evidence where possible. The Strategy is informed by current evidence. However, evidence is constantly improving and priorities and effective responses will develop during the term of the Strategy. Innovation and leadership in the development of new approaches is encouraged within the framework of harm minimisation. Supporting research and building and sharing evidence is a key mechanism that allows a national approach to leverage better outcomes from local implementation. Where evidence is not available or limited, effective policy should still be implemented, especially when this will expand the knowledge base.

### **National direction, jurisdictional implementation**

The Strategy describes a nationally agreed harm minimisation approach to reducing the harm from alcohol, tobacco and other drug use. Examples of evidence informed approaches are described in the Strategy. However, funding and implementation occurs at all levels of government and the Commonwealth Government, state and territory governments and local governments are all responsible for regulation and the funding of programs that reduce the harms of drug use.

Jurisdictional implementation allows for governments to take action relevant to their jurisdiction within the national harm minimisation approach. Strategies should reflect local circumstances and address emerging issues and drug types. Coordination and

collaboration supports jurisdictions to develop better responses and innovations within the national approach that can inform and benefit all jurisdictions by sharing practices and learning.<sup>536</sup>

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<sup>536</sup> Intergovernmental Committee on Drugs, *National Drug Strategy 2016-2025*, p. 7.



## Appendix 4: National Ice Taskforce Terms of Reference

The ice epidemic in Australia cannot be ignored. The Australian Crime Commission reports that, despite increased investment in border protection, the past 5 years has seen significant growth in the detected importation, manufacture and supply of crystal methylamphetamine (ice). On the ground, reported use of ice by methylamphetamine users has more than doubled, increasing from 22% in 2010 to 50% in 2013 and those who do use, do so more frequently. The purity of ice has also increased making it even more dangerous.

Combating ice is a priority for the Australian Government and all states and territories. Building on work being done in all jurisdictions, the Australian Government has established a National Ice Taskforce that will drive the development and implementation of the National Ice Action Strategy.

### Role of the Taskforce

The Taskforce, working with the states and territories, will:

- Take a comprehensive stock-take of existing efforts to address ice at all levels of government;
- Receive submissions from community consultations and expert groups to ensure all Australians affected by ice have the opportunity to be heard;
- Identify potential gaps in knowledge specifically around treatment models, associated criminal activity and the impact of ice on vulnerable groups, including people living in regional Australia and Aboriginal and Torres Strait Islanders;
- Identify specific initiatives that are currently providing good outcomes for the community;
- Examine ways to ensure existing efforts to tackle ice are appropriately targeted, effective and efficient.
- Provide advice on appropriate primary prevention activities, informed by evidence and best practice;
- Consider options to improve levels of coordination and collaboration of existing efforts at the local, regional and state and territory level;
- Develop a package of recommendations to be actioned as part of developing a broader National Strategy for Action on Ice.

The Taskforce will present an interim report to the Prime Minister for consideration by the Council of Australian Governments. Following consideration by COAG, the Taskforce will then:

- Consolidate the Commonwealth's leadership role in national prevention efforts;

- Work collaboratively with states and territories to draft a strategy which outlines priority actions and jurisdictional roles to ensure a collaborative approach to tackling ice by all governments;
- Provide a final report outlining options for a National Action Strategy on Ice to COAG for consideration and action.

### **Membership**

Members of the Taskforce will be appointed by the Prime Minister. The Chair of the Taskforce is Mr Ken Lay APM.

### **Secretariat**

A Secretariat for the Taskforce will be established and supported by the Department of the Prime Minister and Cabinet and will comprise representatives from relevant Departments.

### **Reporting**

The Taskforce will report to the Prime Minister.

### **Timeframes**

The interim report will be provided to the Prime Minister in June 2015 for subsequent consideration by COAG.

