



GOVERNMENT OF  
WESTERN AUSTRALIA

---

**METHAMPHETAMINE  
ACTION PLAN  
TASKFORCE**

---

**FINAL REPORT**



**© State of Western Australia 2018**

There is no objection to this report being copied in whole or part, provided there is due acknowledgement of any material quoted or reproduced from the report. Published by the Department of the Premier and Cabinet, Western Australia, November 2018.

This report is available on the Department of the Premier and Cabinet website at [www.dpc.wa.gov.au](http://www.dpc.wa.gov.au)

**Disclaimer**

The Western Australian Government is committed to quality service to its customers and makes every attempt to ensure accuracy, currency and reliability of the data contained in this document. However, changes in circumstances after time of publication may impact the quality of this information. Confirmation of the information may be sought from originating bodies or departments providing the information.

# Contents

<b>The Methamphetamine Action Plan Taskforce</b>	<b>7</b>
<b>From the Chair</b>	<b>9</b>
<b>Executive Summary</b>	<b>11</b>
<b>Summary of Recommendations</b>	<b>17</b>
<b>PART 1 INTRODUCTION</b>	<b>31</b>
<b>Chapter 1 This report.....</b>	<b>31</b>
1.1 Purpose .....	31
1.2 Structure .....	31
1.3 Principles guiding the Taskforce's advice .....	33
1.4 Methodology .....	34
<b>Chapter 2 Methamphetamine, what you need to know .....</b>	<b>37</b>
2.1 What it is .....	37
2.2 How people use it .....	38
2.3 Effect on users – from the 'highest high to 'my entry to hell' .....	39
2.4 Why people use it .....	43
<b>Chapter 3 The magnitude of the methamphetamine problem .....</b>	<b>45</b>
3.1 Community attitudes .....	45
3.2 Methamphetamine supply .....	46
3.3 How much is consumed in Western Australia .....	51
3.4 Who is using methamphetamine .....	54
3.5 Social and economic costs .....	61
<b>PART 2 OPPORTUNITIES TO IMPROVE SERVICES AND SUPPORT IN WESTERN AUSTRALIA</b>	<b>71</b>
<b>Chapter 4 Helping people stay away from methamphetamine in the first place .....</b>	<b>71</b>
4.1 Reducing supply .....	71
4.2 Reducing demand .....	74

<b>Chapter 5 Intervening early to prevent entrenched use.....</b>	<b>99</b>
5.1 What the Taskforce heard.....	99
5.2 Reducing stigma .....	100
5.3 Screening and brief interventions .....	107
5.4 Early intervention in the workplace .....	111
<b>Chapter 6 Providing treatment and support services for those seeking help .....</b>	<b>119</b>
6.1 What the Taskforce heard.....	119
6.2 What works when people need help .....	121
<b>Chapter 7 Reducing the harm associated with methamphetamine use.....</b>	<b>155</b>
7.1 What the Taskforce heard.....	156
7.2 Reducing harm among users .....	157
<b>Chapter 8 Regional communities .....</b>	<b>171</b>
8.1 What the Taskforce heard.....	171
8.2 The extent of methamphetamine use in the regions .....	173
8.3 Service delivery in the regions .....	174
8.4 Providing better services.....	178
8.5 Place-based approaches to planning, commissioning and delivering services .....	180
<b>Chapter 9 Helping groups vulnerable to high rates of methamphetamine use.....</b>	<b>185</b>
9.1 Aboriginal people .....	185
9.2 Justice populations .....	198
9.3 LGBTIQ (lesbian, gay, bisexual, transgender, intersex and questioning) .....	218
9.4 Culturally and linguistically diverse (CaLD) communities.....	222
<b>Chapter 10 Helping to rebuild a person's life after methamphetamine.....</b>	<b>227</b>
10.1 What the Taskforce heard.....	227
10.2 What is 'recovery' from problematic or substance use dependency? .....	228
10.3 Housing for people recovering from methamphetamine use.....	230
10.4 Getting back to work .....	237
10.5 After treatment support .....	240

<b>PART 3</b>	<b>OPPORTUNITIES FOR CROSS SECTOR COLLABORATION</b>	<b>245</b>
<b>Chapter 11</b>	<b>Cross-sector collaboration and coordination .....</b>	<b>245</b>
11.1	What the Taskforce heard.....	245
11.2	What the Taskforce observed .....	246
11.3	Why collaborate and coordinate .....	248
11.4	Delivering a more effective system to better meet people's needs .....	253
11.5	Opportunities for the business sector to contribute.....	270
<b>PART 4</b>	<b>DEVELOPMENT OF PERFORMANCE INDICATORS AND TARGETS</b>	<b>273</b>
<b>Chapter 12</b>	<b>Measuring performance .....</b>	<b>273</b>
12.1	Outcomes measurement.....	273
12.2	Service (or consumer) level and program (or organisation) level results .....	275
12.3	Whole-of-government impact and population level results.....	281
<b>Appendix A</b>	<b>Methamphetamine Action Plan Taskforce Terms of Reference</b>	<b>287</b>
<b>Appendix B</b>	<b>Consultation List</b>	<b>290</b>



## The Methamphetamine Action Plan Taskforce

The Members of the Taskforce are:

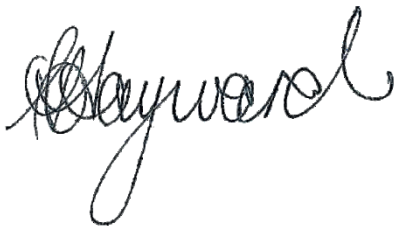
- Mr Ron Alexander (Chair) former Director General of the Department of Sport and Recreation;
- Professor Daniel Fatovich (Deputy Chair), Professor of Emergency Medicine at Royal Perth Hospital and The University of Western Australia; and Head of the Centre for Clinical Research in Emergency Medicine, Harry Perkins Institute of Medical Research;
- Ms Michelle Fyfe APM, former Assistant Commissioner Judicial Services, Western Australia Police Force; and Chief Executive Officer, St John Ambulance Western Australia;
- Professor Colleen Hayward AM, Chair Alcohol and Other Drug Advisory Council; Head of Kurongkurl Katiitjin (Centre for Indigenous Education and Research) and Pro-Vice-Chancellor, Equity and Indigenous, Edith Cowan University;
- Professor Simon Lenton, Director, National Drug Research Institute, Curtin University; and
- Mr Don Punch MLA, Member for Bunbury.



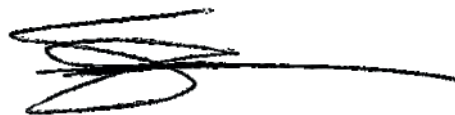
Mr Ron Alexander  
Chair



Professor Daniel Fatovich  
Deputy Chair



Professor Colleen Hayward AM



Professor Simon Lenton



Ms Michelle Fyfe APM



Mr Don Punch MLA

Dated: 16 August 2018



Left to right: Professor Simon Lenton, Professor Colleen Hayward AM, Professor Daniel Fatovich, Mr Ron Alexander, Ms Michelle Fyfe APM, Mr Don Punch MLA



## From the Chair

The creation of the Methamphetamine Action Plan Taskforce was the starting point for a new conversation we as a community must have if we are to change the traumatic impact of methamphetamine on so many lives.

Accepting the reality that the supply of illicit drugs, including methamphetamine, cannot be stopped world-wide we need to look at different ways of doing things. Many policies we thought would protect us from harm are failing, some are even counter-productive. The social and economic costs of methamphetamine use in our community are staggering and we need to find more effective and humane ways to manage it.

Around the world governments are coming to the realisation they can't keep doing the same things and expect different outcomes. So they're trialling new approaches. Some of the alternatives being looked at may seem challenging but we should monitor the progress of what's happening elsewhere and be part of the genuine global debate to see what could offer new solutions for Western Australians. We don't need to be reckless, but we do need to be a little bit brave if we are to stop ceding control to the criminal gangs who control the supply of methamphetamine and all the harms that go with it. Allowing those harms to persist, and our sons and daughters to continue to be indebted to criminals, isn't an option for the future.

So why is methamphetamine different, and why are some meth users especially difficult? The nature of the drug is that heavy meth users can be irrational, erratic and frustrating, even threatening, which can make their participation in life generally, but rehabilitation especially, inconsistent. This makes it difficult to obtain and sustain successful outcomes. So people give up on them. Some parents, understandably, feel they have no choice but to close the door on their children.

Meth is a drug that can destroy lives, families and communities. It can take years to get hooked and during that time, people think they have it under control. But not everyone does. For many people life gets much tougher. Meth is illegal. If you want it, you have to break the law to get it. And if you're truly addicted, there isn't much you wouldn't do to get that next shot. And meth is everywhere. "Take a walk with me" meth users have said to me. "I'll find you three shots in 15 minutes."

But drug dependence is not a crime, it is a treatable health problem often underpinned by social disadvantage and mental health issues. Many of us treat drug users as social outcasts instead of people who need help. We as a society can do better.

The focus of the Taskforce has been to talk with people in the community and learn from those with lived experience of methamphetamine use and its harms what works for them and what doesn't, what's unclear when trying to quantify the problem, and what is contentious. The Taskforce didn't set out to write the definitive guide to understanding meth use, but we spoke to a great many people to very clearly understand what the people of WA believe, and it is their views that are reflected in this report, that have driven the recommendations we have made.

Any discussion around methamphetamine is challenging but creating a new beginning in this very contested debate is crucial to finding a better way for the future. I believe we have ignited a truly contemporary conversation. We now pass the torch to the Western Australian Government with the challenge to keep that flame alive.

I would like to take this opportunity to thank my Taskforce colleagues for sharing their expertise and continued commitment throughout this process: Deputy Chair Professor Daniel Fatovich, Ms Michelle Fyfe APM, Professor Colleen Hayward AM, Professor Simon Lenton, and Mr Don Punch MLA. My Taskforce colleagues and I would also like to thank the dedicated staff of the Secretariat for their service and support.

My most profound thanks goes to all of the people who opened their hearts and told us their stories. They have placed their trust in us to be a force for positive change and I can say, unequivocally, that change is achievable.

A handwritten signature in black ink, appearing to read 'Mr Ron Alexander', written in a cursive style.

Mr Ron Alexander  
Chair

16 August 2018

## Executive Summary

The health and welfare of our community has been the focus of deliberations for the Methamphetamine Action Plan Taskforce.

Methamphetamine is the illicit drug of most concern to our community right now. Our concerns aren't unique to Western Australia – around the world there are growing calls for new approaches to stem the tide of misery and harm caused by illicit drug use. Advocates are calling for more humane and effective policies shaped by scientific evidence, public health principles and human rights standards because the reality is there are no easy answers.

For families and communities who live with, and do their best to care for, people affected by meth, the burden is often overwhelming. Proportionally, Australia uses more methamphetamine than almost any other country and Western Australia currently has the highest consumption rate of methamphetamine of any state or territory. It can cause psychosis, cardiovascular problems, kidney failure, stroke, seizures, anxiety and depression.

Methamphetamine use in our community is a complex, multi-dimensional problem driven by the social determinants of health. These are the conditions in which people are born, grow, work, live and age, and they're further impacted by the distribution of money, power and resources at global, national and local levels. But there are things we can do now, that can make a difference in Western Australia.

With this report, the Taskforce has deliberately sought to challenge current thinking and encourage debate about taking a different approach. Any attempt to reduce demand, harm and supply must necessarily involve every part of society, through governments, industry, business, community, family and the individual. Methamphetamine isn't someone else's problem. It is everyone's concern.

Recognising more can and should be done to minimise the impact of methamphetamine use on individuals, families and communities, the Taskforce was appointed on 26 June 2017 to provide advice to the Western Australian Government on how programs can be best delivered and targeted to the areas of greatest need. The work of the Taskforce will help inform the Government's \$131.7 million *Methamphetamine Action Plan*.

To better understand the impact in Western Australia the Taskforce talked to people, collecting more than 700 responses. The Taskforce held a series of community engagement forums, seminars and meetings across all regions in Western Australia and the greater metropolitan area – more than 500 people attended. Information has been provided by more than 140 agencies and organisations, and 145 comments were received through an online portal open from January to March 2018. The people of Western Australia were keen to have a conversation about the best way to deal with methamphetamine use in our community. For many, it was the first opportunity they'd had to take part in this discussion.

Issues identified by the community guided Taskforce inquiries. The authentic voices of people who have lived experience of methamphetamine use shaped this contribution by the Taskforce to the current and ongoing discussion. Not surprisingly, what the Taskforce heard is reflected in conversations happening around the world, and in evidence arising from local, national and international research.

## What the Taskforce heard

*Methamphetamine use is a health and community issue – it cannot be solved by law enforcement alone*

The Taskforce recognises law enforcement measures are critical to reducing the supply of methamphetamine and acknowledges disrupting the business model of organised crime must remain a priority. The Taskforce also heard that methamphetamine use cannot be seen as a problem to be solved by law enforcement alone. More must be done to address the issues associated with methamphetamine through the health system and at a community level. The Taskforce believes the impact it has on individuals and families across every part of our society dictates these problems must be approached and managed primarily as health and community issues. The links between disadvantage, ill-health and problematic drug use are beyond dispute. **The Taskforce concludes while law enforcement efforts are vital and must continue, any additional resources made available to tackle the problem of methamphetamine use in our community should go to prevention, harm reduction and treatment measures.**

*Providing better access to treatment*

The Taskforce heard people in the community find the system that is intended to help them is complex, and difficult to access and navigate. The perception is the system has evolved over time and does not support individuals, their families or the wider community to manage the broad range of impacts methamphetamine use can have on every aspect of someone's life. It treats or manages specific issues as they arise, often in isolation. The Taskforce also heard overwhelmingly that there are not enough treatment places to meet people's needs. Innovative approaches to procurement that allow a more rapid response are required. **The Taskforce makes a series of recommendations to address unmet and immediate demand for treatment, use a case-management approach for people with multiple and complex needs and improve access to information about treatment availability [Recommendations 15, 16, 19, 49].**

*Preventing people from using in the first place*

Methamphetamine can make people feel powerful, confident and in control. Not surprisingly, it will be most attractive and entrenched among people and communities where there is hopelessness, despair, damage and disconnectedness. At its most fundamental level, any strategy to prevent problematic and entrenched use of drugs must recognise and address the underlying social and economic factors driving drug use. Strategies to reduce risk factors and increase resilience in individuals and communities that include addressing social and economic disadvantage, along with providing accurate, non-judgemental evidence-based publicly available information and education, are some of the most effective prevention tools we have. The Taskforce recognises there is considerable work being done in schools and the community but there are missed opportunities to deliver more targeted programs that could potentially yield better results. **The Taskforce makes a series of recommendations for schools to give alcohol and other drug education greater priority and go beyond 'universal' programs to tailored approaches, to work with young people at greatest risk [Recommendations 1, 2, 3, 4, 5].**

