PENINGTON INSTITUTE

NSW Special Commission of Inquiry into the Drug 'Ice'

Issues Papers submission

May 2019

Introduction

Our mission

Penington Institute actively supports the adoption of approaches to drug use which promote safety and human dignity.

We address this complex issue with knowledge and compassion. Through our analysis, research, workforce education and public awareness activities, we help individuals and the wider community.

Our history

Launched in 2014, Penington Institute, a not for profit organisation, has grown out of the rich and vibrant work of one of its programs, Anex, and its 20 years' experience working with people and families directly affected by problematic drug use.

Penington Institute is inspired by and named in honour of Emeritus Professor David Penington AC, one of Australia's leading public intellectuals and health experts.

Our vision

Our vision is for communities that are safe, healthy and empowered to manage drug use.

Our understanding

Drug use trends, drug development and markets historically move faster than research and policy responses. With our outreach to the front-line we are well-placed to know and understand the realities of how drugs are impacting communities – well before the published literature surfaces significant issues.

We combine our front-line knowledge and experience with our analysis of the evidence to help develop more practical research and policy, support services and public health campaigns. Our strong, diverse networks provide an excellent platform for building widespread support for effective initiatives.

Our activities:

We:

- Enhance awareness of the health, social and economic drivers of drug-related harm.
- Promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use.
- Build and share knowledge to empower individuals, families and the community to take charge of substance use issues.
- Better equip front-line workers to respond effectively to the needs of those with problematic drug use.

Our purpose is framed by our knowledge that we need to look at more effective, cost-efficient and compassionate ways to prevent and respond to problematic drug use in our community.

Our submission

Penington Institute welcomes the opportunity to make a submission to the NSW Government's Special Commission of Inquiry into the Drug 'Ice', noting that this not only includes crystal methamphetamine, but all amphetamine-type substances (ATS), including MDMA (ecstasy). In our responses, where the evidence is related to a particular ATS (e.g. ice) we have specified the substance, but where we are indicating the group of substances as a whole, these are referred to as ATS.

We read with interest the four detailed issues papers. In our response, we have focused on six key topic areas:

1. Decriminalisation
2. Priority populations
3. NSPs and harm minimisation in correctional centres
4. Alternative models and community responses
5. Pillars of harm and funding
6. Education

Our responses to key questions are grouped under these topic areas.

Decriminalisation

In this section, Penington Institute addresses the question of decriminalisation and legalisation of drugs including amphetamine-type substances. Specifically, it addresses the questions 2.2.3 and 2.1.10 in the issues paper on Justice:

2.2.3 How and to what extent does the criminal prohibition of ATS promote or frustrate the National Drug Strategy?

The overarching goal of Australia's *National Drug* Strategy (NDS) is to minimise the harms associated with and caused by drugs. The 'three pillars' that support this goal are demand reduction, supply reduction and harm reduction. Australia's efforts to reduce the availability and supply of illicit drugs are primarily organised around law enforcement activities and supply reduction efforts receive the lion's share of funding. Unfortunately, these efforts have made little substantive or lasting progress against the goal of reducing supply – a fact broadly acknowledged by experts, decision makers and law enforcement representatives. Most succinctly, former Chief Commissioner of Victoria Police, Ken Lay stated that 'we can't arrest our way out of our problems [with drugs and drug use]'.[1]

In relation to methamphetamine, the *National Ice Action Strategy 2015* report noted that low price, high purity and wide availability had not been affected by supply reduction activities.[2]

More recent evidence from the latest *National Wastewater Drug Monitoring Program* report shows that in that in 2018 Australians spent an estimated $9.3 billion on just four illicit substances.[3] Of this, 78% was spent on methamphetamine. The total weight of methamphetamine consumed nationally is estimated at 9,847 kilograms for 2018, up from 8,405 kilograms in 2016. There were 12 wastewater sites monitored in New South Wales in August 2018; five in capital cities sites and seven in regional areas. The report found that while the average level of methamphetamine showed a modest decrease in Sydney, it rose in regional areas of NSW.[4]

Additional data from the *National Drug Strategy Household Survey 2016* show that the use of methamphetamine in Australia has grown in recent years and remains high.[5] The survey reveals that methamphetamine is the most common form of amphetamine used nationally, increasing from 22% in 2010 to 57% in 2016. Further, rates of daily methamphetamine use doubled from 2010 to 2016.

The *Illicit Drug Data Report* for 2016/17 states that amphetamine-type substances (ATS) 'remained a large, relatively stable supply market'. While the number of detections of methamphetamine at the Australian border decreased 3.7% between 2015-16 and 2016-17, it remains unclear if this indicates a shrinking

[1] The Age (2016) 'The war on drugs is a losing battle', *Fairfax Media*: https://www.theage.com.au/national/victoria/the-war-on-drugs-is-a-losing-battle-20160707-gq0m5f.html

[2] Commonwealth of Australia, Department of the Prime Minister and Cabinet (2015), *National Ice Action Strategy 2015*, Canberra.

[3] Australian Criminal Intelligence Commission (2019) *National Wastewater Drug Monitoring Program – Report 6*, Commonwealth of Australia.

[4] Australian Criminal Intelligence Commission (2019) 'Wastewater results show highest cocaine use in NSW': https://www.acic.gov.au/media-centre/media-releases-and-statements/wastewater-results-show-highest-cocaine-use-nsw-0

[5] AIHW (2016) *National Drug Strategy Household Survey 2016: Detailed Findings*, Australian Institute of Health and Welfare.

market, more sophisticated methods of avoiding detection at the border, or growth in domestic production. However, the wastewater monitoring program data suggest that more methamphetamine is being consumed nationally.

In New South Wales, the lack of effective supply reduction efforts is acknowledged by law enforcement. The NSW Crime Commission's 2015-16 Annual report offered this assessment:

> The illicit drug trade continues to be the main stream of income for organised crime groups operating in Australia. Drugs that are predominantly manufactured overseas including cocaine and amphetamine-type stimulants (ATS), continue to command high prices domestically when compared to their cost offshore. As a consequence, international crime groups have continued, and likely have increased, their efforts in importing prohibited drugs into Australia…
>
> Organised crime is increasing and is at levels not previously seen in New South Wales. The growth of organised crime is almost entirely driven by the prohibited drug market and the indicators relied upon for this conclusion include the following:
>
> > **Availability of drugs:** Methamphetamine ('ice') and cocaine supplies are still high; prices for both drugs are considerably lower than five years ago and the detection and seizures are increasing in both number and volume.
> >
> > **Australia is a supply driven market:** Offshore interests decide the volume of drugs that are imported into Australia and domestic drug consumption market will consume whatever is available… Commendable law enforcement efforts around the country have resulted in larger seizures and more arrests, but they have had little, if any, effect on the quantities of drugs available for consumption in Australia

The failure of supply reduction efforts relating to ATS is further evidenced by arrest data. National ATS arrests remained relatively stable in 2016-17, however this followed five consecutive increases leading to a record 47,625 ATS-related arrests reported in 2015-16. The latest data from the New South Wales Bureau of Crime Statistics and research show arrests for possession of amphetamines increased 9.7% in the quarter ending December 2018.[6]

Clearly, supply reduction efforts in Australia, and in New South Wales specifically, have failed to reduce the availability of methamphetamine (as well as other drugs).

In regard to whether the criminalisation of ATS frustrate the goals of the *National Drug Strategy*, the evidence is quite clear. The overarching goal of the National Drug Strategy is to minimise the harms associated with drugs and drug use. The harms associated with methamphetamine consumption and dependence to individuals, families, communities and society at large are well known. Having a wholly unregulated supply of methamphetamine that is easily accessible is clearly a primary driving factor of methamphetamine-related harms.

Contact with the criminal justice system is also harmful both to society and to individuals. The criminal justice system is costly to the state and harmful to the individual. People with dependence on

[6] Bureau of Crime Statistics and research (2017) 'New South Wales recorded Crime Statistics – Quarterly Update December 2018', NSW Government: https://www.bocsar.nsw.gov.au/Documents/RCS-Quarterly/NSW_Recorded_Crime_December_2018.pdf

methamphetamine, who are already at a higher risk of experiencing problems such as mental ill-health, poverty, poor physical health, unemployment and low quality of life, are unlikely to benefit from criminal charges. In fact, a criminal conviction and possibly incarceration are likely to exacerbate the significant challenges they already face.

Given the amount of methamphetamine consumed in Australia, as well as the high number of arrests for methamphetamine consumption, the continued criminalisation of ATS in NSW and Australia broadly does frustrate the primary goal of Australia's *National Drug Strategy*.