A final report will be provided to the Prime Minister with a final strategy to be considered by COAG before the end of 2015.<sup>537</sup>

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<sup>537</sup> Department of Prime Minister and Cabinet, *National Ice Taskforce Terms of Reference*, Australian Government, 2015, viewed on 13 October 2015, [http://www.dpmc.gov.au/sites/default/files/files/national\\_ice\\_taskforce\\_terms\\_reference.pdf](http://www.dpmc.gov.au/sites/default/files/files/national_ice_taskforce_terms_reference.pdf).

## Bibliography

ABC News, *Grandparents call for support as Northern Territory fights scourge of ice*, viewed 26 October 2015, <http://www.abc.net.au/news/2015-01-19/grandparents-call-for-support-as-nt-fights-scourge-of-ice/6024524>

ABC 7.30 Report, *This is the ice controversial treatment former addicts swear by*, 13 October 2015, viewed 26 October 2015, <http://www.abc.net.au/7.30/content/2015/s4331084.htm>.

ABC News, *Online classified ads allegedly used to sell drug ice, Melbourne man arrested*, 23 July 2015, viewed on 5 August 2015, <http://www.abc.net.au/news/2015-07-23/melbourne-man-arrested-for-allegedly-selling-drug-ice-in-online/6641456>.

ABC News, *Violence facing ambulance paramedics prompts SA safety awareness campaign*, 27 May 2015, viewed 19 October 2015, <http://www.abc.net.au/news/2015-05-27/violence-ambulance-paramedics-awareness-campaign-sa-health/6501006>.

Attorney-General Department (AGD), *Clandestine Drug Laboratory Remediation Guidelines*, Canberra, AGD, 2011.

Australian Crime Commission (ACC), *The Australian Methylamphetamine Market – The National Picture*, Canberra, Commonwealth of Australia, 2015.

Australian Crime Commission, *Illicit Drug Data Report*, viewed on 27 July 2015, <https://www.crimecommission.gov.au/illicit-drug-data-report-2013-14>.

Australian Crime Commission, *Illicit Drug Data Report 2013-14*, ACC, Canberra, 2015.

Australian Crime Commission, *Illicit Drug Data Report 2012-13*, ACC, Canberra, 2014.

Australian Crime Commission (ACC), *Australian responses to illicit drugs: Drug courts*, viewed 30 October 2015, [http://www.aic.gov.au/criminal\\_justice\\_system/courts/specialist/drugcourts.html](http://www.aic.gov.au/criminal_justice_system/courts/specialist/drugcourts.html).

Australian Drug Foundation, *The stepped care model: a useful intervention strategy for people who use methamphetamine*, Melbourne, Australian Drug Foundation, September 2008.

Australian Drug Foundation, *Policy Talk: Workplace drug testing*, Australian Drug Foundation, November 2012, viewed on 14 October 2015, <http://www.adf.org.au/policy-advocacy/policy-talk-november-2012>.

Australian Drug Foundation, *Ice family and friends support guide*, viewed on 1 September 2015, [http://www.druginfo.adf.org.au/images/documents/AU\\_Ice\\_Brochure-Web.pdf](http://www.druginfo.adf.org.au/images/documents/AU_Ice_Brochure-Web.pdf).

Australian Federal Police, *AFP Practical Guide on Drug Diversions (ACT Policing)*, viewed on 26 August 2015, <http://www.afp.gov.au/~media/afp/pdf/ips-foi-documents/ips/publication-list/pr10076%20drug%20diversions%20act%20policing.pdf>.

Australian Government Department of Health, *Methamphetamine: What you need to know about speed, ice, crystal, base and meth*, Canberra, Australian Government Department

of Health, viewed on 7 October 2015,

<https://comorbidity.edu.au/sites/default/files/Methamphetamine.pdf>.

Australian Government Department of Health, *Needle and Syringe Programs*, viewed on 20 August 2015, <http://health.gov.au/internet/publications/publishing.nsf/Content/illicit-pubs-needle-frame-toc~illicit-pubs-needle-frame-nee>.