*Intervening early, and then at every stage of someone's use*

Once someone has started using methamphetamine, early intervention is important to prevent use becoming problematic or entrenched. Screening for harmful use of alcohol and other drugs including methamphetamine is not often carried out in primary health care settings, despite evidence before the Taskforce suggesting up to 40 per cent of methamphetamine users first seek help from their GP. GPs and other front-line health and allied workers need more support to help people who want help for their methamphetamine use. And while early intervention is key, it is important to acknowledge there are opportunities to intervene at every stage of a person's drug use, including in the workplace. **The Taskforce makes a series of recommendations to better support GPs and other health and allied workers, and build the capability of employers, especially small businesses, to better manage and support staff with problematic and dependent use of methamphetamine [Recommendations 10, 11, 12, 13].**

*Stigma and shame gets in the way*

Stigma is perhaps the biggest barrier that prevents people asking for help for their methamphetamine use. Families also told the Taskforce that stigma isolates them from the support they need from other family, friends and the wider community. We acknowledge the behaviours of some methamphetamine users create challenges for the people trying to help them. Anti-social, destructive behaviours are difficult to manage, but they are also signs someone is in trouble. Stigma associated with methamphetamine use means most users do not seek help until their problems are severe, and it can take between five and 10 years from the time a person's use becomes problematic to the time they seek help through treatment. By this time their lives are often unravelling with jobs lost, homes gone, relationships destroyed and children removed into care. Stigma creates barriers that stop people getting help earlier, inevitably increasing the social and economic cost of methamphetamine use to our community. **The Taskforce makes a series of recommendations to eliminate judgemental language and use of inappropriate stereotypes that are barriers to help seeking for those with alcohol and other drug problems, by health care professionals, law-enforcement agencies, public policy makers, and the media [Recommendations 7, 8, 9].**

*Reducing health harms to individuals*

Despite the best efforts of Government and service providers, some people will continue to use drugs in a way that is potentially harmful. Recognising there are, as yet, no proven pharmacological treatments for methamphetamine dependence, the focus for harm reduction strategies in Western Australia has been delivering services that provide information, education, care and support for people who continue to use so they don't cause further harm to themselves and others. The Taskforce also heard families want an alternative to a police cell or hospital for people in crisis from their methamphetamine use – a short-term place that will keep them, their families and the community safe. **The Taskforce makes a series of recommendations to examine alternative crisis management responses, while improving the visibility of existing harm-reduction strategies and their role in reducing stigma and encouraging people to seek help [Recommendations 26, 27, 28, 29].**

### *Regional Western Australia faces special challenges*

Methamphetamine consumption is highest in regional Western Australia where access to services is especially challenging. People living in the regions experience a range of underlying drivers of drug use, depending on their circumstances, but all are exacerbated by geographic isolation, the heightened stigma that can occur in smaller communities, longer distances from services and limited transport options. The Taskforce heard that the current competitive process for procuring treatment and support services needs to be more collaborative and integrated to deliver the best outcomes – this is particularly the case for services in the regions. **The Taskforce makes a series of recommendations to establish a place-based regional planning and procurement model founded on a set of principles with community and other agencies, for implementation across every region in Western Australia [Recommendations 30, 31, 32].**

### *Aboriginal communities are particularly vulnerable*

Methamphetamine use crosses cultural, social, economic and geographic divides, however the Taskforce recognises some communities are more vulnerable to the effects of methamphetamine than others. The Taskforce heard that the people most vulnerable to the harmful impacts of its use in Western Australia are Aboriginal people. This is likely caused by the social and economic disadvantage experienced by many Aboriginal people; intergenerational trauma; and a legacy of systemic discrimination that continues to this day and which continues to erode much of the trust Aboriginal people might have in mainstream services. There are organisations working hard to deliver culturally inclusive services, but the magnitude of the complex needs of Aboriginal people who are using methamphetamine requires an even more targeted approach. **The Taskforce makes a series of recommendations to help develop capability to meet the alcohol and other drug treatment needs of Aboriginal people, including employing and training more Aboriginal people to work in the sector [Recommendations 33, 34, 35, 36].**

### *Justice populations have special needs*

Methamphetamine use among people entering the justice system is higher than in the general population, however access to treatment and support is limited. The Taskforce believes everyone in custody should be assessed for substance use and anyone willing to address their alcohol and other drug use should have easy access to these services. This group often has a range of complex issues that influence their offending, which may not be isolated to alcohol and drug use. Providing a more holistic approach to supporting people in the justice system may be more effective than simply targeting their substance use issues alone. **The Taskforce makes a series of recommendations to improve outcomes for people in the justice system including universal substance use assessment, providing appropriate treatment and support for anyone who wants it, investigating a more holistic approach to treatment and support, expanding through-care services to all prisons and to all prisoners on remand, and establishing a needle syringe exchange program in Western Australia prisons [Recommendations 37, 38, 39, 40, 41].**



*Helping to rebuild people's lives is crucial*

Helping people who were previously problematic users of methamphetamine to rebuild their lives is important to prevent and manage relapse and enable people to fully recover. Access to accommodation that supports recovery and helps people transition back into their communities, a return to work or study, and continued support and care after treatment ends are all factors which help people re-establish their lives when they stop using methamphetamine. This is particularly true for people who are re-entering the community after a period in custody related to their methamphetamine use. **The Taskforce makes a series of recommendations for continued investment in accommodation and support programs post treatment, creating partnerships to develop structured return-to-work programs, and supporting service providers to deliver assertive aftercare and support [Recommendations 44, 45, 46, 47].**

*Alternative models of regulation and control*

One of the most challenging discussions arising from this inquiry is the need to find alternative models to regulate and control the use of methamphetamine and other drugs in the community. Methamphetamine causes significant harm and threatens community safety, and many in the community agree every effort should continue to be made to reduce supply. Disrupting the business model of organised crime must remain a law enforcement priority.

However, all models of drug regulation have limitations, and the Taskforce heard the current regulatory model is not achieving its goal. The Taskforce does not recommend what model should replace the prohibition of some drug use. There are reforms being implemented internationally that encompass a broad range of approaches. The Taskforce considers that as yet, there is not enough evidence to determine the long-term effectiveness of those models, and consequently does not recommend a particular approach that would best suit the needs of all Western Australians. However, the Taskforce believes an informed, community discussion about alternative models of drug regulation needs to start in earnest now, to achieve better outcomes today, tomorrow, and for future generations. **Recognising methamphetamine addiction as a health and community issue, the Taskforce recommends a Parliamentary inquiry be undertaken to consider and report on alternative models for drug regulation and control, and their effectiveness in addressing the harms and costs to individuals, families and the community [Recommendation 48]. This inquiry should:**

- be bipartisan in structure and composition;
- be subject to specific reporting time-frames;
- involve consultation across the sector;
- be open to and engage with the public; and
- be required to report to the Parliament of Western Australia on the outcomes of the inquiry.

### *Tracking our progress*

Achieving a meaningful reduction in the supply, demand and harm associated with methamphetamine use will require continuing evaluation of the actions we take, and a willingness to adapt our strategies if they're not working. The Taskforce believes strong, community-led discussion should inform the way forward. To ensure we target the areas of greatest need in the most efficient and effective way now, the Taskforce recommends the Western Australian Government appoint a leadership group responsible for implementing the actions arising from this report. **The Taskforce recommends a plan to implement the Government's response to the Taskforce's report be developed, with measures to hold agencies accountable for their performance [Recommendation 57].**

### **Thank you**

The Taskforce recognises this report would not have been possible without the invaluable contribution of the many people, organisations and agencies who, in speaking to and engaging with the Taskforce, contributed to the ongoing discussion on the use of methamphetamine in the community. We have heard your voices. Thank you for sharing your stories.



## Summary of Recommendations

### Chapter 4 – Helping people stay away from methamphetamine in the first place

#### **Recommendation 1:**

The Department of Education and the Mental Health Commission liaise with the School Curriculum and Standards Authority to mandate a minimum level of alcohol and other drug education in all schools.

#### **Recommendation 2:**

The Department of Education gives greater prominence to alcohol and other drug education in schools by including statements in future strategic documents and directions to schools that:

- positions the issue in the context of student health and well-being;
- addresses the impacts of not just students' own use, but also use of alcohol and other drugs by others;
- requires alcohol and other drug education programs to be based on best practice;
- takes a whole-of-school approach; and
- provides for both universal and targeted programs to meet the needs of individuals and/or groups of students at greater risk.

#### **Recommendation 3:**

Recognising that schools are required to comply with a large number of policies, the Department of Education should highlight alcohol and other drug education as a priority through existing systems and communications that set directions and expectations for schools and school services (such as through the Director General's *Focus* document).

#### **Recommendation 4:**

The Department of Education monitor and publicly report alcohol and other drug program delivery in public schools to ensure alignment with best practice and effective targeting of individuals and/or groups of students at greater risk.

#### **Recommendation 5:**

The Department of Education undertake and publicly report on an independent evaluation of the effectiveness of its current school-based alcohol and other drug education programs and resources. The results of the evaluation will be used to inform improvements to alcohol and other drug education programs and resources.

### **Recommendation 6:**

In order to strengthen community level protective factors aimed at young people and their families, the Department of Communities ensures existing evidence-based, best practice models for adolescent leisure or extracurricular activities are implemented more broadly in Western Australia.

### **Recommendation 7:**

The Mental Health Commission working with the Department of the Premier and Cabinet, liaise with other governments to ensure any future public information and education campaigns run in Western Australia are targeted to meet the needs of specific audiences, at risk groups, and/or local needs, and that campaigns focus on:

- seeing methamphetamine use as a health issue first and foremost;
- including the objective to encourage help seeking behaviour and support for those directly affected;
- supporting the de-stigmatisation of methamphetamine use; and
- ensuring all future public information campaigns are evaluated for their effectiveness against their objectives.

## **Chapter 5 – Intervening early to prevent entrenched use**

### **Recommendation 8:**

The Mental Health Commission should work to reduce the stigma associated with methamphetamine use, including:

- developing specific guidelines on the use of appropriate objective and non-judgmental language regarding substance use disorders, addictions and those who use drugs for health care professionals, law enforcement agencies and public policy makers;
- consulting with appropriate agencies to ensure the guidelines are implemented throughout the working practices of these identified groups;
- conveying these guidelines to the media; and
- involving people who have or have had lived experience of methamphetamine and their families in frontline workforce education and training.

### **Recommendation 9:**

The Mental Health Commission promotes positive personal stories of successful treatment to the general public and to those experiencing problematic or dependent use of methamphetamine to address both social and self-stigma and promote help seeking behaviour.

**Recommendation 10:**

The Mental Health Commission to work with the Department of Health, the Western Australian Primary Health Alliance and the Australian Medical Association (Council of General Practitioners) Western Australia to better promote the use of the Next Steps Clinical Advisory Service to primary health and allied health care professionals.

**Recommendation 11:**

The Mental Health Commission to work with other relevant agencies to promote increased screening for alcohol and other drug conditions for people presenting to primary health care professionals and workers in child protection and community health; including increasing awareness and use of alcohol and other drug screening tools and referrals to appropriate services.

**Recommendation 12:**

The Department of the Premier and Cabinet and the Mental Health Commission, with the Western Australian Primary Health Alliance and alcohol and other drug sector, to consult with the Commonwealth Government on measures to improve referral to alcohol and other drug specialist treatment services by GPs.

**Recommendation 13:**

Worksafe in collaboration with the Mental Health Commission to work with employer and employee peak bodies to develop a strategy to build the capacity of (particularly small business) employers to better manage and support employees with drug and alcohol conditions including the management of occupational health and safety risks.

## Chapter 6 – Providing treatment and support services for those seeking help

**Recommendation 14:**

The Department of Health and WA Country Health Service ensure that its agreed State-wide detox policy, the 'Alcohol and other Drug Withdrawal Policy', is implemented by its health services as a priority.

**Recommendation 15:**

Once the outcome of the Office of the Auditor General audit on *The Availability, Accessibility and Effectiveness of Treatment for Methamphetamine* is available, the Mental Health Commission work with the Department of Treasury and the Department of the Premier and the Cabinet to develop recommendations for the Western Australian Government to prioritise funding of alcohol and other drug treatment services to address immediate and unmet demand.

### **Recommendation 16:**

The Mental Health Commission works with alcohol and other drug service providers to establish a centralised waitlist database in order to better identify and utilise existing treatment capacity.

### **Recommendation 17:**

The Mental Health Commission, in consultation with service providers, prioritise additional strategies to further improve the responsiveness to users who wish to prepare for and undertake treatment, including:

- increasing the use of peer workers to 'bridge the gap' between when users decide to seek treatment and then commence treatment;
- introducing walk-in or no-wait services, based on models in other jurisdictions, for incorporation into existing services; and
- use of e-Health and other strategies that enable an immediate response to users during the small window in which users decide they want to change.

### **Recommendation 18:**

The Mental Health Commission works with the alcohol and other drug sector to improve consumers' (including users and families) understanding of what the rehabilitation process involves, and rehabilitation options available for consumers and families beyond residential rehabilitation, including clarifying what is involved in planned detox, residential services, and community based services.

### **Recommendation 19:**

The Mental Health Commission works with alcohol and other drug service providers to ensure that service users, families and significant others are involved in the design and delivery of services, including training and professional development of service staff.

### **Recommendation 20:**

The Mental Health Commission works with alcohol and other drug service providers to ensure the outcomes of services referred to in Recommendation 19 specifically support and assist families and others who support methamphetamine users.

### **Recommendation 21:**

The Mental Health Commission expands the Parent Peer Support volunteer service beyond the current level of service provision to provide more assertive outreach into, and presence in, the community, and provide greater support for families of methamphetamine users.

**Recommendation 22:**

The Mental Health Commission collaborates with the peak bodies in mental health and alcohol and other drug sectors to ensure co-morbidity guidelines (set out in the *Co-morbidity of mental disorders and substance use: A brief guide for the primary care clinicians* and *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions*) are implemented, monitored and reported on in Western Australia.

**Recommendation 23:**

The Mental Health Commission works with the Department of Health and other key stakeholders to ensure a 'no wrong door' approach by making sure that service providers are applying the nationally developed and validated tools to assess and evaluate service capability to deliver integrated services (as set out in *Dual Diagnosis Capability in Addiction Treatment Toolkit*, *Dual Diagnosis Capability in Mental Health Treatment Toolkit*, and *Integrated Treatment for Co-occurring Disorders Evidence-based Practices Kit*.)

**Recommendation 24:**

The Mental Health Commission ensures that its commissioning policies, process and practices support and reinforce the application of the guidelines and tools referred to at Recommendations 22 and 23.

