Northern Territory Harm Reduction 2018

Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours by the Association of Alcohol and other Drug Agencies NT

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ASSOCIATION OF ALCOHOL AND OTHER DRUG AGENCIES NT

The Association of Alcohol and other Drug Agencies NT (AADANT) is the Peak Body for non-government organisation (NGO) Alcohol and Other Drug (AOD) treatment services. AADANT is part of the National Peaks Network, comprising of peak bodies for NGO AOD Treatment Services throughout Australia.

As an independent, membership-driven, not-for-profit association, we work with our members to support and strengthen AOD service delivery for people who experience harmful substance use in the NT.

Our mission is to build and maintain a strong, sustainable and culturally diverse Alcohol and Other Drugs (AOD) sector that works together to reduce alcohol and other drug related harm across the Northern Territory.

Representation and Advocacy. We understand the challenges of service delivery. We will represent the AOD sector to ensure the needs and interests are heard through a collective, unified voice. We'll work with our membership to ensure our advocacy is well-informed and reflective of current issues. We will seek your views and submissions in relation to issues impacting on AOD service delivery in the NT.

Capacity Building & Workforce Development. We deliver, facilitate or scope a range of activities to support our workforce's capacity to provide effective, meaningful and evidenced-based services to clients. We listen to our membership and work hard to ensure every opportunity is provided to strengthen AOD service delivery in the NT.

AADANT acknowledges the Traditional Owners of the Land on which we live, work and walk.

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The Definition of Harm Reduction and Minimisation

The International Harm Reduction Association defines harm reduction as:

'policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.

The harm reduction approach to drugs is based on a strong commitment to public health and human rights (Harm Reduction International, 2018)

The National Drug Strategy outlines that the harm minimisation approach does not condone drug use. Harm minimisation acknowledges that some people in societies will use alcohol and other drugs and therefore incorporates policies which aim to prevent or reduce drug related harms. Harm reduction is a central pillar of the harm minimisation approach. As of March 2009 at least 84 countries worldwide supported or allowed a harm reduction approach to drug policy (International Harm Reduction Association, 2008). Harm reduction is also supported by the following key international organisations:

- United Nations General Assembly
- UNAIDS - the joint United Nations Programme on HIV/AIDS
- United Nations Office on Drugs and Crime
- World Health Organization
- International Narcotics Control Board
- United Nations High Commissioner for Human Rights.

Harm Reduction Australia (HRA) has an extensive frequently asked questions section on their website which explains how harm reduction and harm minimisation strategies benefit the health and wellbeing of the public. Below are a few questions and answers which outline the need for harm minimisation strategies to be implemented:

What will be the impacts of harm reduction policies on our health care system?

There are likely to be more people willing to seek help and treatment, but the costs of this increase would be offset by both reduced expenditure within the criminal justice system and longer-term health savings from earlier treatment. For instance, increasing access to pharmacotherapy programs, assisting peer-based user organisations and establishing needle and syringe programs all contributed to our low infection rates that have saved millions of dollars.

What harm reduction programs does Australia have in place now?

Currently we have in place a network of community- and pharmacy-based needle and syringe programs, as well as methadone and buprenorphine programs for people using opioids. There is also a supervised injecting facility in Sydney and Melbourne. There are numerous treatment programs for people using methamphetamine, including innovative clinics that provide controlled management of problematic use. Importantly, we also have a number of national peer-based organisations that provide a vital communication link for drug users.

What harm reduction programs should Australia introduce?

Some of the key evidence-based programs that need to be introduced include heroin prescription programs, decriminalisation of personal use of drugs and prison-based needle and syringe programs.

Won't decriminalisation lead to higher levels of drug use?

The research is quite clear that drug use has not increased in countries and jurisdictions where drug use has been decriminalised. What does increase is the number of people seeking assistance and treatment.

How do you distinguish between drug use and abuse?

We don't. Drugs are used with minimal or no problems by the vast majority of people. Think of how many people consume alcohol without incident. Some people do develop problematic use of drugs at times and they need to be the focus of our health-based efforts.