Australian Government Department of Health, *Ice Destroys Lives*, Australian Government, viewed on 23 July 2015,

<http://www.drugs.health.gov.au/internet/drugs/publishingcp.nsf/content/home>.

Australian Government Department of Health and Aging, *National Amphetamine-Type Stimulant Strategy Background Paper*, Monograph Series No. 69, Canberra, Australian Government, 2007.

Australian Government Department of Health and Aging, *Patterns of use and harms associated with specific populations of methamphetamine users in Australia – Exploratory research*, Canberra, Australian Government, 2008.

Australian Institute of Health and Welfare, *Alcohol and other drugs data cubes*, viewed on 16 June 2015, <http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data-cubes/>.

Australian Institute of Health and Welfare (AIHW), *Alcohol and other drug treatment services*, viewed 16 June 2015, <http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/>.

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2012–13*. Drug treatment series 24. Cat. no. HSE 150. Canberra, Australian Institute of Health and Welfare, 2014.

Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2013–14*. Drug treatment series no. 25. Cat. no. HSE 158. Canberra, Australian Institute of Health and Welfare, 2015.

Australian Institute of Health and Welfare, *The effectiveness of the Illicit Drug Diversion Initiative in rural and remote Australia*, Drug statistics series no. 19, Cat. No. PHE 96, Canberra, Australian Institute of Health and Welfare, 2008.

Australian Institute of Health and Welfare, *2001 National Drug Strategy Household Survey: State and Territory supplement*, Drug statistics series No. 10, Cat No PHE 37, Canberra, Australian Institute of Health and Welfare, 2002.

Australian National Council on Drugs, *Summary report of the Australian National Council on Dugs' media project*, viewed 28 October 2015, <http://www.atoda.org.au/wp-content/uploads/Summary-report-of-the-Australian-National-Council-on-Drugs%E2%80%99-media-project.pdf>.

Baker, R & McKenzie, N, 'Shock and awe ice campaign a turn off: research', *The Age*, 23 May 2015, viewed on 17 August 2015, <http://www.theage.com.au/victoria/shock-and-awe-ice-campaigns-a-turn-off-research-20150522-gh7as2.html>.

Baker, A, Lee N, & Jenner, L (eds.), *Models of intervention and care for psychostimulant users*, 2<sup>nd</sup> Edition, National Drug Strategy Monograph Series No. 51, Canberra, Australian Government Department of Health and Aging, 2004.

Barratt, M, Ferris, J & Winstock, A, 'Use of the Silk Road, the only drug marketplace, in the United Kingdom, Australia and the United States', *Addiction*, May 2014, Vol. 9, Issue 5, pp. 774-783.

Billings, P, 'Drugs to order on craigslist', *The Mercury*, 29 July 2015, viewed on 5 August 2015 <http://www.themercury.com.au/news/scales-of-justice/drugs-to-order-on-craigslist/story-fnj8cre7-1227462421878>.

Bromfield, L, Lamont, A, Parker, R & Horsfall, B, *Issues for the safety and wellbeing of children in families with multiple complex problems*, National Child Protection Clearinghouse Issues No. 33, Melbourne, Australian Institute of Family Studies, 2010.

Burke, L, *The unspoken role of ice in Australia's domestic violence*, 29 July 2015, viewed on 5 August 2015, <http://www.news.com.au/lifestyle/real-life/the-unspoken-role-of-ice-in-australias-domestic-violence-problem/story-fnu2q5nu-1227461150488>.

Chandler, P, (Minister for Transport), *Traffic Act and Other Legislation Amendment Bill 2015 (Serial 138)*, Explanatory Statement, Full Text Transcript, 17 September 2015, viewed on 23 September 2015, <http://notes.nt.gov.au/lant/hansard/hansardd.nsf/WebFullTextTranscript/E648882891323AAE69257EC30039E92D?opendocument>.

