Dear sir/madam,

Re: Submission to Special Commission of Inquiry into the Drug ‘Ice’

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to make a submission into the Special Commission of Inquiry into the Drug ‘Ice’.

The recommendations and priorities in our submission reflect the views and concerns of our clinicians and the communities they serve, all of whom want to see more effective and better resourced treatment and management responses to minimise the harm to individuals and communities caused by the drug ‘ice’.

Reducing stigma, promoting early intervention, addressing barriers to drug treatment, and ensuring that health and support services are adequately resourced is considered vital to meeting the needs of users of Amphetamine-type stimulants (ATS). These responses will be critical in supporting people to recover from dependence and reconnect with the community, and in supporting efforts to promote social inclusion, and resilient individuals, families and communities. Such interventions will also effectively reduce demand by preventing uptake, delaying onset of drug use, and critically, minimising the risk of mental illness and other health problems that can result from ATS use.

The RANZCP commends the Special Commission for the genuinely consultative approach it has taken so far, and looks forward to ongoing engagement and collaboration on this important issue.

If you would like to discuss any of the issues raised in the submission, please contact please contact Ben Folino, Policy and Advocacy Advisor, on 9352 3604 or ben.folino@ranzcp.org).

Yours sincerely,

Dr Angelo Virgona
Chair, RANZCP NSW Branch Committee
22nd April 2019

Ben Folino
Policy and Advocacy Advisor
The Royal Australian and New Zealand College of Psychiatrists
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ROZELLE NSW 2039
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Dear Ben Folino,

This submission is made to the NSW branch of the RANZCP for the NSW Special Commission of inquiry into the Drug Ice. I am writing this in my capacity as the addiction psychiatrist clinical lead in Justice Health for the NSW Drug Court Program. My senior colleague, Dr Jill Roberts is making a separate submission to the inquiry on behalf of Justice Health.

The NSW Drug Court is a diversionary program operates at Parramatta, Toronto and Downing Centre courts. The court mandated 12 month program is for drug dependent patients who meet all the eligibility and suitability criteria, and who would otherwise be serving a custodial sentence. An initial assessment is conducted through Justice Health and a treatment plan is developed in consultation with the Local Health District where the patient resides. The program utilises a system of rewards and sanctions, where patients may return to custody for up to 28 days to serve sanctions and to have their treatment plan reviewed. Outlined in the most recent report in 2018 by Senior Judge Roger Dive (http://www.drugcourt.justice.nsw.gov.au/Pages/dc_publications/dc_annual_reviews.aspx), successful outcomes in Drug Court have increased from 44% to 57% of program entrants from 2013 to 2017. Demand for places in the program has outstripped supply to a point that the Parramatta Court has ballotted places.

My submission is best told through an abridged version from a case report of a patient recently completing the Drug Court program journey

"Ms MTA* was assessed in Drug Court clinic in Dec 2017. Then she was then a 36 year old mother of 4 children, aged 4-15 who lived with their maternal grandmother. She was in a relationship of 5 months with her current partner. She had been in gaol since September 2017 with charges of obtaining funds by deception. Her first incarceration was at age 34.

She commenced using Ice at age 33, smoking & injecting up to 2-3 points daily. Her parents didn’t know about this, and would have “disowned” her if they found out. Her longest period of abstinence was previously 15 months while incarcerated and on parole. Ms MTA noted when consuming Ice she experienced psychotic symptoms such as delusions of people following her. In gaol she described urges and cravings for Ice associated with her poor sleep. She ruminated about her children’s welfare in her while in gaol. She also reported a history of problematic gambling; at its peak she spent $1000 per week.

There was a significant trauma history, both in Ms MTA’s childhood and adulthood. Ms MTA reported childhood sexual abuse from age 3 perpetrated by her uncle. By mid adolescence she was cutting her wrists and avoiding school. Her first psychiatric hospital admission was at age 17, after an attempted hanging. She was commenced on antidepressants, and has been on/off antidepressants since with limited benefit. A child psychiatrist diagnosed ADHD around that time and Ms MTA had been on dexamphetamine up until 5 years prior when she became pregnant with her son. Ms MTA also suffered multiple head injuries from a violent ex-partner, with multiple presentations to the local emergency department as a result.

She grew up in the west of Sydney; 1 of 3 siblings. Ms MTA reported a warm relationship with her parents. Her parents did not find out sexual abuse until she was age 21; it became apparent her sister was also abused. Ms MTA left school by year 10, and worked in her parent’s party hire business. It was then she met the 2 Father’s of her 4 children. Both partners were violent to her, with her second partner forcing her to “get drugs for him” and “gambled his pay every week”. Her longest job was age 24, in a discount store. Ms MTA did a certificate in nursing at age 26 but didn’t work in nursing a “couldn’t deal with people dying”.


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While in drug court, Ms MTA started an antidepressant to treat an evolving depressive disorder. She initially was released to a residential rehabilitation in January 2018, but received sanctions for drug use and returned to custody in February 2018. A further retrial in the same rehabilitation 2 weeks latter after sanctions ended resulted in an initial period of stability, before use recommenced and was returned to custody in April 2018. A different residential rehabilitation was sourced and she successfully completed the drug court program in April 2019, roughly 2 years after commencement.

This case journey helps highlight that methamphetamine dependence is a medical condition that responds to contingencies that frameworks like the NSW Drug court provides. Shortages of places in Drug Court as seen by the need for balloting, deprives patients and the community of an efficacious treatment. Investment in the assessment and review in the health delivery to minimise shortages would be welcome.

