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Submission to the Special Commission of Inquiry into the Drug 'Ice'

May 2019

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The RACP represents physicians from a diverse range of disciplines including addiction medicine physicians and public health medicine physicians. RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia’s addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments.

RACP Submission

Thank you for this opportunity to provide a submission to the Special Commission of Inquiry into the Drug 'Ice" established by the New South Wales (NSW) Government to examine:

- the nature, prevalence and impact of crystal methamphetamine ('ice') and other illicit amphetamine type stimulants ('ATS')
- the adequacy of existing measures to target ice and illicit ATS in NSW
- options to strengthen NSW's response to ice and illicit ATS, including law enforcement, education, treatment and rehabilitation responses

The RACP and its Australasian Chapter of Addiction Medicine (AChAM) also wish to thank the Special Commission for inviting us to provide a response to the preliminary consultation on the terms of reference for this *Special Commission of Inquiry into the Drug 'Ice'* and the draft proposals for the conduct of the inquiry earlier this year. We welcome the inquiry's broadened terms of reference which now enable the Special Commission to inquire and report on "other illicit amphetamine type stimulants, in recognition of the nature of drug culture and the fact that many ice users also use other drugs"[1] and to look at the evidence and effectiveness of pill testing as a harm minimisation measure.

This RACP submission has been led by the AChAM and broadly covers a range of topics outlined in I*ssues Paper 3- Health and Community* and *Issues Paper 4 - Data and Funding*.

Introduction

This Special Commission of Inquiry sits within a broader context where New South Wales (NSW) has not had a comprehensive drug and alcohol strategy since 2010. With rapid changes in illicit drug supply markets and increasing use of CMA among methamphetamine users, there is a risk that without a comprehensive strategy and supporting cooperative relationships between police, health professionals and community workers, drug related deaths and harms could rise. NSW needs a strategy that comprehensively addresses drug demand, supply and harm minimisation, in consultation with practicing clinical health professionals.

The RACP and the AChAM are very concerned about the harms caused by Crystal Methamphetamine (CMA) use and other drugs more generally in Australia. It is also important to consider that CMA use is relatively low in comparison with alcohol use at harmful level. This was a key finding of a recent NSW Government surveillance report on methamphetamine use and related harms in NSW[2] which outlined that "there has been a statistically significant decrease in overall methamphetamine use in NSW since 2010, with a more rapid decline from 1.4% of the population in 2013 to 0.7% in 2016" and that "this level of use is very low in comparison to the proportion of the NSW population in 2016 who consumed alcohol at harmful levels (36% single occasion risk of harm, 17% lifetime risk of harm)."

Data from the Australian Institute of Health and Welfare (AIHW) shows that at least 43 percent of Australians aged 14 or over had illicitly used a drug including cocaine, cannabis, MDMA, and meth/amphetamine[3]. There is also concern amongst the medical and law enforcement communities about the consumption levels of synthetic drugs such as fentanyl, which have become a significant public health and social problem in North America.[4,5] Synthetic drugs such as fentanyl are cheap to produce, and for this reason are often mixed into other drugs, including cocaine and ecstasy (MDMA), resulting in record high drug-induced deaths[6].

The impact of problematic drug use is felt across many communities in NSW in terms of both social and health harms. The reasons why people are using drugs are complex so it is important that the harmful impacts of CMA and other drugs on health be contextualised broadly because the harmful use of drugs is often associated with social disadvantage. For example, recent data from the National Drug Strategy Household Survey found that meth/amphetamine use was 3.1 times higher among unemployed people than employed people and that recent meth/amphetamine use declined among people in the highest socioeconomic areas) from 1.6% in 2013 to 0.9% in 2016).[7] This indicates that to be effective at breaking this cycle, policies should include measures to reduce risk factors for health inequalities such as homelessness, unemployment, and lack of education and training and should cross portfolios outside health (such as housing, employment and education). In addition, specific considerations need to be given to the negative impact CMA use can have on employed users. As noted in Issues Paper 3 on p.9, individuals in some occupations may be at higher risk of

CMA use. Any measure to address problematic CMA use in these individuals needs to take into account that the risks associated with their drug use may also impact others through the course of their employment (i.e. increased rate of accidents in truck drivers, construction workers, rail worker etc).