**Recommendation 25:**

The Mental Health Commission should promote the application of evidence based e-Health treatment programs or integrate e-Health treatment programs into established face-to-face models of care as a solution that may assist in: improving access to treatment for more people in general; the lack of available services in regional and rural Western Australia; and concerns about privacy in smaller communities.

## Chapter 7 – Reducing the harm associated with methamphetamine use

### Recommendation 26:

The Department of Health promotes greater awareness of needle syringe programs and needle syringe exchange programs in Western Australia to people who need these services.

### Recommendation 27:

The Department of Health in consultation with Aboriginal Community Controlled Health Services and the WA Country Health Service to implement strategies to:

- provide a more culturally appropriate service for Aboriginal people delivered by Aboriginal people; and
- improve access to and the availability of needle syringe exchange programs particularly in regional areas.

### Recommendation 28:

The Department of Health to examine opportunities for needle syringe program providers to expand their role beyond supplying clean needles and syringes to consumers of their services to include other harm reduction strategies including brief interventions.

### Recommendation 29:

Within 12 months, the Mental Health Commission, Western Australia Police Force and Department of Health establish an appropriate alternative crisis intervention response that would provide a short-term place for methamphetamine users when they are in crisis that will keep them, their families and the community safe, including in the regions.

## Chapter 8 – Regional communities

### Recommendation 30:

In order to better meet regional needs, within 12 months the Mental Health Commission develops regional alcohol and other drug plans in consultation with the community and other key stakeholders to promulgate a place-based approach to planning, investment, delivery and evaluation of services.

### Recommendation 31:

The Mental Health Commission works with the Department of the Premier and Cabinet to propose to the Ministerial Forum on Alcohol and Drugs that future Commonwealth Government resources allocated to address methamphetamine use should be apportioned based on the most recent census data and the relative 'need'

or magnitude of the problem in each state, to enable appropriate levels of funding support to be provided to address use in regional Western Australia.

**Recommendation 32:**

The Minister for Mental Health, through the Ministerial Drug and Alcohol Forum, proposes that a place-based planning and investment program be piloted in Western Australia within 12 months, supported by the Integrated Atlas of Mental Health, Alcohol and Other Drugs – Western Australia, when finalised.

## Chapter 9 – Helping groups vulnerable to high rates of methamphetamine use

**Recommendation 33:**

The Mental Health Commission works with the Aboriginal Community Controlled Health Services and Organisations to develop and deliver culturally appropriate models of residential rehabilitation.

**Recommendation 34:**

The Mental Health Commission works with Aboriginal community leaders, peak bodies and Aboriginal Community Controlled Health Services to incorporate the alcohol and other drug treatment needs of Aboriginal people in the regional alcohol and other drug plans in Recommendation 30.

**Recommendation 35:**

The Mental Health Commission to work closely with the Western Australian Network of Alcohol and other Drug Agencies to establish regular opportunities for both mainstream alcohol and other drug service providers and Aboriginal Community Controlled Health Services to share information and lessons learned about how best to meet the needs of Aboriginal people. This could include enabling inter-organisational staff mobility and training opportunities.

**Recommendation 36:**

The Mental Health Commission to work with Aboriginal community leaders, and peak bodies for Aboriginal health services and the alcohol and other drug sector to develop and implement a strategy to recruit, train and retain Aboriginal staff in both mainstream and Aboriginal-specific alcohol and other drug services.

**Recommendation 37:**

The Department of Justice and other relevant agencies introduce integrated approaches to the assessment and treatment of alleged offenders that provide a holistic, case-managed approach to treatment and support.

**Recommendation 38:**

The Department of Justice expands drug and alcohol through-care services to ensure that prisoners on remand who are released from custody are effectively connected to support and treatment services in the community.

**Recommendation 39:**

The Department of Justice ensures that all persons in custody, including remanded and sentenced offenders, are assessed for alcohol and other drug use, including methamphetamine, and are provided with intervention and treatment to meet the needs identified.

**Recommendation 40:**

The Department of Justice expands drug and alcohol through-care services to sentenced prisoners in regional prisons.

**Recommendation 41:**

The Department of Health and the Department of Justice introduce needle-syringe exchange programs in Western Australian prisons, as part of the response to the Auditor General recommendation that “The Department of Justice review current treatment approaches to demand and harm reduction, to ensure they are up-to-date and able to meet the diverse needs of prisoners”.

**Recommendation 42:**

The Department of Health, in consultation with the Mental Health Commission and representatives from the LGBTIQ community, include in the development of the Western Australian Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy – the impact of illicit drug use on the LGBTI community (including methamphetamine); relevant approaches to addressing illicit drug use, and consideration of the Rainbow Tick Accreditation Program.

**Recommendation 43:**

The Mental Health Commission in consultation with the Office of Multicultural Interests and Culturally and Linguistically Diverse (CaLD) communities, within 12 months, undertake and report on further research and consultation on drug use, its impact on CaLD communities and approaches to address issues identified.



## Chapter 10 – Helping to rebuild a person’s life after methamphetamine

### Recommendation 44:

The Mental Health Commission, working with the Department of Communities, continues to be funded for transitional housing and support for people exiting treatment for alcohol and other drug dependency, including treatment in prisons.

### Recommendation 45:

The Mental Health Commission in consultation with Western Australian Network of Alcohol and other Drug Agencies and peak employer bodies broker a partnership between a willing and capable treatment provider and employer to establish a suitable pilot structured return to employment program in Western Australia.

### Recommendation 46:

The Mental Health Commission to work with the Western Australian Network of Alcohol and other Drug Agencies and consumer groups to introduce a system and practices that support post-treatment transition planning and after care interventions for people exiting treatment, particularly for those in outpatient treatment.

### Recommendation 47:

The Mental Health Commission to specifically fund specialist alcohol and other drug services to develop and promote interventions and pathways to aftercare for clients.

## Chapter 11 – Cross-sector collaboration and coordination

### Recommendation 48:

A Parliamentary Committee inquire into and report on alternative models for drug regulation, regulatory systems and controls in other jurisdictions, including both prohibition and non-prohibition models, their effectiveness in addressing the costs and harms to individuals, families and the community, and their suitability for introduction into Western Australia. This inquiry should:

- be bipartisan in structure and composition;
- be subject to specific reporting time-frames;
- involve consultation across the alcohol and other drug sector;
- be open to and engage with the public; and
- be required to report to the Parliament of Western Australia on the outcomes of the inquiry.

**Recommendation 49:**

The Mental Health Commission works with other government agencies and the alcohol and other drug sector to integrate a case-management approach, which meets the multiple and complex needs of individuals and families, into its service delivery model.

**Recommendation 50:**

The Western Australian Government, as part of the Machinery of Government changes, consider how the State's alcohol and other drug response can be given greater priority across all portfolios and how it can be most effectively positioned within the public sector to maximise efficiency, effectiveness and engagement with the community. In particular, the Government should commission an independent body/investigator to determine the extent to which the objectives of the amalgamation of the Mental Health Commission and the Drug and Alcohol Office in 2015 have been achieved with the view to improving accountability and transparency of service delivery.

**Recommendation 51:**

The Mental Health Commission, in consultation with the Western Australian Network of Alcohol and other Drug Agencies, target service consumers and evaluate the effectiveness of information services, including: awareness of services; reach of services, including to regional areas; suitability of current delivery modes; and optimal levels and mix of service provision, within 12 months.

**Recommendation 52:**

The Department of Health works with key stakeholders to identify sources of support for specific alcohol and other drug research to make this a stated research priority.

**Recommendation 53:**

The Department of Health continues the Western Australia Illicit Substance Evaluation Study as an ongoing valuable early warning system for rapid identification and reporting of conventional and novel psychoactive drugs causing toxicity in patients.

**Recommendation 54:**

The Department of Treasury and the Mental Health Commission establish a working group to define a strategy for the adoption of a social impact investment approach, including identifying potential areas in which a social impact bond could be created, for the Western Australian Government's consideration.

## Chapter 12 – Measuring performance

### **Recommendation 55:**

The Mental Health Commission works with the Western Australian Network of Alcohol and other Drug Agencies and other drug agencies to review the current data collection and analysis system, warehoused through the Service Information Management System, to identify and implement improvements that enable the capture and demonstration of outcomes and support improved quality of specialist alcohol and other drug services.

### **Recommendation 56:**

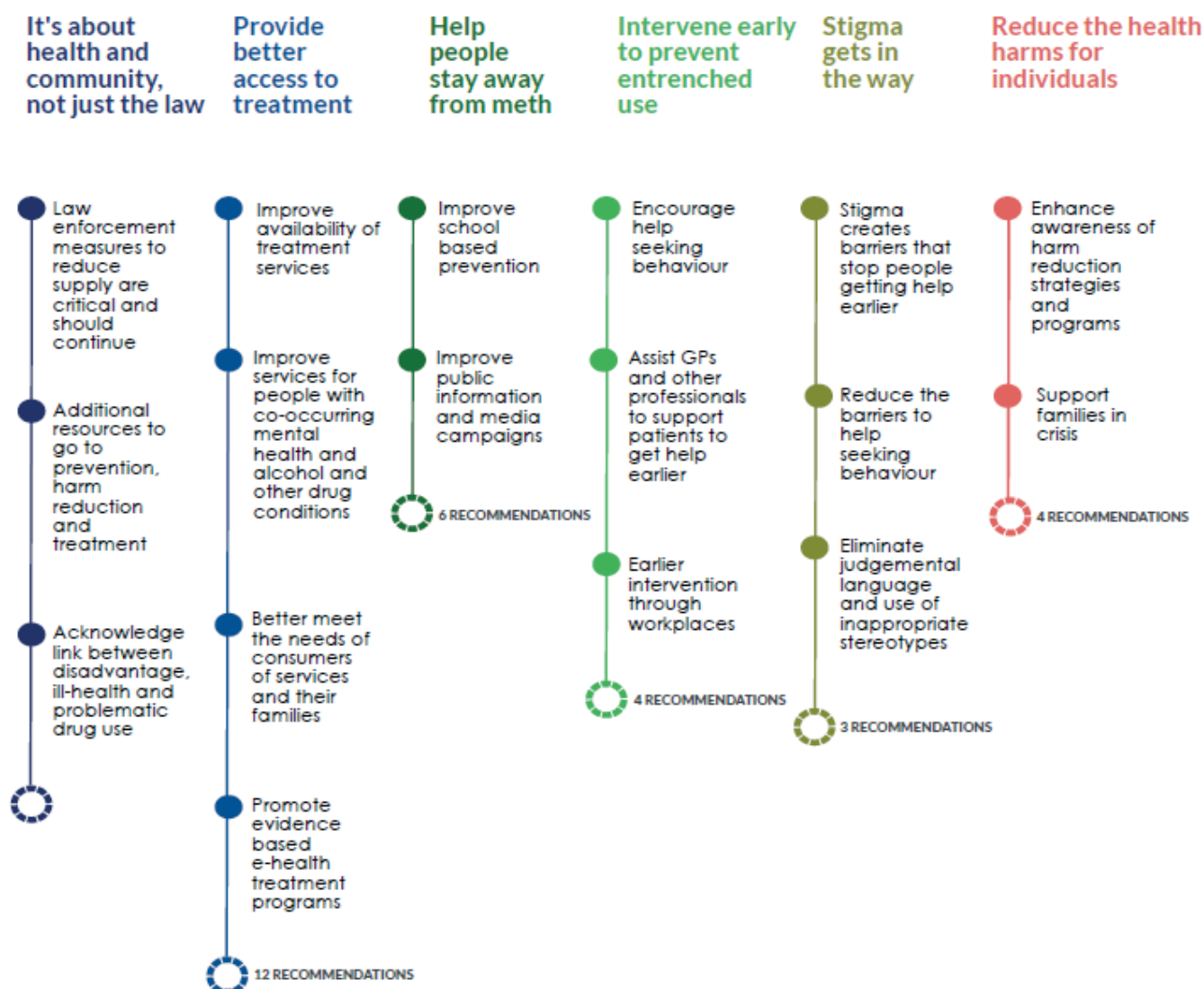
The Mental Health Commission and the Department of Health consult with relevant stakeholders to identify the appropriate mechanism for regulating alcohol and other drug specialist service providers, particularly those that are not government funded, to ensure that the community, vulnerable individuals, and potentially referring services can be confident in the quality of these services.

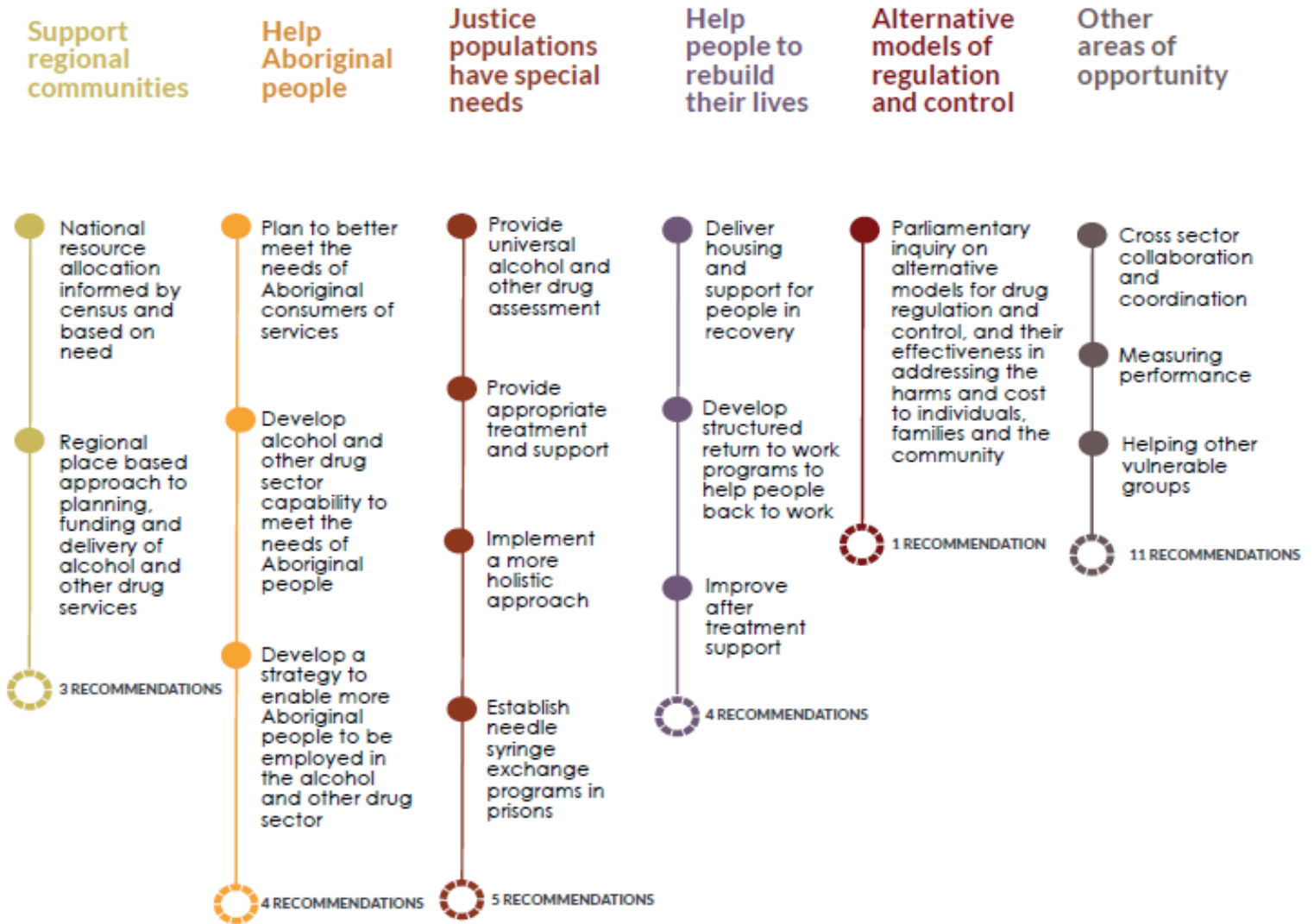
### **Recommendation 57:**

The Community Safety and Family Support Cabinet Sub Committee establishes a Methamphetamine Action Plan Senior Officer Working Group reporting to the Directors General Implementation Group. The purpose of which will include to:

- develop a plan to implement recommendations of this report supported by government;
- develop and finalise an accountability framework for measuring whole-of-government performance, including development of performance indicators (wherever possible drawing on existing preferably national data sets) and targets.

