

National Drug Strategy Beyond 2009

Anex Response to Consultation Paper

Consultation Draft



Purpose of this Paper

The purpose of this Consultation Draft is to invite comment on the submission that Anex has drafted in response to the National Drug Strategy Beyond 2009 – Consultation Paper. Responses to this draft are welcome and the process for responding is below.

Submission Process

Submissions close on **COB 19 February 2010**

Submissions can be made via hard copy or email using the addresses as set out below:

Hard copy:

*Ms Ann Maree Bajada
Feedback on Anex Consultation Draft – National Drug Strategy
Level 2/Suite 1
600 Nicholson Street
FITZROY NORTH VIC 3068*

Email:

*info@anex.org.au
Feedback on Anex Consultation Draft - National Drug Strategy (in subject line)*

If you have any queries, please contact Ann Maree Bajada on **03 9486 6399**.

About Anex

Anex is a non-profit, public health, drug policy organisation. A key focus of the work that Anex does is the translation of robust evidence into service delivery and practice. Anex has a national role in advocating for service improvement based on the available evidence, particularly in the delivery of Needle and Syringe Programs (NSPs).

NSPs are a proven public health protection measure. They reduce the transmission of blood borne viruses such as hepatitis C and HIV. They also reduce the harms associated with drug use by providing referral to treatment, advice on reducing harms and in some cases, primary health services. In essence, NSPs provide a whole of community benefit by reducing the risk of blood borne virus transmission between individuals affected by drug use, and in turn, reduce the risk of blood borne virus transmission for the whole community. As a result of avoided illnesses and disease, NSPs reduce the costs associated with drug use and provide a referral pathway into treatment.

Anex does not condone drug use but rather, seeks to protect people from harms associated with using drugs while at their most vulnerable.

Response from Anex to the National Drug Strategy Consultation Paper – Beyond 2009.

The Consultation Paper asks an overarching question as to how:

“emerging issues and developments identified in the Consultation paper might impact on patterns of tobacco, alcohol and illicit drug use, and the misuse of licit substances, in the next five years and appropriate responses to these patterns”.

Given the breadth of this question, our response is limited to the area of the use of licit substances in an illicit manner as well as the use of illicit drugs. We note the existence of the Preventative Health Taskforce. The Taskforce has published papers on the broader strategy for preventing harms associated with alcohol, tobacco and obesity in the Australian population both now and into the future. Our view is that much of the work related to tobacco and alcohol that may need to have been included in this strategy has been completed by the Preventative Health Taskforce and the new National Drug Strategy should align with the work of the Taskforce, rather than replicate or repeat work already completed on these topics.

Other emerging issues that you think are relevant to the next phase of the National Drug Strategy

What you think the top priorities for action should be during the next five years;

Anex is of the view that the top priorities for action during the next five years are:

Increasing the community’s understanding of harm reduction and why it is a good policy.

Harm reduction essentially aims to reduce the harms associated with drug use. As noted above, Anex’s response focuses on the approach of harm reduction to illicit drug use and the use of licit drugs in an illicit manner. Harm reduction measures around tobacco and alcohol have been widely implemented such as decreased access to alcohol at venues, restrictions on tobacco advertising, in Victoria reduced trading hours for licensed venues in the CBD, as well as restrictions on the advertising of alcohol.

In 2009 Anex completed a social research project that sought to assess the level of community awareness and support of harm reduction. A sample of 503 Victorians participated in the survey. It included males and females and people from metropolitan, rural and regional Victoria. This research found that when asked to complete the statement: "To me the term harm reduction in relation to a drug problem means..." 24% of the respondents indicated that they did not know what harm reduction was, and another 43% made responses that were totally incorrect. Nineteen per cent of responses were somewhat correct, and only 13% of responses displayed a clear understanding of the term.

Increased professionalisation of the Drug and Alcohol Workforce

Given the complexity of the presentation of people to drug and alcohol services, there needs to be an increased investment in the building of capacity within the Drug and Alcohol (D and A) Workforce. This includes people presenting with mental health issues, legal issues, dependents requiring care and the intergenerational nature of drug use. Some of the most marginalised people in our community are people who use illicit drugs and have a mental health illness and are homeless. Complexity of this degree requires service providers to have a sophisticated understanding of the nature of co-morbidities, the services available to be called upon, the criteria that are met or not met in certain instances thus enabling access or otherwise to a program, as well as workers needing to be expert at handling crisis situations. Investment must occur in the D and A workforce if the issues listed above are to be properly handled and resolved to avoid further generations also being marginalised.