Ice addiction like other substance addictions is often part of other comorbidities such as a trauma history that have needed parallel psychiatric assessment and treatments. For our Drug Court patients, it can be difficult to access dual diagnosis psychiatric treatment in the community. Shortages of psychiatrists servicing community drug rehabilitation centres, and community mental health teams with limited case capacity have been contributing factors. A foreseeable solution may lie in attracting community psychiatrists to establish closer working relationships with drug rehabilitation centres.

Yours sincerely

Darren Lee MBBS BMed Sci FRANZCP Cert. Addiction Psych  
Deputy Clinical Director  
Drug and Alcohol  
Justice Health and Forensic Mental Health Network

*Patient was de-identified for purposes of submission
Improving the mental health of the community
Introduction

The NSW Branch (‘Branch’) of the Royal Australian and New Zealand College of Psychiatrists (‘RANZCP’) welcomes the opportunity to make this submission to the Special Commission of Inquiry into the Drug ‘Ice’.

RANZCP is a membership organisation that trains doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care.

RANZCP has almost 6000 members bi-nationally, including more than 4000 qualified psychiatrists and around 1400 members who are training to be psychiatrists. The RANZCP NSW Branch (NSW Branch) represents more than 1200 Fellows and 400 trainees.

As mental health specialists, psychiatrists are well positioned to provide constructive input into improving outcomes for consumers with drug addiction.

About our submission

For consistency, we have used the term amphetamine-type substances (or ATS) throughout our submission except where we have determined that it is appropriate to use terms such as ‘ice’, meth/amphetamine, crystal methamphetamine etc. to put into context issues that are being experienced. We should like to stress, however, that when and where we refer to ATS, we are describing substances that are highly addictive and harmful to health.

The term ‘Alcohol and other Drugs’ (AOD) is also used in this submission when referring to a particular category of service provision, e.g. AOD rehabilitation.

In addition to addressing the issues raised in the four issue papers, we wish to refer the Special Commission to other related RANZCP publications: ‘Position Statement 82 - Recognising and Addressing the Harmful Mental Health Impacts of Methamphetamine Use’ and its submission to the National Taskforce on Ice. Both these documents explore the issues associated with ATS use from a mental health perspective, and provides recommendations as to how these issues could be addressed. We also enclose a submission we received from one of our Fellows, Dr Darren Lee, who specialises in addiction psychiatry. His submission describes the effectiveness of drug courts as a diversion and prevention strategy.

In preparing our submission, the Branch consulted with a number of its expert committees, which included the RANZCP’s Subcommittees of Addiction Psychiatry, Forensic Psychiatry, Child and Adolescent Psychiatry, and Perinatal and Infant Psychiatry. These Subcommittees have extensive expertise, knowledge and experience in treating and conducting research in the area of addiction and its effects on individuals and the wider community.

Where appropriate, our submission uses case studies to highlight relevant issues, such as gaps in service provision, and to demonstrate both specific and broader impacts of the ATS on individuals, their families and the wider community.

The overarching aim of our submission is to shine a light on addiction and its strong links to mental illness. Accordingly, our submission covers:
• Prevalence issues
• Impacts of ATS on health and community services
• Treatment, prevention and harm reduction strategies
• Impacts of ATS on the criminal justice system
• Workforce issues

Summary of recommendations
• The NSW Branch recommends that resources be made available to improve AOD capacity to address mental health issues including the identification of the early warning signs of mental illness among ATS users and the provision of appropriate interventions when such signs have been detected.
• These interventions should be offered on a stepped-care basis where service users can have access short-to medium-term accommodation during the early stages of a mental health episode, or after leaving hospital. This would give them greater support in preventing a mental health crisis and assisting them to return to wellness.
• Developing a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards meth/amphetamine use and dependence and enable affected individuals to seek treatment and help, is paramount to both minimising harm and reducing demand.
• Targeted and culturally appropriate supports and services should be provided to Aboriginal and Torres Strait Islander peoples in regional, rural and remote areas. Where possible, these services should be delivered by Aboriginal and Torres Strait Islander peoples and organisations.
• The NSW Branch also recognises that a key strategy to prevent the uptake of drugs in Aboriginal and Torres Strait Islander peoples and their communities is to retain young people in education for as long as possible and to provide ongoing employment and training opportunities.
• Young people need to be provided with the necessary supports to address underlying issues such as mental health and alcohol and drug dependencies. For this to be realised, all parts of the health and community services sector which includes education, community services, and justice, need to work together in a coordinated and flexible manner to intervene at all ‘touch points’ to prevent revolving door presentations and adverse contact with the justice system. These services also need to be sustainably funded.
• The AOD service sector needs more support and resources to meet demand for treatment and bed shortages, particularly in rural and remote NSW where services are limited. Services in these areas need more funding and investment not only to meet demand, but also reduce the need for clients to travel long distances to metropolitan or larger regional centres to access treatment.
• Governments at all levels need to invest more in supporting families who have a strong role to play in supporting recovery.

• Rehabilitation and detoxification as early in pregnancy as possible is the best option for perinatal women and their baby. Identifying and engaging these women and their dependents in antenatal care and addressing other medical and social risk factors, such as comorbid mental illnesses, unstable housing, poor nutrition, domestic violence, poverty, incarceration and relationship problems, is crucial.