## The Taskforce makes 57 recommendations to the Western Australian Government Themes and recommendations are summarised below







## PART 1 INTRODUCTION

### Chapter 1 This report

#### 1.1 Purpose

This report represents the advice and recommendations of the Methamphetamine Action Plan Taskforce (the Taskforce) to the Western Australian Government to help inform the Government's \$131.7 million *Methamphetamine Action Plan*. The Plan includes \$83.5 million to establish a Western Australian Meth Border Force, and other funding to develop and implement a range of strategies to reduce methamphetamine demand, harm and supply.

Recognising that more can and should be done to reduce the impact of methamphetamine on individuals, families and communities, the Government established the Taskforce on 26 June 2017, to provide advice on the following:

1. Identify opportunities for improvement
  - Provide advice on how programs can be best delivered and targeted to areas of greatest need, including regional areas.
  - Provide advice on how Government can best communicate with the community and vulnerable groups about methamphetamine.
  - Provide insights into the lived experience of community members who have been directly affected by methamphetamine.
  - Provide advice on how research can inform Government initiatives and programs aimed at reducing the harm, supply and demand for methamphetamine.
  - Review successful interventions from interstate and overseas with potential for adoption in Western Australia.
2. Identify opportunities for cross-sector collaboration
  - Identify opportunities for Government, community and/or business sector collaboration to reduce methamphetamine harm, supply and demand, and make recommendations for Sub Committee consideration.
  - Identify opportunities for the community and business sectors to contribute to reducing methamphetamine harm, supply and demand.
3. Advise on the development of performance indicators and targets that can be used to measure the success of the Methamphetamine Action Plan initiatives, for Sub Committee consideration.

The full Terms of Reference for the Taskforce can be found at **Appendix A**.

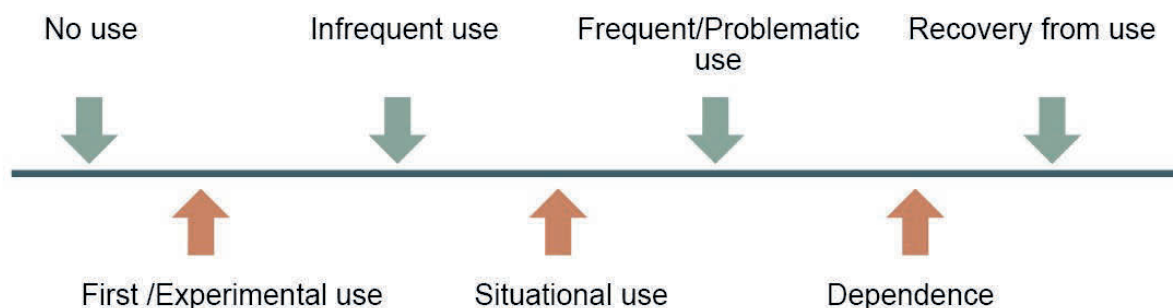
#### 1.2 Structure

The structure of the Taskforce's report is based on its Terms of Reference.

*Part 1 – Introduction* sets out the guiding principles developed by the Taskforce to underpin its advice to Government, and the methodology used to present its findings. It also shares what the Taskforce has learnt about the nature and magnitude of the problems associated with methamphetamine use in Western Australia. This includes how people use methamphetamine, how much they use and who they are; the effects of methamphetamine on users, families, and the wider community; the social costs of methamphetamine use; and current issues around demand and supply.

*Part 2 – Opportunities to improve services and support in Western Australia* considers how programs can be best delivered and targeted to areas of greatest need and is framed around the spectrum of methamphetamine use.

**Figure 1: Alcohol and Other Drug Spectrum of Use**



Source: Adapted from the Alcohol and Drug Foundation (<https://adf.org.au/alcohol-drug-use/>)

Figure 1 shows the different types of relationships people have with alcohol and other drugs. Some people choose not to use; some experiment or use in ways which are not necessarily problematic, including infrequently in social settings, or in particular situations, for example, to manage stressful circumstances. A smaller number of people experience problematic use, and a limited number of people develop entrenched and chronic use or addiction to a substance, or substances. It is important to recognise that one type of involvement does not necessarily or inevitably lead to another.

Further in *Part 2*:

- Chapter 4 examines how people can be helped to stay away from methamphetamine in the first place;
- Chapter 5 examines what could be done to intervene earlier to prevent methamphetamine users becoming entrenched or dependent users;
- Chapter 6 examines the treatment and support needed by those who are seeking help with their own or another's methamphetamine use;
- Chapter 7 considers how the harms can be reduced when people use methamphetamine;
- Chapter 8 considers the needs of people in regional communities;
- Chapter 9 looks at groups in our community where the proportion of methamphetamine users is higher than the general population and who tend therefore to be more vulnerable to the harms associated with methamphetamine; and
- Chapter 10 discusses what can be done to help people rebuild their lives after methamphetamine.

*Part 3 - Opportunities for cross-sector collaboration and coordination* looks at system level changes that are needed to more effectively meet the needs of consumers of services.

*Part 4 – Development of performance indicators and targets* considers how best to measure the effectiveness and progress of efforts to tackle methamphetamine use at program, sector and whole of government levels.



### 1.3 Principles guiding the Taskforce's advice

The Taskforce developed a set of principles to underpin the advice that it provides to Government. Below are the ten principles the Taskforce agreed would inform its advice.

**1. A balanced approach across demand, supply and harm reduction responses is required.**

There ought to be a balanced approach to interventions across demand reduction (to prevent uptake and delay first use), supply reduction (to reduce drug availability and accessibility) and treatment and harm reduction (to reduce risky behaviours and improve access to and the effectiveness of services that treat highly dependent users).

**2. Focus on preventing the initial uptake of methamphetamine and intervening early**

The earlier a person uses drugs, the greater the risk of harm to themselves and others. Preventing and delaying drug use early, before problems become entrenched, is a key focus.

**3. Recognise and address the underlying determinants of methamphetamine use**

Drug use is influenced by a range of social, health, political, cultural and economic factors. Comprehensive approaches, which take into account these determinants of health and health behaviours are required.

**4. Methamphetamine use should be treated primarily as a health issue**

Law enforcement efforts are essential to addressing the very significant problems associated with methamphetamine use in our community. While reducing the supply of the drug and community safety should continue to be a major priority, any response to the harms caused by methamphetamine requires greater emphasis on a targeted and more effective public health response.

**5. Ensure practice is informed by the best available evidence**

Responses to illicit drug use issues must be evidence-based, with effective data collection, monitoring, evaluation and research underpinning Government efforts.

**6. The system and services should be centered on addressing the needs of the client**

Information and support systems should be simple and easy to access and navigate. As many barriers as possible to seeking help including treatment should be removed or better managed. Treating the needs of clients holistically should be standard practice (e.g. services need to respond to the fact that methamphetamine is seldom used in isolation of other drugs and alcohol, and is often accompanied by mental health issues).

**7. More targeted approach for vulnerable populations and communities**

An approach is needed where services are more targeted to meet the needs of vulnerable population groups and communities that experience greater impacts from methamphetamine use.

**8. Support consumers of services, including families and significant others to be actively involved in the planning and design of services and strategies**

Meaningful participation is essential in the development and delivery of services that are better tailored to meet the needs of consumers, families and significant others. Services and programs need to be person-centred, and involve consumers, their families and significant others in their planning.

**9. Emerging drug issues and new priorities must be assessed**

Priority drugs of concern change over time and may differ from one community to another. The changing nature of drug use requires continual monitoring and strategies to address new and emerging problems.

**10. Evaluation of programs and services is essential to good practice and ongoing improvements**

Highest priority should be given to supporting strategies that are effective, backed by research, and sustained by continuous improvement and evaluation.

## **1.4 Methodology**

This report by the Taskforce is a contribution to the current and ongoing discussion on methamphetamine use, presenting issues as they were identified and prioritised by the community. It should not be seen as a comprehensive 'bible' of definitive source material. The following sources of information were examined and drawn upon by the Taskforce in formulating its advice to the Government on methamphetamine use and its impact in Western Australia.

### **1.4.1 Community consultation**

The Taskforce consulted broadly with a targeted range of groups and individuals who are either directly affected by methamphetamine use, or whose work is related to, or impacted by, methamphetamine.

The Taskforce visited and spoke with communities in the metropolitan area, as well as in Albany, Bunbury, Geraldton, Northam, Kalgoorlie, Exmouth, Karratha, Port Hedland and Broome.

More than 500 people participated in community meetings, formal stakeholder workshops or forums in the metropolitan area and in the regions, including:

- metropolitan and regional consumers of services and family members affected by methamphetamine use, particularly Aboriginal Australians;
- representatives of the South Sudanese community;
- workplace representatives, including large and small employers, employees and their representative bodies; and
- metropolitan and regionally based service providers and government agency representatives with responsibility for services that address methamphetamine use.

More than 140 organisations and agencies provided information to the Taskforce. An online comments portal was open between 16 January and 16 March 2018 to enable members of the public to provide their views and experiences to the Taskforce.

Another 145 responses were received through the portal from users and ex-users of methamphetamine, families, frontline workers and service providers.

In addition to the formal workshops, the Taskforce met with and visited a number of services, including:

- individuals with lived experience of drug use;
- major alcohol and other drug service providers with regional and metropolitan based services;
- peak bodies and advocacy groups; and
- representatives from relevant Commonwealth, State Government and Local Government agencies.

A comprehensive list of those consulted is at **Appendix B**.

#### **1.4.2 Work elsewhere and literature review**

The Taskforce reviewed and took into consideration work done by other governments across Australia to inquire into and respond to the increasing harms associated with the use of methamphetamine. The Taskforce was also interested in plans, policies, initiatives, services and programs developed nationally and in other states and territories to address methamphetamine use, where they highlighted opportunities that could be considered for use in Western Australia.

As well as this work, the Taskforce reviewed the literature available on policy, system, program and treatment responses to methamphetamine, with a specific focus on the effectiveness of approaches to reducing the use and harms associated with methamphetamine use for individuals, families and their communities. This review considered a range of different program types including those aimed at preventing first use, intervening early to prevent problematic and high dependency use, and the provision of treatment and support for dependent users.

The literature review also considered the effectiveness of services for groups more vulnerable to the impacts of methamphetamine, including friends and families of users, those living in regional and remote areas, Aboriginal people, and culturally and linguistically diverse groups.

#### **1.4.3 Stocktake of current services and programs in Western Australia**

The Taskforce undertook a stocktake of the services and programs currently available in Western Australia to address methamphetamine use and minimise its adverse effects on methamphetamine users, families and communities.

The stocktake included capturing information across all levels of government, the non-government community sector, and private providers. The scope of the stocktake included both methamphetamine specific activity as well as methamphetamine related activity, such as alcohol and other drug services for methamphetamine affected consumers. It should be noted the stocktake did not evaluate any of the included services, programs or initiatives.

The stocktake provided an overview of the range and location of services available, and also provided general information on current funding across the system.

#### **1.4.4 Use of language**

The Taskforce has made every attempt, throughout the report, to use language that is appropriate and non-judgemental regarding alcohol and other drug use, substance use disorders, and those who use drugs. We have tried, wherever possible, to refer to 'alcohol and other drug' issues as this is the generally applied terminology. Where that language is not used, it has been for quoting or referencing the work of others, or used in a clinical context.

## Chapter 2 Methamphetamine, what you need to know

### 2.1 What it is

Methamphetamine belongs to a class of stimulant drugs known as amphetamines, which also includes dexamphetamine, which is a prescribed medication used to treat conditions such as Attention Deficit Hyperactivity Disorder.

Methamphetamine comes in three main forms: powder or pill (speed), a sticky paste (base), and crystal methamphetamine (ice). The characteristics of these different drug compounds are outlined in Figure 2.

**Figure 2: Main forms of methamphetamine**

#### **SPEED**

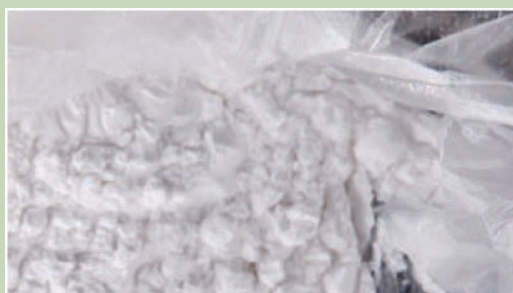


Image source: Cracks in the Ice

#### **APPEARANCE:**

Powder that can range from fine to more crystalline or coarse. Can come in a range of colours, including white, yellow, brown, orange or pink.

#### **POTENCY:**

Low – medium. Fairly easy to cut (dilute/mix with other substances).

#### **METHOD:**

Speed is typically snorted, swallowed or injected.

#### **BASE or PASTE**



Image source: Cracks in the Ice

#### **APPEARANCE:**

A gluggy, waxy, oily, 'wet' powder, resulting from the conversion process which produces the alkaline form of methamphetamine.

#### **POTENCY:**

Medium - high.

#### **METHOD:**

Swallowing or injecting.