2.1.10 Should NSW consider the legalisation and/or the regulation and control of the supply of ATS?

Given the lack of efficacy in supply reduction efforts discussed above, it is a reasonable proposition of New South Wales to consider regulatory changes, such as the decriminalisation of amphetamine-type stimulants, as well as legalisation and controlled supply of other substances that are currently prohibited. This is consistent with the recent unanimous support for decriminalisation of personal drug use and possession, as confirmed by the United Nations Chief Executives Board, which represents the 31 UN agencies[7].

In addition to considering the decriminalisation of ATS, taking into consideration the relative harms of various substances, New South Wales should as an urgent priority, consider the legalised supply and control of other substances currently prohibited, such as cannabis. Several other jurisdictions – notably Uruguay, Canada and many US states – have legalised the personal use, possession and growth of cannabis. The profile of harm in relation to cannabis is minor compared to ATS, particularly methamphetamine[8]. Unfortunately, it is easier and cheaper to manufacture and supply ATS than cannabis. We recommend that decisions around supply control and legal status of substances should be more nuanced and focus policing and law enforcement efforts on drugs that are more harmful[9].

There are several benefits to the legalisation of currently prohibited drugs. The most obvious benefit is one that has eluded supply reduction efforts for decades: the control of supply. Legalisation enables the state to tightly control a range of factors relating to the supply of the substance in question such as price, control of access, strength (purity) and quality (the presence of adulterants) more effectively than under regimes of criminalisation.

This also directly undercuts the highly successful business models of the organised crime groups (which depend upon continued criminalisation) that currently supply large amounts of amphetamines to the New South Wales market (and to Australia more broadly). With legalisation, the significant amount of money spent supporting organised crime through the purchase of illicit drugs can be reduced significantly. Profits from large scale domestic illegal cannabis production in Australia is known to finance the importation of ATS by criminal networks. Local consumers of cannabis are required to engage with the criminal underworld to purchase cannabis. Disentangling cannabis from the illicit drug market would therefore reduce the financial capacity of criminal networks to shift their cannabis market profits into ATS supply and protect cannabis consumers from exposure to the broader illegal drug market.

[7] http://www.dpnsee.org/cms/files/2019/03/UN-Chief-Executives-Board-Minutes-1901.pdf

[8] Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. The Lancet, 376(9752), 1558-1565.

[9] Ibid

Another benefit of legalisation is that models of controlled supply put the state directly in contact with consumers prior to their entry into the criminal justice system. If New South Wales were to legalise cannabis, it would reduce the marginalising effect of criminalisation on substance users and put people using cannabis into direct contact with the state through legalised supply channels, providing an opportunity for intervention and support.

There is evidence suggesting that cannabis availability may act as a protective factor against consumption of other, more harmful drugs, such as methamphetamine. One recent study in New Zealand found that high levels of cannabis availability was associated with lower methamphetamine availability in rural townships.[10] This is supported by the earlier claims of the NSW Crime Commission that Australia is a supply-driven market: Australians consume what is available. There is also emerging evidence from the US that in states where cannabis is legal, doctors' issue fewer prescriptions for opioids and patients consume lower doses.[11]

In sum, the criminalisation of ATS does little to stem their use and hinders the goals of Australia's *National Drug Strategy*. In contrast, the legalisation of some currently prohibited substances, especially cannabis, would enable much tighter regulation of supply of these substances while also facilitating the minimisation of harms.

[10] Wilkins et al (2018) 'Determinants of high availability of methamphetamine, cannabis, LSD and ecstasy in New Zealand: Are drug dealers promoting methamphetamine rather than cannabis', *International Journal of Drug Policy*, vol. 61: 15-22.

[11] Halperin, (2019) 'Can marijuana help end the opioid crisis?', 2nd April 2019, *The Guardian*: https://www.theguardian.com/society/2019/apr/01/marijuana-opioids-crisis-exit-drug

Priority populations

In this section, Penington Institute addresses the question of priority populations relating to harms from amphetamine-type substances. Specifically, it addresses the questions 1.1.9, 3.1.7, 3.2.6, and 3.3.9 from the issues papers on Use, Prevalence and Policy Framework, and Health and Community.

1.1.9 Who are the at-risk populations for harmful ATS use? Are there geographical differences? What is the evidence that supports the identification of these populations as being at-risk populations?

Both Issues Paper 1 and 3 identify groups at particular risk of harm, particularly Indigenous people, those living in rural / regional areas, families, those from culturally and linguistically diverse communities, people who are or have been incarcerated, those who identify as LGBTQI+, families, and young people. We agree that the current evidence supports that there is an increased risk from ATS-related harms in these groups, however, by grouping them in this way, it does not recognise that the underpinning risk factor is most likely socio-economic status and economic and social vulnerability. We also think it relevant to note that the most prevalent group of those who use (meth)amphetamine are males, particularly those aged 20-39 and in low socio-demographic groups[12], therefore, it is important that focus on this group is not lost, when considering other at-risk populations. We also highlight that the majority of population-based data on drug use, which informs understanding of at-risk populations, are based on self-report; the use of self-reported data is prone to under-reporting due to issues of legality and stigma.

There is significant evidence that there is a socio-economic gradient in both (meth)amphetamine use and harms, with those who are economically and socially vulnerable most at risk[13]. Findings from the 2016 Australian Household Drug Survey showed that recent use of (meth)amphetamine was highest in the lowest socio-economic quintile, and that over time (meth)amphetamine use has declined in those in the highest socio-economic quintile, meaning that the gradient has become steeper[14], shown in Figure 1. In contrast, cocaine use is more prevalent in higher socio-economic groups[15], and this difference in socio-economic demographics between cocaine and methamphetamine may be driven by the higher price of cocaine, meaning that demand for ATS in those with increased disadvantage is being met by methamphetamine; this is an issue given that methamphetamine is more harmful than cocaine[16]. Furthermore, treatment outcomes are poorer for those of reduced socio-economic status[17], suggesting that retaining individuals in treatment will be more difficult for those who are vulnerable. This is particularly relevant for crystal methamphetamine (ice), as this is associated with a shorter pathway to

[12] Australian Institute of Health and Welfare (2017) *National Drug Strategy Household Survey 2016: detailed findings*, Commonwealth of Australia.
[13] Hayes-Smith, J., & Whaley, R. B. (2009). Community characteristics and methamphetamine use: A social disorganization perspective. *Journal of Drug Issues*, 39(3), 547-576.
[14] Australian Institute of Health and Welfare (2017) *National Drug Strategy Household Survey 2016: detailed findings*, Commonwealth of Australia.
[15] ibid
[16] Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. The Lancet, 376(9752), 1558-1565.
[17] Brecht, M. L., Greenwell, L., & Anglin, M. D. (2005). Methamphetamine treatment: trends and predictors of retention and completion in a large state treatment system (1992–2002). *Journal of Substance Abuse Treatment*, 29(4), 295-306.

dependence, over other ATS[18]. Given these, we recommend that re-framing ATS-related harms in the context of socio-economic status and vulnerability may aid in identifying at-risk populations and provide for more targeted prevention and harm minimisation efforts.

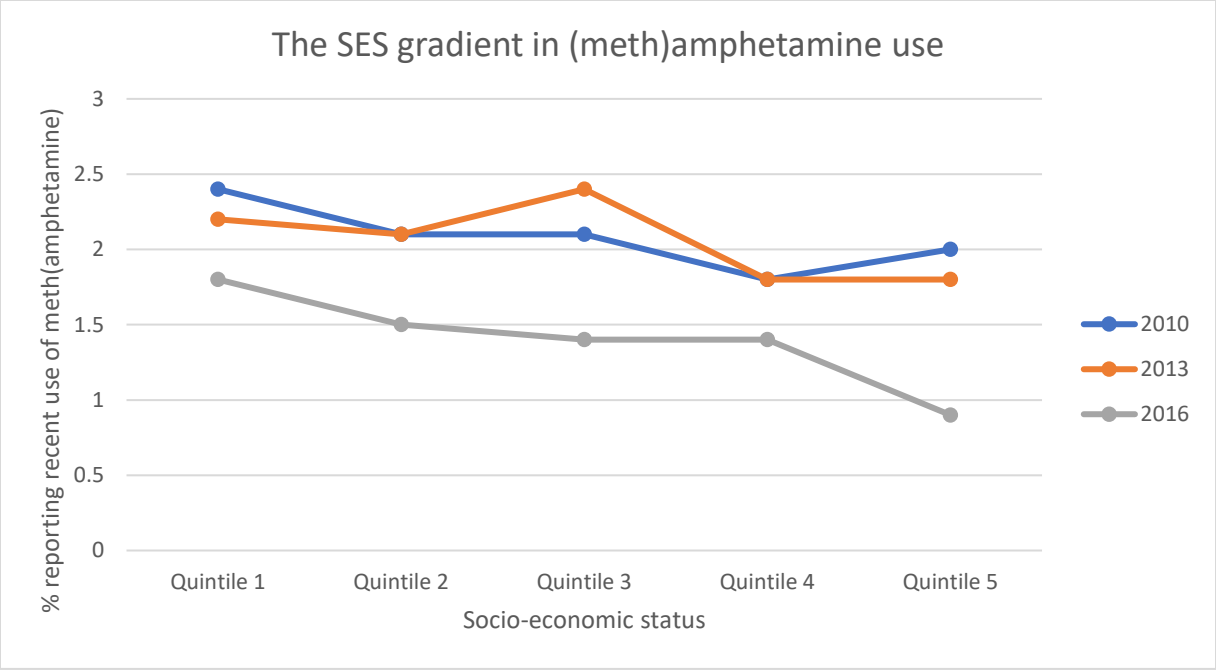

Figure 1 – the SES gradient in Australian (meth)amphetamine use. Graph based on data from the 2016 Australian Household Drug Survey (table 8.3), where quintile 1 is the most disadvantaged and quintile 5 is the least disadvantaged.