• Further research to determine perinatal prevalence, use of services and impact is also urgently needed.

• Any meaningful strategy seeking to address problem drug use, including methamphetamine, must contemplate the broader social determinants of health and drug use, and seek to reduce social inequality and lack of opportunity. Focussing on drug use behaviours alone cannot hope to provide any cohesive or comprehensive solution.

• It is essential that offenders with substance use disorders are able to receive adequate intervention and treatment to help them minimise further substance abuse and the potential for ongoing criminal acts.

General comments/Statement of Principles underlying the Recommendations

This section of our submission sets out what we believe are the key requirements for an effective, highly responsive and equitable AOD service system, encompassing recovery and support as well as clinical care. Many of the principles enunciated in this section derive from the policy work undertaken by the College over the years in addiction mental health care and focus on ‘what works’ in responding to the harmful effects of ATS on individuals and the broader community. Thus:

• ATS is a destructive, dangerous, and highly addictive drug that can have adverse physical effects, adverse behavioural effects and causes acute mental disorders including psychosis. The pharmacology of methamphetamine means it has a significant impact on cognitive capacity, mood, perception and executive function, which leads to impacts on mental health, relationship and vocational function. Recovery is dependent on these capacities and takes time, support and abstinence.

• An effective response to ATS use requires a multi-faceted approach engaging all levels of government including the health and community services, law enforcement agencies, and importantly AOD rehabilitation services. It is the Branch and College’s belief that ‘stepped care’ is the most effective method to improve service integration and making the best use of available resources.

• Effective treatment for addiction to any drug must involve the management of issues that may underline its use and abuse (such as using drugs to cope with developmental trauma or other major life events), as well as the associated physical, psychological and social effects of regular use, withdrawal and recovery.
• ATS use should be primarily regarded as a health issue with responses addressing its underlying causes, such as poverty, unemployment, and homelessness.

• Effective response needs to recognise users of ATS rarely use this substance exclusively. Poly-drug use (using several different drugs at the same time or alternately) is a common practice amongst people who use ATS because of the need to manage the ‘come down’ or withdrawal effects of the drug. Benzodiazepines, cannabis, and opiates and/or alcohol are some of the drugs used to mitigate the adverse effects of ATS.

• In our view, a very significant gap continues to exist between clinical need and the provision of evidence-based AOD services particularly in rural, regional and remote communities and across all demographic and geographic settings. It is a sector that needs more support and resources to meet demand for treatment and bed shortages, particularly in rural and remote NSW where services are limited.

• Services in rural communities need more funding and investment not only to meet demand, but also reduce the need for clients to travel long distances to metropolitan or larger regional centres to access treatment. The allocation of these funds must be informed evidence-based assessment of population and community need.

• Rehabilitation and detoxification is currently the most beneficial treatment option as there is currently no pharmacotherapy option for people addicted to more pure and potent forms of ATS, such as crystal methamphetamine.

• Rehabilitation services need to be affordable, accessible, holistic and provide adequate aftercare supports. Wrap-around supports should include links to mental health supports, education and employment, housing, child protection support, and other community services.

• A shift in culture is needed whereby users of ATS are not criminalised, encouraging a greater number to seek treatment and diversion. This would require investing in treatment facilities to meet the increasing demand. It is critical users are able to access treatment closer to home so they can be supported in their recovery by their family and social supports and have greater access to diversion options to prevent adverse contact with the criminal justice system. People exiting custody need to receive an adequate and right levels of support to decrease the likelihood of reoffending.

• Social measures such as those underpinning justice reinvestment approaches need to be developed and implemented to assist the families of Aboriginal and Torres Strait Islander peoples to raise their children before they become enmeshed in the justice system. Moreover, the underlying causes of poverty and transgenerational trauma need to be the focus of such efforts.

• An AOD workforce development strategy should be established and resourced to support ongoing education, training and capacity building in the sector. It should also focus on recruiting and retaining suitably qualified staff in rural and remote areas.
• The impact of ATS use on foetuses, infants and children of mothers who are using these drugs needs further research and consideration. The impact of parents using these substances on their children and the need to consult child protection services in NSW about their perspective needs greater consideration than is currently the case.

SOCIAL, HISTORICAL AND POLITICAL CONTEXT OF ATS

The direct effects of ATS on the body and mind increase activity in a range of ways. Users describe their heart racing, along with experiences of feeling more focussed, less anxious and able to tackle tasks that had previously overwhelmed them.

For many regular users, there is an overall experience of well-being, capability, and drive to action. Society’s propensity to judge individuals by their busyness and achievements, is a subtle reinforcer of a mindset that values the effects of stimulant drugs. Cognitive enhancement among university students with prescribed stimulant medication could be seen as a socially acceptable expression of the same thinking that drives methamphetamine use among marginalised communities.

In the past century, stimulant use became popular during World War II, when it helped workers who needed to maintain the war effort (Meredith, Jaffe, Ang-Lee, & Saxon, 2005). They have been used to assist weight loss, to keep pilots awake in flights over enemy territory and are taken in a range of industries where wakefulness or stimulation increase productivity. ATS use occurs in social settings to increase energy, activity and sexual arousal. This also occurs in exploitative situations, including some areas of the sex industry and in intimate partner abuse.

