T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 4 September 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Mark Gepp
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witness

Dr Nicole Lee, director, 360 Edge.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We are next to hear from Dr Nicole Lee of 360 Edge. Welcome, Nicole. You are the last person for the day.

Dr LEE — Lucky last.

The CHAIR — I am sure you are going to give us some great information and great insight into the areas that you have been involved in. You would be aware that the committee has been looking at this issue now for a number of months. It is a very broad topic in terms of the broad range of issues of drug treatment and drug law reform issues that we have been looking at. We are very interested to hear your perspective from 360 Edge. You will be aware that Hansard is recording what is being said. A transcript will come to you of the discussion we have had for you to correct any technical issues, if there is a need. That will then go on the public record. If you would like to share your perspective, I see you have presented us with some material, which is good. We will work through that and then have some questions that we might want to follow up with you.

Dr LEE — Thank you for the opportunity to come and speak today. I have been working in the area of alcohol and drug practice and research for about 26 years. I am the director of 360 Edge and also professor at the National Drug Research Institute, which is based at Curtin University, but which has an office in Melbourne as well.

My main area of expertise is around policy to do with treatment and intervention, so I am going to be speaking mostly about that. Drug policy in Australia is largely directed by the *National Drug Strategy*, as you know, which is explicitly based on a harm minimisation approach equally in theory among three pillars, which is harm reduction, supply reduction and demand reduction.

If you have a look at the first slide, when you look at the implementation of the policy you can see that it is not very balanced at all. Only 2 per cent of all drug funding is spent on harm reduction activities and 66 per cent on law enforcement or supply reduction. We see that there has been some modelling that has shown that for every $1 we spend on drug treatment, we save about $7 in other costs as well.

This imbalance that we see in the implementation of the *National Drug Strategy* is really a reflection on the prevailing law on drugs approach and the prohibitionist approach to drug policy. It continues to focus on eliminating drug use rather than reducing harms, and this has an impact on a range of areas, including treatment, which is what I am going to be talking about. It means that our treatment services are chronically underfunded because of the policy approach that we have taken. Modelling from the same group — the drug policy modelling program at New South Wales University — shows that across Australia less than half the need is being met by the current funding levels in treatment. This has meant that our services are not flexible enough to respond to changing drug trends. We have seen that really clearly over the last five years with the ice problem in Australia and in Victoria.

The recent issues around methamphetamine have really highlighted for us how unhelpful this approach can be in finding a solution to the problem of drugs in the community. If you have a look at a graph that I have got on the slides here, it is a graph from the national drug household survey, which shows the percentage of the general population over 14 who uses various drugs. You can see that the dark line there is methamphetamine, and you can see the rate of methamphetamine use has been steadily decreasing for the best part of two decades. So this is not a new phenomenon; it is something that has been going on for 18 years or more probably.

But what we have seen is a change in the way that people use the drug, which has increased harms. A greater percentage of people who use methamphetamine now say they prefer to use the crystal form, which is commonly referred to as ice, over the powdered form, which is commonly referred to as speed. We have seen a switch in the way that people use to more dangerous ways of using the more potent forms, and we have seen as a result of that significant increases in methamphetamine-related presentations to specialist treatment services.

This next slide with the red line for methamphetamine is data from the national minimum dataset, which records the number of episodes of care in specialist treatment services. You can see that that has been substantially going up over the last five years or so. We have seen a whole range of other frontline services as well struggling with increases in harms associated with meth use, including hospitals, ambulance and emergency departments. The coroner has noted an increase in drug-induced deaths related to a whole load of drugs, but particularly methamphetamine.

If we continue to focus on use, as you can see we can have a situation where use is coming down but harms are still increasing, and that is what has been highlighted by the meth problem. If we continue to focus on trying to reduce use, we are going to fail in making a significant impact on the problem. The second part of that I think is that drug use is not an all-or-nothing phenomenon. There are safer and less harmful ways of using; there is no doubt about that. Drug use falls along a continuum.

If you have a look at the table on the next slide, you can see that by far the majority of people in that first column use a range of drugs irregularly, so less than 12 times a year — only a handful of times a year predominantly. They are still at risk of acute harms every time they use, even though their use is fairly low.