Preventing harms caused by injecting drug use in resident Australian population – particularly Aboriginal communities, as well as those migrating to Australia.

Anex has completed work with the Victorian Aboriginal Community Controlled Health Organisation that has sought to increase the effectiveness of responses to injecting drug users and reduce rates of HIV and hepatitis C infection. At present, Aboriginal injecting drug users are reported to contract HIV at a rate which is six times that of the non Indigenous injecting drug user population (Ward et al., 2008). Indigenous women have a three times higher rate of contracting HIV than non Indigenous women. Given the Government's stated commitment to reducing Indigenous disadvantage, and the projected rates of population growth for the Indigenous people in Australia, it is imperative that actions are taken to reduce the harms caused by injecting drug use in Aboriginal communities.

The next National Drug Strategy will also need to take into account the changing demographic of the Australian population with increased levels of migration from countries which have history of war and disadvantage. People migrating from these countries can have a number of problems associated with their exposure to violence, their isolation from family and community in Australia, and economic disadvantage that may occur owing to qualifications acquired overseas not being recognised in Australia. This situation creates a 'perfect storm' for further disadvantage and potential harm to all parts of the Australian community as the cultural understanding of blood borne viruses may differ widely from accepted standards of infection control. As a result, people migrating from countries with traumatic histories and interrupted education, may not be aware of how best to avoid blood borne virus infection associated with illicit drug use. Investment will be required in the protection of vulnerable populations to blood borne virus transmission.

Ageing population and use of opioids to treat chronic pain and the diversion of these

Anex wishes to comment in detail on the use of illicit substances and the use of licit substances in a manner for which they have not been prescribed or by person to whom they have not been prescribed. Research completed by Anex in rural and regional Victoria indicates that large amounts of diverted opioids such as MS Contin, Oxy Contin, Panadeine Forte and other tablet forms of opioids are injected, or used by people in a manner that could be termed harmful. In parts of rural and regional Victoria it is reported that illicit substances such as heroin are very rarely available, but rather, injecting drug use appears to mainly involve tablet forms of opioids being injected. It can also involve amphetamines – this is largely also dependent on availability.

Emerging patterns include the increasing prescription of these opioids for chronic pain as pain management is occurring in the community setting, but further complexity is added to this by the ageing of the population. It is likely therefore that there will be larger numbers of people in the community who will need pain management as a result of chronic pain associated with the effects of ageing and ageing related diseases such as arthritis, osteoporosis, Parkinson's disease, pathological fractures etc.

An intelligent response to this forecast situation would be to increase GP's expertise in the management of chronic and complex pain presentations. This is not to say that GPs are not currently prescribing pain relief appropriately, but rather, that they provision of peer support through access to pain management specialists who may be available to discuss particularly complicated cases, may be of benefit to GPs handling chronic, and apparently intractable pain. This will require increasing investment in the medical workforce as pain management clinics currently have long waiting periods, and the number of pain management specialists is of concern given the ageing of the population.

There is also an argument to be made for a new approach to chronic pain, which is the management of such pain through slow release synthetic opioids such as methadone and buprenorphine. These drugs may prove more effective at managing long term pain and the current systems set up in each jurisdiction in relation to their dosing, reduces their risk of diversion. The current use of tablet opioids on a wide scale in the community is a risk to increased rates of diversion of prescribed opioids for illicit use.

The construction of GP Super Clinics also presents an opportunity for the institution of new service models around pain management and this may include housing Pain Management Specialists at these clinics for sessional periods to review the treatment and management of patients with chronic intractable pain. This would provide GPs with on site support as well as possibly increase patient access to Pain Management expertise. The follow on from this may be a more sophisticated approach to longer term pain management.

Hepatitis C prevalence and access to treatment.