Won't decriminalising drugs increase crime rates?

Some studies have shown that crime is reduced by the introduction of harm reduction policies and decriminalisation of drug use.

(Harm Reduction Australia, 2018)

Needle Syringe Programs – Supervised Injecting/Consumption Centres

Programs such as needle syringe programs delivered through the Northern Territory Aids and Hepatitis Council (NTAHC) have dramatically reduced the spread of blood borne viruses and hepatitis C among injecting drug users. This program has been available in Australia since 1986 as part of the National Drug Strategy, considered a world-leader in education and prevention of hepatitis C. The Needle Syringe Program (NSP) offers 24-hour dispensing units, a naloxone access program, and education and health promotion. All employees of the NSP are current or former users and share their advice and experience with those participating in the NSP.

This harm minimisation approach gives injecting users safe equipment and safe disposal, education on the effects of injection drugs and the safe use of drugs and offers peer support to those who may need it. This program also offers a point of contact to for those in precontemplation or contemplation stages of change. This is an important element to the outreach of potential clients who may want a referral, or for employees to provide brief intervention.

As the needle and syringe program provides all of these benefits to participants and the general public, supervised injecting centres do the same type of work to ensure the safest use for the participant and an opportunity to engage. Supervised injecting centres are an important harm minimisation strategy to combat blood borne virus and disease and mitigate the potential for overdose with medical help onsite.

In Australia, the first supervised injecting centre opened in 2001 in Kings Cross, Sydney. The second supervised injecting centre in Australia opened as a pilot project in Richmond, Melbourne in 2018. While these centres will reduce the harms and health risks associated with injecting drugs, there is a demand for a broad range of services to be delivered at these sites.

The populations of Australia (25 million) and Canada (36.29 million) are similar including the number of people living in remote communities which may be inaccessible during certain times of the year. The Canadian Government have developed Supervised Consumption Sites (SCS). These centres offer various services for those who wish to use them including injection, intranasal, oral, drug checking, peer assistance and inhalation. There are 30 operational sites offering all or some of the services listed above, and another 12 with applications pending or in review. Below is information on the SCS by Health Canada.

Reasons for supervised consumption sites

Problematic substance use has devastating impacts across Canada, on individuals, families and communities.

It is a complex issue. There is no simple solution.

SCS are part of our harm reduction approach to the Canadian drugs and substances strategy. This is because Canadian and international evidence shows clearly that they help to save lives and improve health. Research also shows that SCS are cost effective and do not increase drug use and crime in the surrounding area.

SCS are an entry point to treatment and social services for people who are ready to stop or reduce their use of substances. They do not provide their own drugs or substances.

People will use SCS for a number of reasons. They provide:

- a safe, clean place to consume illegal substances
- less risk of violence or confrontation with police
- drug checking to detect adulterants using methods such as fentanyl test strips
- emergency medical care in case of overdose, cardiac arrest or allergic reaction (anaphylaxis)
- basic health services, such as wound care
- testing for infectious diseases like HIV, Hepatitis C and Sexually Transmitted Infections (STIs)
- access to sterile drug use equipment and a place to safely dispose of it after use
- health professionals and support staff, including for overdose intervention

They also offer:

- education on harms of drug use
- safer consumption practices
- safer sex
- referrals or information on health and social services including drug treatment and rehabilitation (detoxification or drug substitution therapy)
- housing services

- primary health care
- mental health treatment
- community services
- social welfare programs
- needle exchange programs

Goals of supervised consumption sites

The key aims of SCS are to:

- prevent overdose deaths
- facilitate entry into drug treatment services
- reduce the risk of disease transmission (such as Hepatitis C and HIV) caused by unhygienic practices, such as needle sharing
- reduce public disorder from public consumption of illegal substances
- publicly discarded consumption equipment
- connect people who use drugs with basic health and social services
- reduce impact on Emergency Medical Services attending to drug overdoses

Health and social services include:

- drug treatment
- counselling
- withdrawal management
- access to detoxification for people that are ready and willing to seek treatment
- housing services

How sites work

To be effective, SCS are set up in areas where there is public drug use. They are aimed at sub-populations of people who:

- use illegal drugs
- have limited contact with the health care system

These may include those who are homeless or living in insecure accommodation or shelters.

