Dear Mr Ramsay

Re: Inquiry into Supply and Use of Methamphetamines, particularly ‘ice’

Thank you for your letter of 19 September inviting Western Region Health Centre to make a submission to the above named inquiry being conducted by your Committee.

Background – Western Region Health Centre

Western Region Health Centre (WRHC) is a not-for-profit community health organisation that employs approximately 330 staff to deliver a broad range of services including community and allied health, medical, dental, counselling, mental health, health promotion and support and outreach to people and communities in Melbourne’s west. In addition to this WRHC delivers statewide programs (Refugee Health Nurse Coordination, Multiple and Complex Needs Initiative) and is delivering the Health Champions project in 14 local government areas (LGAs) across Victoria.

WRHC develops, reviews and delivers services based on the recognition that the conditions in which people live, work and play either enhance or damage their health. This is known as the social model of health and is as relevant to understanding how best to minimise any damage done by drug use as it is to understanding why poverty and poor health outcomes are so closely related.

Health Works, a service of WRHC, is a specialist alcohol and other drug primary health service (SAPHS) for people who inject drugs. It provides a Needle and Syringe Program (primary and secondary) and offers holistic care underpinned by the social model of health with the aim of addressing health inequities experienced by people who inject drugs.

The service is confidential, responsive and based on a harm reduction framework encompassing community development principles to empower and educate people who inject drugs, in order for them to make informed decisions about their health. Health Works provides a multidisciplinary team that values personal, professional and academic experience.

Health Works was established on the basis of two major pieces of research undertaken by the Macfarlane Burnet Centre for Medical Research in 2000 - “Primary Health Care among the Street Drug-using Community in Footscray: A Needs Analysis” and “A Centre for Primary Health Care for the Street Drug-using Community In Footscray: A Feasibility Study”. Both these documents outlined the significant barriers experienced by people who inject drugs (PWID) and advocated for the establishment of culturally appropriate, accessible and holistic health services. An important feature of both pieces of research is that the PWID community was consulted and therefore had input into various aspects of the service delivery model.
It was always expected that the service would develop as the needs of service users became known. From this position, Health Works’ staff began an intentional, collaborative and ongoing partnership with service users across all areas of service delivery. This position has reached a point where consumer engagement and participation is securely embedded in service delivery.

The Committee has received submissions and evidence from a number of organisations who consider the prevalence of use and usage patterns. WRHC’s submission will be focused on the community context and feedback from people who use methamphetamine obtained through a discussion group facilitated by Health Works.

**Harm Reduction**

Harm reduction has been the overall policy framework for alcohol and drug services since the 1980s and the program response has seen many thousands of lives saved as a result of community and user education, needle and syringe programs and diversion programs. As the ongoing policy of the Victorian Government it would be expected that the Committee’s report continues to embrace harm reduction in framing recommendations and future work.

Methamphetamine does not damage in isolation, rather harm can be increased through the impact of many factors. These factors may result from poor self-management as well as contribute to it, and drug use in the first instance; and include access to secure housing, strong personal relationships and networks, ability to participate in employment, training or education, access to health services or support when required. It is also clear that some of the harms associated with methamphetamine can be mitigated through user education and appropriate use strategies.

From the understanding and experience gained through implementation of the harm reduction approach we know it is the most effective way to reduce harm and illness as a result of the impact of alcohol, licit and illicit drugs. The challenge introduced by methamphetamine is that it requires us to understand how harm reduction can be delivered across the service and support spectrum as the nature of harms may be different. This is particularly the case for long term mental health impacts as a result of chronic long term use and in some instances casual use.

**Service Users**

There is no doubt that methamphetamines have great destructive potential. There is evidence that it can have long term health consequences, though this is not the case for all users. For those using occasionally or irregularly there may be little long term or ongoing impact. This of course will vary from person to person with underlying illnesses / conditions being relevant.

Many Health Works’ service users report a history of trauma from early childhood neglect, physical and sexual abuse and limited education, many have undergone prison sentences related to drug use. They also report a high level of polydrug use – both opiates and stimulants, these practices require increased flexibility from the alcohol and drug treatment sector.

Different population groups have varying service response requirements – this is core to the understanding that drug use occurs within the context of the user’s life. This requires a commitment to respecting the human rights of people who use drugs and ensuring that they are not subject to discrimination as a result. The stigmatisation of people who use drugs results in increasing isolation within the community, lower levels of engagement with support services and greater harms done to themselves and the broader community as a result.

For people who are Aboriginal and Torres Strait Islanders issues of grief / loss and related mental health issues play a specific role, which when combined with lower health service access can increase harm and result in poorer self management – increasing risks for the broader community. For lesbian, gay, bisexual or transgender people in addition to traditionally lower levels of service access and higher levels of mental illness the use of methamphetamine as a party drug can exacerbate risk taking behaviours which have flow on health impacts.
It is of note that the service presence of refugees and asylum seekers is increasing, though not necessarily among recent arrivals (last 1 or 2 years), rather as a result of settlement failure over the previous decades. This is particularly prevalent among young men who are experiencing housing insecurity, low rates of employment, disengagement with education/training and detachment from their cultural communities.

Across these groups the diverse needs and relatively low engagement with the health service system generally may require additional formats of service delivery and understanding how to engage with these populations.

**Service response**

In recognising that drug use patterns may be changing, that new drug types with unknown long term impacts are emerging onto the market (as was given in evidence to the Committee) it would be appropriate to review if the current service profile is of the best possible design to support ongoing and evolving approaches to harm reduction.