This aspect of use is important and could cause specific cost to other workers, members of the public and industry and should be considered in policy development. Often people who test positive in industry are simply discharged from employment and there is no referral for additional treatment.

There is clear evidence indicating the inadequacy of services available in NSW to respond to all drug and alcohol problems[8]. This underscores the urgent need for increased measures from the NSW Government to respond to all drugs (including alcohol) that are causing health and social problems. The use of CMA is part of the 'all drug and alcohol problem'. It is therefore impossible to only examine responses to CMA-related problems without examining the adequacy of measures to respond to all drug and alcohol-related problems. Moreover, standalone drug measures to a drug problem are ineffective and unable to meet the needs of the community.

Drug and alcohol addiction: a complex, chronic and relapsing health issue

Drug and alcohol addiction is a health issue with complex biological, psychological and social underpinnings. It is a chronic relapsing, remitting disorder characterised by drug seeking and use that is compulsive, difficult to control and persists despite harmful consequences[9]. The diagnostic term 'substance use disorder' in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) refers to recurrent use of alcohol or other drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Substance use disorder is defined as mild, moderate, or severe.

The underlying causes of drug and alcohol addiction can be primarily attributable to environmental factors and early adverse life experiences such as trauma, abuse, a chaotic childhood or home, parent's use and attitudes, and peer and commercial influence, and also to biological factors including genetics, being male, and concurrent mental health disorders[10]. Other social determinants that impact on a person's substance use and dependency include their socio-economic status, housing status and security, and education. Substance abuse is a complex issue, not simply a personal choice. We are seeing the increasing emergence of intergenerational cycles of poverty, substance use, mental health and many other social problems.

Practitioners describe seeing the third or even fourth generation attending specialist treatment for substance use problems. It is also important to note that some substance abuse disorders result from drugs of dependence being prescribed by one or more doctors for the symptomatic relief of pain, insomnia and anxiety amongst other symptoms. While there are many reasons why people choose to try or take drugs, it should be understood that repeated drug or alcohol use leads to changes to the brain that challenge an addicted person's self-control and interfere with their ability to resist intense urges to take drugs.

The distinction between someone needing to quit drugs including alcohol because of a clinical need and their personal motivation to quit also needs to be recognised. Evidence and clinical experience shows that behaviour change is key to overcoming substance dependency; successful drug treatment requires some level of motivation from the individual involved to instigate and sustain this behaviour change.

We believe that all drug rehabilitation and treatment services should reflect an understanding that:

- Drug and alcohol use is complex and varied:
    - Drugs and alcohol are substances that alter the way we think, feel and behave. People use drugs and alcohol for a variety of reasons (e.g. for enjoyment, to relax, to socialise, to avoid or reduce their psychological distress and/or physical pain, etc.).
    - The frequency of use varies widely from occasional use to regular and dependent use with a range of harms associated with different types of drug use, and different patterns of drug use. As such, although all drug and alcohol use has the potential to become harmful or risky and

could reinforce maladaptive behavioural patterns, not all drug use will become problematic or cause health harms.
    - As the 1999 NSW Parliament Drug Summit showed, problematic drug use is associated with adverse childhood events including trauma and neglect, family violence, poverty, social inequalities, mental ill health, homelessness and isolation. Intergenerational cycles of deprivation and disadvantage are seen within families and across communities where problematic drug use is most common.
- Whilst we need to address the social norms that perpetuate views that drug and alcohol use can be an acceptable and effective way to cope, socialise, or to minimise internal distress, we also have to accept that the use of drugs, whether licit or illicit, is a part of our society which we are extremely unlikely to eradicate fully and which will require ongoing regulation. Thus, there is an ongoing need for effective, evidence-based policies focused on preventing and reducing harm to drug users, their families and society more broadly.