Mr GEPP — Sorry, Nicole. Can you just tell us what is in those boxes? I cannot read it.

Dr LEE — So if you have a look at the top, the first column is 'Irregular users' —

Ms PATTEN — Irregular users.

Dr LEE — Irregular — people who use less than once a month. 'Occasional users' in the second column is once a month or more but less than once a week. 'Regular users' use once a week or more, and 'Daily users' — there is no data for methamphetamine for daily use. But we know that for people who use methamphetamine weekly or more, use is associated with dependence. So it is only really this 15 per cent that are likely to become dependent on it and require treatment. The other 85 per cent are really at risk of acute harms. We also know that generally most people who use drugs, even when they are young, eventually give up over time without help from anybody.

The question that I am interested in really is: how does all this impact on treatment? We know that treatment is effective and it is cost-effective — one to seven ratio — but a different yardstick is often applied to alcohol and drug treatment compared to other chronic illnesses like cancer, diabetes and heart disease. So treatment in those areas is considered effective if it reduces symptoms, if it increases functioning and if it prevents relapse to pretreatment levels. But what we apply to alcohol and drugs is abstinence forever. The belief that treatment is a failure if a person is not completely abstinent from drugs is unhelpful, and again it is a legacy from this prohibitionist war on drugs approach, and it impacts on how well people do in treatment ultimately.

The outcomes: when you apply the same yardstick to alcohol and drugs the outcomes are very similar to other chronic illnesses, but the focus on use over harms has also focused treatment at the abstinence end as well. We know that because most people will not need treatment they eventually stop without any help, but the people who do need a range of options. For example, residential rehab, which is often the first thing that people think of when they think of treatment, and I do not know if you have ever been to resi rehab or been involved in or have seen one, but they are very, very intensive places. They are very hard work for participants and they are quite confronting. You have to really think about yourself and your drug use, and it is all day, every day, for months and months and months. But not everyone is ready for that when they want to go to treatment, especially right at the beginning of their treatment journey. And if they are not, they are much more likely to get benefit from a lighter touch treatment that is not abstinence-oriented necessarily, and eventually people do give up. So it is worth still providing a wide range of treatment options from very brief interventions to very intensive interventions. We know in the case of methamphetamine that even as little as two sessions can have a huge impact on increasing abstinence and reducing drug use and harms across the board.

I guess the last thing I want to say, just in this opening, is that drug responses can seem counterintuitive, and I think that it is really important that we use the evidence base in order to avoid unintended consequences. For example, it might seem logical that if you show young people the worst of the horrible consequences of drug use, they might want to avoid them, but actually we know that that does not happen. The people who were never going to try drugs are just more determined not to, and those who are at risk become actually more interested in trying them, and that is not what we want to see at all. So I think we need to really make sure that our drug policy and laws use the evidence base and we use what we know works and we do not do what we know does not work, and that will help us avoid those increased harms and unintended consequences.

The CHAIR — Okay, you are saying, number one, I guess, government needs to spend a lot more on treatment, but it does not necessarily have to be residential rehab treatment.

Dr LEE — Yes, I think what you might call a plurality of treatments is required, so a whole range of treatments is effective. My area, as you can probably tell, is in the methamphetamine area, so I know a lot more about that treatment and what has been happening in the last few years, and we know that even just a few sessions can have a huge impact. People actually do not necessarily do that well in residential rehab when they are using methamphetamine. There is a really high relapse rate and a really high dropout rate. So if it is just all or nothing — abstinence or nothing — then people may choose nothing, and we need to fill in that gap in-between with a continuum of care.

The CHAIR — So the short-term — this a day for somebody who has got an ice problem to get them started? What might be the essence of that form of treatment?

Dr LEE — Well, for all drugs, not just for ice, a range of treatments on offer is important — anything from harm reduction interventions to brief interventions. We know that for alcohol, for example, just 5 minutes of advice from a GP has a 30 per cent reduction in drinking. So even just a light touch can have quite a big impact for people who are ready to make changes.