We also recommend more explicit acknowledgment that while the majority of ATS-harms relate to the person who uses them[19], harms do extend to others, particularly family members. Though this aspect is covered in Issues Paper 3, we recommend that the harm minimisation approach in relation to ATS encompass harms to others. Consideration of ATS-related harms within an Ecological Systems Theory[20] model, where the individual interacts with their environment at multiple scales, provides for a public health focussed view on ATS use and harms, and influences and impacts beyond just the affected individual can be considered.

3.1.7 Are there groups of people within NSW experiencing unique or particular impacts of ATS use that have not yet been identified?

As discussed in response to question 1.1.9, we recommend taking a broader view of risk, focussing more on social and economic vulnerability, rather than identifying specific at-risk demographic groups. Nevertheless, we think that there are two groups that may require specific research and targeted harm

[18] McKetin, R., Kelly, E., & McLaren, J. (2006). The relationship between crystalline methamphetamine use and methamphetamine dependence. Drug and alcohol dependence, 85(3), 198-204.
[19] Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: a multicriteria decision analysis. The Lancet, 376(9752), 1558-1565.
[20] Bronfenbrenner, U. (1992). Ecological systems theory. Jessica Kingsley Publishers.

minimisation efforts, in relation to ATS use (particularly in relation to methamphetamine); women and those with pre-existing mental health conditions.

Women are a specific risk group for harms related to methamphetamine use, due to differing patterns in use, and harms experienced. While overall, a higher percentage of Australian men report (meth)amphetamine use, past-year use in older women is increasing, compared to stable or decreasing trends in men, and the percentage of people reporting past year use are becoming more equivalent between genders[21], as shown in Figure 2.

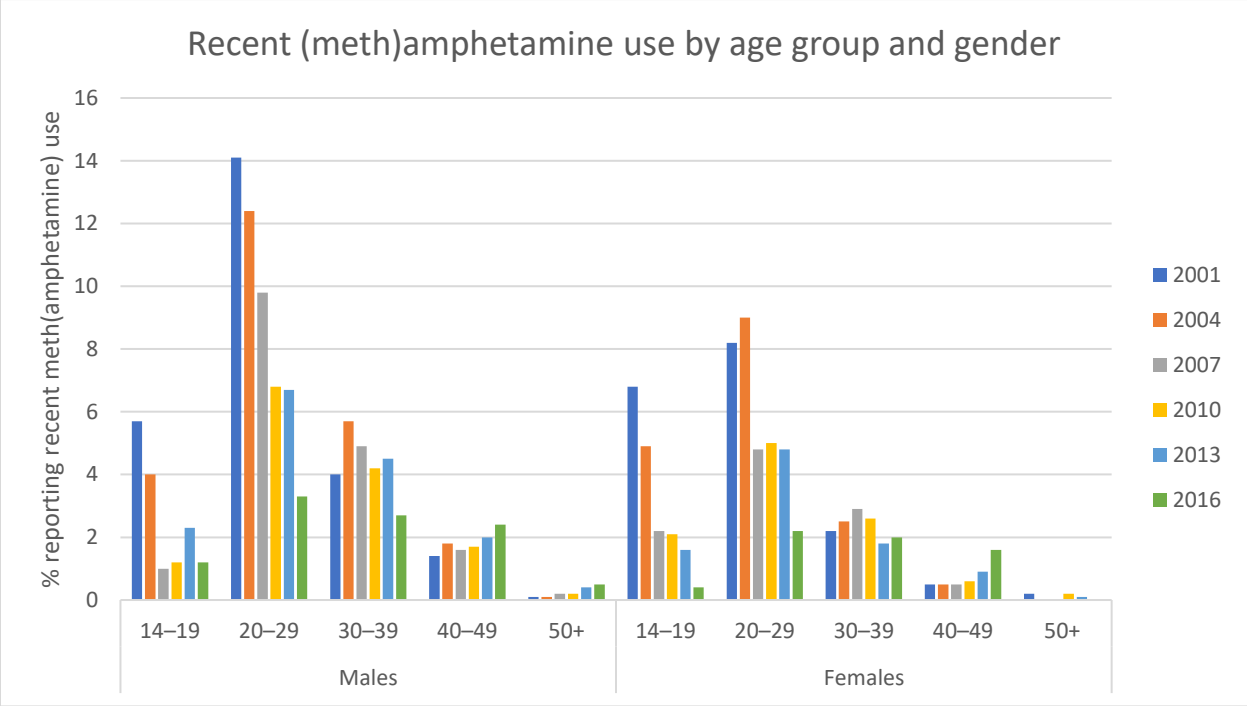

Figure 2 – age and gender trends in (meth)amphetamine use. Graph based on data from the 2016 Australian Household Drug Survey (table 5.42).

In women, dependent methamphetamine use is more strongly correlated to a history of childhood trauma or violence, than compared to men with dependent use[22]. Women also experience differing types of harms in relation to methamphetamine use. Women are more likely to have major depression as a comorbidity with methamphetamine use than men and are more likely to become dependent on methamphetamine[23]. Conversely, women are less likely than men to seek treatment for methamphetamine dependence[24]. Women are less likely than men to have methamphetamine-related mortality but are at an increased risk of cerebral haemorrhage than men, suggestive of sex-specific

[21] Australian Institute of Health and Welfare (2017) *National Drug Strategy Household Survey 2016: detailed findings*, Commonwealth of Australia.
[22] Messina, N., Marinelli-Casey, P., Hillhouse, M., Rawson, R., Hunter, J., & Ang, A. (2008). Childhood adverse events and methamphetamine use among men and women. *Journal of Psychoactive Drugs*, 40(sup5), 399-409.
[23] Dluzen, D. E., & Liu, B. (2008). Gender differences in methamphetamine use and responses: a review. *Gender Medicine*, 5(1), 24-35.
[24] McKetin, R., Mcketin, R., Kelly, E., Mcketin, R., & Kelly, E. (2007). Socio-demographic factors associated with methamphetamine treatment contact among dependent methamphetamine users in Sydney, Australia. *Drug and Alcohol Review,* 26(2), 161-168.

toxicity[25]. The knowledge base of methamphetamine-related harms and treatment is primarily derived from studies where participants are mainly men. For example, men are more highly represented in studies that have guided treatment (e.g. the Methamphetamine Treatment Evaluation Study (MATES) and the Melbourne injecting drug user cohort study (MIX)), limiting women-specific knowledge. This issue is well-recognised in the alcohol and other drug field[26], but currently, the evidence base remains primarily from men. This reflects population-based data, with higher ATS use in men, but limits understanding of sex-specific harms.

The use of methamphetamine has been associated with serious mental health problems.[27,28] However, data from growth areas of Victoria suggest that demand for mental health services have far outstripped projections – a situation driven primarily by escalating harms related to crystal methamphetamine[29], a drug that has a short pathway to dependence[30]. The relationship between methamphetamine use and mental health is bi-directional and complex[31,32], with some people using methamphetamine as a means of managing mental health symptoms, though mental health symptoms can be intensified by methamphetamine use; thus, people with co-morbid mental health issues and methamphetamine use are a particularly at-risk group. The populations of people who are more likely to use methamphetamine often face additional risk-factors harms, such as:

- People in rural/remote areas are 2.5 times more likely to have tried methamphetamine than people living in major cities;
- Unemployed people were 3.1 times more likely to have used methamphetamine;
- And people that identified as homo- or bisexual were 5.8 times more likely to use ecstasy and methamphetamine.

Living in rural areas, being unemployed and identifying as gay or bisexual are all independent risk-factors for poor mental health. These groups (rural, unemployed, gay/bisexual) often face additional barriers to accessing health and support services. The lack of availability of treatment options for those suffering co-morbid mental health and drug issues is particularly concerning in light of these figures.

