PENINGTON INSTITUTE

A community controlled approach to problematic ice use

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Ice use is not a problem we can solve overnight, and not something we can simply arrest our way out of.[1]

Ken Lay, Chair, National Ice Taskforce

[1] Ken Lay, Chair, National Ice Taskforce, 6 October 2015

Introduction/overview

- Drug use is widespread and common practice throughout Australia. Recently we have been straining to deal with the acute and growing harms associated with crystal methamphetamine – ice. Rural and regional Australia has 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.
- Australia has typically sought to prevent drug harms by discouraging drug use – mostly using criminal law enforcement and education and public communication campaigns. This approach has sometimes had success, but has generally worked least for those at greatest risk. While investment in drug treatment and community action is important, treatment commonly serves people who are already dependent on drugs.
- The limitations of criminal and custodial approaches to drug use have become noticeably evident. There needs to be a fundamental shift towards managing drug use as a health issue at the community level. As the National Ice Taskforce Report states; we cannot arrest our way out of these problems. A rethink of how we deal with drugs is required now.
- While we have started to lift the coverage and quality of our health approaches, crucial gaps remain. Services responding to the increased use of ice are far from adequate and are not able to respond quickly and effectively. Greater and more innovative approaches to reduce the most harmful forms of drug use are urgently needed. In light of these realities, it is sensible to try to prevent problematic drug use, rather than detect and punish it. A more effective responsive to prevention would:
    - identify people early as being at risk of problematic drug use and (if necessary) divert them to the most appropriate support service and away from criminal and custodial responses; and
    - support people using drugs and their families to address the risk factors that might lead to problematic use before serious harms occur.
- 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.
- A community controlled primary health system approach needs to be trialled. A community model needs to be developed to allow those in need to access appropriate support and services to minimise or prevent problematic drug use as early as possible.

The Vision:

- Communities are safe, healthy and empowered to manage drug use in their community.
- Support and services for people using drugs and their families are provided through a community led health system to prevent problematic drug use as early as possible.
- Drug use is handled as a public health rather than primarily a moral and criminal issue.

Increasing ice use in Australia

Drug use is widespread in Australia and drug problems are immense, complex and urgent.[2] The problematic use of drugs,[3] which Australia is experiencing with the increased use of ice, is a complex issue and deeply concerning for many families and communities.[4] Despite Australia's large financial investment to enforce drug laws, treat addiction and educate the community, drugs remain widely available. Communities across Australia are straining to deal with the acute and growing harms associated with the increased use of crystal methamphetamine - 'ice'. As is the case for most illicit drugs, the use of ice and its associated problems are enormous, requiring an urgent and multi-faceted response from governments and affected communities.

In 2014, it was estimated that there was well over 200,000 Australians using ice, which places Australia higher almost than any other country on a per capita basis. The potency and wide spread use of ice is greater than at any other time in history and is challenging governments, communities, frontline workers, families and individuals in ways unlike any other drug has in the past. With the shift from the powdered form of the drug methamphetamine, commonly known as 'speed', to the more potent and dangerous crystallised form, commonly called 'ice', communities across Australia are struggling to respond.

The National Ice Taskforce report, released in December 2015, has provided us with a comprehensive insight into Australia's ice problem, showing that communities are struggling with a drug like no other, which is 'causing a great deal of harm across our community'.[5] The reality is that ice is very easy to access, with devastating effects disproportionate to that caused by any other drug. Heavy use, often in combination with other drugs, is increasingly entrenched in many communities and particularly prevalent throughout rural and regional Australia. Use is

[2] National Drug Strategy
[3] We have defined problematic drug use as 'Drug use leading to adverse consequences for short term health, long term health, public safety, public order, relationships and/or personal commitments.' The greater the number and/or severity of these consequences, the more seriously problematic the drug use.
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[5] Commonwealth of Australia (2015), Department of the Prime Minister and Cabinet, Final Report of the National Ice Taskforce

often associated with aggressive or even psychotic behaviour and is taking many young and innocent lives and contributing to family violence.

Data from police and emergency services reveals the extent of the crisis. Since 2010 there has also been a marked increase in drug related offences across Victoria. As shown in figure 1 below, drug offences have doubled from 15,021 to 30,347 in the short space of five years.