As noted by Hepatitis Australia: "In Australia, more than 200,000 people have chronic hepatitis C, and an estimated 160,000 Australians are living with chronic hepatitis B. Worldwide, one in 12 people are living with chronic hepatitis B or C." ⁱ While hepatitis B is not as prevalent amongst injecting drug users as hepatitis C, there is no vaccine for hepatitis C, and hence the long term risk amongst this population group is that hepatitis C will continue to remain at high levels amongst injecting drug users. Injecting drug use is the most common way in Australia that hepatitis C is contracted.

This is clearly one of the most serious harms associated with injecting drug use and more needs to be done in the new strategy to increase the distribution of sterile injecting equipment through NSPs, Syringe Vending Machines, Pharmacies and hospitals to prevent a rise in the level of hepatitis C amongst both injecting drug users and the broader community. Also, hepatitis C is treatable, however access to treatment can be problematic. Long term harms arising from untreated hepatitis C include cancer and cirrhosis of the liver. These diseases require sophisticated, intensive medical management. The Australian health care system is unlikely to be able to provide adequate care to people with hepatitis C if rates remain high within the injecting drug using community.

Getting the balance right between supply reduction, demand reduction, harm reduction. Identifying how we know we have got the balance right.

Harm reduction steps into the gap when both supply reduction and demand reduction have failed. It is clear from the above information that we have not got the balance right in relation to the three pillars of the National Drug Strategy. More investment is required in those services and systems that are required to respond when supply reduction and demand reduction fail. Greater investment in harm reduction is also an investment in the safety of the broader community as it means that diseases such as HIV and hepatitis C are better understood and managed, thus reducing their rates of transmission across sub population groups.

Harm reduction can also act as an avenue to demand reduction, with NSPs being funded over recent years by COAG to deliver interventions with clients that would encourage them to seek treatment.

In relation to supply reduction we would suggest that significant investment in this area is already in place and in spite of this, illicit drugs are still being used in Australian communities. Australian communities expect a degree of investment in supply reduction, however, it may be more useful to invest in the development of an 'early warning system' that can report when the supply reduction system has failed. In order to better protect the health of people who are using drugs, better systems of information sharing and management need to be established. We have recently seen a number of episodes of heroin being combined with Anthrax which was first observed in Scotland earlier this year. Networks used to share information in the drug sector were used to provide information to service providers about this incident. However, these mechanisms for information sharing are not formalised but rather have grown organically within and across the harm reduction sector. If a more formalised system was to be used, we stress that carefully agreed protocols would be required. The aim of these protocols would be to ensure illicit drug users were not targeted, but rather, a system wide approach was taken to implement methods of ensuring better responses to illicit drug use.

A number of key consultation questions are asked through the paper. Our response has been prepared to a select number of these:

How can structures and processes under the National Drug Strategy more effectively engage with sectors outside health, law enforcement and education?

The Australian National Council on Drugs has a number of meetings throughout the year in different capital cities. Anex is of the view that this is an excellent way for the ANCD to remain up to date on local issues, but also those that have a national impact. The MCDS could consider something similar with bi-annual meetings/forums/seminars in different capital cities/locations. This would enable service providers to have their voices heard at yet another level of the National Drug Strategy infrastructure.

Which sectors will be particularly important for the National Drug Strategy to engage with?

The evidence suggests that many people using drugs problematically have multiple co-morbidities. Sectors with which the National Drug Strategy will need to engage with are: the harm reduction, education, mental health, Aboriginal health, housing, law enforcement, primary health care as well as the broader community.

Where should efforts be focussed in reducing substance use and associated harms in Indigenous communities

Research completed by Anex (unpublished to date) indicates that much harm is caused by alcohol and tobacco in Aboriginal communities. These are not new issues. However, as highlighted above, the harms caused by injecting drug use are also substantial and much greater impact may be seen in the short to medium term by increasing access to sterile injecting equipment in Aboriginal communities, increasing access to education on the benefits of harm reduction, greater cross cultural collaboration between mainstream and Community Controlled Health Services to enable both workforces to understand different cultural approaches to the provision of harm reduction services.

How could Aboriginal and Torres Strait Islander peoples needs be better addressed through the main National Drug Strategy Framework

From the research that Anex has completed, it is noted that Aboriginal and Torres Strait Islander peoples can have similar problems to the broader community, however the most effective responses are sometimes different to those that are on offer or available through mainstream services. Work done by Anex indicates that responses need to be tailored to Aboriginal communities and their needs. That is, there needs to be an individualised response in the context of a broad and jointly endorsed strategy. It is important that we do not replicate service systems as this is cumbersome, slow and inefficient. Rather, we should use existing service systems in smarter ways and more collaboratively.