Other research describes the problem of disconnected and poorly coordinated services as systemic and commonplace. A 2010 report on housing, mental health and drug treatment services identified a

[25] Kaye, S., Darke, S., Duflou, J., & McKetin, R. (2008). Methamphetamine-related fatalities in Australia: demographics, circumstances, toxicology and major organ pathology. *Addiction*, *103*(8), 1353-1360.
[26] Back, S. E., Contini, R., & Brady, K. T. (2006). Substance abuse in women: does gender matter. *Psychiatric Times*, 24(1), 1-7.
[27] Victorian Government (2016), *Victoria's Mental Health Services Annual Report 2015-16*, p. 43.
[28] Darke (2008), "Major physical and psychological harms of methamphetamine use", *Drug and Alcohol Review*, 27(3):253-62.
[29] Victorian Government (2016), *Victoria's Mental Health Services Annual Report 2015-16*, p. 43.
[30] McKetin, R., Kelly, E., & McLaren, J. (2006). The relationship between crystalline methamphetamine use and methamphetamine dependence. Drug and alcohol dependence, 85(3), 198-204.
[31] Marshall, B. D., & Werb, D. (2010). Health outcomes associated with methamphetamine use among young people: a systematic review. Addiction, 105(6), 991-1002.
[32] Russell, K., Dryden, D. M., Liang, Y., Friesen, C., O'Gorman, K., Durec, T., ... & Klassen, T. P. (2008). Risk factors for methamphetamine use in youth: a systematic review. BMC pediatrics, 8(1), 48.

multitude of ongoing barriers to effective integrated care arrangements for people whose mental illness is contextualised by additional morbidities such as drug misuse, homelessness or both.[33]

Many mental health services require prospective patients to have completed detoxification prior to accessing the service, preventing those unable to achieve this from accessing mental health services. On the other hand, some drug treatment and harm reduction services are ill-equipped to recognise and respond effectively to co-occurring mental health problems. For example, almost all needle and syringe programs in Australia do not proactively address mental health concerns. This reflects the core aim of these services, preventing the transmission of blood borne viruses, but this is a missed opportunity to proactively address an individual's health issues. This is particularly relevant given that a previous study has found that more than 50% of NSP clients have at least one diagnosable psychological disorder or anti-social personality disorder[34], thus supporting that the harm reduction efforts of NSPs could be enhanced by referral into services for comorbid drug and mental health issues. The gaps that exist in the intersection of drug treatment and mental health services mean that many people experiencing comorbid drug and mental health issues are unable to access treatments that effectively address their needs. Additional investment in education, prevention, treatment and harm reduction is sorely needed to address the harms associated with comorbid drug use and mental illness.

3.2.6 What evidence is there of a link between ATS use and DFV?

There is an accepted relationship between a history of violence being a risk factor for subsequent methamphetamine dependence[35]. What is less clear is whether there is a causal link between methamphetamine intoxication, use, or dependence, and violence, though they are certainly strongly associated[36]. Evidence certainly suggests that methamphetamine intoxication can increase violence compared to when the same person is not using methamphetamine, and that this effect is amplified by co-morbid psychosis and heavy alcohol co-consumption[37]. While evidence is not yet conclusive, there is evidence to suggest that methamphetamine can increase violence occurrence and severity, independent of other substance use[38].

Any perceived link between methamphetamine use and domestic violence is controversial, particularly in relation to perpetration of violence, due to perceptions that citing any substance use as a cause of domestic violence perpetration diminishes personal responsibility. This prevailing narrative that

[33] Flatau et al (2010) 'The integration of homelessness, mental health and drug and alcohol services in Australia', *Australians Housing and Urban Research Institute*.

[34] Kidorf, M., Disney, E. R., King, V. L., Neufeld, K., Beilenson, P. L., & Brooner, R. K. (2004). Prevalence of psychiatric and substance use disorders in opioid abusers in a community syringe exchange program. Drug and alcohol dependence, 74(2), 115-122.

[35] Cohen, J. B., Dickow, A., Horner, K., Zweben, J. E., Balabis, J., Vandersloot, D., & Reiber, C. (2003). Abuse and violence history of men and women in treatment for methamphetamine dependence. *American Journal on Addictions*, 12(5), 377-385.

[36] McKetin, R., McLaren, J., Riddell, S., & Robins, L. (2006). Relationship between Methamphetamine Use and Violent Behaviour, The. BOCSAR NSW Crime and Justice Bulletins, 16.

[37] McKetin, R., Lubman, D. I., Najman, J. M., Dawe, S., Butterworth, P., & Baker, A. L. (2014). Does methamphetamine use increase violent behaviour? Evidence from a prospective longitudinal study. Addiction, 109(5), 798-806.

[38] Dowling, C., Morgan. A (2018). Is methamphetamine use associated with domestic violence? Trends and issues in Crime and Criminal Justice, No. 563 December 2018.

substance use or intoxication is not a cause of domestic violence comes through in both AOD and domestic violence policies in NSW. The Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW[39] state that women should be screened for domestic violence, but not that clients' (either male or female) history of perpetrating domestic violence should be sought. This is despite the Policy and Procedures for Identifying and Responding to Domestic Violence[40] stating that "Changes in the perpetrator's situation such as decreased stability or increased drug use may also escalate violence". There is therefore a policy disconnect between the AOD and family violence sectors in NSW, and part of an effective harm minimisation program needs to consider the potential for substance use to escalate violence, particularly domestic violence and violence towards children.

3.3.9 How can general practitioners be encouraged and supported to better identify, treat and if appropriate, refer ATS users to specialist services?

General Practitioners are a vital part of harm minimisation and treatment for ATS users, particularly in rural and regional areas, which are identified as an at-risk group for ATS-related harms. However, this may place considerable strain upon GP services in rural and regional areas, with limited specialist services available for referral, and where there are overall difficulties in attracting and retaining a health workforce[41]. In response to question 1.3.6 we discuss the potential for the Mansfield RESTART program to provide a template for an innovative place-based and community-led response to ATS-related harms. A key component of this program is workforce development for the local health practitioners, including GPs, which is provided by specialist training, mentoring, and professional development opportunities. Partnerships have been built between Addiction Medicine specialists and hospitals in Melbourne, to support the local health practitioners to identify, treat, and refer those who are experiencing harm from ATS use.

[39] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2008_011.pdf
[40] https://www.health.nsw.gov.au/parvan/DV/Pages/procedures-domestic-violence.aspx
[41] Cosgrave, C., Maple, M., & Hussain, R. (2018). An explanation of turnover intention among early-career nursing and allied health professionals working in rural and remote Australia-findings from a grounded theory study. Rural & Remote Health, 18(3).

NSPs and harm minimisation in correctional centres

In this section, Penington Institute addresses the question of needle and syringe programs (NSPs) and harm minimisation in relation to amphetamine-type substances, implemented within correctional centres. Specifically, it addresses the questions 2.5.9, 2.5.10, and 3.5.6 from the issues papers on Justice, and Community and Health:

2.5.9 Are existing harm minimisation strategies implemented within correctional centres achieving positive outcomes?

Harm minimisation in prisons may include the provision of; condoms, opioid substitution therapy, naloxone, needle and syringe programs (or disinfectant for injecting equipment), and treatment for hepatitis C, as well as harm reduction education. However, harm minimisation programs are inconsistently implemented across Australian prisons by jurisdiction, and no prisons in Australia provide all harm minimisation strategies that are available. This has been identified as an issue in Australian prisons since at least 2004[42,43], and progress to improve harm reduction in correctional centres has been slow, though improvements have been noted with improved hepatitis C treatment[44]. For example, opioid pharmacotherapy is available in all jurisdictions, however, only to women in Queensland, only for withdrawal in ACT, and only for maintenance in WA. Naloxone is available to treat overdose within all Australian prisons[45], but take-home naloxone programs are limited, which is concerning given that post-release is a high-risk time for overdoses and inmates self-report that they would be willing to participate in take-home naloxone programs [46]. The ACT trialled a naloxone education program in the Alexander Maconochie Centre, which led to a small number of dischargees leaving with take-home naloxone[47], and WA is currently trialling a take-home naloxone program at Acacia Prison that began in 2016[48], though this program has not yet been evaluated.

In NSW, harm minimisation provided includes; condoms, opioid substitution therapy (under the terms of the NSW Corrective Services policy on opioid substitution treatment[49]), naloxone (but not take-home naloxone), bleach for disinfecting injecting equipment, and hepatitis C treatment, as well as harm reduction education. This has seen some positive outcomes, particularly with hepatitis C treatment,

[42] Black, E., Dolan, K., Wodak, A. (2004) Supply, demand, and harm reduction in Australian prisons: implementation, cost and evaluation. National Drug and Alcohol Research Centre

[43] Levy, Michael H., et al. "Prisons, hepatitis C and harm minimisation." *Medical Journal of Australia* 186.12 (2007): 647-649.