Our current social welfare system struggles to adequately support those with psychosocial disability and excludes those who have stigmatised problems such as substance use and comorbid severe mental disorder. It also expects unemployed community members to meet targets and demonstrate motivation and action. The current scarcity of proper supportive/strengths based employment networks is a factor in some service users’ reliance on stimulant drugs to drive these actions and meet expectations. Expectations which people with complex problems, and unmet needs, experience as persecutory and unfair. This system could be more effective in providing skilled, engaging, person focussed and strengths-based services – but they need more resources, integration and planning to do it properly.

QUESTIONS REGARDING ATS USE AND PREVALENCE ISSUES

Prevalence of ATS use

People who use ATS are generally younger (under 40 years of age); more men than women use these drugs, and users commonly experience mental health and other substance use problems (AIHW, 2015). Use is more prevalent among some groups more frequently exposed to health risks, especially Aboriginal and Torres Strait Islander peoples, and the gay, lesbian, transgender and transsexual communities. The global incidence of perinatal amphetamine exposure is most likely severely underestimated but acknowledged to be increasing rapidly (Oei, 2012 p.737). Recent use is more common in rural and remote communities. Most people who have used
ATS substances have done so only occasionally; however, the best available data suggest that there are now more regular and dependent users of the drug than at any other time in the past decade (Degenhardt et al, 2016).

Consumption data and research evidence indicate that there are changes in ATS use and harms in Australia. According to a recent report produced by the NSW Ministry of Health, ATS use in NSW has fallen markedly, from 1.4% of the population in 2010 to half that (0.7%) in 2016 (NSW Ministry of Health, 2018). While this is positive news, the report notes that high risk use of the drug is on the rise. This includes a significant shift in use from the powdered form of ATS to the more pure and potent crystallised form of the drug, such as crystal methamphetamine. As noted earlier, more pure forms of methamphetamine are more closely associated with acute side effects and challenging behaviours such as psychotic symptoms during periods of drug use.

While prevalence of ATS use is falling, we are not seeing a corresponding decrease in rates of hospitalisation and possess/use of this particular drug. As the data in the tables below show, the number and trends in incidents of possess/amphetamine use across Sydney and regional NSW (and the state overall) as recorded by Police has increased fourfold in the period between 2007/08 and 2016/17, as has the number of people going to prison for possession. A similar trend is evident in ATS hospitalisations for persons 16 years and over.

One possible conclusion that can be drawn from the data on ATS use is that while prevalence in NSW may be declining, we may be seeing more regular and dependent use of ATS and increases in problematic use of this particular drug.

Table 1

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<td>Total Greater Sydney</td>
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<td>1327</td>
<td>1322</td>
<td>1979</td>
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<td>3214</td>
<td>3393</td>
<td>4683</td>
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<td>Total Regional NSW</td>
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NSW Recorded Crime Statistics April 2007 to March 2017
Table 2

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<td>7,054</td>
<td>124.5</td>
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<td>2016-17</td>
<td>7,763</td>
<td>136.3</td>
</tr>
</tbody>
</table>

Source: HealthStats NSW

Poly drug use

ATS use is often in the context of other substance use, termed poly-drug use. A range of drugs are used with ATS to manage mood or withdrawal symptoms. Some of these ‘other’ drugs include cocaine or ecstasy-type substances, as well as using a range of depressant drugs e.g. alcohol, cannabis, benzodiazepines and opiates.

Poly-drug use can intensify the harms associated with drug use. Not only do different substances have different effects, the combination of them can lead to serious harm and increase the likelihood of unpredictable effects. Concurrent use of these drugs and ATS has been shown to increase psychotic symptoms in some individuals, particularly those with schizophrenia (Jenner & Lee, 2008).

The challenges associated with treating ATS use is often exacerbated by poly-drug use and/or comorbidities. For example, ice users may require treatment and support for mental health and a range of other issues, often along with other trauma issues, at the same time as they receive treatment and support for their ATS use.

In this context, the difficulties of attempting to deal with ATS use in isolation become obvious, as it is clear that people using ‘ice’ and other forms of ATS are doing so in a broader context of drug use. Designing interventions to combat problem drug use and minimising their associated harm must be able to address a wide variety of substances and the reasons for use that underlie these behaviours.

QUESTIONS REGARDING IMPACT OF ATS USE

ATS use and mental illness

Methamphetamine use, as a driver of action and output, is in fact, a substance that reduces the human capacity to stop and think. The agitation, conflict and violence that can occur when methamphetamine is being used, is actually a failure of thinking. Psychosis induced by methamphetamine occurs because there is too much unfiltered input to the brain, unmoderated by reality checking. This reaction is also observable in the community response to methamphetamine use – the tendency to reactive, understandably emotional, catastrophizing has made a thoughtful, nuanced response more difficult.
There is a strong link between people who use drugs such as ATS and co-morbid mental illness. Users of ATS are five times more likely to experience psychotic symptoms when using compared with periods of abstinence (McKetin et al, 2013). Indeed, drug-induced psychosis is one of the most common comorbid psychiatric disorders among ATS users (Dawe & McKetin, 2004) with research showing psychotic symptoms prevalent in 30% of ATS users (Lea et al, 2015). These transient psychotic reactions can look very similar to acute paranoid schizophrenia, including persecutory delusions and hallucinations. Other symptoms can include bizarre behaviours, disordered thoughts and agitation (Dawe and McKetin, 2004). Violence is a key harm associated with ATS use, with studies suggesting there is a dose-related relationship between ATS and hostility and violence (McKetin et al, 2014).