In that context, would a separate National Drug Strategy Aboriginal and Torres Strait Islander Complementary Action Plan continue to have value?

On the basis of the points made above, Anex is of the view that a separate strategy document is not required, *so long as* the final National Drug Strategy document articulates an inclusive, culturally appropriate and tailored approach to tackling drug problems in both mainstream and Aboriginal communities.

Where should effort on the support and development of drug and alcohol sector workforce be focused over the coming five years?

In our view, the effort on the support and development of the drug and alcohol sector workforce should be focused on the following areas:

- Increased professionalism of D and A Workforce
- Hepatitis C prevalence and access to treatment
- Harms caused by injecting drug use in resident Australian population – particularly Aboriginal communities, as well as those migrating to Australia to ensure greater collaboration across sectors
- Ageing population and use of opioids

Where should efforts be focussed over the coming five years to increase the capacity of the generalist health workforce to identify and respond to substance use problems?

Anex considers that training at undergraduate level of medicine and nursing in the area of D and A interventions would be of benefit and enable broader based responses to substance use problems. Another outcome of increased training at undergraduate would be the normalising of D and A treatment/interventions as a part of every day practice. Finally there should be an investment to increase the ability of health workforce to identify drug and alcohol problems early, and existing co-morbidities, and offer appropriate interventions.

How can efforts under the National Drug Strategy better complement the social inclusion agenda such as addressing unemployment, homelessness, mental illness and social disadvantage?

A matched investment needs to be made in each of the Drug/Alcohol, Housing and Mental Health sectors to form extensive collaborative networks within each jurisdiction. The work being completed by the Prime Ministers' Social Inclusion Committee could inform this network and how it is established. We note that the National Homelessness Strategy has recently resulted in a grants round that sought requests for funding for research. This research was required to look at corollary issues affecting homeless people, and in some instances the most marginalised of homeless people, that is, those who are homeless, have mental health problems and are injecting drug users. Intervention at an earlier point provided to someone who has a mental illness or has commenced injecting drug use would have large, follow on benefits for both the individual and the community.

Where should effort be focussed in reducing substance use and associated harms among vulnerable populations?

People in prison continue to inject drugs, regardless of the strict prohibitionist approach that is in place. Sterile injecting equipment is not available in any prison in Australia. Australian prisoners, and in particular, Australian female prisoners who inject drugs, would be one of Australia's most vulnerable and disadvantaged populations. A pragmatic response which would protect prisoners from potentially contracting blood borne viruses while in prison through injecting drug use would be the implementation of needle and syringe exchanges (with exchange being purposefully chosen) in Australia prisons. This would also represent an opportunity for improved occupational health and safety for Australian prison officers as they are less likely to acquire a needle stick injury from injecting equipment that has been secreted in prison walls, clothing, containers or other non-visible places.

Are publicly available performance measures against the National Drug Strategy Desirable?

Our view is that some high level measures against the National Drug Strategy can provide useful evidence as to the success of the strategy. However, if the measures were to be complex, this would add to the workload of the sector and serve to be a distraction rather than of assistance.

If so, what measures would give a high level indication of progress under the National Drug Strategy?

Supply Reduction:

A comparative measure of seizures of illicit drugs versus reports of drugs being used via early warning system outlined above. Estimates of the proportion of total drugs stopped at border control based on data obtained via early warning system and distribution patterns for those drugs that did penetrate borders.

Demand Reduction:

Treatment episodes provided and who required repeat treatment in the last 24 months given that some treatments appear to have varying levels of efficacy; extent of work conducted collaboratively across agencies and service systems.

Harm Reduction:

Number of needles and syringes distributed, number of contacts with clients, number of employees recruited, number of employees which left to work in another sector (i.e. not retained by the D and A sector) and level of qualification. Extent of work conducted collaboratively across agencies and service systems.

ⁱ http://www.hepatitisaustralia.com/media_news/documents/Media_Release_World_Hepatitis_Day_2009.doc