A SCS in an area with high rates of public consumption helps reduce public injecting and publicly discarded needles in the vicinity of the site.

They are often located near established illegal drug markets. This is how they can reach their target population.

However, there are different types. A SCS can be:

- integrated with existing health and social services, including other harm reduction interventions
- a specialized standalone service that focuses on supervised consumption
- a mobile service that caters to a smaller number of people who use drugs and who are spread across a wider distance

Often, SCS are set in areas where demand is greatest. However, they may be within an integrated site with other health, social and/or harm reduction services. In this case, the location may have been chosen based on availability of space or existing clinical or treatment services.

The hours of operation for SCS vary by:

- type of site
- site location
- capacity/resources

For example, a mobile site may operate at times when fixed sites are closed. This can fill any service gaps. Sites that serve a smaller number of clients may operate on a reduced schedule.

SCS staff varies by site, but generally include:

- nursing staff
- social workers
- peer and community workers

Depending on the site, SCS may permit use of substances by:

- injection
- inhalation (smoking)
- oral and intranasal (consuming pills and snorting)

The types of services provided are based on the needs of the population being served.

By introducing supervised consumption sites to Australia - the Northern Territory specifically - these health centres can take the burden off emergency services and provide life-saving prevention and treatment to those who consume drugs. As specified by the Canadian Government, crime rates dropped significantly in areas which a SCS and created a relationship with those using the service to have conversations about their drug use.

The main principle of harm reduction is recognising and acknowledging that people will use substances and that will never change whether it is alcohol, drugs, tobacco, or caffeine. What can change is the ability to treat those who experience harmful use through a health-based model ensuring safe use and an opportunity to engage and educate.

A national survey of more than 11,000 young people aged 18-29 by triple J found 55% of young people surveyed said they have taken illicit drugs into a music festival, and 83% said they would use pill testing if it was available. Another important part to drug education is allowing people who want to take pills the ability to do so safely. Pill testing does not condone the consumption of pills, it provides a safe space for conversations and a first point of contact for those who want to safely use.

The survey found over 50 per cent of young people who responded had used marijuana in the last 12 months, while ecstasy/MDMA was the second most popular substance used at 38% (What's Up In Your World Survey, Triple J 2018)

During the Australian-first pill testing trial at Canberra's Groovin' in the Moo music festival, Tedd Noffs Foundation CEO Matt Noffs admitted the best part was speaking to people about

their use and giving them more information. The results of the trial were released on twitter by Matt Noffs the following day.

- 128 participants
- 85 samples tested
- 50% was 'other' (lactose, sweetener, paint)
- 50% was pure MDMA
- 2 samples were deadly

As cannabis and ecstasy/MDMA are the most popular drugs within this population, the Northern Territory Government has the opportunity to acknowledge and offer harm minimisation strategies to young people. Pill testing should be widely available, not just at events but on evenings and weekends, and must be offered for free to anyone who needs to use the service. This could be part of a range of SCS in Australia used anonymously by young and older people who can receive results, information, and education on the substances they plan to use.

Legalisation of Cannabis and other Drugs

Northern Territory Chief Minister Michael Gunner recently expressed his interest in solutions to antisocial behaviour and the benefits of harm minimisation approaches to addictive behaviours. While alcohol remains a principal concern, the legalisation of cannabis would not only stimulate the economy but can be regulated in the same way alcohol is regulated currently.

Chief Minister Gunner spoke to media in May 2018 about the legalisation of Cannabis explaining, "No one in Australia has done it yet... I do think it's going to become a more common topic in Australia. I recognise we're probably behind in the conversation in some respects around how you handle drugs in this country. We're going through a parliamentary committee process first. I don't think it's beyond the realms of discussion anymore about how you can do it and how you can manage it."