Patterns of drug use

Polydrug use is an issue of great concern as it increases the risk of overdose, accidents and deaths. Concomitant use of drugs, including alcohol, cannabis, benzodiazepines, MDMA, cocaine or opioids is very common among drug users. By using multiple drugs, these users not only can cause harm to themselves, but also can potentially impact on every level of society. It is noteworthy that compared with CMA, cannabis and MDMA are used more widely; opioid use leads to more deaths; and alcohol and tobacco cause substantially more harm in NSW Communities. In this respect, harms from other drugs and alcohol use shouldn't be underestimated.

Illicit drug use is most prevalent for people in remote and very remote areas as outlined in the latest available National Drug Household Survey Data (2017) which shows that "people in remote and very remote areas (25%) were more likely to have used an illicit drug in the last 12 months than people in major cities (15.6%), inner regional areas (14.9%) and outer regional areas (14.4%)".[11]

The type of illicit drugs used amongst people living in regional, rural and remote areas of Australia also differs from their counterparts living in major cities and this aligns with the availability/unavailability of different types of drugs by location. As outlined in the NHRA's Fact Sheet on illicit drug use in rural Australia (2015), "people living in remote and very remote areas were twice as likely as people in major cities to have recently used meth/amphetamines, but less likely to have used ecstasy compared with those from major cities. Cannabis use and the use of pharmaceuticals not for medical purposes is higher in remote/very remote areas than in major cities: 8 per cent compared with 11 per cent and 3.1 per cent, compared with 5.2 per cent, respectively".[12]

People living in regional, rural and remote areas of Australia face significant barriers to accessing health services in general, and drug rehabilitation services and treatment are no exception. Research has shown that compared to their counterparts living in major cities, people living in regional, rural and remote areas experience the following issues with regard to access to drug rehabilitation and treatment services:

- limited access to general health services and drug treatment options
- relative scarcity of services and a limited range of services
- distance and isolation which impacts on client access and to the times and costs involved in outreach service delivery
- poor public transport
- concerns about confidentiality
- concerns about stigma and a relative lack of anonymity[13]
- Higher proportion of Aboriginal and Torres Strait islander populations.

There are severe shortages of alcohol and other drug treatment services across Australia with estimations that current services only meet the need of fewer than half of those seeking treatment.[14] This shortage is even more acute in rural, regional and remote areas.

The *NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales* recommended "that the NSW Ministry of Health implement, as a matter of urgency, a population-based planning tool, such as the Drug and Alcohol Service Planning model, to ascertain what rehabilitation services and how many beds are required throughout New South Wales, and in which regions".[15] This recommendation was acknowledged and supported by the NSW Government in its response to this Inquiry[16] earlier this year. Using a planning tool like this would be a major step forward for NSW, as it would facilitate an informed, evidence based approach to long term service planning across the State and should be adopted by the NSW Government as a matter of priority.

Prevention of the development of drug and alcohol dependence and harmful use

There is now sufficient research evidence that early exposure to drug and alcohol misuse, and a range of other childhood experiences increases the lifetime risk for development of drug and alcohol dependency as an adolescent or adult.[17]

Early identification of children at risk of poor psychosocial outcomes is feasible, and a number of interventional approaches are available, including parenting programmes, programmes to improve executive functioning and self-control and interventions such as trauma focussed cognitive behavioural therapy (CBT).

Key principles for the planning and delivery of effective evidence-based drug rehabilitation and treatment services

The National Ice Taskforce found that despite the efforts of law enforcement agencies, the market for CMA remains strong across Australia, this drug is easily obtainable, and its price remains stable.18 The evidence shows that law enforcement approaches to drug problems are more expensive and less effective than treatment approaches19. Funding allocations should be focused on cost-effective interventions that include medical treatment, together with an additional focus on research to inform refinements to existing treatment services and to address the unmet demand for services. For example, more research is required to develop the evidence base for specific vulnerable groups such as pregnant women who use methamphetamines as there are currently no specific treatment for this group beyond counselling and occasional withdrawal.