Committee for Geelong, *ICE Declaration Day*, media release 21 November 2014, viewed on 31 August 2015, <http://www.committeeforgeelong.com.au/news-updates/committee-for-geelongs-weekly-addy-opinion-piece-ice-declaration-day/>.

Counselling Online, viewed on 13 October 2015, <https://www.counsellingonline.org.au/>.

Coyne, J, White, V & Alvarez, C, *Methamphetamine: Focusing Australia's National Ice Strategy on the problem, not the symptoms*, Barton ACT, Australian Strategic Policy Institute, October 2015.

Cruickshank, C & Dyer, K, 'A review of the clinical pharmacology of methamphetamine', *Addiction*, vol. 104, no. 3, p. 1085-1099.

Darke, S, Kaye, S, McKetin, R & Duflou, J, 'Major physical and psychological harms of methamphetamine use' *Drug and Alcohol Review*, vol. 27, issue 3, May 2008, pp. 253-262.

Dawe, S, Harnett, P & Frye, S, *Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do*, Child Abuse Prevention Issues No. 29, Melbourne, Australian Institute of Family Studies, 2008.

Department of Prime Minister and Cabinet, *National Ice Taskforce*, viewed on 12 August 2015, <http://www.dpmc.gov.au/taskforces/national-ice-taskforce>.

Department of Prime Minister and Cabinet, *National Ice Taskforce Terms of Reference*, Australian Government, 2015, viewed on 13 October 2015, [http://www.dpmc.gov.au/sites/default/files/files/national\\_ice\\_taskforce\\_terms\\_reference.pdf](http://www.dpmc.gov.au/sites/default/files/files/national_ice_taskforce_terms_reference.pdf).

Department of the Prime Minister and Cabinet (NZ), *Tackling Methamphetamine: an Action Plan*, Department of the Prime Minister and Cabinet, Wellington, 2009.

Department of the Prime Minister and Cabinet (NZ), *Methamphetamine – Indicators and Progress Reports*, viewed 27 October 2015, <http://www.dpmc.govt.nz/dpmc/publications/methamphetamine>.

Devaney, M, Ferris, J & Mazerolle, L, 'Online reporting of pseudoephedrine pharmacy sales: does Australia require a mandatory system?', *International Journal of Pharmacy Practice*, Vol. 23, Issue 4, 2015, pp. 248-255.

Elferink, J, (Attorney-General), *Misuse of Dangerous Drugs Amendment Bill (Serial 136)*, Explanatory Statement, Full Text Transcript. 16 September 2015, viewed on 23 September 2015, <http://notes.nt.gov.au/lant/hansard/hansardd.nsf/WebFullTextTranscript/D0DF13E6AF3DF5C69257EC20053010D?opendocument>.

enHealth, *enHealth Position Statement: Clandestine Drug Laboratories and Public Health Risks*, 14 August 2013, viewed on 13 August 2015, [https://www.health.gov.au/internet/main/publishing.nsf/Content/A12B57E41EC9F326CA257BF0001F9E7D/\\$File/Clan-Labs.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/A12B57E41EC9F326CA257BF0001F9E7D/$File/Clan-Labs.pdf).

Erceg-Hurn, D, 'Drugs, Money, and Graphic Ads: A Critical Review of the Montana Meth Project', *Prevention Science*, Vol. 9, Issue 4, December 2008, pp. 256-63.

Fair Work and Building Construction, *Drug and Alcohol Testing under the Building Code 2013*, Australian Government, viewed on 14 October 2015, <http://www.fwbc.gov.au/drug-and-alcohol-testing-under-building-code-2013>.

Family Drug Support, viewed on 1 September 2015, <http://www.fds.org.au/>.

Fitzgerald, J, 'Don't panic? the 'ice pandemic' is a myth', *The Age*, 18 May 2015, viewed on 7 October 2015, <http://www.theage.com.au/comment/dont-panic-the-ice-pandemic-is-a-myth-20150515-gh2plm.html>.