Such psychotic episodes are probably more likely in those with pre-existing vulnerabilities, but also occur in people who are psychologically well. ATS users are likely to experience other adverse socio-behavioural consequences which include: relationship/social problems (e.g. relationship breakdown), homelessness (Wermuth 2000), and criminogenic outcomes (e.g. involvement in criminal behaviours, contact with the criminal justice system) (Milloy et al, 2009).

In our experience, people who use drugs, such as ATS, and experiencing mental health issues, often fall ‘through the gaps’ of the healthcare system. Many services are designed for other types of drugs—for example, some detoxification services do not cater well for the comedown associated with stimulants, and some services lack appropriate follow-up for the extended withdrawal period associated with ice. Specialised treatment options for ATS use are also limited, and available programs may lack the intensive psychological and behavioural management necessary to support people through recovery (McKetin et al, 2010). And due to the underlying dysfunction in these patients’ lives and their poor coping skills, relapse and non-compliance are common (Degenhardt et al, 2016).

**Recommendations**

The NSW Branch recommends that resources be made available to improve AOD capacity to address mental health issues including the identification of the early warning signs of mental illness among ATS users and the provision of appropriate interventions when such signs have been detected.

These interventions should be offered on a stepped care basis where service users can have access short-to medium-term accommodation during the early stages of a mental health episode, or after leaving hospital. This would give them greater support in preventing a mental health crisis and assisting them to return to wellness.

**Stigma and discrimination**

Stigmatisation of mental illness is now widely recognised as a serious issue which is harmful to consumers and their supports, creates barriers to accessing treatment and leads to discrimination, lowered self-esteem and isolation. In recent years, there have been several public campaigns to address stigmatisation of mental health in general and specific illness such as depression and anxiety.
There has been nowhere near this level of engagement with the stigmatisation of consumers with drug use disorders. Rather, people with drug use disorders continue to experience widespread discrimination. The developments that have occurred in other parts of mental health mean that it increasingly widely understood that it is not acceptable to stereotype, blame or shame consumers. There is much work to be done in the area of substance use disorders to move towards a similar place of de-stigmatisation and acceptance.

If we are to minimise potential harms from ATS use, it is important to encourage people into treatment, and ensure the provision of appropriate evidenced based care. It is crucially important to not stigmatise drug use. Stigmatising users reduces the prospect that those who need care will actually seek it (Roche 2015).

**Recommendation**

Developing a sustained and comprehensive stigma reduction strategy to improve community and service understanding and attitudes towards meth/amphetamine use and dependence and enable affected individuals to seek treatment and help, is paramount to both minimising harm and reducing demand.

**QUESTIONS REGARDING IMPACT OF ATS ON VULNERABLE PEOPLE AND COMMUNITIES**

There are some specific population groups in which the use of ATS is becoming increasingly common and problematic or a high risk of this. This section of our submission examines the impact of ATS use on people we consider to be at risk of using ATS including:

- Aboriginal and Torres Strait Islander peoples
- Young people
- People living in rural communities
- Pregnant women
- Children of parents who use
- Offenders

**Aboriginal and Torres Strait Islander peoples**

The socio-economic disadvantages that may Aboriginal and Torres Strait Islander peoples’ experience, place them at a significantly higher risk of exposure to illicit drugs. According to AIHW, Aboriginal and Torres Strait Islander people are 2.2 times more likely to have recently used meth/amphetamine counterparts and more likely to develop dependency issues than their non-Aboriginal (AIHW 2017).

These communities are also more vulnerable to the detrimental health effects of drug use. According to a government published report “drug-related problems play a major role in disparities in health and life expectancy between Indigenous and non-Indigenous Australians” (Ministerial Council on Drug Strategy 2011).
Effective drug and alcohol interventions for the mainstream population have been found to be less effective for Aboriginal and Torres Strait Islander people, as these interventions may not have been delivered in a way that is appropriate to this population (National Indigenous Drug and Alcohol Committee 2014). The NSW Branch and RANZCP believe, therefore, that the most appropriate and successful strategies to address Aboriginal and Torres Strait Islander peoples’ ATS use are those that are culturally appropriate and/or developed within communities themselves and involving Aboriginal and Torres Strait Islander peoples in their implementation and management (National Indigenous Drug and Alcohol Committee 2014).

**Recommendations**

The NSW Branch also recognises that a key strategy to prevent the uptake of drugs in Aboriginal and Torres Strait Islander peoples and their communities is to retain young people in education for as long as possible and to provide ongoing employment and training opportunities. Whilst such considerations also apply to non-Aboriginal young people, the evidence suggests that young Aboriginal and Torres Strait Islander people are particularly vulnerable when there are insufficient education, employment or training opportunities to act as a buffer against the uptake of problematic alcohol and other drug use.

**Young people**

ATS use can have harmful effects on the mental and physical health of young people and in some cases can have lethal consequences with higher rates of suicide and overdoses among young people. While ATS use is of concern for the general population, earlier initiation and poly-drug use are of significant concern throughout the phase of adolescent development. The prevalence of mental illness amongst young people also adds to concern as any pre-existing mental health issues are likely to be greatly exacerbated by ATS use.

The school environment remains an important site for ensuring children and young people are equipped to respond to the social environment they encounter now and in the future. The policy announcement by the NSW Government during the 2019 election to employ full-time counsellors, psychologists and support workers in every public school is welcome news in this regard, and when implemented, will provide much needed boost in resources for young people to receive help for any mental health issues they may be experiencing and/or any illicit drug use that may be detected during this stage in life.