## ICE or CRYSTAL METH



Image source: Wikimedia Commons:  
Radspunk (CC-BY-SA-4.0)

### APPEARANCE:

Clear, ice-like crystals

### POTENCY:

High. Difficult to cut dilute/mix with other substances).

### METHOD:

Smoking or injecting

This report uses the term ‘methamphetamine’ and the shortened form ‘meth’ to refer to the psycho-stimulant drug which affects the central nervous system and, due to structural differences, produces a stronger response than the psycho-stimulant amphetamine. The term is synonymous with the term ‘methamphetamine’.

Other terms used, such as ‘amphetamine-type stimulants’ (ATS) or ‘meth/amphetamine’ will appear when referring to specific datasets or research literature capturing or reporting on a broader group of drugs related to methamphetamine. The Australian Criminal Intelligence Commission states: “Amphetamine-type stimulants refers to a group of psycho-stimulants drugs that are related to the parent compound amphetamine, including amphetamine, methamphetamine and 3,4-methylenedioxymethamphetamine (MDMA) – otherwise known as ecstasy.”<sup>1</sup> Meth/amphetamine is a term used to describe the same groups of drugs, but excluding MDMA.

## 2.2 How people use it

According to the *Final Report of the National Ice Taskforce 2015*, Australia uses more methamphetamine than almost any other country and the number of users continues to grow.<sup>2</sup> Drugs are used in different situations and frequencies and for different reasons, depending on the individual and the specific point in their life. People can move between categories of use, one stage does not inevitably lead to another, and there is no clearly defined start or end stage. The majority of people who use alcohol and other drugs do not become dependent or develop serious problems as a result.<sup>3</sup>

<sup>1</sup> Australian Criminal Intelligence Commission. Illicit Drug Data Report 2015-2016, Canberra; 2017, p. 24. [accessed 2018 Nov 7] Available from:

[https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/illicit\\_drug\\_data\\_report\\_2015-16\\_full\\_report.pdf?v=1498019727](https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/illicit_drug_data_report_2015-16_full_report.pdf?v=1498019727)

<sup>2</sup> Australian Government. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015, Canberra: The Department; 2015, p. iii. [accessed 2018 Nov 7] Available from:

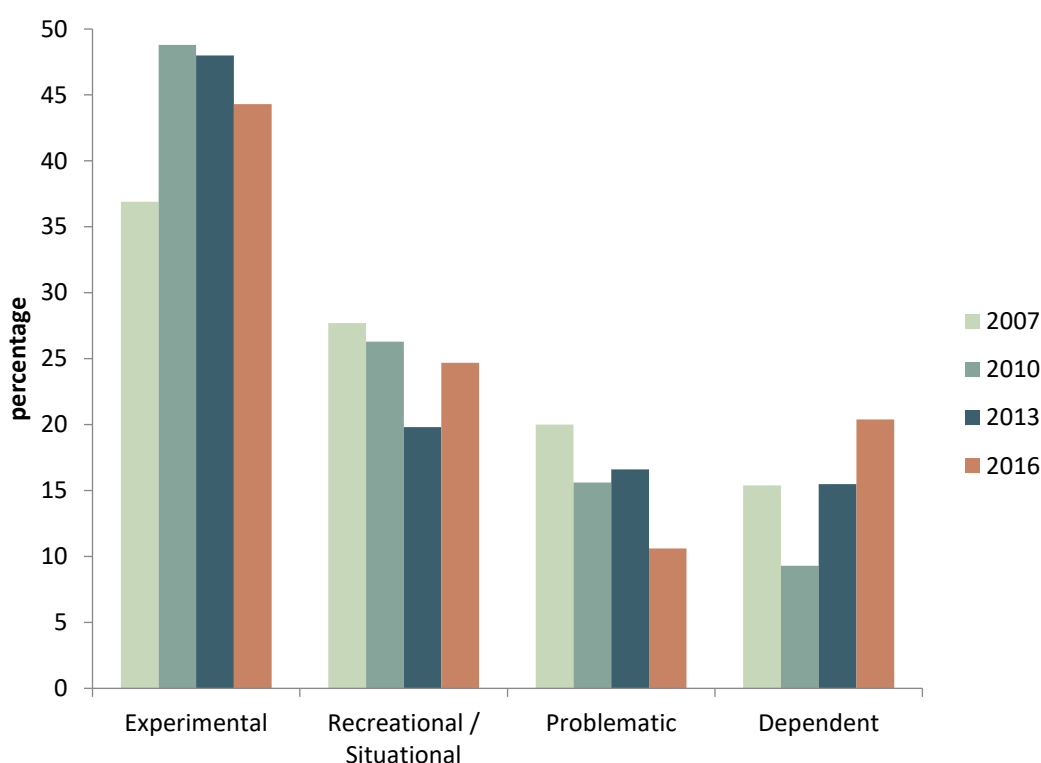
[https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

<sup>3</sup> National Council on Alcoholism and Drug Dependence Inc. Understanding addiction. 2018.

[accessed 2018 Nov 7] Available from: <https://www.ncadd.org/about-addiction/drugs/understanding-addiction>

Figure 3 shows four categories of methamphetamine user, based on their frequency of use. The majority of people who used methamphetamine in the past 12 months were categorised as experimental users, using only once or twice a year and the relative size of this group appears to be declining since 2010. 'Recreational users' – which this Taskforce report refers to as infrequent users – and 'situational' users, use methamphetamine every few months. Use by this group increased between 2013 and 2016. 'Problematic' users tend to use monthly and, as with infrequent or situational users, use by this group appeared to be declining, while the number of 'dependent' users or people who use once a week or more, increased.

**Figure 3: Types of meth/amphetamine use based on frequency of use amongst people who have consumed in the last 12 months**



Source: *National Drug Strategy Household Survey 2016 Detailed findings (table 5.44).*

## 2.3 Effect on users – from the 'highest high to 'my entry to hell'

Taskforce members heard people's experience of methamphetamine ranged from 'the highest high' to 'my entry to hell'.

Given this range of lived experience of the drug the Taskforce has sought to understand the appeal of methamphetamine and, in particular, why some people are willing to risk so much to continue with its use. The answer to this question is found, at least in part, in studies on the effects methamphetamine has on the brain.

The effect on an individual will depend on a variety of factors, including amount taken, purity of the drug, physiological factors such as age and general health, as well as tolerance to the drug and context.



### 2.3.1 The sought after effects of methamphetamine

Methamphetamine is a central nervous system stimulant which increases levels of dopamine, serotonin and noradrenaline. “Dopamine is involved in the regulation of movement; cognitive processes related to attention, working memory and motivational behaviour; and is the primary neurotransmitter involved in reward or pleasure pathways.”<sup>4</sup> “Serotonin has a role in a variety of physiological processes and in complex behaviours such as mood, appetite, sleep, cognition, perception, motor activity, temperature regulation, pain control, sexual behaviour and hormone secretion.”<sup>5</sup> “Noradrenaline is responsible for mediating cardiovascular effects, arousal, concentration, attention, learning and memory.”<sup>6</sup>

The immediate effects of methamphetamine are reported as intense pleasure and clarity, enhanced confidence, energy, sexual stimulation, increased concentration, reduced appetite, and feelings of intense competence.<sup>7</sup>

This is a result of methamphetamine dramatically increasing the levels of dopamine in the brain, shown to be to a far greater degree than that occurring from any other pleasure seeking activity or drug. Figure 4 shows comparative levels of dopamine released in the brain by different drugs measured on animals in laboratory studies. Methamphetamine releases more than 1,000 units of dopamine above base level, which is about three times more than from cocaine.

---

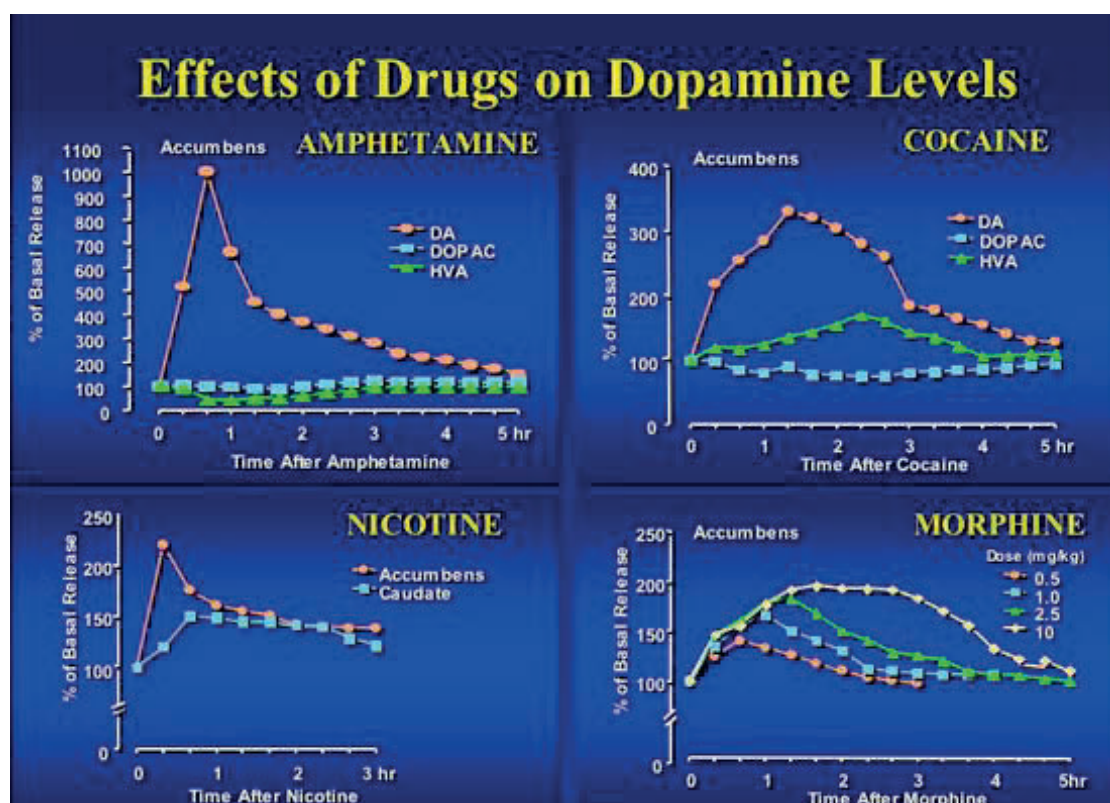
<sup>4</sup> Tzschenke, T.M. Pharmacology and behavioural pharmacology of the mesocortical dopamine system. *Progress in Neurobiology*. 2001. 63 (3), 241-320. Cited by Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 33. Available from: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

<sup>5</sup> Kema, I.P., de Vries, E.G., & Musket, F.A. Clinical chemistry of serotonin and metabolites. *Journal of Chromatography B-Biomedical Applications*. 2000. 747 (1-2), 33-48. Cited by Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 33. Available from: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

<sup>6</sup> Ressler, K.J., & Nemeroff, C.B. Role of norepinephrine in the pathophysiology and treatment of mood disorders. *Biological Psychiatry*. 1999. 46 (9), 1219-1233. Cited by Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 33. Available from: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

<sup>7</sup> Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 33. Available from: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)



**Figure 4: Effects of different drugs on dopamine levels in the brain**

Source: Meth and the Brain, Richard A Rawson, Ph.D Adjunct Associate Professor in the Department of Psychiatry and Biobehavioural Sciences, David Geffen School of Medicine, University of California, Los Angeles.<sup>8</sup>

### 2.3.2 The adverse effects of methamphetamine

The short-term adverse consequences of methamphetamine use, sometimes called the 'come down', include: "restlessness, irritation, anxiety, agitation, tremor, teeth grinding, insomnia, confusion, increased heart rate and irregular heartbeat, abdominal pain, sweating, dilated pupils, fatigue, and parasitosis (picking and scratching skin)."<sup>9</sup>

Once methamphetamine is taken at higher doses and/or more frequently, use can result in deficits in memory, decision-making and verbal reasoning, reduced immunity, high blood pressure, cardiovascular problems, kidney failure, depression, anxiety and dental problems.<sup>10</sup>

Some of the more serious health effects from 'normal' doses of methamphetamine are strokes and seizures, as well as mental health consequences including "sleep

<sup>8</sup> Available from <https://www.pbs.org/wgbh/pages/frontline/meth/body/methbrainflash.html>. Based on the work of Di Chiara G, and Imperato A, Drugs abused by humans preferentially increase synaptic dopamine concentrations in the mesolimbic system of freely moving rats, *Proc. Nat. Acad. Sci. USA* Vol 85, pp 5274-5278, July 1988. [accessed 2018 Nov 7]

<sup>9</sup> Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 34. [accessed 2018 Nov 7] Available from:

[http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

<sup>10</sup> Ibid.

disorders, psychosis, paranoid hallucination, agitation, confusion, severe panic, anxiety and depression.”<sup>11</sup>

Methamphetamine is also associated with violence and violent behaviour. “Using the drug increases the ‘fight or flight’ response, which can make people react more aggressively to situations where they feel threatened. They often experience heightened confidence, strength and stamina in these situations, making them more threatening and more of a threat to other people. These situations can be triggered by paranoia that is brought on by the drug which can also affect judgement, leading people to respond impulsively and irrationally.”<sup>12</sup>

### 2.3.3 The impact of longer term regular use

Over the longer term and with regular use, methamphetamine alters the activity of the dopamine system such that the brain’s dopamine reserve is drained and the ability of the body to produce more is damaged. Regular and large bursts of dopamine damage and effectively wear out dopamine receptors in the brain, diminishing the brain’s ability to experience pleasure naturally. This leads to users no longer ‘feeling normal’ without methamphetamine, causing re-use and, for some, chronic abuse of the drug.<sup>13</sup>

The prolonged chemical effects of methamphetamine on the brain have been shown to cause not only functional but structural changes to the brain. These significant changes in the brain are such that even after people have stopped using, it can take one to two years before these brain changes subside.<sup>14</sup> The protracted nature of the changes to the brain offers, in part, an explanation for the views put to the Taskforce during its community consultations that methamphetamine is a very challenging drug to get off once users are dependent, and the incidence of relapse is high.

Overdosing on methamphetamine can cause heart failure and death. A recent study of methamphetamine-related death in Australia over seven years (2009 to 2015) reports there were 1,649 such deaths and the annual death-rate doubled from about 150 to 300 a year.<sup>15</sup> Deaths were due to accidental toxicity (43.2 per cent) most frequently involving multiple drugs; natural disease (22.3 per cent) the most frequent of which was cardiac and/or cardiovascular disease; suicide (18.2 per cent), predominantly by violent means; other accident (14.9 per cent),

---

<sup>11</sup> Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 34. [accessed 2018 Nov 7] Available from: [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

<sup>12</sup> Australian Government. Department of Health. National Drug and Alcohol Research Centre. Methamphetamine: What you need to know about speed, ice, crystal, base and meth. Canberra: The Department; 2014. p.5. [accessed 2018 Nov 7] Available from: <https://comorbidity.edu.au/sites/default/files/Methamphetamine%20Detailed%20Resource%20%28for%20Parents-Teachers%29.pdf>

<sup>13</sup> Australian Government. Department of Health. Cracks in the Ice: How Does Ice Work? Canberra: The Department; 2018. [accessed 2018 Nov 7] Available from: <https://cracksintheice.org.au/how-does-ice-work>.