Freye, E, *Pharmacology and Abuse of Cocaine, Amphetamines, Ecstasy and Related Designer Drugs*, Springer, Netherlands, 2010, p. 120.

Giles, A, (Chief Minister), *Appointment of Select Committee on the Prevalence, Impacts and Government Responses to 'Ice' in the Northern Territory*, Motion, Full Text Transcript, 25 March 2015, viewed 26 March 2015, <http://notes.nt.gov.au/lant/hansard/hansardd.nsf/WebFullTextTranscript/48C0D127E4ADFDDF69257E13004FF48F?opendocument>.

Government of Western Australia, Drug and Alcohol Office, *Media*, viewed 28 October 2015, <http://www.dao.health.wa.gov.au/vsu/pages/Media.htm>.

Government of Western Australia Mental Health Commission, *The Western Australia Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, viewed 27 October 2015, <http://www.mentalhealth.wa.gov.au/ThePlan.aspx>.

Greater Geelong Collective Community Effort on Substance Abuse, *Our Town's ICE Fight*, viewed on 31 August 2015, <http://www.icefight.com.au/latest-news>.

Iverson, J & Maher, L, *Australian NSP Survey: 20 Year National Data Report 1995-2014*, Sydney, Kirkby Institute, UNSW Australia, 2015.



- Hannam, H, *Current Issues in Delivering Indigenous Justice: Challenges for the Courts*, AIJA Indigenous Justice Conference, viewed on 17 September 2015, <http://www.aija.org.au/Ind%20Courts%20Conf%2013/Papers/Hannam.pdf>.
- Hughes, C & Ritter, A, *A summary of diversion programs for drug and drug-related offenders in Australia*, Monograph No. 16, DPMP Monograph Series, National Drug and Alcohol Research Centre, Sydney, 2008.
- Intergovernmental Committee on Drugs, *National drug Strategy 2016-2025, Draft: For public consultation*, Australian Government, Canberra, October 2015.
- Jenner, L & Lee, N, *Treatment Approaches for Users of Methamphetamine: A Practical Guide for Frontline Workers*, Canberra, Australian Government Department of Health and Aging, 2008.
- Jones, R, 'Grandparents call for support as NT fights scourge of ice', *ABC News*, 19 January 2015, viewed on 4 August 2015, <http://www.abc.net.au/news/2015-01-19/grandparents-call-for-support-as-nt-fights-scourge-of-ice/6024524>.
- Joudo, J, *Responding to substance abuse and offending in Indigenous communities: review of diversion programs*, Research and Policy Series No. 88, Australian Institute of Criminology, 2008.
- Lancaster, K, Ritter, A & Colebatch, H, 'Problems, policy and politics: making sense of Australia's 'ice epidemic'', *Policy Studies*, Vol. 35, No. 2, 2014, pp. 147-171.
- Lee, N, 'Are we in the midst of an ice epidemic? A snapshot of meth use in Australia', *The Conversation*, 8 April 2015, viewed on 7 October 2015, <https://theconversation.com/are-we-in-the-midst-of-an-ice-epidemic-a-snapshot-of-meth-use-in-australia-39697>.
- Lee, N, *Ice age: who has used crystal meth and why*, 11 March 2014, viewed on 13 October 2015, <https://theconversation.com/ice-age-who-has-used-crystal-meth-and-why-23031>.
- Lee, N, Kay-Lambkin, F, McKetin, R & Baker, A 'Everything old is new again: the application of drug treatment to the emerging challenge of methamphetamine use and dependence' in Moore, D & Dietze, P (eds), *Drugs and Public Health: Australian Perspectives on Policy and Practice*, Oxford University Press, Melbourne, 2008.
- Lee, N, Johns, L, Jenkinson, R, Johnston, J, Connolly, K, Hall, K. & Cash, R, *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine dependence and treatment*, Fitzroy, Victoria, Turning Point Alcohol and Drug Centre Inc., 2007.
- Linden, J, *Magistrates Early Referral Into Treatment Program (MERIT)*, Judicial Commission of New South Wales, viewed on 26 August 2015, [http://www.judcom.nsw.gov.au/publications/selected\\_papers/merit](http://www.judcom.nsw.gov.au/publications/selected_papers/merit).
- Magistrates' Court of Victoria, *CREDIT Bail Support Program*, viewed on 26 August 2015, <https://www.magistratescourt.vic.gov.au/court-support-services/credit-bail-support-program>.
- McGowan, M, *Methamphetamine Action Plan Fact Sheet*, viewed on 11 August 2015, [http://www.markmcgowan.com.au/files/Methamphetamine\\_Action\\_Plan\\_Fact\\_Sheet.pdf](http://www.markmcgowan.com.au/files/Methamphetamine_Action_Plan_Fact_Sheet.pdf).