[44] Levy, Michael H., and Carla J. Treloar. "Health protection and Australian prisons, 2018." *The Medical journal of Australia*209.10 (2018): 460-461.

[45] Black, E., Dolan, K., Wodak, A. (2004) Supply, demand, and harm reduction in Australian prisons: implementation, cost and evaluation. National Drug and Alcohol Research Centre

[46] Curtis, M., Dietze, P., Aitken, C., Kirwan, A., Kinner, S. A., Butler, T., & Stoové, M. (2018). Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use. Harm reduction journal, 15(1), 48.

[47] Olsen A, McDonald D, Lenton S & Dietze P. 2015, *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program', 2011-2014; final report*. Melbourne, Centre for Research Into Injecting Drug Use.

[48] Dwyer, R., Olsen, A., Fowlie, C., Gough, C., van Beek, I., Jauncey, M., ... & Hayllar, J. (2018). An overview of take-home naloxone programs in Australia. Drug and alcohol review, 37(4), 440-449.

[49] https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/opioid-substitution-treatment.pdf

where micro-elimination of hepatitis C has occurred in some facilities[50]. Overall, hepatitis C rates in correctional centres are significantly higher than in the general population; 20.7% reported having hepatitis C, compared to less than 1% of the total Australian population[51]. Treatment of hepatitis C needs to occur in conjunction with prevention strategies, particularly as one of the major health risks associated with drug use in correctional centres is the transmission of blood borne viruses, particularly attributable to needle sharing. The provision of sterile injecting equipment is therefore key to preventing hepatitis C transmission and infection, particularly in a transient population such as in a correctional centre.

No correctional centres in Australia provide sterile injecting equipment via a needle and syringe program, including those in NSW. Therefore, inmates in correctional centres may receive education regarding equipment sharing, but do not have the means to fully act upon this information. This is evidenced by the fact that inmates report a high level of understanding about the need for sterile injecting equipment, and a high willingness to use sterile injecting equipment. Indeed, more than 97% of prison inmates stated that they understood that using sterile equipment would protect against infections, and a similar number said that they would go out of their way to obtain sterile equipment when it was available in the community[52]. Inmates also report using a cleaning agent / disinfectant (Fincol) that is readily available, to try to manually clean injecting equipment when sterile injecting equipment is not available; most (85.4%) of those who reported using a cleaned needle used Fincol.

2.5.10 Is there evidence to suggest additional harm minimisation strategies should be trialled/implemented?

A significant gap in the harm minimisation strategies implemented within correctional centres is the lack of NSP programs, despite evidence of their effectiveness and safety in this setting[53,54,55], which we discuss in detail in response to question 3.5.6 below.

Furthermore, take-home naloxone should be evaluated as a potential strategy to prevent overdoses post-release. Inmates who inject drugs report a high willingness to participate in take-home naloxone programs[56], and internationally, take-home naloxone programs aimed at prison dischargees have been

[50] Levy, Michael H., and Carla J. Treloar. "Health protection and Australian prisons, 2018." *The Medical journal of Australia*209.10 (2018): 460-461.
[51] Justice Health and Forensic Mental Health Service (2015). Network Patient Health Survey, NSW Health
[52] Justice Health and Forensic Mental Health Service (2015). Network Patient Health Survey, NSW Health
[53] Kamarulzaman, A., Reid, S. E., Schwitters, A., Wiessing, L., El-Bassel, N., Dolan, K., ... & Altice, F. L. (2016). Prevention of transmission of HIV, hepatitis B virus, hepatitis C virus, and tuberculosis in prisoners. The Lancet, 388(10049), 1115-1126.
[54] Lazarus, J. V., Safreed-Harmon, K., Hetherington, K. L., Bromberg, D. J., Ocampo, D., Graf, N., ... & Wolff, H. (2018). Health outcomes for clients of needle and syringe programs in prisons. Epidemiologic reviews, 40(1), 96-104.
[55] Heino Stöver & Fabienne Hariga (2016) Prison-based needle and syringe programmes (PNSP) – Still highly controversial after all these years, Drugs: Education, Prevention and Policy, 23:2, 103-112, DOI: 10.3109/09687637.2016.1148117
[56] Curtis, M., Dietze, P., Aitken, C., Kirwan, A., Kinner, S. A., Butler, T., & Stoové, M. (2018). Acceptability of prison-based take-home naloxone programmes among a cohort of incarcerated men with a history of regular injecting drug use. Harm reduction journal, 15(1), 48.

successful[57,58]. Evaluation information from the trial at Acacia Prison in WA may assist in determining the potential impacts of a take-home naloxone trial in NSW.

3.5.6 Should the scope of the NSP program be expanded to include the provision of clean needles and syringes in prisons?

People who use illicit drugs (including ATS such as methamphetamine) in custodial centres require both health and harm reduction interventions. This is a group that may experience concurring mental health disorders and engage in risky injection and sexual behaviours.

The 2015 survey on the *Health of Australian Prisoners* found that drug use in prison was reported by 10% of dischargees, and 6% reported injecting drugs in prison, while 4% of dischargees reported using a needle and syringe that had been used by someone else, while in prison[59]. NSW specific data showed that 15.6% of inmates reported using methamphetamine in prison, compared to 22.1% who reported using cannabis and 12.9% reported using heroin in prison. Injecting drug use was comparable to rates of overall use, with 9.5% reported injecting methamphetamine and 8.9% reported injecting heroin. This reflects the finding that more than half of participants (56.4%) claimed that drugs were either quite easy or very easy to obtain in prison[60]. These figures highlight that injectable drugs, including ATS, are highly prevalent in NSW prisons, despite the efforts made to limit their supply, which makes the case for strong harm minimisation strategies even more compelling.

The case for controlled NSP in Australian prisons has been previously argued by Penington Institute (under the previous organisational name Anex), based on the understanding that 'prisoner health is community health'[61]. In recognising the efforts prison administrators have made in harm minimisation programs around supply and demand reduction, the report called for a more significant commitment to institutionalised prison management practices in the area of harm reduction and efforts to ensure that prisoners be entitled to health services comparable to those available to the general community. The Victorian Auditor-General's report noted that the case to introduce NSP within Australian prisons is not based around condoning the use of illicit drugs within prison, but rather is founded on the public health imperative that leads to the minimisation of harm when people continue to use drugs, be it inside prison or beyond[62]. Systems should be strengthened to enhance the psychological and physical health of people who are incarcerated. This should include improving capacity to participate in and contribute to family and community (including being work ready), upon release.

[57] Penington Institute (2017) Not just naloxone: insights into emerging models to reduce drug harms, Melbourne: Penington Institute.

[58] Penington Institute (2018) Saving Lives: Australian naloxone access model, September, Melbourne: Penington Institute.

[59] AIHW (2015), *The health of Australia's prisoners 2015*, Cat. no. PHE 207, Canberra: AIHW, p. 102.

[60] Justice Health and Forensic Mental Health Service (2015). Network Patient Health Survey, NSW Health

[61] Anex (2010). With Conviction: the case for controlled needle and syringe programs in Australian prisons. Melbourne, Anex.

[62] Victorian Auditor General Report (2013). Prevention and Management of Drug Use in Prisons. Melbourne

Alternative models and community responses

In this section, Penington Institute addresses the question of alternative models and community responses to harm arising from the use of amphetamine-type substances. Specifically, it addresses the questions 1.3.6, 2.4.19, and 3.5.8 from the issues papers on Use, Prevalence and Policy Framework, Justice, and Community and Health:

1.3.6 Are there alternative models for supporting the broader community to take ownership of and address AOD issues that should be considered?

Rural and regional Australia, as well as disadvantaged communities in the outer metropolitan suburbs, have been particularly hard hit by the increased availability and use of ice, with families and communities struggling to deal with this complex and challenging issue. However, more communities are now realising that they need to better understand the role of drugs in their community and take an active role in prevention and early intervention before someone's drug use in their community becomes a problem to be dealt with by the criminal justice system.

There needs to be a fundamental shift across communities towards managing drug use as a public health issue at the community level. A community-controlled primary health system approach will allow those in need to quickly access appropriate support and services, to minimise or prevent problematic drug use as early as possible. For communities to be safe, healthy and ultimately support and protect people who use drugs and their families, they must not only be given the mandate and resources to take control, but also supported in developing a locally controlled model. A local institution, such as the community hospital is well placed to take a lead role in designing and supporting such a model.

The Mansfield RESTART program is currently being implemented and evaluated in Victoria, and offers a template for design, delivery, and evaluation of community led interventions targeted at minimising the harms from ATS.