Despite this extra investment, the NSW Branch maintains that further investment is still needed in specialist youth mental health services to address underlying mental health conditions and reduce associated risks of illicit drug taking. It is generally well-known that young people have low uptake of community and social services for a variety of reasons, so active follow-up by established mental health services is key to ensure young people remain engaged with services.
Recommendations

Young people need to be provided with the necessary supports to address underlying issues such as mental health and alcohol and drug dependencies. For this to be realised, all parts of the health and community services sector which includes education, community services, and justice, need to work together in a coordinated and flexible manner to intervene at all ‘touch points’ to prevent revolving door presentations and adverse contact with the justice system. These services also need to be sustainably funded.

People living in rural communities

Regional and rural communities are particularly vulnerable to problematic ATS use. According to the AIHW, people living in remote and very remote regions were 2.5 times more likely to have used ATS than those from major cities (AIHW 2018). According to the National Rural Health Alliance's Illicit Drug use in Rural Australia report, the causes of illicit drug use in rural and remote areas are multiple and inter-related:

- Low incomes which means less capacity to afford basic goods and services such as health care
- Lower education levels which can mean lower health literacy
- They are more likely to live in poverty because of fewer employment opportunities, and
- They are more likely to live in housing distress (National Rural Health Alliance, 2015).

Another factor putting rural communities at risk of and appropriately responding to ATS use is geographic spread. The demographics of rural and regional populations are different to metropolitan populations and therefore the factors bearing on ATS use and rural communities’ capacity to respond to it are also different from those encountered in metropolitan contexts. Key challenges include, but are not limited to: access and availability of alcohol and drug services including rehabilitation services and withdrawal services; rural health workforce shortages particularly clinical specialists; and, issues pertaining to anonymity and confidentiality (i.e. stigma) in rural communities.

Recommendations

The AOD service sector needs more support and resources to meet demand for treatment and bed shortages, particularly in rural and remote NSW where services are limited. Services in these areas need more funding and investment not only to meet demand, but also reduce the need for clients to travel long distances to metropolitan or larger regional centres to access treatment.

People living in marginalised communities

In socially marginalised communities, where there are high levels of unemployment, poverty and unstable housing, ATS use can flourish. Residents of some
marginalised housing areas describe easy access to ATS substances through neighbours and other local sources, usually more accessible and available than treatment services. There is an association between ATS use and poverty/marginalisation. While it would be simple to assume that drug use leads to poverty and other psychosocial problems, the clustering of significant substance use issues in areas with high levels of poverty and marginalisation, suggests that the core problem is actually more complex than drug use as the causative driver.

Scarcity and poverty both affect decision making and impulsivity, leading to problems with delaying gratification or inhibition of risky behaviour, including drug use. There is also evidence that scarcity of resources changes attention and the ability to focus on differing demands. While we would like to say that behaviour is predictable and that it is simple to influence people to healthier choices, the reality is that in poor/marginalised communities, choices of behaviour are not always directly linked to increasing health or safety – e.g. increased rates of borrowing among the poor (Shah et al, 2012). Public health measures that would work for the mainstream (such as taxes and disincentives) are less effective in shifting behaviour in marginalised groups – e.g. While increasing tax on cigarettes has reduced smoking rates in the whole community it has not been as effective in communities that experience high rates of mental disorder.

**Recommendations**

Any meaningful strategy seeking to address problem drug use, including methamphetamine, must contemplate the broader social determinants of health and drug use, and seek to reduce social inequality and lack of opportunity. Focussing on drug use behaviours alone cannot hope to provide any cohesive or comprehensive solution.

**Children, parents and families**

Children of parents who use drugs, such as ATS, and young people in out-of-home care or involved in the child protection system are another group we have identified as receiving relatively little attention.

Children of parents who use are at risk of interrupted emotional and physical development which can occur because of chaotic and unstable household environments which can lead to a children’s physical, emotional and developmental needs being unmet, and/or an increase in abuse or neglect. A recent study in the United States found that children whose parents use drugs were three times more likely to be physically, sexually, or emotionally abused and four times more likely to be neglected than their peers (Smith et al, 2015). Parental drug use can have long term effects on the child’s health, safety and wellbeing. It is important that health professionals can identify key signs that a child may be at risk of suffering abuse or neglect and intervene early. Exposure to drug use at a young age can increase the likelihood of a child using drugs themselves.

Family and Community Services in NSW, as part of the Their Futures Matter, have implemented Family Preservation Programs. The programs are focussed on assisting parents with improving safety for their children. One particular evidence
based therapy – Multi-Systemic Therapy for Child Abuse and Neglect (MST-CAN) – has been working with parents who have used methamphetamine and utilises Reinforcement Based Treatment for substance use problems (This is a treatment module that incorporates cognitive, behavioural and motivational strategies – it uses voucher rewards for clean urine tests, activity and employment planning along with functional analysis of use and relapses). The MST-CAN model is an intensive, home-based program – a therapist visits families three times a week over 6-9 months – an intensity which has assisted in helping parents maintain abstinence from methamphetamine. This type of model could be used in drug treatment services as a more intensive community treatment model for ATS users with complex problems.¹

**Recommendations**

Governments at all levels need to invest more in supporting families who bear much of the burden but also have a strong role to play in supporting recovery.

