National Ice Taskforce

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Contents

cohealth provides the following to the National Ice Taskforce for its community consultation.

cohealth encourages the Taskforce to give consideration to ice or methamphetamine use as a health issue and locate its policy response in the harm reduction approach which has provided the policy framework for response to drug use in Australia since the 1980s.

About cohealth

cohealth is a not-for-profit registered community health service operating across the north and western metropolitan regions of Melbourne.

cohealth provides integrated medical, dental, allied health, mental health and community support services, and delivers programs to promote community health and wellbeing. Over 110,000 people a year use our services, which operate from 44 sites across 14 local government areas in the north and west of Melbourne. We prioritise those who are disadvantaged or marginalized because we know that these groups experience the poorest health. This includes people who are homeless or at risk of homelessness, Aboriginal and Torres Strait Islanders, refugees and asylum seekers and people who use illicit drugs.

cohealth was formed on 1 May 2014 as a result of the merger of Doutta Galla Community Health, North Yarra Community Health and Western Region Health Centre; three agencies with a history of working with disadvantaged population groups and delivering services that are shaped and tailored in partnership with service users and communities.

cohealth's approach is based on human rights, co-design, and a social model of health. Codesign is about engaging consumers and users of products and services in the design process, with the idea that this will ultimately lead to improvements and innovation (Burkett, 2014)

Our codesign approach means that we work in partnership with consumers, clients, carers and the community. We create opportunities for active and meaningful participation in decisions about people's own health and health care, as well as how cohealth's services are designed and delivered.

cohealth 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 harm done by drug use, as it is to understanding why poverty and poor health outcomes are so closely related.

cohealth services for people who use drugs

Health Works and Innerspace are specialist alcohol and other drug primary health services (SAPHS) for people who inject drugs. They provide a Needle and Syringe Program (primary and secondary) and offer holistic care underpinned by the social model of health with the aim of addressing health inequities experienced by people who inject drugs.

The services are 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.

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 Australian Government it would be expected that the Taskforce'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 or contribute to poor self-management and drug use in the first instance. These factors can also include access to secure housing, strong personal relationships and networks, ability to participate in employment, training or education, and access to health services or support when required.

It is also clear that some of the harms associated with drug use – be they opioid, methamphetamine or other drugs –can be mitigated through user education and appropriate use strategies. These strategies include encouraging users to sleep, eat and drink water regularly and using in a safe environment with people that they know and trust.

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 of methamphetamine use 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 and physical health impacts as a result of chronic long term use and in some instances casual use.

Discussion groups with people who use methamphetamines

In October 2014 cohealth conducted three facilitated discussion groups with regular methamphetamine users to explore their personal experiences. Groups were held in Collingwood, Footscray and Braybrook and recruited from Needle and Syringe Program attendees in those places.

Three questions were put to each group for general discussion:

1. What are the harms– related to methamphetamine use?
2. How do you manage these harms?
3. What kind of support would you like from us as service providers, and more broadly?

Harms from use were readily identified by participants:

- Overdose
    - Vomiting
    - "Everything goes white"
    - Racing heart
- Paranoia and hallucinations – psychosis
- Anxiety
- Sleep deprivation
- Reduced immune system response
- "Picking"
- Memory loss and time displacement
- Dry mouth and teeth grinding
- Increased risk if pre-existing mental health issues
- Enormous variation in quality of product – a driver in harms:
    - Causing arguments when quality low
    - Risk of overdose when quality high
    - Cutting agents identified as increasing negative side effects – scattered thoughts, confusion, lethargy, "fried"
- Violence being part of culture, rather than caused by methamphetamine use:
    - Macho street culture where prison time can be a status symbol

    - Stimulants being used to increase capacity for violence
    - Pervasive domestic violence, regardless of drugs used
    - Important to hold people (men) responsible for their violence
- Disclosing use of ice seen as a risk in and of itself
    - difficult to recruit women for discussion groups – fear of exposure as user cited as reason in several instances. Particularly high risk for women who have children
    - fear of judgment from others, particularly in poorer communities. Feel guilty/judged for spending money on non-essentials (internalized stigma). Can also be a driver of isolation
    - Fear of disclosure means young people miss out on valuable information from their parents
- Methamphetamine use seen as one of many factors impacting on life – work, family, housing, police.
    - Methamphetamine use sometimes framed as a way to manage other adverse life circumstances – mood enhancer, pain relief
- Impact of methamphetamine use identified as varying from person to person
- Identifying isolation and boredom as drivers of mental health harms when using ice:
    - "I try and always go out – do something social"
    - "When my neighbour tells me he hasn't seen me for a few days, I know it's time to pull up"
- Glass pipe/smoking as route of administration seen as both potentially harmful and helpful
    - Can lead to compulsive use
    - Less efficient than injecting – pipe use by dealers described as a driver of "cutting" by one participant
    - Can be used to assist identifying "cut" drugs
    - Some say qualitative effect of smoking more pleasurable and less unpleasant feelings than injecting

Responding to harms – safer using strategies already in place

From all workshops, participants identified safer using strategies such as:

- Not using alone
- Taking breaks between bouts
- Getting enough rest
- Eating and drinking
- Looking after oral hygiene
- Considering non-injecting routes of administration – smoking, swallowing
- Being wary of purity and dose size in terms of overdose risk
    - One participant took his pulse after a shot as a means of ascertaining strength

Responding to harms – considering mental health

- Participants identified need to have meaningful activity while using
    - Time spent alone while high could "do your head in"
    - Even activities like online console gaming can be protective
- Self awareness seen as an important tool for managing long term stimulant use:
    - Be aware of impact on others while high – adjust behaviour accordingly
    - Have time out strategies in place for managing intense emotions such as anger
    - Being respectful towards self and others
- Cultivating meaningful relationships seen as important

What support would help?