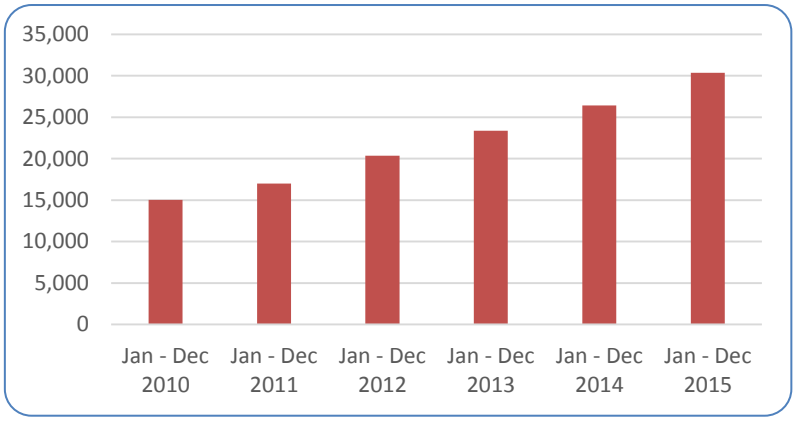

Figure 1: Drug Offences for Victoria, 2010 – 2015[6]

Between 2011/12 and 2012/13, the number of methamphetamine related ambulance attendances increased by 88 per cent in metropolitan Melbourne and nearly 200 per cent in regional Victoria. The daily number of all amphetamine-related ambulance attendances has continued to increase in 2013/14 with a 23 per cent increase in metropolitan Melbourne and a 27 per cent increase in regional Victoria.[7] During this time, methamphetamine related emergency department presentations also rose 20 per cent. Acute drug toxicity deaths involving methamphetamine have increased from one in 25 deaths in 2010, to one in 11 deaths in 2012. The Victorian Parliament's 2014 *Inquiry into the Supply and Use of Methamphetamines, Particularly 'ice'*, in Victoria identified the rise in ice use by young people between 20 and 29, and confirmed its disproportionate effects in regional Victoria.

The first drug testing of waste water in regional Victoria found twice the amount of methamphetamines compared to metropolitan Melbourne, raising concern about a lack of rehabilitation and health resources available for users. Testing in 2015 for a range of drugs

[6] Source: Crime Statistics Agency, Drug Offences for Victoria

[7] Lloyd, B., Matthews, S., Gao, C.X., Heilbronn C., & Beck, D. (2015). Ambo Project – Alcohol and drug related ambulance attendances: Trends in alcohol and drug related ambulance attendances in Victoria 2013/14. Fitzroy: Turning Point Alcohol and Drug Centre. - See more at: http://www.druginfo.adf.org.au/topics/quick-statistics#amphetamines

(Table 1), showed that 1.8 grams of ice was being consumed per day per 1,000 people in regional Victoria, in comparison there was 1 gram per 1,000 people for Melbourne.[8]

Table 1: Drug Testing of Victoria's Waste Water

	Regional Victoria June/July 2015	Melbourne March 2015
	Consumption per day/1000 people	
Methamphetamine -ice	1819mg	978mg
Cocaine	77mg	245mg
MDMA (ecstasy)	298mg	273mg
Alcohol	20L	13.5L

Deaths from overdose are over-represented in rural and regional areas

Deaths from drug overdose continue to increase across Australia, with rural and regional areas significantly overrepresented. From 2004 to 2014, there was a 61 per cent increase in fatal overdoses in Australia, reaching 1,137 deaths (44 per million). Deaths in rural and regional areas increased from 31 to 57 per million from 2008 to 2014; an increase not seen in metropolitan areas with only a slight increase from 42 to 44 deaths per million.[9] During the same period, there was an 87 per cent increase in deaths resulting from prescription opioids, again the greatest increase (148 per cent) occurring in rural and regional areas.[10] This is a real problem which needs to be addressed in its own context.