<sup>14</sup> Ibid.

<sup>15</sup> Darke S, Kaye S, Duflou J. Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study. 2017. *Addiction* 112 (12).

most commonly driver motor vehicle accident; and homicide (1.5 per cent).<sup>16</sup> In 40.8 per cent of cases, death occurred outside the major capital cities,<sup>17</sup> despite only a third of Australia's population living outside major capital cities.<sup>18</sup> The average age of those who died was mid-30s, and 78.4 per cent were male.<sup>19</sup> A third were employed, and a third were married or in de-facto relationships.<sup>20</sup> Of particular note from this study is:

- few of those who died were in treatment at the time of death;
- those who died were generally not young or inexperienced, and were older than the average age of people who sought entry for treatment for methamphetamine dependence;
- the role of disease is given less attention than death by violence, with heart disease a major factor in methamphetamine death; and
- poly-drug use was a prominent feature of the study.<sup>21</sup>

## 2.4 Why people use it

Methamphetamine use in our community is a complex, multi-dimensional problem driven by the social determinants of health. The World Health Organisation defines these as the “conditions in which people are born, grow, live, work and age. These circumstances are further shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.”<sup>22</sup>

The concept of the social determinants of drug use emerges from studies of human development and the social determinants of health. These studies conclude that drug use behaviours are the result of a complex interplay of individual and environmental factors across a life course. A 2004 study into the social determinants of drug use and the structural interventions to address them, conducted through the National Drug and Alcohol Research Centre, determined:

“A variety of factors contribute to drug use and other problem outcomes, both individual and environmental. While drug prevention and treatment have traditionally focused on changing individual behaviours, such efforts can have only limited impact when changes are not made to the environment, that is, to the social determinants of drug use.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Australian Bureau of Statistics. Australian Demographic Statistics, 3101.0. Canberra: Australian Bureau of Statistics; 2016.

<sup>19</sup> Darke S, Kaye S, Duflou J. Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study. 2017. *Addiction* 112 (12): 1- 6.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.

<sup>22</sup> World Health Organization. Social determinants of health. 2018. [accessed 2018 Nov 7] Available from: [http://www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/)

These include the social and cultural environment, the economic environment and the physical environment.”<sup>23</sup>

The risk factors for determining drug use include social alienation, isolation and marginalisation, prolonged or chronic stress which impact on mental and physical health, economic hardship and related social disadvantage and trauma, the impact of which is sometimes transmitted across generations. For Aboriginal people the risk factors are exacerbated as the result of a long history of dispossession of their lands, active disruption of Aboriginal society and cultural practice, discrimination, and intergenerational trauma caused by government policy and interventions that have ranged from brutal to misguided or poorly conceived.<sup>24</sup>

Because methamphetamine can make people feel powerful, competent, confident and in control, <sup>25</sup> it will be most attractive and entrenched among people and communities where there is hopelessness, despair and disengagement. The 2004 National Drug and Alcohol Research Centre study into the social determinants of drug use concluded that because there were multiple risk factors for drug use across multiple domains, a failure to address the spectrum of contributing factors would result in limited benefit.<sup>26</sup> “Any single intervention, single sector or single worker can have only a limited impact on drug-use problems. No person, agency or sector by itself can ‘fix’ an individual or a community. Comprehensive and sustained action is needed for effective prevention and treatment.”<sup>27</sup>

---

<sup>23</sup> Spooner C, Hetherington K. Social Determinants of drug use, Technical Report Number 228. National Drug and Alcohol Research Centre. University of New South Wales. Sydney; 2004. [accessed 2018 Nov 7] Available from:

<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf>

<sup>24</sup> Spooner C, Hetherington K. Social Determinants of drug use, Technical Report Number 228. National Drug and Alcohol Research Centre. University of New South Wales. Sydney; 2004. p. v-xiii. [accessed 2018 Nov 7]. Available from:

<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf>

<sup>25</sup> Australian Government. Department of Health and Aging. National Amphetamine-Type Stimulant Strategy Background Paper: Monograph Series No. 69. Canberra: The Department; 2007. p. 33. [accessed 2018 Nov 7] Available from:

[http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf)

<sup>26</sup> Spooner C, Hetherington K. Social Determinants of drug use, Technical Report Number 228. National Drug and Alcohol Research Centre. University of New South Wales. Sydney; 2004. p. v-xiii. Available from: <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf>

<sup>27</sup> Ibid.

## Chapter 3 The magnitude of the methamphetamine problem

Reports of the problems arising from methamphetamine use have attracted increased media, community and policy attention in Australia and Western Australia, particularly since 2015. The Taskforce has heard from researchers, health and alcohol and other drug front-line workers, and law enforcement officials who have differing views about whether methamphetamine use and demand is increasing. For this reason, it was important for the Taskforce to better understand how many people and who is using the drug, how frequently and what the impacts of use are on the community.

### 3.1 Community attitudes

“Meth is a growing problem affecting everyone from housewives to nurses to friends and family. I think the stigma around it needs to be removed so that people struggling know they are not the only one and be more willing to access help.”

*Online comment*

There has been a clear shift in community perceptions towards methamphetamine in Australia in recent years. According to the 2016 *National Drug Strategy Household Survey*, methamphetamine has become the drug of most serious concern to the general community, overtaking alcohol with concern more than doubling since 2013 (from 16 per cent to 40 per cent).<sup>28</sup> It was also nominated for the first time as the drug most likely to be associated with a ‘drug problem’ (the proportion more than doubling between 2013 and 2016, from 22 per cent to 46 per cent).

Despite this perception, the current level of community concern regarding methamphetamine does not appear to correlate to the level of harm which methamphetamine actually causes in the community when compared with that caused by alcohol and other drugs. For example, tobacco causes more ill health and premature death than any other drug, and alcohol-related hospital admissions are higher than those for any illicit drug.<sup>29</sup> Further, results of the National Drug Strategy Household Survey (NDSHS) 2016<sup>30</sup> (a self-disclosure survey of people aged 12 or older who provide information on their drug use patterns, attitudes and behaviours) indicate that the use of meth/amphetamines generally has been in decline across Australia since 2001, although amphetamine use remains more prevalent in Western Australia than any other state or territory.

However, it should be noted there are concerns about the under-reporting of drug use, particularly by cohorts considered to be ‘heavy’ or ‘problem’ users, in data sets

<sup>28</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

<sup>29</sup> Ibid. p. 2.

<sup>30</sup> The NDSHS is an important source of data on the prevalence of meth/amphetamine use. It is a triennial national survey of alcohol, tobacco and illicit substance use in Australia. In 2016, 23,772 people aged 12 or older gave information on their drug use patterns, attitudes and behaviours.



such as the NDSHS which may undermine prevalence estimates.<sup>31</sup> In the case of methamphetamine, under reporting of use in the NDSHS is attributed to increased media attention that stigmatises users of the drug.<sup>32</sup>

### 3.2 Methamphetamine supply

The majority of methamphetamine seized in Australia originates from China and its provinces.<sup>33</sup> It has become more economical to purchase the finished product from overseas rather than manufacture methamphetamine domestically, and consequently it has become more profitable to sell.

Figure 5 shows the number of clandestine laboratory detections in Western Australia has declined five-fold from the peak in 2010-11. Of the 33 clandestine laboratories detected in Western Australia in 2016-17, only 19 were meth-related. The majority of clandestine laboratories detected in Western Australia were small addiction-based labs which use the Nazi/Birch<sup>34</sup> production method. Only one laboratory was classified as medium size.

---

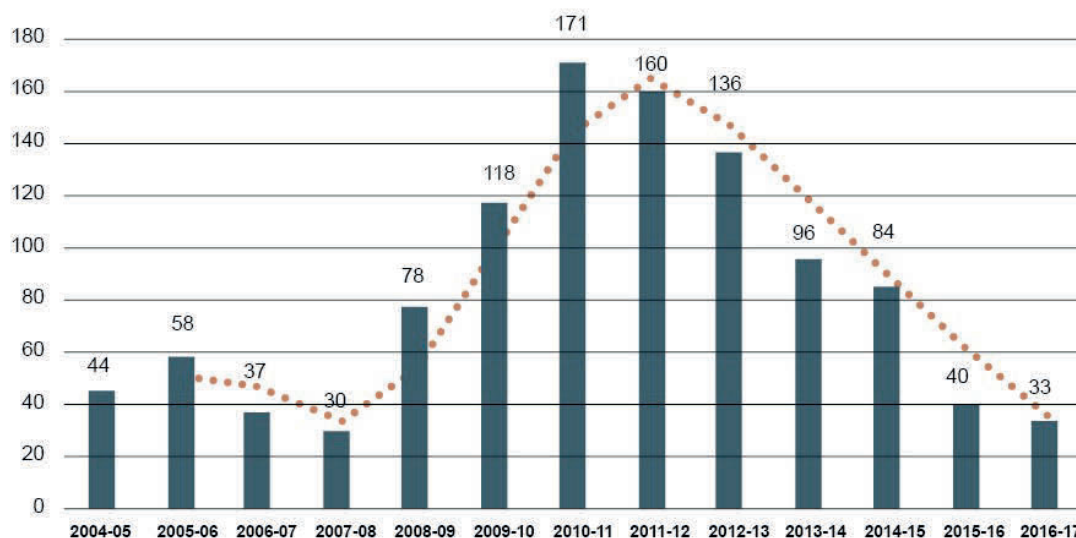
<sup>31</sup> These populations are under-represented in household surveys because a proportion of these users will be institutionalised or homeless and stigma and concerns about the illegality of substance use can lead to under reporting.

<sup>32</sup> National Drug Research Institute. The Social Cost of Methamphetamine in Australia 2013/14. Perth: Curtin University; 2016. p. 30. [accessed 2018 Nov 7] Available from: <https://ndri.curtin.edu.au/ndri/media/documents/publications/T246.pdf>

<sup>33</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC,). Illicit Drug Data Report 2015–16. Canberra: ACIC; 2017. p. 33. [accessed 2018 Nov 7] Available from: [https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/iddr\\_2015-16\\_introduction.pdf?v=1498020198](https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/iddr_2015-16_introduction.pdf?v=1498020198)

<sup>34</sup> The 'Birch reduction' method, also called the 'Nazi method' is a process for the (clandestine) manufacture of methamphetamine commonly used to convert ephedrine and pseudoephedrine to methamphetamine. The name 'Nazi method' is variably attributed to its use by soldiers in 1942 Germany, or to an early method circulated on stationery bearing a neo-Nazi logo. Caldicott D, Pigou P, Beattie R, Edwards J. Clandestine drug laboratories in Australia and the potential for harm. Australian and New Zealand Journal of Public Health. 2005 Vol 29 (2): 155-162.

**Figure 5: Number of clandestine laboratory detections in Western Australia 2004-05 to 2016-17**



Source: Western Australia Police Force.

Western Australia saw record seizures of meth/amphetamine in 2017, including the biggest in Australia's history involving a single seizure of 1.2 tonnes in Geraldton worth a reported \$1.04 billion. According to ABC news reports, based on National Wastewater Drug Monitoring Program results this seizure would have been enough to feed the meth/amphetamine appetite of Australia for two months.<sup>35</sup>

This seizure reflects the trend of significantly increasing weights of seizures. Despite the increasing number of seizures by law enforcement, weights of drug being seized are also increasing, as shown in Figure 6. Since 2010-11 there has been a five-fold increase in the number of seizures, and a 19-fold increase in the total weight of seizures.

<sup>35</sup> Menagh, J. Record methamphetamine haul leads to man's guilty plea after 1.2 tonnes seized at Geraldton. ABC online. 2018 March 28. [accessed 2018 Nov 7] Available from: <http://www.abc.net.au/news/2018-03-28/guilty-plea-over-australias-largest-seizure-of-methamphetamine/9597854>

**Figure 6: Amphetamine-type stimulants seizures in Western Australia 2010-11 to 2015-16 by numbers and weight**



Source: ACIC, Illicit Drug Data Reports 2010-11 to 2015-16<sup>36</sup>

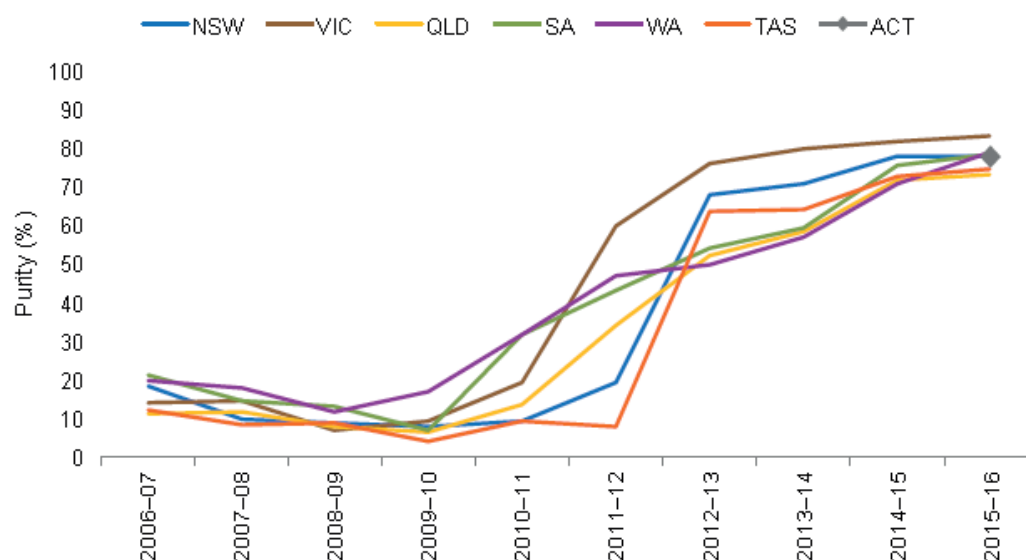
Concurrently, the average purity of the drug has also increased and users report it is easily available.

<sup>36</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC). Illicit Drug Data Reports 2010-11 Table 32, p. 182; 2011-12 Table 39, p.210; 2012-13 Table 49, p. 236; 2013-14 Table 49, p.210;2014-15 Table 51, p. 192;2015-16 Table 51, p. 210.



Figure 7 from the 2016 *Illicit Drug Data Report 2015–16* shows the purity of methylamphetamine samples significantly increased between 2010–11 and 2015–16.