McGrath, C, 'Darwin man Ricky-Lee Jones paid teenage for work with drug ice, jailed for six years', *ABC News*, 2 October 2015, viewed 14 October 2015, <http://www.abc.net.au/news/2015-10-02/ricky-lee-jones-jailed-after-teen-paid-for-work-with-ice/6823676>.

McInerney, J, *Ice epidemic claims overstated: drug expert*, ABC Radio National, 17 August 2015, viewed on 18 August 2015, <http://www.abc.net.au/radionational/programs/counterpoint/why-claims-of-an-ice-epidemic-are-overstated/6699080>

McKetin, R, Kelly, E & McLaren, J, 'The relationship between crystalline methamphetamine use and methamphetamine dependence', *Drug and Alcohol Dependence*, vol. 85, no. 3, 2006, pp. 198-204.

McKetin, R, McLaren, J, Lubman, D & Hides, L, 'The prevalence of psychotic symptoms among methamphetamine users', *Addiction*, vol. 101, issue 10, 2006, pp. 1473-1478.

Meade, A, 'Abbott government defends almost identical anti-ice TV ads', *The Guardian*, 20 May 2015, viewed on 17 August 2015, <http://www.theguardian.com/australia-news/2015/may/20/abbott-government-defends-almost-identical-anti-ice-tv-ads>.

Ministerial Council on Drug Strategy, *National Drug Strategy 2011-2015*, Canberra, Commonwealth of Australia, 2011.

Ministerial Council on Drug Strategy, *National Amphetamine-Type Stimulant Strategy 2008-2011*, Canberra, Commonwealth of Australia, 2008.

Mission Australia, *Drug and Alcohol Youth Service*, viewed on 24 August 2015, <http://sd.missionaustralia.com.au/386-drug-and-alcohol-youth-service>.

Moon, C, *Northern Territory Drug Trends 2014. Findings from the Illicit Drug Reporting System (IDRS)*, Australian Drug Trend Series No. 134, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015.

National Centre in HIV Epidemiology and Clinical Research, *Return on investment 2: Evaluation the cost-effectiveness of needle and syringe programs in Australia*, Sydney, UNSW Australia, 2009.

Northern Mallee Community Partnership, *Project Ice Mildura*, viewed on 31 August 2015, <http://www.nmcp.org.au/project-ice-mildura>.

Northern Territory Department of Health, *Priority Action Area 3: Targeting Smoking, Alcohol and Substance Abuse*, viewed on 11 August 2015, [http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/40/41.pdf&siteID=1&str\\_title=Priority%20Action%20Area%20%20-%20Targeting%20Smoking.%20Alcohol%20and%20Substance%20Abuse.pdf](http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/40/41.pdf&siteID=1&str_title=Priority%20Action%20Area%20%20-%20Targeting%20Smoking.%20Alcohol%20and%20Substance%20Abuse.pdf).