In July 2014, the town of Mansfield, Victoria held a Forum attended by more than 250 people to discuss ice use and to seek information and advice as to what they should do in response to the increasing problem of ice in their community. The Forum showed that the community has recognised many of the challenges associated with increased drug use in the community, while also showing willingness to mobilise and address the growing use of drugs and ultimately find a better way to handle drugs.

In 2017, Mansfield District Hospital was funded to develop a locally controlled intervention to respond to the problems of drugs in the community. On May 9th, 2018, the three-year Mansfield based RESTART Program was launched. This program is community led, focusing on case management, treatment and prevention approach to tackle the problems of illicit drugs in the community.

A Community Health Nurse who specialises in drug and alcohol support/rehabilitation and client case management has been employed to deliver the intervention. The model of care is governed by key community stakeholders, including Mansfield District Hospital, local GPs, local government, lawyers, police and other strategic service providers and key persons within the community.

The model is person-centred, community controlled, and holistic with a strong primary health focus. The one-year evaluation of the program is currently underway, however, there are early and promising signs of success. In the first twelve months, 64 people have been referred into the program through numerous

pathways, including from GPs, the justice system, and family and friends. These people have been connected with multiple other services through outward referrals, including finance counsellors, psychologists, and social workers. Support for the program remains high within the Mansfield community, and while the program will be fully evaluated at the end of the three-year trial period, the interim evaluations are being used to provide timely feedback and to support continual improvement.

2.4.19 Is there evidence to suggest that other innovative justice strategies (including collective-impact, place-based approaches) would be effective at addressing ATS use and/or harms?

As discussed in response to question 1.3.6 above, the Mansfield RESTART program may form the model for a place-based and community led intervention to minimise ATS-related harms.

The program is designed to receive referrals from an interaction with police. This could arise following a person reporting to the police – as a victim, offender, or party to family violence. Referrals may also happen opportunistically from day-to-day interactions between the police and the public on the street. A potential client is given a card/brochure about the program, including details about who to contact. Referring clients into the program from the local court has occurred as a separate intervention from the existing diversion program and has been identified as an important referral pathway. It is likely that as the program evolves, the intake process may broaden to incorporate mandatory referral.

The program may provide an early intervention and alternative pathway to diversion, which is particularly beneficial in rural / regional areas, where diversion can be more challenging to implement. Government investment into diversion programs is proving to be a valuable outlay and works best where there are formal institutions and services available to receive people for treatment and support. This, however, is often not the case for regional and rural Australia. Too often there is nowhere for rural and regional based authorities to refer people experiencing problems with drug use. Suitable services are often not available or within easy access for people in need who live in regional and rural communities. The current state of alcohol and drug (AOD) services means that referral and follow-up is not immediate and when referral eventually occurs, people are referred away from their community.

3.5.8 Are there other innovative harm reduction strategies that may assist in strengthening NSW's response to ATS?

In relation to other ATS, particularly MDMA and other festival drugs, we recommend that a trial of drug checking at music festivals would be a timely and innovative response to harm reduction, which could save lives. Given that traditional supply control approaches are not achieving the goals of the National Drug Strategy, there is a growing need for alternative innovative strategies to be trialled and evaluated. It is not uncommon for Australians to take MDMA (ecstasy); the 2016 Australian Household Drug Survey shows that 18.7% of those aged 20-29 and 24.7% of those aged 30-39 have taken MDMA in their lifetime, with 7.0% and 2.6% respectively having taken MDMA in the last 12 months. Notably, this is higher than the percentages of Australians in the same age group who report recent use of meth(amphetamine)[63]. Clearly then, this is not a rare behaviour. Furthermore, music festival attendees report higher levels of

[63] AIHW (2016) National Drug Strategy Household Survey 2016: Detailed Findings, Australian Institute of Health and Welfare.

illicit drug use than the overall Australian population[64], though it is difficult to compare rates of harms between the general population and those attending music festivals, due to a lack of detailed data collection on both fatal and non-fatal overdoses at a spatial scale that enables delineation of harms occurring at music festivals[65]. Overdose of festival drugs (including ATS like MDMA) can be influenced by the strength (purity) of the drug, adulterants within the drug taken (quality), and mixing of festival drugs with other substances and alcohol. The NSW Coroner is currently investigating the deaths of seven people who died of suspected overdoses at music festivals, highlighting the potential cost, and that there is further work to do in harm minimisation. Onsite drug checking can provide valuable and timely information on two of these key aspects of overdose; purity and quality. Furthermore, it provides the opportunity to engage with people, at the time of testing, so that public health messages about mixing substances or use of the ecstasy with alcohol can be discussed.

A study in the UK found that one in five substances sold at a UK festival in July 2016 were not as described by dealers. Two-thirds of people who discovered they had had substances mis-sold to them subsequently handed over further substances to the police[66]. Similarly, a study in Austria found that 50% of those who had their drugs tested said the results affected their consumption choices, and two-thirds said they wouldn't consume the drug and would warn friends in cases of negative results[67], highlighting that drug checking can change behaviour.

The first pilot of onsite drug checking at an Australian festival was held in Canberra in 2018. 85 substances were tested at the festival, which identified not only high purity MDMA, but also two potentially lethal substances, that were immediately disposed of. An evaluation of this pilot found that three-quarters of those who brought drugs for testing received some AOD brief intervention counselling. 42% reported that their drug consumption behaviour would change as a result of the testing and 18% indicated that they would either discard the drugs in the amnesty bins provided or were uncertain as to what they would do as a result of the information provided by the service[68]. The success of the pilot is highlighted by the fact that it was trialled again at the same festival in April 2019.

NSW would benefit from trialling drug checking, including a rigorous evaluation of the benefits, costs, and harms, so that evidence-based policy on this potential life-saving intervention can be developed and implemented, if appropriate.

[64] Day, N., Criss, J., Griffiths, B., Gujral, S. K., John-Leader, F., Johnston, J., & Pit, S. (2018). Music festival attendees' illicit drug use, knowledge and practices regarding drug content and purity: a cross-sectional survey. Harm reduction journal, 15(1), 1.

[65] https://www.smh.com.au/entertainment/music/question-mark-hovers-over-tragic-music-festival-deaths-20180917-p5047k.html

[66] Measham, F. C. (2018). Drug safety testing, disposals and dealing in an English field: Exploring the operational and behavioural outcomes of the UK's first onsite 'drug checking'service. International Journal of Drug Policy.

[67] European Monitoring Centre for Drugs and Drug Addiction (2001). An inventory of on-site pill-testing interventions in the EU. EMCDDA.

[68] STA-SAFE consortium (2018). Report on the ACT GTM Pill Testing Pilot: a Harm Reduction Service.

Pillars of harm and Funding

In this section, Penington Institute addresses the question of the pillars of harm embedded in the National Drug Strategy and funding models related to amphetamine-type substances. Specifically, it addresses the questions 1.2.2, 1.3.10, 3.5.4, 3.5.9, 4.1.7, 4.2.2 and 4.2.7 from the issues papers on Use, Prevalence and Policy Framework, Community and Health, and Data, Resources and Funding:

1.2.2 How effective is law enforcement in reducing the production and supply of ATS within NSW? What is the evidence for this? What options are available to improve NSW's response to the supply and production of ATS?

As discussed in detail in our response to question 2.2.3, the *National Ice Action Strategy 2015* report noted that low price, high purity and wide availability had not been affected by the nation's supply reduction activities.[69] Furthermore, the failure of supply reduction efforts relating to ATS is evidenced by arrest data. National ATS arrests remained relatively stable in 2016-17, however this followed five consecutive increases leading to a record 47,625 ATS-related arrests reported in 2015-16. The latest data from the New South Wales Bureau of Crime Statistics and research show arrests for possession of amphetamines increased 9.7% in the quarter ending December 2018.[70]

Rather than focussing on additional options to improve NSW's response to the supply and production of ATS, we recommend that additional funding be made available for reduction of demand and reduction of harm, to support supply reduction efforts.

1.3.10 What are the limitations of the three pillars of harm minimisation strategy under the NDS, having regard to (a) the policy itself, and (b) its implementation?

The NDS is a useful starting point for thinking about key concepts in addressing problems associated with drugs. However, the three pillars framework is limited – the activities that sit under them are not all resourced adequately, nor does the evidence suggest they are equally meritorious or even complementary. Merely continuing to toil away under each pillar will not deliver substantively against the Strategy's objectives. Empirical experience with the NDS, which has grown alongside an increasingly compelling international evidence base, suggests many solutions to Australia's contemporary drug problems would necessitate carefully integrating the best aspects of the three pillars.

3.5.4 Should the remit of the MSIC be extended to include other methods of drug consumption?

An MSIC serves the community not just through the prevention of overdoses, but also through the provision and referral of services to support individuals more broadly.

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[69] Commonwealth of Australia, Department of the Prime Minister and Cabinet (2015), *National Ice Action Strategy 2015*, Canberra.