While Australia has fewer deaths from drug overdoses than the United States which recorded a staggering 163 per million,[11] our rate continues to rise and is worryingly greater than the

[8] Lloyd B. and Killian J. (2015) Alcohol and Drug Testing in Wastewater: Summary Results from March 2015 Testing in Melbourne. Fitzroy, Victoria: Turning Point
[9] Australia's Annual Overdose Report 2016 – a Penington Institute report
[10] NB: this statistic is for total drug-related deaths, not just overdose deaths.
[11] Rudd, R. Seth, P., David, F. et. al. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015 Weekly / December 30, 2016 / 65(50-51);1445–1452
https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm

European Union's mean of 19.2 deaths per million. This is a clear warning for Australia to look towards Europe and particularly Portugal and France in an effort to do better.[12]

Portugal has consistently been below 5 per million with 4.5 in 2014. In Portugal, possession and use of any illicit drug, if not for trafficking, was legalised in 2001. An Institute for Dissuasion of Addiction (IDT) was established in every one of Portugal's Departments and problem users are referred to these. They have a right to impose 'administrative penalties' in requiring participation in withdrawal, treatment or rehabilitation as judged appropriate. Needle and syringe programs were implemented and a high level of HIV infection in people who inject drugs was brought down to well below other European figures within five years. Management of all problem drug use in the devolved pattern of IDTs means decisions are made at a local community level, and funded through the national Health Department, rather than through Law and Order agencies. Seizures of illicit drug importation are frequent in Portugal with drugs entering Europe from many countries and remain the responsibility of police and customs authorities.[13]

France had deaths due to illicit drugs at 5.4 per million in 2014, joining Portugal as the lowest in Western Europe and Scandinavia.[14] In France possession or use of illicit drugs remains illegal, but prosecutors are advised by the government to issue cautions or refer for counselling or treatment unless there are special circumstances. Most cases are required to attend a course about appropriate drug use for which they are required to pay a fee. There are both government funded institutions for withdrawal and rehabilitation and also a large number of GPs handling both withdrawal and treatment on an outpatient basis – probably the bulk of cases. GPs prescribe substitution drugs such as buprenorphine across the country.

Initiatives to deal with illicit drug use and associated harms

Australia's current approaches to tackling drug problems are set out in the National Drug Strategy which focuses largely on supply reduction through the operation of Border Protection, police and the criminal justice system tackling criminal trafficking gangs. Prevention, early intervention and health care strategies continue to be only a small part of the strategy.

[12] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.
[13] Hughes CE; Stevens A, 2015, 'A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalization of illicit drugs', in New Approaches to Drug Policies: A Time for Change, pp. 137 - 162, 10.1057/9781137450999.0016
[14] European Monitoring Centre for Drugs and Drug Addiction (2016), *op. cit.* p. 76

Law enforcement has had limited success, as it has failed to effectively prevent problematic drug use with adverse health, social and economic consequences that are increasingly felt by many communities across Australia. The Victorian Government will spend more than $1 billion on prison operations alone in the current financial year and this will continue to consume a significant portion of the budget, with over $700 million spent recurrently, excluding the costs of prison expansion. Two-thirds (67 per cent) of prison entrants have used an illicit drug in the past 12 months[15] and 46 per cent of those prisoners reported that they have injected drugs while in prison.[16] As the recent focus on Victoria's growing prison population and worsening reoffending rate (44.1 per cent) has demonstrated, there are significant problems with the effectiveness of reintegration strategies back in to the community for all prisoners.[17]

While there are opportunities to improve access to drug treatment and other services within prisons, incarceration remains inherently limited in stopping the recurrence and escalation of problematic drug use in the community. Imprisonment has failed to effectively prevent problematic drug use and reduce the adverse health, social and economic consequences that are increasingly felt by many communities. On average, criminal offenders—65 per cent of whom use drugs,[18] and around half of whom directly attribute their charges to drug and/or alcohol use[19]—experience a range of poor outcomes.[20] It must also be noted that the period shortly after release from prison is associated with a substantially increased risk of death from drug-related causes (primarily as a result of drug overdoses), with a mortality rate much higher than from all causes among the general population.[21] People convicted of a drug offence in Australia consistently report that their conviction is a barrier to finding work, even when there is no clear risk relationship between the job and their conviction and when they have discontinued using drugs.[22] This further entrenches socioeconomic exclusion, compounding the stressors that lead to problematic drug use.