In June 2018, the Canadian Government legalised the recreational use of marijuana nationwide. A report from Deloitte states, "Legal marijuana is expected to be a more than $6bn business with $4.3bn coming from recreational sales and $1.7bn from medical."

Canadian Prime Minister Justin Trudeau explained the recreational and medicinal use of marijuana is popular throughout Canada, and the regulation of the drug means only certified growers will be able to sell legally. Trudeau recognises the benefits of regulating the marijuana industry as a harm minimisation strategy.

The NT has already proved the cultivation of hemp is possible in Katherine. "Following a successful department trial, the Territory Labor Government believes there is serious potential to grow industrial hemp as a new job-creating industry," a spokesperson told media. "Hemp can be used in many daily products ... and we believe it will create long-term local jobs and business opportunities."

Countries such as The Netherlands legalised narcotics under The Dutch Opium Act in 1928. Their tolerance of 'soft drugs' such as cannabis products, sleeping pills and sedatives are associated with low risk use and are available for purchase in coffee shops. The Netherlands

"applies a policy of toleration in relation to the sale of soft drugs in coffee shops. This means that the sale of soft drugs in coffee shops is a criminal offence, but the Public Prosecution Service does not prosecute coffee shops for this offence. Neither does the Public Prosecution Service prosecute members of the public for possession of small quantities of soft drugs." (Government of the Netherlands)

These quantities are defined as follows:

- no more than 5 grams of cannabis (marijuana or hash);
- no more than 5 cannabis plants.

The Netherlands tolerates the sale of soft drugs in coffee shops and takes rigorous action to suppress the sale of hard drugs. By adopting this strategy, the government separates these two markets. Cannabis users are not obliged to buy their soft drugs from unauthorised dealers who may bring them into contact with hard drugs.

This harm reduction approach to the consumption of soft drugs recognises those who use may do so in the company of others at the coffee shop where the sale of alcohol is not permitted. They may also take personal amounts home with them in an effort to prevent harmful use.

Portugal decriminalised possession of all drugs in 2001 for personal use. The country looked at substance use as a health issue and treated it as such. The possession of drugs is no longer a criminal offence, but an administrative violation. Those who are substance dependent are encouraged to seek treatment but are not mandated to do so. Law enforcement and health officials recognised criminalisation and marginalisation of people who use drugs contributed to their drug use.

To manage the use of drugs in Portugal, a "more humane, legal framework" (*Transform,* 2014) was developed. Greater resources were allocated to expanding and improving prevention, treatment, harm reduction, and social reintegration programs. The Portuguese welfare state expanded to include a guaranteed minimum income. In 2014, *Transform* curated a report on the statistics relating to drug decriminalisation in Portugal. The report alludes to the health and social reforms underpinning the success of decriminalisation in Portugal. The data shows three of many positive outcomes from decriminalisation:

- Drug use has declined among those aged 15-24, the population most at risk of initiating drug use
- Rates of past-year and past-month drug use among the general population – which are seen as the best indicators of evolving drug use trends – have decreased
- Rates of continuation of drug use (i.e. the proportion of the population that have ever used an illicit drug and continue to do so) have decreased

While the results have been overwhelmingly positive for the health of Portugal, reductions in the health and welfare budget "have led to fears that the country may experience a dramatic increase in HIV infections as Greece did when it closed drug treatment and harm reductions programs as part of its attempts to reduce public spending." (*Transform,* 2014) The report also disclosed harm reduction services are facing partial closure or delays in public funding impacting the quality of service offered.

While in an economic recession, it is important to offer the same services depended on by people who regularly use them. Adequate health and social investment has shown through the decriminalisation of drugs for personal use, health outcomes are better and crime rates drop. The investment needs to be stable and continued for sustainable change to those who experience harmful substance use, or to those who use recreationally.