**Figure 7: Annual median purity of methylamphetamine samples, 2006-07 to 2015-16 (by state)<sup>37</sup>**



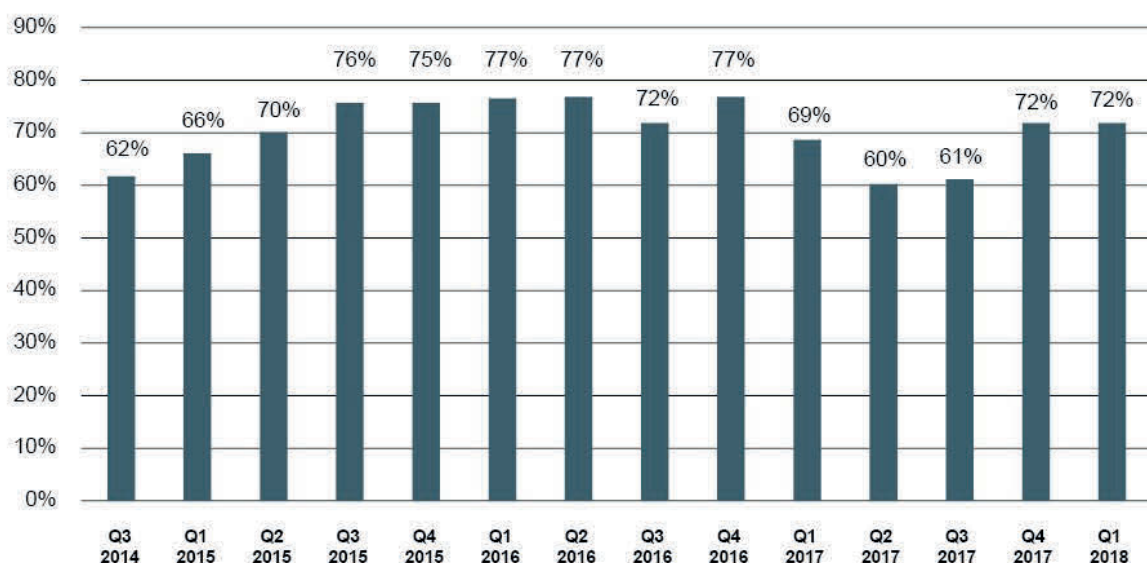
Source: Australian Criminal Intelligence Commission, 2017.

As Figure 8 shows, the Western Australian ChemCentre Quarterly Report for quarter one 2018<sup>38</sup> shows while the overall purity of methamphetamine seizures has increased since 2014, the quarterly average purity<sup>39</sup> of seizures decreased in 2017 from highs reported in 2016, before increasing once again.

<sup>37</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC,). *Illicit Drug Data Report 2015-16*. Canberra: ACIC; 2017. p. 48. [accessed 2018 Nov 7] Available from: [https://www.acic.gov.au/sites/g/files/net3726/f/2017/06/illicit\\_drug\\_data\\_report\\_2015-16\\_full\\_report.pdf?v=1498019727](https://www.acic.gov.au/sites/g/files/net3726/f/2017/06/illicit_drug_data_report_2015-16_full_report.pdf?v=1498019727)

<sup>38</sup> Quarterly Report provided by ChemCentre to WA Police Force. Quarter one 2018.

<sup>39</sup> Purity determination is limited to samples in excess of 2 grams or those submitted for “WalkThru” analysis.

**Figure 8: Average purity of methamphetamine seizures analysed by the Western Australian ChemCentre**

Source: Western Australia Police Force with permission provided by ChemCentre.

The results of sample tests are supported by reports from users of methamphetamine. Survey participants nationally reported that the purity of crystal methamphetamine or ice was 'high', and that high purity methamphetamine was considered 'easy' or 'very easy' to obtain<sup>40</sup>. In 2015, a survey of Perth injecting drug users also reported that ice purity was 'high', and was rated 'easy' or 'very easy' to obtain by most participants.<sup>41</sup> A survey conducted by the Australian Criminal Intelligence Commission confirmed ice is easily available, with the number of regular injecting drug users reporting ice as 'easy' or 'very easy' to obtain, increasing from 91 per cent in 2014 to 95 per cent in 2015.<sup>42</sup>

Despite record seizures and concurrent increases in weight and purity of available supply, the price of crystal methamphetamine or ice has continued to drop, making it increasingly affordable. During 2015-16 the street price per gram for ice across Australia ranged from \$150 to \$1200, compared with \$300 to \$1600 in 2013-14.<sup>43</sup> Five drug users surveyed in Perth in 2016 as part of the national Illicit Drug Reporting System put the average price of methamphetamine at \$450 per gram, down from \$700 in 2015.<sup>44</sup>

<sup>40</sup> Stafford J, Breen, C. Australian Drug Trends 2016. Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series no. 163. Sydney: National Drug and Alcohol Research Centre, UNSW Australia; 2017. p. xvi.

<sup>41</sup> Fetherston J, Lenton S. WA Drug trends 2015: Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series no. 151. Sydney: National Drug and Alcohol Research Centre, UNSW Australia; 2016.

<sup>42</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC). Illicit Drug Data Report 2015–16. Canberra: ACIC; 2017. p. 50. [accessed 2018 Nov 7]. Available from: [https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/iddr\\_2015-16\\_introduction.pdf?v=1498020198](https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/iddr_2015-16_introduction.pdf?v=1498020198)

<sup>43</sup> Ibid. p.47.

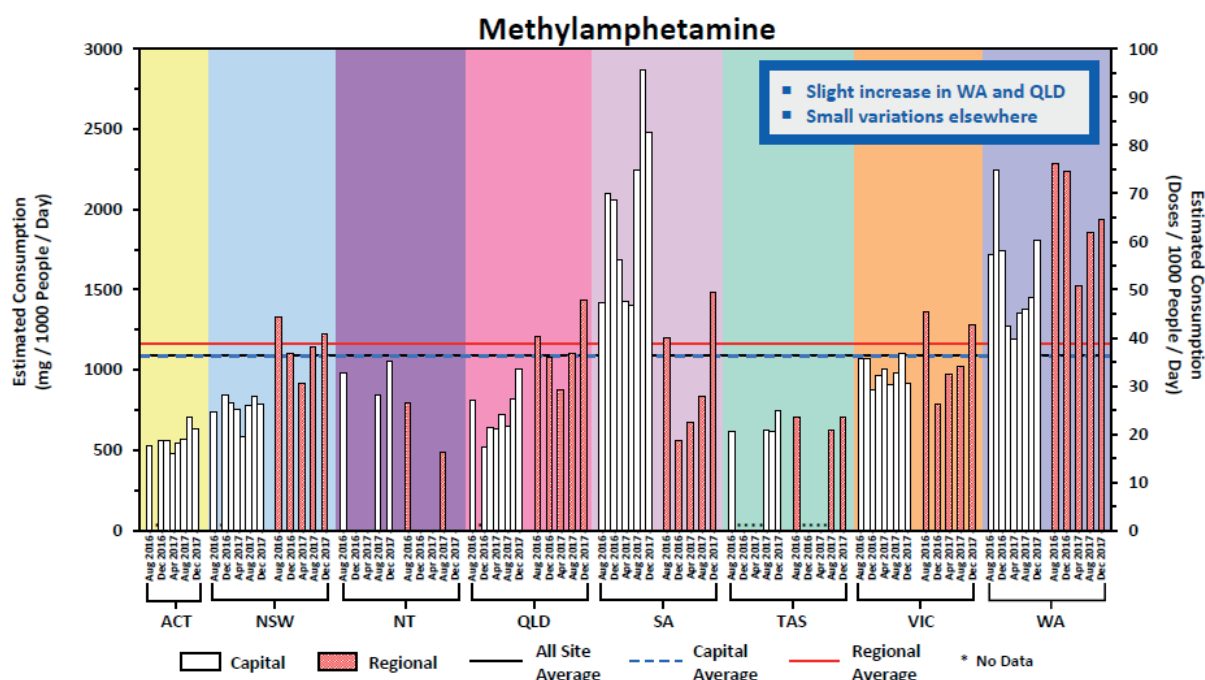
<sup>44</sup> Fetherston J, Lenton S. WA Drug trends 2016: Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series no. 169. Sydney: National Drug and Alcohol Research Centre, UNSW Australia; 2017. p. xi.

More recently, patients presenting to the emergency department at Royal Perth Hospital in 2017-18 reported the price of methamphetamine as \$100 per point (0.1 gram).

### 3.3 How much is consumed in Western Australia

The April 2018 Australian Criminal Intelligence Commission's fourth report from the National Wastewater Drug Monitoring Program<sup>45</sup> reported that the rate of consumption for methamphetamine in regional Western Australia (not to be confused with a measure of the number of people using the drug) is higher than all other jurisdictions.<sup>46</sup>

**Figure 9: Estimated average consumption of methamphetamine by state/territory, to December 2017**



Source: Commonwealth of Australia, Australian Criminal Intelligence Commission, *National Wastewater Drug Monitoring Program Report, Report 4*, Canberra, Commonwealth of Australia, 2017, p.33.

As shown in Figure 9, the fourth report of the National Wastewater Drug Monitoring Program also indicated that Western Australia recorded significantly higher levels of

<sup>45</sup> Wastewater analysis is now a standard method for measuring population-scale use of a range of different chemical compounds, in particular selected substances of concern in most populated regions of Australia. In August 2017, a total of 22 wastewater treatment plants in capital cities and a further 32 regional sites participated in the project, covering a population of 14 million Australians. Australian Government. Australian Criminal Intelligence Commission (ACIC). National Wastewater Drug Monitoring Program Report: Report 4. Canberra: ACIC; 2018. [accessed 2018 Nov 7] Available from: <https://www.acic.gov.au/sites/g/files/net3726/f/nwdmp4.pdf?v=1522809564>

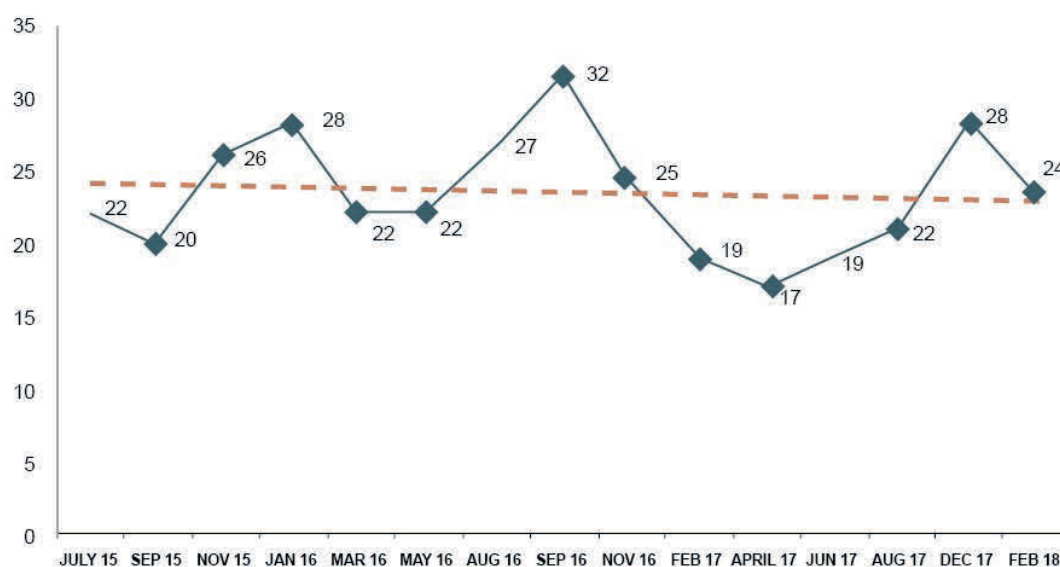
<sup>46</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC). National Wastewater Drug Monitoring Program Report: Report 3. Canberra: ACIC; 2017. p.33. [accessed 2018 Nov 7] Available from: [https://acic.govcms.gov.au/sites/g/files/net3726/f/national\\_wastewater\\_drug\\_monitoring\\_program\\_report\\_3.pdf?v=1513140704](https://acic.govcms.gov.au/sites/g/files/net3726/f/national_wastewater_drug_monitoring_program_report_3.pdf?v=1513140704)

methamphetamine in its wastewater in regional areas compared with all other jurisdictions. However, Perth's status as the 'capital of methamphetamine', as reflected in the first report of the NWDMP, has been overtaken by Adelaide.<sup>47</sup>

The Western Australia Police Force commenced its own Methamphetamine Wastewater Analysis Project in July 2015. The Project analyses wastewaters in the Perth metropolitan area and selected regional locations and provides longer-term data on the extent of the methamphetamine issue in Western Australia.

Figure 10 shows the estimated weekly methamphetamine consumption in the Perth metropolitan area fluctuates over time, peaking in September 2016 and recording the biggest low in April 2017. Average weekly consumption was 23kg in 2015, 26kg in 2016 and 21kg in 2017. There has been a slight downward trend since the project commenced.

**Figure 10: Perth metropolitan estimated weekly methamphetamine consumption (kg)**



Source: Western Australia Police Force.

The estimated total weight of methamphetamine consumed in the week tested in February 2018 for the Perth metropolitan area was 23.65kg. This represents an estimated street value of \$23,650,000 per week or approximately \$1.23 billion annually.