- Proper information about ice - addressing myths, up to date facts and statistics. "All the ads are bullshit. I just want to write 'bullshit' all over them"
- Testing kits
- Counsellors who understand the drug
- Peer support
- Low stimulus room available
- Information about drug interactions
- Better access to injecting equipment – dispensing machines as an option (this came up in the 2 western suburbs groups and highlights poorer access in this area compared to Collingwood, where Inner Space is based)
- Pipe program – to engage people who don't inject
- General education in respect for others and self
- Advocacy for drug law reform. "They have to legalise it – a legal place to sell it where there is no reason to <cut> it for your own benefit"
- Housing an over-arching issue for our client group

What we learnt from these discussions includes:

- Like any drug, methamphetamine doesn't "cause" problems by itself, but is intertwined with complex personal and cultural stories
- People who regularly use methamphetamine already have strategies to make use safer and more sustainable
- There are voices not heard in this exercise – particularly women.
    - How do we hear these voices?
    - Women are already under-represented in service access
- The stigma and discrimination towards people who use methamphetamine is a significant driver of harms
    - Advocacy is required to address this and broader discrimination against people who use and inject drugs
- There is a need for detailed, neutral and factual information about methamphetamine
    - For new users
    - For workers/counsellors

recommendations to reduce harms associated with methamphetamine use

- Stigmatising and demonising people who use methamphetamine is antagonistic to harm reduction approaches and philosophies. Current community awareness campaigns that are being conducted around ice use are hysterical in their presentation and reduce the likelihood that people who use methamphetamine will disclose their use to family and friends and reduce the likelihood of seeking other forms of support or access appropriate services.
- Abstinence based strategies for methamphetamine use are no more likely to be successful than they are with alcohol or other drugs. A harm reduction approach is the best way to promote individual and community safety and create or allow for the potential of conversations about recovery in an opportunistic fashion..
- Families and peers are ill equipped to support safe or reduced use due to the lack of factual information available. Promoting fear of people who use methamphetamines is not sustainable and will drive further isolation of this group and reduce access to vital services and support.
- Engaging with people who use methamphetamines to improve community awareness and develop a responsive service system will have the greatest impact in reducing harms.

- People who use drugs indicate that poly-drug use is the normal pattern of use. This means that a policy response isolated to one particular drug, will be less effective than an approach seeking to reduce harms associated with drug use per se.
- There is a current lack of integration between Alcohol and Other Drug Services and the mental health service system. The mental health system is grossly under-resourced particularly when it comes to responding to drug use, and is ill-equipped to deal with the increase in demand as a result of poly-drug use. This means that people whose methamphetamine use may be contributing to, or driven by, mental illness are not able to access treatments and supports most appropriate to them.
- The service system that exists to support people who use methamphetamines is lagging behind the presenting needs.
- The peer worker / engagement approach to community education and harm reduction is a model that has been successful in the alcohol and other drug services as well as in the mental health sector to improve engagement with service systems and reduce risk associated with use and con provide access for those not currently using health services, "hidden" populations.
- While methamphetamine use may increase risk taking behaviour, or exacerbate behaviours which jeapordise the safety of methamphetamine users and those around them; it appears that this is built upon a pre-existing likelihood of risk-taking or dangerous / violent behaviours.
- The risk/ harms associated with methamphetamine use in relation to mental health are much greater for people who have a family history of mental illness or have a pre-existing mental health condition. Because of the nature of government sponsored community education campaigns this message has not been presented or promoted, but could significantly reduce the harms associated with methamphetamine for this population group were this message presented factually and without the hysteria.
- It is important to support the health workforce with access to factual information and support so that when people who use methamphetamine disclose this they can be supported and where appropriate referred should there be a need. The clinical management of people who use methamphetamine is a developing area and resources should be applied to clinical education to improve health support provided.
- The engagement with young people around drug use in schools is often ineffective particularly where it is delivered as part of one of sessions by people without a pre-existing relationship with students. There is greater benefit in the design of programs that are embedded within curriculums that are taught by teachers or through organisations with appropriately qualified staff who have a long term relationship with students and who are accessible for confidential discussions outside of the classroom

Appendix 1: Excerpt from Western Region Health Centre (now cohealth) submission to the Parliament of Victoria Law Reform, Drugs and Crime Prevention Committee *Inquiry into Supply and Use of Methamphetamines, particularly 'ice'*

October 2013.

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.

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 from 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

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 opiod substance range and so further development and eduction 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.