What is clear in the Australian context is with increased arrests and detection of the supply of drugs has not ceased and has resulted in increasing number of arrests of those who use drugs. This does not acknowledge the statistics which indicate those with problematic drug use are a small part of the drug using community. Criminalising drugs use effects the most vulnerable such as youth and indigenous populations leading to further social disadvantage in the short and long term.

Schaeffer's model demonstrates the larger Experimental pattern through to the Compulsive (Figure 1), and the reduction of population. Corresponding explanation of the model from the Australian Government Department of Health:

In the context of identifying a young person's needs it may be useful to reflect on Schaeffer's model which reminds us that not all young people's AOD use is inherently problematic. In our assessments with young people we need to be able to distinguish between different patterns of AOD use and intervene appropriately depending on the type of use identified.

Experimental use – Drug use is motivated by curiosity or desire to experience new feelings or moods. This may occur alone or in the company of one or more friends who are also experimenting. It normally involves single or short-term use.

Social/recreational use – Drugs are used on specific social occasions by experienced users who know what drug suits them and in what circumstances (e.g. ecstasy use by experienced users at dance parties, or alcohol with a meal).

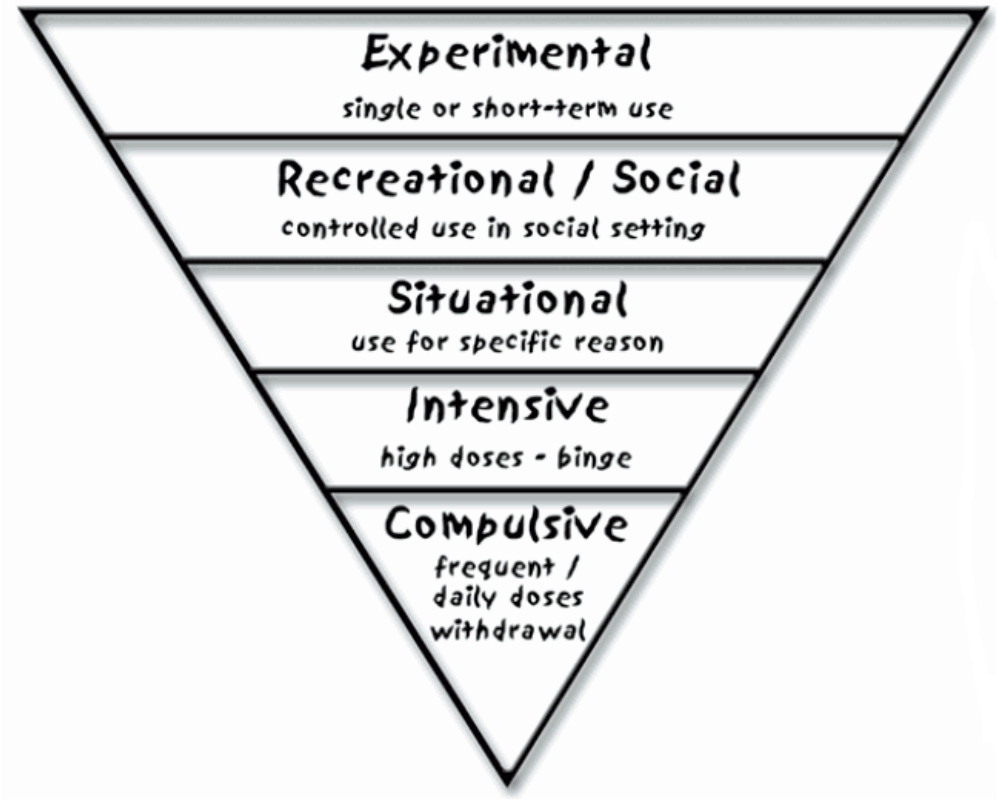
Circumstantial/situational use – Drugs are used when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought. (e.g. truck driving shift work or studying for exams).

Intensive use – This drug use is similar to the previous category, but more intensive. It is often related to an individual's need to achieve relief or to achieve a high level of performance. It can also involve binge AOD use, where there is excessive use of a substance at one time. The pattern of binge use may be occasional or may relate to specific situations.