Northern Territory Department of Health, *Withdrawal Services*, viewed 13 October 2015, [http://www.health.nt.gov.au/service\\_locator/withdrawal\\_services/index.aspx](http://www.health.nt.gov.au/service_locator/withdrawal_services/index.aspx).

Northern Territory Department of Health, *Alcohol and Other Drug Related Links*, viewed 13 October 2015, [http://www.health.nt.gov.au/Alcohol\\_and\\_Other\\_Drugs/Related\\_Links/index.aspx](http://www.health.nt.gov.au/Alcohol_and_Other_Drugs/Related_Links/index.aspx).



New South Wales Ministry of Health, *Methamphetamine: Speed and Ice: The Facts*, Sydney, New South Wales Ministry of Health, 2014, viewed on 7 October 2015, <http://yourroom.com.au/wp-content/uploads/2013/05/Speed-facts.pdf>.

New South Wales Ministry of Health, *Crystal Methamphetamine Background Paper – NSW Data*, August 2015, New South Wales Ministry of Health, viewed on 25 August 2015, <http://www.health.nsw.gov.au/crystallinemethamphetamine/Publications/background-paper.pdf>.

NT News, 'Chemists give leads on ice baking', *NT News*, 13 October 2015.

Parliament of Victoria, *Inquiry into the Supply and Use of Methamphetamine, Particularly Ice, in Victoria*, Victoria, 2014.

Penington Institute, *Ice campaign hits home with those most at risk*, viewed on 17 August 2015, <http://www.penington.org.au/ice-campaign-hits-home-with-those-most-at-risk/>.

Pennay, A & Lee, N, 'Prevention and early intervention of methamphetamine-related harm', *Prevention Research Quarterly*, No. 6, Australian Drug Foundation, September 2008.

Pidd, K, Roche, A & White, M, *Workplace Drug and Alcohol Testing*, National Centre for Education and Training on Addiction, Flinders University, Adelaide, October 2011.

Pidd, K & Roche, A, *Workplace Drug Testing: Evidence and Issues*, National Centre for Education and Training on Addiction, Flinders University, Adelaide, 2011.

Prichard, J, Lai, F. Y, Kirkbride, P, Bruno, R, Ort, C, Carter, S, Hall, W, Gartner, C, Thai, P K & Mueller, F M, 'Measuring drug use patterns in Queensland through wastewater analysis', *Trends and issues in crime and criminal justice*, June 2012, No. 442, Canberra, Australian Institute of Criminology.

Puddy, R, 'Former meth labs 'toxic death traps'', *The Australian*, 13 October 2015.

Quinn, B & Dietze, P, 'Awareness campaigns need to target the real victims of ice', *The Conversation*, 13 May 2015, viewed on 17 August 2015, <https://theconversation.com/awareness-campaigns-need-to-target-the-real-victims-of-ice-40631>.

Ritter, A, Bright, D & Gong, W, *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*, Monograph Series No. 44, Canberra, National Drug Law Enforcement Research Fund, 2012.

Ritter, A, McLeod, R, Shanahan, M, *Government Drug Policy Expenditure in Australia – 2009/10*, Monograph No. 24, Sydney National Drug and Alcohol Research Centre, June 2013.

Select Committee on Action to Prevent Foetal Alcohol Spectrum Disorder, *The Preventable Disability*, Northern Territory Legislative Assembly, Darwin, February 2015.

Siggins Miller, *Evaluation and Monitoring of the National Drug Strategy 2004-2009*, 2009, viewed on 12 August 2015, [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FD973BE3A786C9B0CA257682000E70DC/\\$File/eval1.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/FD973BE3A786C9B0CA257682000E70DC/$File/eval1.pdf).

Sindicich, N & Burns, L, *Australian Trends in Ecstasy and Related Drug Markets 2014. Findings from the Ecstasy and Related Drugs Reporting System*, Australian Drug Trends Series No. 136, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015.