There are better and cheaper ways of reducing crime and building more resilient communities than prison and these options need greater support and investment.

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[15] Australian Institute of Health and Welfare 2015 *The health of Australia's prisoners 2015,* Canberra: AIHW. p. 96-97

[16] Fetherston J, Carruthers S, Butler T, Wilson D & Sindicich N 2013. Rates of injection in prison in a sample of Australian-injecting drug users. Journal of Substance Use 18:65–73

[17] Victorian Ombudsman*, Investigation into the rehabilitation and reintegration of prisoners in Victoria,* September 2015

[18] Australian Institute of Health and Welfare, "Prisoner health: Illicit drug use", http://www.aihw.gov.au/prisoner-health/illicit-drug-use/. This figure is much higher, at 76 per cent, for prisoners aged 18-24.

[19] Australian Institute of Criminology, "How much crime is drug or alcohol related? Self-reported attributions of police detainees", *Trends and issues in crime and criminal justice* (No. 439, May 2012), http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi439.pdf

[20] Australian Medical Association (2012), "Position statement: Health and the Criminal Justice System", https://ama.com.au/position-statement/health-and-criminal-justice-system-2012

[21] Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria*, September 2015 p. 112.

[22] Australian National Council on Drugs (August 2013), *ANCD Position Paper: Pre-employment criminal record checks*.

Diversion of drug users for treatment and rehabilitation

Following the introduction of the 'Tough on Drugs' program in 1997/98, which resulted in a very large increase in young drug users in prisons and many awaiting appearance in court, the Prime Minister introduced the diversion program in 1999. Through this program, both police and courts were given the option of transferring drug users to counselling and treatment, rather than to the courts. Diversion can take a number of forms, but broadly occurs at detection/arrest (by police) or at charge/hearing (by courts). Court-managed diversion, especially through specialised drug courts in major metropolitan areas, tends to focus on more complex clients with drug dependency and more serious or frequent offending.

The beneficiaries of simpler and earlier, police-level diversion are typically people arrested for drug use, possession or low level supply, and for the first time. Providing there is an agency for counselling and treatment readily available for use of the 'diversion' process it could be widely applied, and similar diversion could apply from rural and regional magistrates' courts for looking after 'redeemable' country drug users.

The value of diverting drug offenders away from criminal and custodial responses has been acknowledged in Australia and overseas for some time. If the great bulk of such individuals across Victoria were diverted to treatment and counselling as happens in France, there would be no need to consider decriminalisation as has occurred in Portugal. The Australian Medical Association has endorsed expanded diversionary and non-custodial options as public health improvement measures.[23] Diversion leads to:

- Lower reoffending rates;
- Improved health outcomes; and
- Reduced drug use. [24]

In 2000, state legislation was introduced in Victoria to secure drug diversion as an option. Victoria Police has recently acknowledged the potential for greater use of the police diversion program (IDDI) in its strategy in response to the increased use of ice. Utilisation of the police diversion program has increased by 17 per cent since 2010 to a yearly average of 49 per cent of those who are eligible. A record 1,634 Drug Diversions were issued in 2012/13.[25] However,

[23] Australian Medical Association (2012) *op. cit.*
[24] Australian Institute of Criminology (2008), "Police drug diversion: a study of criminal offending outcomes", http://www.aic.gov.au/media_library/publications/rpp/97/rpp097.pdf, p. 70. The Australian Institute of Criminology has favourably evaluated Australia's Illicit Drug Diversion Initiatives (IDDI). Across most jurisdictions, people involved in police-based IDDIs did not reoffend in the 12-18 months after their program was completed. On the whole, those that did reoffend only did so once. For first-time offenders, the trend was particularly positive: in Victoria, 81 per cent of diversion graduates had no record of reoffending within 18 months of completing a diversion program.
[25] Victoria Police Submission To The Parliament Of Victoria, Law Reform, Drugs And Crime Prevention Committee Inquiry into The Supply and Use of Methamphetamines, Particularly 'Ice', In Victoria, 2013

given the mounting number of drug offences (figure 1) it is far from clear that police diversion is as widely used as it could be, particularly in regional areas where it is so badly needed in response to the increased use of ice.