Compulsive/dependent use – Drug use leads to psychological and physiological dependence where the user cannot at will discontinue use without experiencing significant mental or physical distress. Drug use is central to the user's day-to-day life.

When a person is physically dependent they develop withdrawal symptoms when the drug is not taken. Psychological dependence occurs when the drug is central to a person's thoughts, emotions and activities. Drug users in this category have a strong urge to use despite being aware of the harmful effects (see Diagram).

Even though not all use is problematic, there may still be harms and consequences associated with any pattern of AOD use.



(Figure 1: Schaeffer's Model, Australian Government Department of Health 2.2 Schaeffer's Model, 2004)

Northern Territory Alcohol Reform

The Northern Territory (NT) expressed its commitment to alcohol reform through the Alcohol Policies and Legislation Review also known as the Riley Review. This final report includes 220 recommendations for the safer consumption of alcohol and regulations concerning the sale of alcohol in the NT.

The Banned Drinker Register (BDR) marks the return of a tool to minimise harm and restrict the sale of takeaway alcohol to those listed. Alcohol served on licenced premises can still be purchased by those listed on the BDR. This tool helps to minimise the harm associated with harmful drinking including domestic and family violence, drink driving, etc. The BDR is one of many pieces to reduce the harms of alcohol in the NT and needs to work in conjunction with many other services and policies to maximise its positive effect.

Another recommendation was floor price per standard drink at $1.50. This price eliminates the sale of wines under $9 and makes binge drinking on cheap products with high alcohol levels increasingly harder. This targets a group of people who use alcohol in a harmful way and limits what they can purchase by increasing the price of standard drinks in cheap wines.

The Northern Territory Government (NTG) has set the floor price for the NT at $1.30 which passed parliament and will be effective from October 1. Floor price limits excessive amounts of cheap alcohol on the market and in turn keeps alcohol away from those who cannot afford to binge.

With the BDR in place and a floor price on cheap alcohol, another component to reducing the harm of alcohol considering the recreational activities of the NT is regulating the blood alcohol level of boaties. Minister for Primary Industry and Resources Ken Vowles said, "…in 2010 the recreational fishing sector was valued at $80 million." The NTG released a report on the importance of fishing tourism in the Top End, noting:

> Fishing is synonymous with the Northern Territory and has come to be regarded as a signature experience, with some 6,200 kilometres of largely undeveloped coastline riddled with estuaries, wetlands, mud flats and inland islands. The fishing tourism industry's total economic contribution is estimated at $26 million per year, with $22 million of this generated by interstate or international visitors to the Territory. (Fishing Tourism, Tourism NT)

With an emphasis on how important the recreational and tourism fishing industry is to the NT, it is important to note there are currently no restrictions on boats to be registered or for owners to have licenses. The recommendation for a 0.05 BAC applies only to the driver of the boat. This would improve the safety of adults and children travelling on the water ensuring a safe environment. This would also enforce the drink driving rules already in place for vehicles to ensure a day out on the water does not include driving under the influence at its conclusion.

Northern Territory Chief Minister Michael Gunner said the 0.05 BAC reform was about trying to create a safer Territory. "Royal Life Saving have actually shown that we have got the worst water safety rates in the country around this and obviously there's plenty of research and evidence that shows if you have a 0.05 [blood alcohol reading] you aren't safe behind the wheel or behind the tiller."

Royal Life Saving Northern Territory executive director Floss Roberts confirmed the NT consistently had the highest drowning rate per capita in the country. There are currently no plans to enforce this recommendation with many Territorians opposing alcohol regulations on the water.

Research on wet houses or managed alcohol programs (MAPs) has progressed and shown these programs can cut down harmful drinking as well as provide health and homelessness services. While many different programs internationally provide varied services to their clients, the aim of wet houses is to engage those who cannot receive homelessness or rehabilitation services due to their alcohol use.

By banning drinking in shelters, those who experience homelessness and harmful consumption of alcohol are unable to access homelessness services. This cohort would not otherwise be able to access shelter.