I guess if we are thinking about a stepped care model, the next step would be some kind of briefer therapy — maybe two to six sessions, some more intensive outpatient therapy, so counselling. You might go once a week or a couple of times a week to see a counsellor. Then day rehabilitation, and there are some new day rehabilitation programs in Victoria that have just been developed in the last couple of years. Then residential rehab would be the most intensive.

What we recommend in terms of treatment is that we offer people the least intensive treatment that we think will be effective for them. If someone has a child at school and they have got a job, then we will not want to put them into residential rehab because that will interrupt all their social networks and all the social capital that they have that keeps them healthy. We might say, 'How about you go to see a counsellor once a week and see how you go with that?'. Then if that does not work, we might step it up, but if that is working, then we might step it back down again as they improve.

Ms PATTEN — I am sorry I had not actually looked at this just before you came, but it is a great submission. Looking at pharmacotherapy treatments for methamphetamine — it has been something that has been raised by a number of people. I note your list — it is kind of interesting that naltrexone and dexamphetamine are on the same list. I understand why. I am wondering if you could tease out whether either of those treatments has been used in Victoria. Naltrexone, when we think of it — it is a blocker I suppose, and it is just about not receiving any stimulation from a substance, where dexamphetamine is quite different.

Dr LEE — Yes. So these pharmacotherapies have all been trialled with people who use methamphetamine. We did a review for what was the ANCD a few years ago. It is now ANACAD, the federal government's supervisory committee on drugs. And what we found was that these five drugs had some limited evidence of benefit — more than the rest in the other two columns — but they did different things, so they did not all operate in the same way, as you have alluded to. But none of them were effective enough. Dexamphetamine, I know, gets a lot of press and it gets a lot of interest from the medical fraternity, but even dexamphetamine did not show particularly good outcomes. None of them showed enough effective outcomes to be recommended to be used widely. So they are being used off-label by some people. That is not to say that some people do not get some benefit from them. It is just that we could not recommend them at this stage as a routine treatment, as we can with buprenorphine and methadone for heroin dependence.

Mr TILLEY — With naltrexone in particular, I have noticed that 360 Edge is down in Elwood. Is it George O'Neil out of Perth?

Dr LEE — Yes.

Mr TILLEY — He was running a small trial out of there?

Dr LEE — A trial is probably an overstatement, but yes. He is a big fan of naltrexone in particular.

Mr TILLEY — The implants.

Dr LEE — The implants. He has developed his own implants, and he uses them for a range of drugs. There has not been any trialling of naltrexone implants for anybody really — meth users or heroin users — so we do

not really know whether they are effective or not. He believes they are, but they have not been subjected to clinical trials.

Mr TILLEY — So in that case would it be worth exploring?

Dr LEE — I think there have been a lot of studies on a lot of drugs and none of them have shown much effect. I am not going to suggest that it is not worth continuing to look for something, but based on the evidence that we have got from a lot of studies, compared to, say, in the 60s and 70s when methadone was introduced — that was an absolute goer right from the beginning. The very first trials showed really good outcomes, and they just got better and better as we refined the technology of dosing and all of that stuff, but it has not been the case for methamphetamine. On the upside, the psychotherapies for methamphetamine use have been shown to have quite good outcomes, so that is best practice at the moment and that is what we are relying on.

Mr TILLEY — So it is fair to say that the same cap does not fit everybody in the circumstances.

Dr LEE — Yes, that is right. But in the case of methamphetamine and medications for methamphetamine, there are no medications that fit a lot of people, like, the majority of people.

Mr GEPP — Look, I think I know the answer to the question — your attitude to prison needle and syringe programs?

Dr LEE — I guess the general principle of harm reduction applies there. We know from a long history of prisons in Australia and the rest of the world that it is impossible to stop drugs being in prison. We know that they are in prison, we know that prisoners use them. We have, in a way, turned our prisons into these hotbeds of bloodborne virus incubators. If you take a harm reduction approach to that problem, then it is a no-brainer that we should have needle and syringe exchange in prisons.

Mr GEPP — Thank you. You talked a bit earlier about the funding, and you showed the graph — it was I think 2 per cent on harm reduction now.