Stafford, J and Burns, L, *Australian Drug Trends 2014. Findings from the Illicit Drug Reporting System (IDRS)*, Australian Drug Trend Series, No. 127, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015.

Stancombe Research + Planning, *National Drugs Campaign 2015 Evaluation Research*, Stancombe Research + Planning, Sydney, August 2015

The Sydney Morning Herald, 'Ice: The drug that's hard on the head – and hard on families', *The Sydney Morning Herald*, 21 July 2014, viewed on 13 October 2015, <http://www.smh.com.au/lifestyle/diet-and-fitness/chew-on-this/ice-the-drug-thats-hard-on-the-head--and-hard-on-families-20140720-3c8ou.html>.

Thomson, N & Moore, D, 'Methamphetamine 'facts': The production of a 'destructive' drug in Australian scientific texts', *Addiction Research and Theory*, December 2014, Vol. 22, Issue 6, pp. 751-762.

Torok, M, Darke, S, Kaye, S, Ross, J & McKetin, R, *Comparative rates of violent crime amongst methamphetamine and opioid users: Victimisation and offending*, Monograph Series No. 32, Hobart, National Drug Law Enforcement Research Fund, 2008.

United Nations Office on Drugs and Crime, *2014 Global Synthetic Drugs Assessment: Amphetamine-type stimulants and new psychoactive substances*, United Nations, New York, 2014.

United Nations Office on Drugs and Crime, *From coercion to cohesion: Treating drug dependence through health care, not punishment*, United Nations, New York, 2010.

Van Buskirk, J, Roxburgh, A, Bruno, R & Burns, L, *Drugs and the Internet, Issue 2*, March 2014, Sydney, National Drug and Alcohol Research Centre.

Victorian Government, *Cracking Down on Drunk, Drugged Drivers*, media release, 12 July 2015, viewed on 25 August 2015, <http://www.premier.vic.gov.au/cracking-down-on-drunk-drugged-drivers>.

Victorian Ice Action Taskforce 2015, *Ice Action Framework*, Victorian Government, p. 7, viewed on 12 August 2015, [http://www.dpc.vic.gov.au/images/documents/Ice\\_Action\\_Plan\\_-\\_Framework\\_document\\_-\\_Final\\_4\\_Mar\\_2015.pdf](http://www.dpc.vic.gov.au/images/documents/Ice_Action_Plan_-_Framework_document_-_Final_4_Mar_2015.pdf).

Victorian Ice Action Taskforce 2015, *Ice Action Plan*, Victorian Government, viewed on 12 August 2015, <https://4a5b508b5f92124e39ffc8d8d0b92a93a9c1ab1bc91ad6c9bfdb.ssl.cf4.rackcdn.com/2015/03/Ice-Action-Plan-Final-Summary-Documents-Web-Version.pdf>.

Weekend Australian, 'Ice: the drug that shatters lives' *Weekend Australian*, 26 September 2015, viewed on 1 October 2015, <http://www.theaustralian.com.au/opinion/editorials/ice-the-drug-that-shatters-lives/story-e6frg71x-1227544300232>.

Whittaker, E and Burns, L, *Northern Territory Trends in Ecstasy and Related Drug Markets 2014. Findings from the Ecstasy and related Drugs Reporting System (EDRS)*, Australian Drug Trend Series No. 143, Sydney, National Drug and Alcohol Research Centre, UNSW Australia, 2015.

Yee Tan, W & Johnson, M, *A Report into the Effectiveness of Civil Commitment in the Treatment of Alcoholism, and its Sustainability for Implementation in the Northern Territory*, Aurora Project, Summer 2013, viewed on 17 September 2015, <http://www.naccho.org.au/download/aboriginal-health/NACCHO%20resources%20-Full%20Report%20on%20NT%20Mandatory%20Rehabilitation-1.pdf>.