**Pregnant women**

There is growing concern about the use of ATS during pregnancy and the postnatal period, although the prevalence and impact of such use on this particular groups remains under-researched (Oei et al, 2012). Findings from research show that ATS use during pregnancy seriously damage the health of the woman, the unborn foetus and the child’s development once he or she is born (Oei et al, 2012). ATS use is associated with mothers attending antenatal care less frequently than the users of other drugs and can result in:

- Multiple admissions to hospital for management of complications associated with ATS use
- Cardiovascular collapse and seizures
- Foetal growth restrictions

**Recommendations**

Rehabilitation and detoxification as early in pregnancy as possible is the best option for perinatal women and their baby. Identifying and engaging these women and their dependents in antenatal care and addressing other medical and social risk factors, such as comorbid mental illnesses, unstable housing, poor nutrition, domestic violence, poverty, incarceration and relationship problems, is crucial (Oei et al, 2012).

Further research to determine prevalence, use of services and impact is also urgently needed.

**Offenders**

There are strong links between ATS use and the criminal justice system. As previously noted, ATS use and mental illness (i.e. psychosis) often go hand-in-hand,

¹ Another model that could be used is an asset mapping recovery model, advocated by Professor David Best – University of Sheffield and Turning Point.
and adverse contact with the criminal justice system is prevalent amongst this group. There is a significant overlap between drug induced psychosis and schizophrenia (Callaghan et al, 2012) and the difference is not able to be readily apparent on cross sectional assessment but the clinical experience is that ATS use can be a barrier to treatment and follow up. In our experience, the justice system is ill-equipped to address the addiction and mental health disorder that led to the person being detained in prison in the first place. Post-release support to prevent reoffending is inadequate or non-existent in the majority of cases. Services tend to be organised in a siloed fashion and there is a paucity of services available for ATS users particularly those with severe mental illness. The ATS group presenting with psychosis is often resource intensive with revolving door presentations.

The research and literature in this area have shown that dual diagnosis substance use rehabilitation requires proper integration of services and coordinated multidisciplinary individualised care (Drake et al, 2004).

**Recommendations**

It is essential that offenders with substance use disorders are able to receive adequate intervention and treatment to help them minimise further substance abuse and the potential for ongoing criminal acts.

**Impact on the healthcare system**

The disordered behaviour associated with ATS use has led to increased strain on emergency departments, acute psychiatric inpatient units and other frontline services.

Hospital admission data shows a tenfold increase in people presenting with a principal diagnosis of Methamphetamine-related hospitalisations and persons hospitalised.

Many consumers who have ATS dependency present in the first instance for treatment of their mental health symptoms, rather than their substance use (RANZCP 2015). Psychiatrists in the public sector report that the growing level of need in the community, as well as the increase in complex and challenging presentations, has put a strain on what were already limited resources. Increased funding is urgently needed to enable psychiatric inpatient units to respond to this heightened level of need and complexity.

**Recommendations**

It is incumbent upon governments to ensure that emergency departments are adequately resourced including funding of ‘upstream’ strategies to effectively deal with people who present to emergency departments in crisis as a result of ATS use.

**WHAT CAN BE DONE - QUESTIONS REGARDING PREVENTION AND HARM REDUCTION STRATEGIES?**

The NSW Branch supports expanding the current three pillar approach of supply reduction, demand reduction and harm reduction to include what is being adopted in Victoria and in countries like Switzerland and Canada (Vancouver) that take a more
health-focused approach and includes preventing the uptake of harmful drug use. However, it is imperative these pillars continue to consider social inclusion, social disadvantage, unemployment, homelessness, Aboriginal and Torres Strait Islander peoples, income support, child protection, and the justice system.

Tackling problematic ATS use is no simple task and needs to be addressed systemically and utilise a variety of interventions that are based on solid evidence. The following recommendations, in addition to the aforementioned, are key measures we believe the Special Commission should consider in their report:

1. **Develop a sustained and comprehensive education and awareness raising strategy.** If we are to reduce both demand and minimise harm, it is important that we continue to raise the communities understanding and awareness of the drugs being used, their effects, and the harms associated with their misuse and the appropriate and available means for professional support and effective interventions and treatments. Given the reluctance of many ATS users to attend traditional treatment services, their relatively young age and the patterns of use, it makes sense that 24-hour telephone and internet support services, and technology-based interventions be considered as alternative early intervention priorities. Addressing stigma towards ATS use is an important component of this strategy.

2. **Support to families.** Family members are also an important part of effective treatment and recovery. It is important, therefore, that when developing these types of interventions that families and significant others are supported to receive education, support and practical assistance to help them understand the issues, improve their own wellbeing, and continue to provide positive source of support for ATS users. Where there is family dysfunction and the parents are also abusing substances, interventions need to be conducted in tandem.

3. **Diverting individuals from the justice system.** Diverting drug offenders into treatment is an effective and less expensive option that offers the best chance of recovery when compared to the expensive option of incarceration, which does little to help the offenders’ substance use problems and/or reduce drug use in the wider community. In our opinion, there should be greater utilisation of treatment and rehabilitation programs for offenders with drug-related crimes.

4. There is also **scope for a justice reinvestment approach** which is targeted at reducing offending and increasing community safety at a local level. These initiatives are community led and invariably involve AOD strategies. An example of this are the Cowra and Bourke justice reinvestment program which targets Aboriginal and Torres Strait Islander peoples who are at risk of contact with the criminal justice.