[70] Bureau of Crime Statistics and Research (2017) 'New South Wales recorded Crime Statistics – Quarterly Update December 2018', NSW Government: https://www.bocsar.nsw.gov.au/Documents/RCS-Quarterly/NSW_Recorded_Crime_December_2018.pdf

The Uniting MSIC in King's Cross states that:[71]

> *"More than 12,000 referrals have been accepted by our clients, connecting them to health, drug treatment and social welfare services. Among our frequently attending clients, 80% have ultimately accepted a referral for addiction treatment.*
>
> *All of the other 20% of frequently attending clients have had a referral offered to them but not accepted as yet. Most have agreed to talk about their situation with a staff member, who outlines the benefits of treatment. Importantly, we continue to work with everyone we see."*

Enabling those who smoke or snort (as well as those who inject) methamphetamine or other ATS to utilise the MSIC broadens the potential for service provision and referrals to this group. However, this may present additional demand upon the MSIC's services, which would need to be catered for.

3.5.9 Should the possession of equipment used for inhalation of ATS (e.g. glass pipes) be decriminalised?

Most recent data shows that among those who predominantly used crystal methamphetamine (ice), injecting was the second most common method of use (behind smoking), however, concerningly, injecting among this group has more than doubled between 2013 and 2016; increasing from 9.4% to 19.2% of those who predominantly use ice[72]. Data on injecting methamphetamine use indicate that this is the most harmful way by which to consume this drug and puts people at risk of blood borne virus (BBV) transmission. People injecting methamphetamine are at a significantly greater risk of becoming re-infected with HCV after treatment for the virus[73]. The Australian NSP survey reports that 4% of participants who had last injected methamphetamine were HIV positive compared to less than 1.5% of those people who had last injected heroin. Moreover, there is an association between methamphetamine use and risky sexual practices that may contribute to an increased risk of HIV infection[74]. In addition to the risk of BBV transmission, injecting methamphetamine is related to increased risk of suicide[75]. It is also related to increased risk of dependence on this drug[76].

The expansion of evidence-based interventions that address the harms related to injecting methamphetamine is required. Such intervention may involve the provision of smoking equipment. For instance, the provision of smoking equipment is a harm reduction intervention for methamphetamine and 'crack' users that has been investigated in Canada and the US. Research with a group of people using

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[71] https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/what-the-uniting-sydney-msic-does

[72] AIHW (2016) *National Drug Strategy Household Survey 2016: Detailed Findings*, Australian Institute of Health and Welfare.

[73] Grebely, J., Knight, E., Ngai, T., Genoway, K. A., Raffa, J. D., Storms, M., Gallagher, L., Krajden, M., Dore, G., Duncan, F., & Conway, B. (2010). Reinfection with hepatitis C virus following sustained virological response in injection drug users. Journal of Gastroenterology and Hepatology, 25, 1281-1284.

[74] Lyons, A., Pitts, M., & Grierson, J. (2013). Methamphetamine use in a nationwide online sample of older Australian HIV-positive and HIV-negative gay men. Drug and Alcohol Review, 32(6), 603-610.

[75] Marshall, B. D., Galea, S., Wood, E., & Kerr, T. (2011). Injection methamphetamine use is associated with an increased risk of attempted suicide: A prospective cohort study. Drug and Alcohol Dependence, 119(1), 134-137.

[76] Quinn, B., Stoove, M., Papanastasiou, C. & Dietze, P. (2013). Methamphetamin use in Melbourne, Australia: Baseline charactersitics of a prospective methamphetamine-using cohort and correlates of methamphetamine dependence, Journal of Substance Use, 18(5), 349-362.

crack found that providing smoking equipment increased their contact with services and also caused some participants to shift from injecting to smoking[77]. However, research with Australian treatment seekers found that people who injected and also smoked methamphetamine had similar rates of risky injection behaviours as those who only injected methamphetamine[78]. This means that providing smoking equipment may not address injecting-related harm; however, given the serious harms associated with injecting, it is an avenue that warrants further exploration and evaluation. There is not a great deal of evidence around preventing or delaying uptake to injecting from other administration routes such as snorting or smoking methamphetamine. However, there is some research that suggests that even the provision of brief interventions has some impact[79]. As the provision of smoking equipment may be found to be effective as a harm minimisation strategy, it would be necessary for glass pipes and other equipment used for inhalation of ATS to be de-criminalised.

4.1.7 How has the National Surveillance System for Alcohol and other Drug Misuse and Overdose addressed gaps in the evidence needed to inform policy, intervention and evaluation activities at both a state and national level?

The National Surveillance System for Alcohol and other Drug Misuse and Overdose forms a useful resource for determining changes in harms, including non-fatal overdoses, arising from alcohol and other drugs (including ATS). However, a limitation of this dataset is that it is based on ambulance attendances as the measure of harm, and ambulances do not attend all deaths. Thus, fatal overdoses (both intentional and unintentional) are likely to be under-reported in this dataset.

This resource would be complemented by Australia's Annual Overdose Report, produced by Penington Institute[80]. This report utilises coronial data, to examine spatial and temporal trends in drug-related deaths. The 2018 report shows that in Australia, deaths related to amphetamines have risen sharply in recent years and have overtaken alcohol to now be the third most common substance involved in drug-related deaths (behind opioids and benzodiazepines). However, in regional NSW, amphetamine is the second most common substance associated with accidental deaths, overtaking benzodiazepines in 2016. In metropolitan Sydney, amphetamine-related deaths are also continuing to sharply increase, whereas both pharmaceutical opioid and benzodiazepine-related deaths are trending downwards. The increase in amphetamine-related deaths is the highest of all substance classes; increasing by 3.7 times between the comparison periods for all Australia, and 2.8 times in NSW.

These findings highlight the pressing need to direct resources towards preventing amphetamine-related overdoses and expand upon the current focus of overdose which is on opioids. As such, we suggest that Australia's Annual Overdose Report is a valuable resource to sit alongside the National Surveillance System for Alcohol and other Drug Misuse and Overdose, as it provides additional data on fatal overdoses.

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[77] Leonard, L., DeRubeis, E., Pelude, L., Medd, E., Birkett, N., & Seto, J. (2008). "I inject less as I have easier access to pipes": Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed. International Journal of Drug Policy, 19(3), 255-264.

[78] McKetin, R., McKetin, R., Ross, J., McKetin, R., Ross, J., Kelly, E., ... & McKetin, R. (2008). Characteristics and harms associated with injecting versus smoking methamphetamine among methamphetamine treatment entrants. Drug and alcohol review, 27(3), 277-285.

[79] Hunt, N., Stillwell, G., Taylor, C., & Griffiths, P. (1998). Evaluation of a brief intervention to prevent initiation into injecting. Drugs: education, prevention and policy, 5(2), 185-194.

[80] http://www.penington.org.au/australias-annual-overdose-report-2018/

Furthermore, an improved understanding of the potential for amphetamine-related overdoses could be achieved through activities linked to International Overdose Awareness Day[81], and via education resources such as Understand Ice (which we discuss in more detail in our response to question 3.4.2 under Education).

4.2.2 What is the proportion of funding allocated to the Health and Justice clusters in NSW for responses to ATS? Is the proportion appropriate? If no, why not? If yes, why?

A public health approach must inform any strategy to address methamphetamine use. Such an approach should reinforce the three policy pillars that have underpinned activity in this field in Australia for many years and made us a world leader in drug and alcohol policy:

- reduction in supply of illicit drugs and the inappropriate and harmful supply of licit drugs
- reduction in demand through an integrated approach across all sectors, including health, justice and harm reduction elements
- reduction in the harm caused to both individuals, their families, workplace colleagues and the wider community.

Recent analysis of government expenditure on illicit drug use shows the very small amount of money spent on reduction of demand and reduction of harm[82]. The largest amount of expenditure was on law enforcement (64%), followed by prevention (10%), treatment (22%), harm reduction (2%) and other (1%). It is notable that the Federal budget for law enforcement has increased over the past few years from 55% in 2002-2003, whereas harm reduction expenditure has decreased from 3% in the same period[83].

Yet, judging by research on public attitudes commissioned by Penington Institute in 2009 (under the previous organisational name, Anex), Victorians are in favour of greater balance between taxpayer funding on law enforcement measures to address illicit drug-related issues and harm reduction interventions[84]. When asked the question 'if the government had $100 to spend on addressing problems associated with illegal drugs, how much do you think they should spend on each of the following?', results analysis found that the preferred division for a majority of respondents was as follows:

- Police, courts and imprisonment for people who use or produce illegal drugs: $20
- Educating people to prevent commencement of illegal drug use: $30
- Treatment programs that aim to reduce or end use in people using illegal drugs: $20
- Programs to reduce harms to individuals and the community resulting from illegal drugs use: $20

These figures indicate that many people want to see drug use addressed through public health strategies. In relation to methamphetamine use specifically, community capacity and knowledge are key to responding to the use and related harms of this drug. This is because most people who use methamphetamine are not injecting the drug, and do not typically access traditional AOD services, such

[81] https://www.overdoseday.com/

[82] Ritter, A., et al. (2013). Government Drug Policy Expenditure In Australia 2009-2010. Drug Policy Modelling Program. Sydney, National Drug and Reseach Centre, University of New South Wales.