The director of New Zealand's National Addiction Centre, Professor Doug Sellman, was struck by the comments of the people in the study *Where Harm Reduction Meets Housing First: Exploring Alcohol's Role in a Project-based Housing First Setting* from the US National Library of Medicine National Institutes of Health. "The people said they no longer have to drink as heavy to keep warm, to put themselves to sleep or to forget about the fact that they were homeless. This self-medication with very heavy drinking didn't occur when you gave people some semblance of normality in terms of a place to live."

Findings from this study showed, "Housing first (HF) programmes provide low-barrier, nonabstinence-based, immediate, supportive and permanent housing to chronically homeless people who often have co-occurring substance-use and/or psychiatric disorders. Project-based HF programmes offer housing in the form of individual units within a larger housing project. Recent studies conducted at a specific project-based HF programme that serves chronically homeless individuals with alcohol problems found housing provision was associated with reduced publicly funded service utilisation, decreased alcohol use, and sizable cost offsets." (Collins, Susan E., et al 2013)

Another study *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems* from 2009 found:

"Homeless people have high barriers to health care access generally but use acute care services at high rates. Mortality rates among homeless adults are 3 or more times that of the general population. Chronically homeless people with severe alcohol problems, sometimes referred to as chronic public inebriates, are highly visible on the streets and are costly to the public through high use of publicly funded health and criminal justice systems resources. Typical interventions such as shelters, abstinence-based housing, and treatment programs fail to reverse these patterns for this population. Health conditions and mortality rates within this population are similar to those found in developing countries. Average age at death is estimated to be 42 to 52 years, with 30% to 70% of deaths related to alcohol." (Larimer, Mary E et al. 2009)

An interview with Dr. Jeff Turnbull who helped launch the Managed Alcohol Program in Canadian capital city Ottawa said, "To get into the program you have to be an inveterate ... long-term alcoholic who's failed at traditional treatment programs… By far the majority of all of the people who have come through these doors have stabilized, gotten better, got control of their life and are still drinking… by far the majority are substantially better than they were when they came in." (Virginia Smart, CBC News 2017)

The MAPs in Ottawa allows a maximum of 15 drinks (wine) per day, with the option to drink less and have watered down drinks. Participants pay for their alcohol and tobacco as well as their room and board through their social assistance or Canada Pension Plan cheques – similar to Centrelink.

Demand for Specialised Treatment and Prevention Services

The Northern Territory Government (NTG) Department of Health (DoH) has embarked on a demand study for AOD treatment services in the NT as outlined in the Northern Territory Harm Minimisation Action Plan 2018-2019.

This study endeavours to map gaps in service for the AOD sector, and understand the capabilities of the workforce and their ability to deliver the services needed in the NT.

AADANT undertook a project similar to the NTG DoH study published July 2017. This project titled *Consult, Develop, Collaborate: Alcohol and other Drugs Services Review* explored gaps in service for the NGO AOD sector and expressed:

- a lack of understanding about the referral processes,
- lack of appropriate information sharing (e.g., numerous assessments),
- lack of exit planning and aftercare options and,
- communication with funding bodies and tender processes was difficult for organisations working in small teams who felt disadvantaged by their capacity to complete tender processes.

The *Youth Alcohol and Other Drugs Services Northern Territory* service mapping project showed a glaring need for specialised service for young people under the age of 25 in the Northern Territory. This study was completed by Xenia Girdler for AADANT.