5. Allied to this, **police and courts need to continue making use of the range of diversionary powers** available to them in order to reduce young offenders’ adverse contact with the juvenile justice system. These options need to be applied consistently by all police across all local area commands to ensure young offenders are treated in an equitable and non-discriminatory manner. The government needs to allocate extra resources and funding for police to develop
the right level of cultural competence to enable them to work effectively especially with Aboriginal and Torres Strait Islander peoples.

6. **Expand specialist courts**, such as the Koori Youth Court and Youth Drug and Alcohol Court. These need to be expanded into areas of identified need to ensure young offenders who are experiencing issues of social or cultural disadvantage, such as living with a disability, substance abuse, and mental health conditions receive support to address the underlying cause of their offending. The Youth Koori Court needs to be expanded to address the over representation of Aboriginal and Torres Strait Islander peoples in the juvenile justice system. See submission from Dr Darren Lee.

7. **Detoxification and residential rehabilitation facilities.** There is an immediate and pressing need to increase the capacity of residential rehabilitation beds across the state, ensuring that this service is equitably available across NSW. In order to combat a drug or alcohol addiction, a process of detoxification (‘detox’) is required. For many ‘detox’ can be an extremely painful and traumatic process, and if poorly managed can result in severe and life-threatening complications particularly if the client is a long-term user.

8. **Increased support in the public system for longer admissions and more intensively supportive treatments, is needed.** Private psychiatrists in NSW report that they see more effective treatment outcomes in the private hospital system, where a three-week admission supports progress to recovery more effectively than in the public hospital system, where detox admissions are usually limited to 7-10 days, at the most. This difference may also be due to those in the private system having access to more family and environmental supports, more access to ongoing treatment, or that those accessing treatment in the public hospital system have more complex and difficult problems.

9. **To improve the opportunities for change and recovery, mental health support and treatment for people who use ATS needs to be accessible and reliable.** ATS, both its regular use and periods of early abstinence, impair executive function, decision making skills and the ability to accurately self-monitor or regulate (Nordahl et al, 2014). In the period of early abstinence, the common symptoms experienced are lethargy, low mood, lack of energy and motivation – all of which make relapse more likely. In some cases, withdrawal and early abstinence can lead to severe depressive symptoms, suicidal thoughts and behaviours. Each of these symptoms increase the likelihood of relapse, as a way to manage distress or risk to the individual in withdrawal. Managing this period of distress or change in use requires support and is best done in circumstances where the person wanting to change is encouraged, assisted and reminded of the benefits of change, to assist them in tolerating the physical and psychological effects of withdrawal.

10. **Greater integration with health and mental health.** As noted earlier, people with mental health issues are particularly vulnerable to substance abuse and those with substance abuse issues are also particularly vulnerable to mental health issues. Comorbidity should therefore be a focus of some service models. There is increasing evidence that integrated treatment models that have the
capacity to address both mental illness and substance abuse are both feasible and effective (Deady et al, 2013).

11. **More assertive models of care are needed.** Treatment approaches need to consider whether expecting those with ATS use disorders to access treatment in hospitals and community health centres is providing enough support for people who have problems with motivation, organisation and executive function problems. Ambulatory treatment programs should be encouraged to consider more assertive models that have the option for home visits and other places of engagement/treatment, or using other contacts such as needle-syringe programs or community hubs with integrated services – many of those with the most difficult problems have complex, multi-problem needs.

12. **Build the capability of the generalist health workforce, and AOD specialist workforce** is critical to achieving and sustaining effective responses to drug use. Being familiar and having up to date knowledge on the specific harms and risks associated with meth/amphetamine abuse and dependence (e.g. poly drug use, behavioural and psychological disturbances) is essential in order to provide targeted and relevant interventions.

13. **Invest in specialist services.** Any action plan developed as a result of this inquiry must recognise the need for specialist services for people with severe substance dependence who are at risk of serious harms due to associated mental illness or cognitive impairment. It is NSW Branch’s view that there is a shortage of addiction medicine specialists, including psychiatrists, in NSW as a result of little investment going into addiction medicine and psychiatry training at both an undergraduate and postgraduate level. A concerted state and federal workforce plan is required to provide supported training, specialist positions, and the allocation of Medicare item numbers to allow for medical remuneration and sufficient time to deliver complex high quality care.

14. **An holistic and recovery focussed approach is needed.** People with substance abuse issues often have complex needs, and a coordinated response addressing mental and physical health is needed. This approach must also be trauma-informed.

15. **Addressing the social determinants** to reduce demand for ATS use and minimise harm. While not specific to the issue of problem drug use, no holistic approach to addressing social issues can be undertaken in isolation. At a population level, there are clear associations between problem drug use and poverty, disadvantage and social marginalisation, which extend into health and social outcomes. Reducing social disadvantage has the potential to reduce the propensity for people to develop problem drug use by ensuring that problem drug users have access to basic social needs such as affordable and stable housing, a job, access to education and training, and access to affordable healthcare.

16. Treatment for ATS dependence is an important area that **needs further research** and investigation to identify the most effective means of treating individuals who are experiencing problematic ATS use, or who would like assistance with cutting down or better controlling their use.
17. Perinatal and infant research to determine prevalence, use of services and impact is also urgently needed.
REFERENCES


18. National Indigenous Drug and Alcohol Committee (NIDAC) 2014 ‘Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples,’ Australian National Council on Drugs, ACT.


24. RANZCP, 2015, submission to National Ice Taskforce.