The differences in the types of drugs being used and the ways in which they are used in regional, rural and remote areas of Australia, as well as the significant barriers to access to drug rehabilitation, have important implications for the planning, resourcing and delivery of services in these areas.

Equitable access to evidence-based services for those most in need is essential and this requires increased public funding targeted at drug and alcohol rehabilitation services that are based on evidence-based frameworks, are tailored to local needs, are culturally safe and are accessible both in terms of cost and location.

The RACP is of the view that the following principles should underpin the delivery of all drug rehabilitation and treatment services in regional, rural and remote New South Wales, and across Australia more broadly:

- An understanding that drug and alcohol use is a chronic health condition with a high rate of relapse estimated between 40 to 60%. The American National Institute on Drug Abuse (NIDA) highlights that "relapse rates (i.e., how often symptoms recur) for people with addiction and other substance use disorders are similar to relapse rates for other well-understood chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioural components".[20]
- Recognising the importance of the delivery of multi-disciplinary clinical care, including medical practitioners (GPs, addiction medicine specialists, addiction psychiatrists); nurses and nurse

practitioners; psychology and other allied health workers; and Aboriginal Drug and Alcohol workers to provide treatment.

- Understanding the need for a wide range of interventions: from hospital consultation liaison and hospital withdrawal, to community-based services including assessment, withdrawal, counselling, medication assisted treatment, day care, residential treatment and harm reduction services.
- Recognising the need for services to support parents, families and consumers of drug treatment services.
- Understanding and addressing the wide range of Social Determinants of Health[21] which play a key part in an individual's drug use and recovery.
- Placing harm minimisation at the centre of rehabilitation and treatment services.[22,23] At present, patients on medication assisted treatment for opioid dependence, who are treated through a community pharmacy, pay out-of-pocket costs directly to the pharmacist of $25-$45 per week. Medicare does not currently provide rebates for these treatments, which are unaffordable for many who are unemployed and a key reason for people discontinuing treatment prematurely, resulting in poor clinical outcomes.
- Using the best research evidence available to plan, design and implement these services.
- Undertaking ongoing monitoring and independent evaluations of treatment outcomes.
- Being led by medically qualified health professionals and specialist physicians, noting that in very remote areas, generalist health service providers may need to be up-skilled to provide AOD services.
- Ensuring equity of access for those most in need – this includes facilitating affordable access and also ease of access to the location of the required rehabilitation and treatment services.
- Adapting services to individual's needs: this includes tailoring the approach to the particular drugs being used (e.g. withdrawal from methamphetamine requires more time than from heroin, so services need to be adapted. Some drug users are also likely to require access to other health professionals such as mental health, etc.).
- Providing services that are culturally safe for Aboriginal and Torres Strait Islander people. This includes developing strategies in consultation with, and where possible led by, the affected communities, and ensuring the community-controlled sector plays a key role in developing and implementing these strategies, as well as ensuring access to a long term, supported, multidisciplinary workforce.
- Improving the integration and coordination between withdrawal/detoxification programs and drug residential services to minimise the risk of relapse. The wait time between completing a withdrawal program and being admitted to a residential service is an issue and it is not uncommon for clients to experience a relapse during this period, further prolonging their admission.
- Providing high quality after-care/follow-up care post-residential treatment.
- Ensuring seamless evidence based care during transitions to and from corrections.
- Working towards uniformity of regulations across States and territories.
- Providing drug treatment services should be part of routine pharmacy quality assurance. This is important in the bush where access to services is more tenuous.
- Improved training for clinicians in Aboriginal Medical Services concerning substance use and medical education in general.
- Aboriginal Medical Services, especially rurally, must better support drug treatment services. This may be by providing dosing services or assisting with transport to such services.