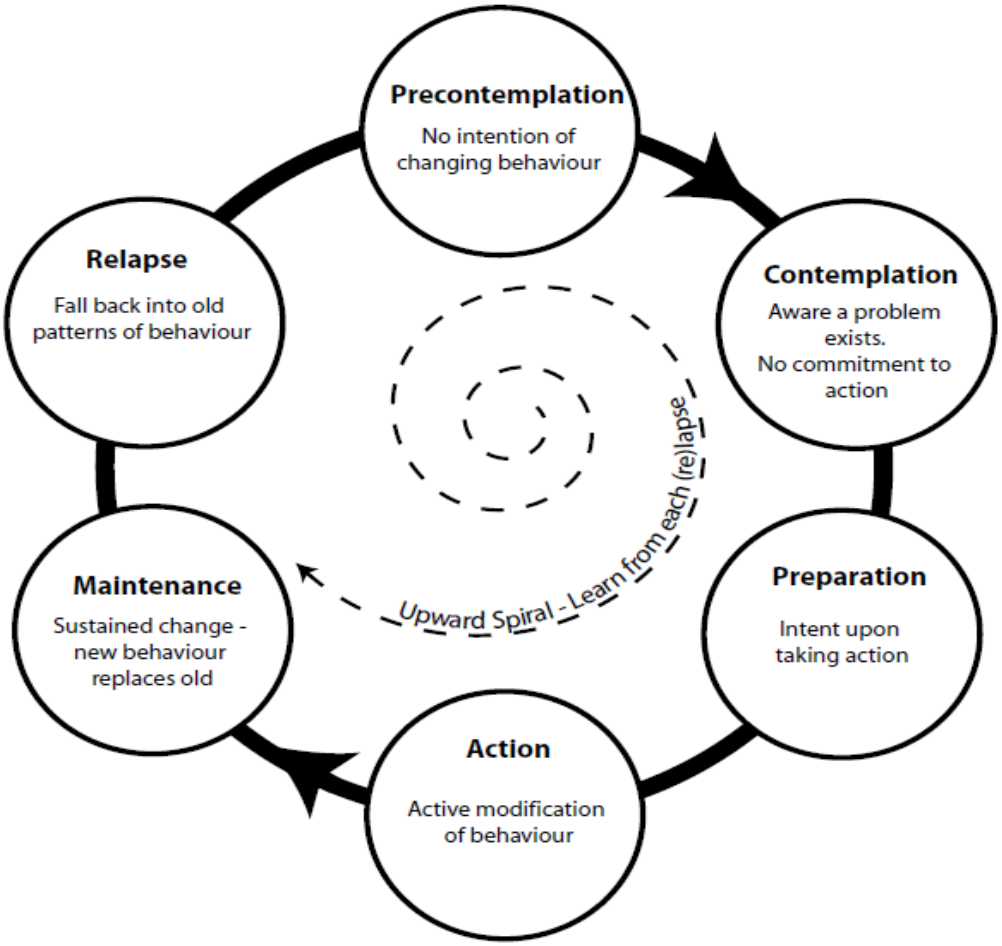
Early intervention and prevention programs, day programs and non-residential options, and family inclusive service were mentioned as the largest needs for youth in the NT through an AADANT survey.

Working within a harm minimisation perspective, organisations in the NGO sector acknowledge alcohol and/or drug use is a part of life for many people. The majority of people who use substances do so without harm to themselves or others (Harm Reduction Australia). For those who use substances in a harmful way, a health-based approach needs to be applied and harm minimisation strategies are included into their case management/treatment plan.

The Transtheoretical Model (Stages of Change Model, Prochaska and DiClemente) explains readiness to change and the cycle of treatment stages. (Figure 2)

For many people who use alcohol and other drugs, the precontemplation stage may never evolve into the contemplation stage. In this case, there needs to be appropriate measures in place to ensure alcohol and drugs are consumed safely. Education in schools, for parents and carers, and for teachers is an important step to acknowledging the experimentation occurring in adolescence and responding to those actions by young people who may experience drug and alcohol use. Prevention is more cost effective than treatment; initiating and allowing conversations about the use of alcohol and other drugs fosters educated young people and adults without condoning the harmful use of alcohol or the use of illicit substances.

Harm minimisation underpins treatment services throughout organisations in the Northern Territory and needs to be accepted by the Northern Territory Government through policy to recognise abstinence models do not work for everyone.



(Figure 2: The Transtheoretical Model (Stages of Change Model, Prochaska and DiClemente)

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