Dr LEE — Yes.

Mr GEPP — What is the right sort of balance? Do you have a ballpark view of where it should be, or is it one of those things that will continue to evolve over time?

Dr LEE — I think probably some modelling, and some people who know about modelling could better answer that than me, but clearly 2 per cent compared to 66 per cent is a huge difference. When you think about the number of people who are affected by harms, which is everybody who uses drugs, then you would think that that would be where the bulk of at least our intervention funding went to, because that would have a huge public health benefit. As we get kind of more to the pointy end, to the treatment end, then fewer people need to access treatment compared to people that need to access harm reduction, if that makes sense.

Mr GEPP — Yes.

Dr LEE — So you would think it would be a lot more than 2 per cent.

The CHAIR — In terms of treatment, I see in your report that you have talked about private treatment centres. Do you want to make some more comments about the variability of private treatment services?

Dr LEE — Yes, sure. I think this is one of the things that has also been highlighted by the problems that we are seeing around meth lately and compounded by the lack of treatment funding for the sector. A lot of new treatment providers have popped up. I am not suggesting that all of them are unscrupulous or do not do good work, but many of them are unscrupulous and do not do good work.

The problem is that the whole sector is completely unregulated. So anybody in this room could set up a drug rehab without any qualification or any experience to do so. At least for publicly funded services they are required to report on outputs and some limited outcomes, and they are required to have some accreditation, and private hospitals are required to be registered. But other drug and alcohol centres have no such requirements. You can just set them up. Unfortunately then the general public do not have really the information to say what is good and what is not good and make a true judgement.

The CHAIR — Make a balanced judgement or an educated judgement.

Dr LEE — That is right. That is one of the huge gaps in the sector. I think related to that is that even for government-funded services, outcomes are not well monitored and not published, and it also makes it very hard for the public to discern which is a good treatment centre and which is not a good treatment centre.

Ms PATTEN — We have been learning this all day. I mean, even the corrections drug treatment programs I do not think sounded like they were very well evaluated as to whether they provided the outcomes that we placed them there for.

Dr LEE — Yes, I agree. I think we have improved a long way, but I think even a lot of our good treatment services are driven by ideology rather than evidence, and I think we need to refocus ourselves on the evidence and what works and what does not work.

Mr TILLEY — The government has recently made an announcement about real-time prescription monitoring — probably getting a bit ahead of the committee and its findings, the stuff that we have significantly been hearing about from a lot of witnesses on such a model. Do you have a view on or are you able to assist the committee, which in turn might assist the government, with what other resourcing would be needed around that for patients presenting with an issue relating to pharmaceutical use, abuse or whatever the case may be? So what other resources need to go around that? You just cannot —

Dr LEE — Yes, just real-time monitoring is not going to solve the problem. That is going to go a long way to helping doctors have the right information for prescribing — and that is important — and for pharmacists to have the right information for dispensing so they can pick up on people who may be overusing medications or diverting medications. But there are a whole range of other things that are required as well. In my view we get a good bang for our buck if we educate the community and we increase the level of health literacy among the community so they understand they can regulate their own drug use. A lot of pharmaceutical misuse is accidental initially — not understanding how drugs work and not having good information from the prescriber and dispenser.

There is also a requirement I think for some education for prescribers and dispensers, but just with the caveat that it tends to be a small number of prescribers who prescribe a lot of these drugs. So it needs to be targeted at those people.

Mr TILLEY — So does that flow in at all with the pharmaceutical salespeople in those companies as well, with GPs taking it up and so on?

Dr LEE — It is hard to say how much impact that has, but if you look at the US, who have a much bigger pharmaceutical misuse problem than we do, they have much looser laws around advertising and academic detailing, which is the main strategy that pharmaceutical reps use. So you might conclude from that that has had some impact on the availability of pharmaceuticals in the community, which has therefore increased harms.

Mr GEPP — But we heard earlier today that 78 per cent of overdose deaths in this country are related to pharmaceuticals.

Dr LEE — Yes. It has kind of flipped over.