In addition, with specific regard to CMA, the RACP advises the following:

- Recognising that CMA is frequently consumed as poly-substance abuse, improving drug treatments generally
- Providing better support for families dealing with parents or children consuming CMA. This may be a cause of family violence. As there can be a natural reluctance to trigger Apprehended Violence Orders, solutions not involving incarceration should be explored.
- enhancing voluntary services which are currently poorly resourced across NSW
- increasing the visibility of these services so people know they exist and how to access them. This requires adequate resourcing for intake and rapid responses and effective health promotion
- increasing consultation liaison support with Emergency Departments, mental health services and other locations where CMA users are identified for treatment.

Specific strategies to reduce harm from CMA use

In terms of specific harm reduction strategies related to CMA use, the RACP supports and advocates for the following measures:

- More medically supervised injecting centres in areas of need to reduce overdose death and increase links to treatment and support services.
- The RACP supports supervised injecting centres as an evidence-based approach to reduce the burden of disease associated with opioid overdose, as well as to improve links to treatment and support services. 24 Supervised injecting centres also improve local neighbourhood amenity, and reduce blood borne virus transmission. 25 Importantly, such services target a particularly hard to reach group of marginalised people who inject drugs.
- The urgent establishment of needle syringe programs in custodial settings to address not only the health of inmates, but also the wellbeing, health and safety of the broader community.
- Custodial settings provide a unique opportunity to protect not only the health of those in custody but also the general community. Needle Syringe Programs (NSPs) have been the mainstay of Australia's prevention of an epidemic of HIV within the population of people who inject drugs. In 2005, the Australian Department of Health undertook a review of the evidence with regard to NSPs, it concluded that:

  > *"the evidence of the effectiveness of Needle and Syringe Programs is consistent and compelling and has been sufficient to persuade many major scientific authorities and governments around the world about the substantial benefits of these programs. Needle and Syringe Programs are a critical component of strategies to reduce the spread of HIV, hepatitis C and other blood borne viral infections among injecting drug users and the wider community. These Programs have been found to be highly cost-effective compared to the cost of treating HIV and hepatitis C infection. Needle and Syringe Programs have not been found to increase drug injecting, discarded used injecting equipment or result in any other serious negative consequences. These programs also facilitate referral to drug treatment and other health services. In areas where Needle and Syringe Programs have been established, they generally receive strong community support."*[26]

  There is abundant evidence of HCV and HIV transmission in prisons, including within Australian prisons, and yet no prison in Australia currently has an NSP.[27] The RACP fully supports their establishment in custodial settings.

Pill testing

The RACP also supports the establishment of carefully designed and evaluated pill testing trials to keep people as safe as possible at music festivals. We have urged all State and Territory governments to consult with medical experts to establish pill testing trials in their jurisdiction in an Open Letter published on 17 January 2019. One of the key safety issues in relation to illicit drug use at music festivals is that drug users are unaware of what substances may be contained within the drugs they have purchased. This, combined with other risk factors such as combining drugs with alcohol, heat and dehydration can increase the risk of

accidental overdose or poisoning from unknown substances within the drug. The evidence strongly shows that the moral message to abstain from taking drugs is not effective and that young people take drugs in large numbers[28], it is therefore important to focus our efforts on effective policies that have been proven to minimise harm. For these reasons and based on the evidence available, the RACP supports the establishment of well-designed and evaluated pill testing trials across Australia as an additional measure to be implemented in conjunction with other evidence-based harm minimisation measures that prioritise the health and safety of festival goers over criminal and legal measures. Pill testing within these trials should be conducted in purpose-designed facilities by appropriately qualified technical specialists and should be accompanied by appropriate advice and information provided by qualified medical professionals to allow festival goers to make informed choices.