The existing service system for people who inject or use illicit drugs was set up to deal with opiate based drugs. The impact of these drugs on health outcomes, on user behavior and experience and the possible harms to be minimised have different characteristics. Risk taking behaviours can be made worse as a result of long term use and poor self management – this plays out for example through long periods of alcohol use without sleep and food. Sleep deprivation alone can have significant behavioural impacts.

Current primary health services for people who use drugs have developed mainly for people who inject drugs. This is historically the result of the development of the Needle and Syringe Programs to reduce the spread of blood borne viruses and the associated development of primary health services that flow from this. As a result the targeting for many of these services is people who inject drugs.

There are a number of administration methods for methamphetamine with little evidence that harm, risk taking or self-management issues vary depending on the method (smoking, injecting, snorting etc). It is clear that different modes of administration involve different risks and therefore responses. Across population groups there may be different modes that have prevalence and support for users needs to give consideration to this.

This requires greater investment in additional community based health services is required to improve capacity to support people who use drugs, rather than just people who inject drugs. This additional investment is required to provide a better service response to a broader population.

The service continuum should be built on the recognition that there is great diversity in the experiences and pathways for people who use methamphetamine and this requires a diverse range of service responses.

There are those for whom methamphetamine is a substitution drug for other substances (for example other stimulants or heroin) and the use forms a continuation of substance use. While there are many within this cohort who are fully engaged in employment, education and have secure housing there is a sub-cohort for whom attention to whole of life conditions may require attention to support safe use acknowledging that factors such as housing, employment, experience of abuse/violence, or access to education and community networks require consideration. The service response for this latter group is of necessity likely to require specialist skills / and be delivered through the existing network of primary health services for people who use/inject drugs.

People who use methamphetamine report that there are not many services that were particularly effective in engaging them. They also indicated that many of the information resources that were used were identified as either being informal or not specifically focused on addressing methamphetamine use. In discussions with people who use methamphetamine there was a level
of frustration that much of the service response was focused on issues that they have not actually experienced and there has been little engagement around the actual harms that they identified. This appears to be a reference to the focus on the very acute 'psychotic violent' behaviours that get highlighted through media; rather than on the varying and lower level harms which with support / advice / engagement can be managed appropriately.

The most significant population of users includes people who use substances only irregularly or occasionally. For the latter, more 'social' group of users entry to use may be a result of peer engagement or be opportunistic as a result of the social environment – there will be many reasons that could exist that will bring someone to the point where they decide to use a substance – licit or illicit for the first time. Though there will be exceptions this group are likely to feature users who are still engaged with employment, education and have secure housing and social networks. The service response for this population is likely to be facilitated through mainstream health services.

Mainstream capacity building is particularly important for this population of users as their use has been described as starting off ‘socially’ and so people neither regard themselves as requiring a specialist service response and are not likely to access specialist services, rather they may seek advice through anonymous forums (for example online) or general practitioners or other primary health services. This requires additional attention and capacity building within the mainstream health service system so that advice and education can be given to support this user group to maintain good health, reduce harm and risk taking, improve self management and lower the potential for use to move from occasional / irregular to chronic and ongoing – where the risk of harm is greater.

One of the key learnings from decades of experience in service delivery for people who use drugs is the importance of engaging and training a peer workforce to deliver education on harm reduction and options available for support. The peer workforce generally appears to have more experience in the opioid substance range and so further development and education of the peer workforce will improve safety of users and the community – through better self-management and allow a better earlier more relevant form of support.

Through the hearings of the Committee it was indicated by a witness that residential rehabilitation for people wishing to access for it was limited as a result of the way services are funded limiting the time. It would be of value to consider where relaxing funding constraints / conditions on services that engage with this user group would allow a more flexible and appropriate service response.

One of the reported experiences of people who use methamphetamine is the significant variability in quality. In recent years there has been a significant increase in strength which results in greater levels of overdose or over administration, which again poses harms and risks to the users. In an unregulated drug market with many supply sources this is impossible to overcome.

There are clearly limited treatment options for people using methamphetamine and this can impact on the ability or decision to stop using. Within the discussions facilitated by Health Works it was noted that there access to other medications which may assist with managing symptoms of withdrawal, however the limited effectiveness of existing pharmacotherapies was noted.

It is important to note that any social marketing campaign which is designed to engage users and reduce harm and risk taking behaviours should be aimed at the user and not the general community. Peer engagement has been shown to have a greater impact on reducing harm and risk taking than expensive media campaigns. Campaigns aimed at prospective users should be regarded with suspicion as they ignore the vital understanding of the context people are in at the time they make the decision to use a substance for the first time.
In summary WRHC recommends that the Committee:

1. continues to embrace harm reduction in framing recommendations and future work;
2. recognise that there is great diversity in the experiences and pathways for people who use methamphetamine and this requires a diverse range of service responses;
3. seek a review of the current service profiles to determine if they are the best possible design to ongoing approaches to harm reduction;
4. consider whether service responsiveness can be supported by changing to conditions placed on funding streams;
5. recommends greater investment in additional community based health services to improve capacity to support people who use drugs, rather than just people who inject drugs;
6. recommends additional investment in building the capacity of the mainstream health service system to ensure improved responsiveness to those who do not and will not access the specialist primary health services for people who inject / use drugs;
7. ensure that recommendations respect the human rights of people who use drugs and protect them from discrimination;
8. promote research into improved treatment options and service responses for people who are using methamphetamine.

Thank you for the opportunity to provide a submission. Should the Committee wish to discuss further any aspect of the above submission I would be pleased to assist your considerations.

Yours sincerely

Lyn Morgain
Chief Executive Officer