[83] Moore, T. (2005). Whart is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia. The Drug Policy Modelling Project Monograph Series. Fitzroy, Victoria., Turning Point Drug and Alcohol Centre. Monograph No. 01.

[84] Anex (2009). Anex Community Research Project - Summary of Findings. Melbourne, Anex.

as harm reduction services (NSP) or treatment services[85]. While the established harm minimisation approaches in place in Australia are still very much needed, methamphetamine poses new challenges, and a greater emphasis is needed to build the capacity of all community services to address drug-related harm.

While we are unable to comment on the current proportion of NSW's overall AOD expenditure is incurred within the Justice Cluster compared to that incurred within the Health Cluster, we advocate for not only a clear understanding of how AOD funding is currently allocated within the three policy pillars, but also the benefits or return on investment for each dollar spent within those areas. We recommend a Productivity Commission investigation in the sector to answer these questions and expand on this in our response to question 4.2.7 below.

4.2.7 What are the existing monitoring and evaluation frameworks being applied for funding of ATS-related services? How is program effectiveness and efficiency currently measured and evaluated?

The disparity between government spending on law enforcement compared to other measures to address drug use signals a need for rigorous economic evaluation in this area. The Australian Government Productivity Commission is best placed to thoroughly examine the effectiveness, or otherwise, of Australia's illicit drug use policy and practice. This applies particularly to allocation and return on investment of resources, as well as the extent to which the use of ATS is contributing to the overall burden of drug-related harms in our communities.

A Productivity Commission investigation of spending in the area of drug use will ensure that drug policy and programs are funded on the basis of what works and what is cost effective rather than being emotionally and ideologically driven. As such, we recommend that the Australian Government Productivity Commission establish a broad-ranging inquiry into the effectiveness and efficiency of illicit drug use policies and responses in Australia, including their impact on private sector productivity.

[85] Quinn, B. (2012). Methamphetamine in Melbourne: Epidemiology of use, related harms and barriers and pathways to professional support. Department of Epidemiology and Preventive Medicine. Melbourne, Monash University. Doctor of Philosophy.

Education

In this section, Penington Institute addresses the question of education related to amphetamine-type substances. Specifically, it addresses the questions 3.3.17, 3.4.2 and 3.4.8 from the issues paper on Community and Health:

3.3.17 Are there opportunities for enhanced professional development of those working with ATS users (such as health professionals and police) to address stigma in order to improve service responses?

Education resources can help workers better respond to client needs and promote public health and safety approaches, by building the capacity and confidence of staff that come into contact with clients who use ice and other ATS.

As an example, Penington Institute, with funding from the Victorian Government, delivered the project *Injecting Ice in the Country*, with 10 videos and factsheets online, and training available free of charge to organisations in Victoria. This project was implemented based on the understanding that while there is limited data about the prevalence of crystal methamphetamine in rural and regional Victoria, preliminary feedback suggested that rural communities were at greater risk of methamphetamine-related harms. This project therefore aimed to build harm reduction capacity in rural and regional areas, including Indigenous communities.

A needs assessment was undertaken, prior to the development of resources and training. At the end of the project, 34 training sessions had been held in 19 locations in rural and regional Victoria, with 267 participants. Training was highly rated, with 80% positive responses, and 92% stating that they would recommend the training to others. Online resources were viewed 2,671 times, with 1,031 video views, and 951 factsheet downloads.

More details on this program can be found at:

http://www.penington.org.au/injectingiceinthecountry/

A similar program could be implemented in NSW to improve professional development and reduce stigma in relation to ATS use.

3.4.2 How important is education as a preventative strategy, compared to other prevention approaches?

Education is an effective means of preventing and reducing drug harms including negative consequences for mental health, provided the education is evidence-based, non-judgemental and delivered through effective and accessible means. Education can be delivered in a variety of settings but should be tailored to the needs of specific audiences.

Needle and syringe programs can be effective means of delivering education and informational resources to people who inject drugs. However, due to a range of factors such as a lack of funding and untrained staff, the educational potential of the needle and syringe program is rarely realised.

A limited number of large, well-funded programs located in metropolitan areas are equipped to deliver a full range of services by specially trained staff (harm reduction workers). However, this is not the majority

of NSPs. Many operate out of community health centres and local pharmacies without specialist training, and so cannot provide the specialised service that many clients need. These are missed opportunities for effective intervention.

A Case Study - Educational online resource for young people at risk of ice use, their friends and their families

In 2016, in response to the growing problem of crystal methamphetamine (ice) in Victoria, Penington Institute, with philanthropic funding support from the Lord Mayor's Charitable Foundation and the William Buckland Foundation, developed an educational online resource for young people at risk of ice use, their friends and their families – Understand Ice (www.understandice.org.au). At that time there were no online resources for young people that provided calm, evidence-based information.

Young people have embraced digital mediums and social media, engaging with these extensively in all aspects of their lives. Many use this medium to access information about drugs — as evidenced by numerous online 'drug forums' where people exchange information and experiences.

Understand Ice provides accessible, straightforward information about ice and its effects on a person's health and life. The resource and the education program are evidence-based and non-judgemental. Evidence suggests that 'scare campaigns' tend to be ineffective and may (further) stigmatise people who use drugs.

The site's information is easy to understand and highlights practical actions including links to health services. It aims to help reduce the fear and anxiety for families and friends.

The resource is structured around four sections, each tailored to a specific target audience (young people or their friends or family:

- The facts about ice (the forms it comes in, its effects, how it is used, problems with more frequent use)
- Ice and health (the potential impacts of ice on a person's mental and physical health)
- Ice and life (the potential impacts of ice on a person's work and study)
- What can I do? (links and help lines plus information about how and when to talk to a young person about their ice use)

The aim of Understand Ice was to contribute to the reduction of adverse consequences of ice use among young people aged 19-24 years by:

1. Encouraging young people to consider the impact that their ice use was having on them and help them manage the impacts of their use.
2. Giving young people support and advice on things they could do if they recognised that their ice use was becoming a problem.
3. Providing harm reduction information that gave people the information and knowledge with which to reduce the harms of their ice use, in the event they choose to continue to use.
4. Linking them in with information, advice and referral if they wanted to take action about their ice use.

Over two years, Penington Institute ran an extensive education campaign across regional and rural Victoria and metropolitan Melbourne to promote the *Understand Ice* resource, using the latest social media promotional tools and advertising as well as more traditional channels such as media relations activities and print advertising.

Penington Institute originally aimed to encourage 10,000 unique visitors to the *Understand Ice* resource during the whole project. As at 30 June 2018 (the end of the campaign) the campaign had attracted more than 52,000 people (unique visitors) to the resource, demonstrating the need for such a resource.

There are many opportunities for education-based intervention focused on preventing and reducing the harms associated with drug use. However, the continuing funnelling of resources into ineffective and at times harmful responses to drug use not only diverts resources away from education interventions but can also actively inhibit their effectiveness. These harm reduction- and prevention-focused interventions improve the wellbeing of clients by empowering clients to take better care of themselves, access available services and have positive interactions with others.

3.4.8 Are there any local communities or stakeholder groups delivering innovative strategies to educate community members about ATS use and issues?

As discussed in response to questions 1.3.6 and 2.4.19, the Mansfield RESTART program provides a potential model for community led public health responses to ATS-related harms. This program includes an education program for the local community and workforce.

The education and support provided to the workforce at commencement of the program comes from a variety of sources:

- Program support from St Vincent's Hospital in Melbourne provided to local staff via visits, phone and email;
- An invitation to participate in Project Echo, a weekly AOD related discussion meeting hosted by St Vincent's Hospital (Melbourne), with the program coordinator invited to participate as an education / mentoring opportunity;
- Local GPs attended the GP information night with a Specialist AOD physician as guest speaker;
- The program coordinator providing education and sessions at the local high school;
- Education forums delivered on topics such as methamphetamine withdrawal management, the needle and syringe program, and ice education for healthcare professionals.

Additionally, in 2018, MAIN*line* completed a project called Speed Limits, which includes a systematic review of harm reduction for ATS, as well as description of eight innovative harm reduction programs related to ATS[86]. This report highlighted the value of education programs, delivered either in person, or online, as a successful means of harm reduction.

[86] https://english.mainline.nl/posts/show/11196/harm-reduction-for-stimulant-users