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 to treat 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.

The Lay Report notes in Chapter 6 that counselling is the dominant form of intervention with ice methamphetamine (over 60 per cent but greater than 80 per cent in SA), and that treatment is non-residential in 70 per cent. It also notes that most treatment facilities are located in metropolitan or major inner-regional centres.

A recent report by Youth Support Access Service (YSAS) found that young people from rural and regional Victoria were found to have significantly more unmet treatment needs, particularly in the areas of mental health and housing.[26] The Rural Outreach Diversion Worker (RODW) program is one program established in 2002 to provide services primarily to offenders aged 25 years or younger in selected areas of rural Victoria. The program provides a safety net for young people who are engaged in substance misuse, providing a link between the community, police, courts and the drug treatment service system. There is a strong emphasis on early intervention to divert individuals away from the criminal justice system through assessment, education and treatment. It is estimated that community based diversion costs one tenth or less of the amount required to detain a young offender in a youth justice facility. Current estimates are approximately $528 per person per day in youth detention, compared to $52-54 a day for community based alternatives.[27]

[26] Bruun, A. (2015) The Victorian Youth Alcohol and Other Drug Service System: A vision realised. March 2015. Youth Support + Advocacy Service Melbourne, Australia

[27] Minister for Community Services Strengthening Youth Justice and Helping Young People Avoid a Life of Crime, media release, 3 May 2011

Action through Primary Health Networks (PHNs) across the country

The National Ice Action Strategy 2015, supports increasing the links that exist between Primary Health Networks (PHNs), health care providers and community services to improve continuity of care, while also enhancing the delivery of early intervention and post-treatment care through PHNs.[28] Acknowledging that local knowledge is crucial in building an effective response, the Prime Minister announced on 6 December 2015 $241.5 million to be invested through the newly formed Primary Health Networks to work with GPs and other primary health care providers, including alcohol and other drug treatment and the mental health sector, to tackle drug use in the community.[29]

Underlying this strategy is the commitment to make care of 'ice' primarily an issue for health care in every section of the community, as indeed was the basis of bringing mental health care and suicide prevention into the realm of the general practitioner with appropriate additional support from appropriately trained community nurses through the PHNs.

There is now an opportunity for these newly formed Primary Health Networks to work with and support local practices to help provide well-coordinated and responsive primary health services for people experiencing problematic drug use.

A primary health system response: early, person-centred and supported by local communities

As documented by the *2014 Victorian Parliamentary Inquiry into the Supply and Use of Methamphetamine, Particularly 'Ice'*, harmful 'ice' use is often associated with other complex human problems and has had a particular impact in regional and rural Australia, where services are fewer and less accessible. Many community forums and ice training sessions have been held throughout metropolitan and regional Australia, bringing together local services to begin empowering concerned community members with sensible and factual information. One outcome from these forums was the realisation that communities 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 becomes a problem to be dealt with by the criminal justice system.

[28] Commonwealth of Australia, Department of the Prime Minister and Cabinet, National Ice Action Strategy 2015
[29] https://www.pm.gov.au/media/2015-12-06/new-action-plan-tackle-ice

In July 2014, the town of Mansfield 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.

The meeting was chaired by a local GP with recent experience of handling local drug users, including withdrawal of the drug in the local hospital. He was supported by the local Shire youth worker, the local Senior Police Sergeant and a local solicitor with court experience with drug users. Professor David Penington AC was also an invited speaker. Also present was a badly damaged recovering ice user from a neighbouring town who had successfully completed a rigorous program in a private rehabilitation service at high cost in another State. He was sitting with his mother, who was able to recount her lack of any support as she saw him slide into deep ice dependence, stealing money and becoming severely mentally impaired. She talked about how the family became fearful of violence and about her son's large debt to a criminal gang supplying drugs to his town. She feared the consequences of notifying him to anyone, as it raised fears of arrest and incarceration, with a prospect of a life of crime following release.

The audience was greatly impressed and was keen to see processes developed to save their community, but nothing has been created to serve the need.