Mr GEPP — Yes, it is pretty big, isn't it?

Dr LEE — It used to be that 70 per cent were due to illicit heroin, and now it is pharmaceuticals. And largely they are pharmaceuticals where it is a polydrug use problem as well. It is rarely just a single drug. So these people who are overdosing are high risk. They are using multiple drugs in dangerous ways.

Mr GEPP — Look, this might be a very stupid question. I am sorry, Chair; I want to prepare you.

The CHAIR — It is your first time!

Mr GEPP — It will not be the last stupid question I ask, I promise. But I dare say that if the five of us went to a GP for pain or whatever it was and the GP prescribed Panadeine Forte for all of us, I reckon I would be on pretty safe ground to say that we would probably all get a script of 20 pills.

Dr LEE — Yes.

Mr GEPP — Why is that? Why is it not that I might get two or four, or whatever. There just seems to be a generic quantity that is always pumped out. Is that related to the drug companies?

Ms PATTEN — Or the PBS.

Dr LEE — Yes. You should ask a pharmacist about this, but my understanding is it is related to a number of factors: the PBS and the subsidies related to that; the packaging — that is from the pharmaceutical company; and the prescribers themselves, who can prescribe larger or smaller amounts as well.

I have, for example, had some non-opioid medication prescribed for one of my family members and the doctor prescribed only five pills, even though the pack came with 40 or something. So the pharmacist dispensing it broke up the pack and gave me just the five pills, because that is what was the —

Mr GEPP — But that would not be a usual occurrence.

Dr LEE — No, it is not. Yes, it is not. The same problem happens when people leave hospital as well: they get given a box of Endone, and it is like 20, 30 or 40 pills sometimes. And then they are in the cupboard. If you have a bit of pain, then that might be something you reach for rather than going back to the doctor, because you have already got it there. So it just increases the risk.

Mr GEPP — That was not such a stupid question, was it?

The CHAIR — No, it was not. It was very good.

Ms PATTEN — I wanted your thoughts about separating treatment out of our three-pillar strategy, noting that treatment does kind of fall across all three.

Dr LEE — Yes, I think in our current national policy treatment falls squarely within demand reduction, but also in amongst that are some things that do not go with treatment that well — prevention, for example, which is quite a different kettle of fish. So there is some benefit in thinking about those things separately. I think the real benefit would be in funding them effectively and to a level where they are able to make an impact regardless of whether they are split out or not in theory. But certainly the ideas of prevention and treatment have pretty different strategies and different purposes, so there would be some benefit in distilling those out.

Ms PATTEN — And given just your experience and broad knowledge about drug policy and how objective your submission to us was, I was wondering if there were specific recommendations you think we could or should make.

Dr LEE — I think we should be really looking very carefully at the funding and how the various areas of drug intervention are funded from supply to demand. But in addition to that I think we should be looking at any measures that reduce harm. I think our focus on use over harms has been detrimental, and we continue to do it. Even when we talk about harm reduction, even among people who support harm reduction, we are still ultimately focused on use in the end and our services tend to be focused that way — not exclusively, but they tend to be focused that way.

So things that reduce harm are things like decriminalisation of drugs. One of the biggest harms from drug use for individuals is being caught with drugs and having charges against them, and that can affect their long-term careers and families and all sorts of things, even travel. We need to be looking at specific harm reduction programs that are effective. We used to be the leaders in the world on this stuff. We had the first needle and syringe program, and as a result of that our HIV rate was the lowest in the world and it still is among the lowest in the world.

We have lost our way on specific harm reduction strategies to this point. So they are going to be things like all the controversial things that we are seeing in the media at the moment, like drug checking, safe injecting facilities, needle and syringe programs in prisons. They are hard things to tackle. Evidence-based policy is about the evidence, but it is also about acceptability and feasibility as well. But I think there is room to introduce some of those measures and educate the community more effectively so that they do become more acceptable. I think when we do that we will start to see some really significant impacts on the drug markets and drug harms.

The CHAIR — It was an excellent contribution. Thank you.

Dr LEE — Thanks so much.

The CHAIR — Your documentation was terrific.

Committee adjourned.