Other medical organisations including the Royal Australian College of General Practitioners and the Australian Medical Association have also stated their support for pill testing trials and pill testing has been adopted by several European countries including the United Kingdom, the Netherlands, France, Spain, Austria, Belgium, Switzerland and Germany. Whilst acknowledging some concerns with pill testing technology, on balance, the evidence from these countries and from the first pill testing trial in Australia last year in the ACT, has shown that pill testing is an effective harm minimisation measure.

Pill testing facilities offer an opportunity for medical professionals to provide trusted face-to-face advice to young people about the risks of drug taking. The advice provided does not claim any substances to be 'safe' and does not condone drug taking, it simply enables those who get their pills tested to make better informed decisions. It can also provide information that enables authorities to issue health warnings on new compounds and assist law enforcement intelligence on illegal drug manufacturing and importations in Australia.

Pill testing trials need to be employed in conjunction with other harm minimisation measures including a stronger health care focus with priority resourcing for ambulance, medical support, protocol development and training so as to improve resuscitation, retrieval and transfer to hospital when overdoses occur; the development of strategies for early identification of serious toxicity; public messaging and support to attend health facility with immunity from police action and positive partnerships between health and law enforcement.

Concluding remarks

As we have outlined in this submission

- Drug addiction is a complex and relapsing health issue which is strongly influenced by a wide range of social determinants.
- Repeated drug or alcohol use leads to changes to the brain that challenge an addicted person's self-control and interferes with their ability to resist intense urges to take drugs or alcohol.
- Illicit drug use is relatively common in Australia and highest amongst people living in rural, regional and remote areas, who face a number of interrelated contributing factors including isolation, limited or no access to public transport and limited leisure activities.
- People in regional, rural and remote areas also face significant barriers to accessing drug rehabilitation and treatment services, all of which need to be addressed to meet the need of the most vulnerable drug users and to manage the impact of drug addiction on themselves as individuals, their families and communities more broadly.
- In NSW and across Australia, alcohol and drug treatment services are significantly underfunded and are estimated to only meet the need of fewer than half of those seeking help. In regional, rural and remote areas, a lack of access and availability of these services is even more pronounced than in major cities.
- The NSW Government needs to provide increased funding for evidence-based drug rehabilitation services led by medically-trained health professionals and specialists to meet the needs of vulnerable drug users and their communities in regional, rural and remote NSW.

Once again, the RACP wishes to thank the Special Commission of Inquiry into the Drug "Ice" for this opportunity to contribute its input to this important issue.

The RACP and its Australasian Chapter of Addiction Medicine (AChAM) would be very happy to nominate one or more representatives to attend the Special Commission's hearing.

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[21] *Note: As defined in the College's Health in All Policies document published in 2016, "an individual's health is shaped by socioeconomic factors, which can be broadly defined as the conditions in which people are born, grow, live, work and age. These social characteristics are influenced by political and economic systems, social*

and economic policies, and development agendas which shape the conditions of daily life. These influences are collectively known as the social determinants of health (SDoH). The key domains of life in which the SDoH have an impact are broad and include (but are not limited to): • Intrauterine development • Early life and childhood development • Educational attainment • Access to health care • Health literacy • Socioeconomic status • Family and relationship stability • Gender • Social security • Housing • Food security • Tobacco, alcohol and illicit drug use • Contact with the criminal justice system • Natural, built and physical environments • Social exclusion."

[22] *Note: As outlined in the National Drug Strategy 2017-26, harm minimisation consists of three pillars:*

1. *Demand reduction: Preventing the uptake and/ or delaying the onset of use of alcohol, tobacco and other drugs; reducing the misuse of alcohol, tobacco and other drugs in the community; and supporting people to recover from dependence through evidence- informed treatment.*
2. *Supply reduction: Preventing, stopping, disrupting or otherwise reducing the production and supply of illegal drugs; and controlling, managing and/or regulating the availability of legal drugs.*
3. *Harm reduction: Reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community.*

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