Families are the most valuable agents to intervene early in someone's drug use, but often fear precipitating arrest of their family member with dire consequences following imprisonment. They may feel far more ready to seek advice from a community nurse with no risk of triggering police intervention. Families are the key stakeholders in drug use and connection to family has been shown to be an important protective factor in relation to drug use.[30] Addressing problematic drug use early in turn prevents many of the impacts of problematic drug use, including associated health risks such as infections and overdose, crime and community safety concerns, and collateral impacts on family and friends.

Early intervention, as the light touch diversion programs have demonstrated, is cost effective and transforms lives for the better. The importance of early intervention must not be understated. An appropriate health system response with family and community involvement is far more effective in addressing problematic drug use than the criminal justice system.[31]

[30] Sale E, Sambrano S, Springer F, Turner C. Risk, protection, and substance use in adolescents: A multi-site model. Journal of Drug Education 2003, 33:91-105.
[31] Westmore T, Van Vught J, Thomson N, Griffiths P, Ryan J (2014) Impacts of methamphetamine in Victoria: a community assessment. Penington Institute Report for the Victorian Department of Health, Melbourne, Australia

Focusing on prevention, early intervention and harm minimisation initiatives through improved access to health care and by providing support services that address the entire person's needs has been proven as an effective way to prevent problematic drug use.

It's time for a new local model

The current response to ice in regional and rural Australia is not working. There needs to be a fundamental shift across these 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 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.

A locally designed model needs to be supported and trialled in consultation with key community stakeholders, including the local hospital, the GPs, local government, lawyers, police and any other strategic service provider or key person within the community. Its success will depend on how strong the partnerships are across the many professions and agencies and the investment in a dedicated coordinator and local institution, such as the local hospital, taking the lead. It is imagined that liaison with regional alcohol and drug services and with a specialist drug withdrawal or rehabilitation service in Melbourne will be required to provide fall back institutional support if needed. If such an approach is to succeed, the model needs to be developed with a clear focus that is person-centred, community controlled and is holistic with a strong primary health focus. This will enable the community to:

- know what is happening and be able to respond or intervene early before drug use becomes an even greater problem,
- provide assistance to busy GPs to make it possible for them, in partnership with a community public health nurse, to make the necessary decisions in managing drug users.
- provide better and immediate access to specialist services if needed,
- ensure the subject's family are fully informed at every stage,
- acknowledge and understand that there are underlying and social factors contributing to someone's problematic drug use and that solutions must address a range of factors, such as mental health, employment, housing, or isolation,
- embed all support within the community in a coordinated way including other community welfare and recreational institutions in addressing both prevention and rehabilitation issues.

The Town of Mansfield might prove to be an appropriate point following that initial town meeting in July 2014 to assess a model which may become appropriate for implementation elsewhere in country Victoria. An initial trial over three years with careful evaluation is envisaged.

An appropriate Trial Model to oversee and support the initiative

In a country town where a hospital is medically staffed by GPs, as in Mansfield, the initiating body should be that hospital. It may choose to appoint an advisory body including a public health nurse working with GPs, the senior medical officer and a nominee of any other GP group. It might meet on a quarterly basis with a respected community leader as Chair. The process for liaison with State AOD services needs to be established at the start. Other institutions with a community interest in welfare might be added to the group. The issue of liaison with the local Police needs to be considered, recognising the need for confidentiality. The GPs should be encouraged to liaise with their professional College. Consideration will need to be given to processes of evaluation of the program.

In Victoria, the 2013/14 reorganisation of AOD services led to heavy centralised control and regionalisation of services largely remote from local communities.[32] Any development of a model which can work for country and regional primary health care will need to take account of appropriate on-going integration with State AOD services.

To date there is no sign that the envisaged special support to primary health care in rural and regional areas is developing in a timely manner though the PHN organisation, but hopefully the nursing role can be provided through that track in due course. Meanwhile the Penington Institute and philanthropic sources can provide the Hospital with necessary financial assistance over the three initial years of the Trial and would provide assistance in setting the processes in place.

[32] Department of Health and Human Services Independent review of MHCSS and Drug Treatment Services Final Report September 2015