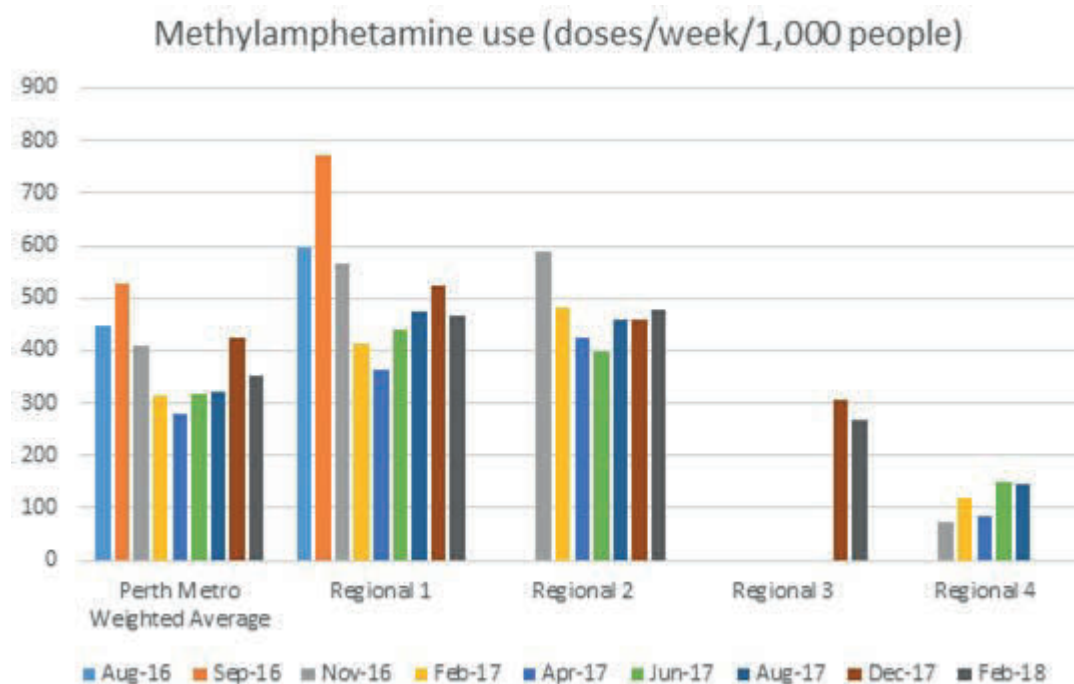
Consistent with the NWDMP, the National Drug Strategy Household Survey 2016 reported evidence of higher meth/amphetamine use in regional areas than in cities. The 2016 survey indicated meth/amphetamine users continue to be more likely to live in remote and very remote areas, with the only significant decrease in use by

<sup>47</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC). National Wastewater Drug Monitoring Program Report: Report 4. Canberra: ACIC; 2017. p.34. [accessed 2018 Nov 7]  
Available from:  
[https://acic.govcms.gov.au/sites/g/files/net3726/f/national\\_wastewater\\_drug\\_monitoring\\_program\\_report\\_3.pdf?v=1513140704](https://acic.govcms.gov.au/sites/g/files/net3726/f/national_wastewater_drug_monitoring_program_report_3.pdf?v=1513140704)

area occurring in major cities (from 2.1 per cent to 1.4 per cent).<sup>48</sup> This is further substantiated by wastewater testing conducted by the Western Australia Police Force.

Figure 11 shows the total consumption of methamphetamine (doses per week per 1,000 people) for each of the tested plants in Western Australia. Average regional consumption is consistently higher than average metropolitan consumption.

**Figure 11: Methamphetamine Wastewater Analysis August 2016 to February 2018, Western Australia**



Source: Western Australia Police Force.

### 3.3.1 Western Australia Police Force Remote Communities Wastewater Analysis Project

In 2015, the National Ice Taskforce summit in Broome raised strong community concern there was a growing problem of methamphetamine use within the Aboriginal population. Limited data existed to validate the concern of high methamphetamine use and wastewater analysis was identified as a way to obtain a greater understanding of the extent of methamphetamine use in remote communities. The wastewater data also provides further information to assist in guiding strategies formed by key government agencies to reduce both supply and demand of methamphetamine in remote communities.

In August 2016, the Western Australia Police Force broadened its wastewater analysis research to include 34 remote Aboriginal communities across the Pilbara (7), Kimberley (22) and Goldfields (5) regions.<sup>49</sup> The analysis showed methamphetamine had been used in all communities tested except one. This

<sup>48</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. p 100. [accessed 2018 Nov 7] Available from:

<https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed>

<sup>49</sup> Testing was undertaken with the consent of the communities.

indicates methamphetamine use is not limited to regional centres and remoteness is no longer a protective factor for communities.

The testing cannot quantify how much methamphetamine is consumed in a given community, it can only determine whether methamphetamine has been used there. This is different to the NWDMP which does estimate the number of doses per week.

### **3.4 Who is using methamphetamine**

Assessing whether methamphetamine is a growing problem for the community and government, and the extent of the problem are contested issues. Some stakeholders and commentators point to declining 'prevalence of use' as evidence of a declining problem, often contrasting the impact of methamphetamine in our community with the evidence on the harms associated with alcohol. Others point to increasing rates of methamphetamine in wastewater testing and other measures, such as emergency department presentations and arrests, as evidence of an escalating problem of 'epidemic' proportion.

The Taskforce has taken into account a range of divergent information from a variety of sources and notwithstanding the sometimes contested nature of the views, presents its best understanding of the situation to date.

While the picture in Western Australia varies, it may be more accurate and helpful to characterise the extent of the problem as 'endemic' (a condition found particularly in a specific area or group), rather than 'epidemic' (a problem that seriously affects many people at the same time). The benefit of seeing the problem as endemic would be to enable a more accurate identification of the underlying causes, and therefore develop more targeted and effective interventions. The use of the word epidemic suggests the problem is 'contagious' and out of control. Conceptualising it in this way does not necessarily offer constructive avenues for solutions, nor does it offer much hope to those needing support to deal with the problems associated with methamphetamine.

#### **3.4.1 The *National Drug Strategy Household Survey 2016***

The 2016 survey was the 12<sup>th</sup> conducted and collected information from almost 24,000 people from a sample of households. People in institutions or the homeless were not included. This survey is the one most often referred to when positing that the number of people using methamphetamine is declining, and that consequently any framing of the problem as an 'epidemic' is over-stated.

The 2016 survey reported that in Western Australia, 2.7 per cent of people aged 14 years and older had used meth/amphetamine in the previous 12 months, categorised as recent use. While this was higher than any other state or territory, the recent use of the drug in Western Australia had declined from a high of 4.2 per cent in 2007, and recent use among people aged between 14 and 19 years and those in their 20s declined significantly. The Western Australia trend in declining recent use is consistent with the national trend, which shows a decrease from 2.1 per cent in 2013 to 1.4 per cent (or 280,000 people) in 2016.



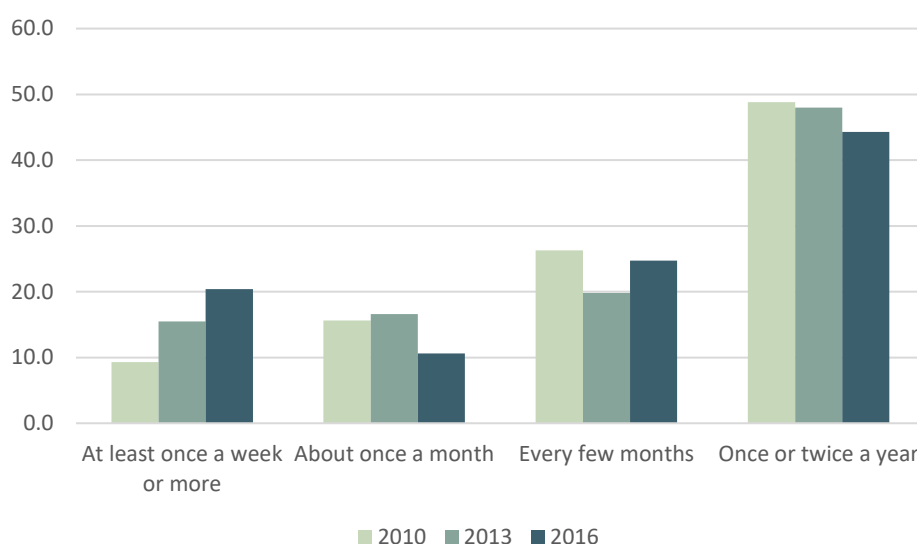
Results from the 2016 survey also indicate that the cohort of people who use meth/amphetamine is aging. The average age of people using the drug in 2016 was 34, compared with 30 years in 2013, and 26 years in 2001.<sup>50</sup>

However, more and most meth/amphetamine users (57 per cent) reported using the drug in its most harmful form, ice, with rates of ice use doubling in the previous decade.<sup>51</sup>

The proportion of people injecting methamphetamine also doubled from 9.4 per cent in 2013 to 19.2 per cent in 2016<sup>52</sup>, although the majority of recent people using smoked the drug (42 per cent).

Further indication of a decline in circumstances, as shown in Figure 12, is the increasing number of recent users who used meth/amphetamine more frequently, with weekly or more often use more than doubling from 9.3 per cent in 2010 to 20 per cent in 2016.<sup>53</sup> This rate of methamphetamine use weekly or more often is much higher than for users of cocaine (at 2 per cent), and MDMA or 'ecstasy' (at 3 per cent).<sup>54</sup>

**Figure 12: Frequency of meth/amphetamine use, recent users<sup>55</sup> 14 years or older from 2010 to 2016 (per cent)**



Source: National Drug Strategy Household Survey, Table 5:14 Frequency of drug use, recent users aged 14 or older 2010 to 2016 (per cent)

<sup>50</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. p 58. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

<sup>51</sup>Ibid. p. 51 and 68.

<sup>52</sup>Ibid. p. 71

<sup>53</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. p 59. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

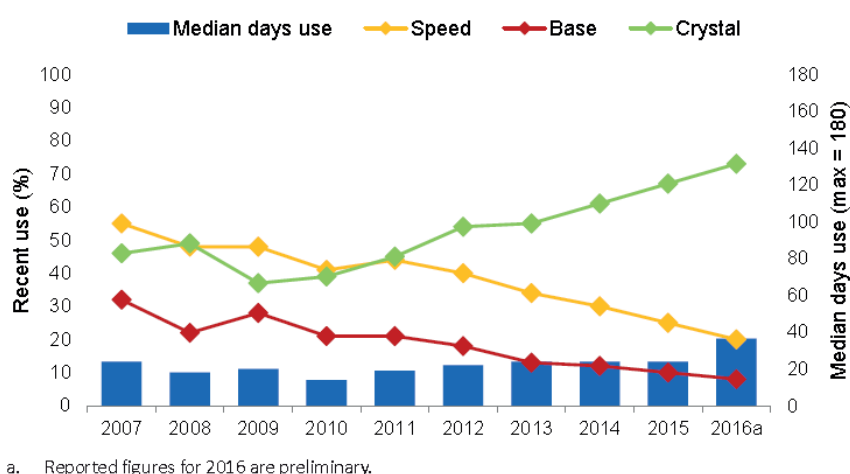
<sup>54</sup> Ibid. p. xi.

<sup>55</sup> Used in the previous 12 months.



The increasing frequency of use by regular users reported in the 2016 survey is consistent with a national study of regular injecting users. Figure 13 shows the reported median days of methamphetamine use in the six months preceding interview for regular injecting users went from 24 days in 2015 to 36.5 days in 2016. The study also found that within this population, the proportion of respondents reporting recent use of ice increased from 61 per cent in 2014 to 67 per cent in 2015, with early findings from the 2016 study indicating this has further increased to 73 per cent.<sup>56</sup>

**Figure 13: Proportion of a regular drug injecting user population reporting recent use of speed, base or crystal and median days of use of any form of methamphetamine, 2007 to 2016<sup>57</sup>**



Source: Australian Criminal Intelligence Commission

### 3.4.2 Use by Aboriginal people

The 2016 survey reports<sup>58</sup> that Aboriginal Australians are 2.2 times more likely to use meth/amphetamine than non-Indigenous Australians. Between 2010 and 2016, reported recent meth/amphetamine use among Aboriginal Australians decreased from 3.6 per cent to 3.1 per cent.<sup>59</sup>

### 3.4.3 Use by sexual orientation

A growing body of research within Australia and overseas indicates that individuals identifying as lesbian, gay, bisexual, transgender and intersex are at higher risk of the harms associated with methamphetamine. The 2016 survey reported recent

<sup>56</sup> Australian Government. Australian Criminal Intelligence Commission (ACIC). Illicit Drug Data Report 2015-16. Canberra: ACIC; 2017. p. 40. [accessed 2018 Nov 7] Available from: [https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/iddr\\_2015-16\\_introduction.pdf?v=1498020198](https://www.acic.gov.au/sites/g/files/net1491/f/2017/06/iddr_2015-16_introduction.pdf?v=1498020198)

<sup>57</sup> Ibid., p.41

<sup>58</sup> As Indigenous Australians constitute only 2.4 per cent of the 2016 NDSHS (unweighted) sample (or 568 respondents), the results must be interpreted with caution, particularly those for illicit drugs use.

<sup>59</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: Table 8.6 Drug use by Indigenous status, people aged 14 years or older, 2010 to 2016 (per cent)

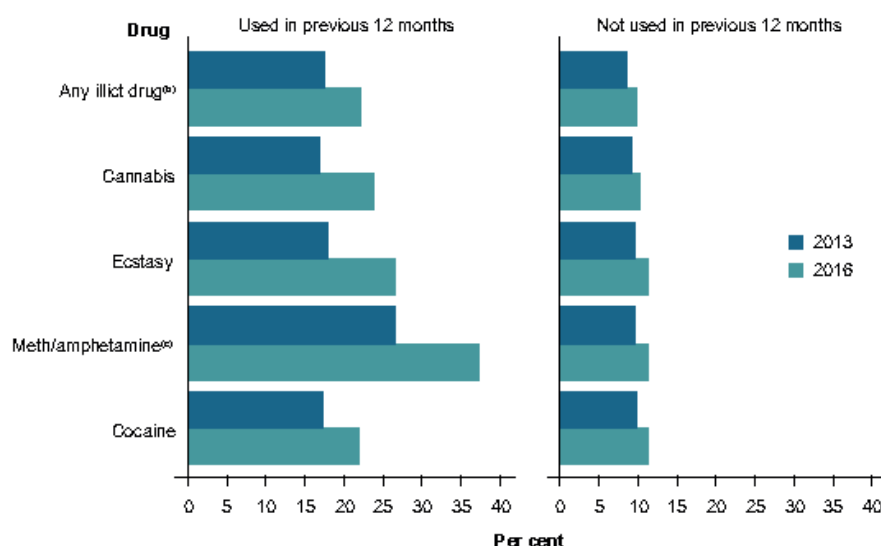
meth/amphetamine use among homosexual and bisexual people<sup>60</sup> was 5.8 times higher than for heterosexual people.

### 3.4.4 People with mental health conditions

There is a reported strong association between illicit drug use and mental health issues. However, it can be difficult to isolate to what degree drug use causes mental health problems and to what degree mental health problems give rise to drug use, often in the cause of self-medication.<sup>61</sup> (See Section 6.2.4 for treatment of comorbid alcohol and other drug use disorders and mental health conditions for further information.)

As shown in Figure 14, the 2016 National Drug Strategy Household Survey reported the proportion of recent meth/amphetamine users experiencing high or very high levels of psychological distress increased significantly between 2013 and 2016 (from 21 per cent to 37 per cent). This was three times higher than for people who had not used meth/amphetamine in the previous 12 months, and higher than was reported for any other illicit drug.

**Figure 14: Reported high or very high levels of psychological distress, by illicit drug use status, people aged 18 or older 2013 and 2016 (per cent)**



(a) K10 score High: 22–29; Very high: 30–50.

(b) Used at least 1 of 16 illicit drugs in the previous 12 months in 2016; the number of illicit drugs used has changed over time.

(c) Non-medical use.

Source: Table 8.11.

Source: Australian Government. Australian Institute of Health and Welfare. *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW; 2017.

<sup>60</sup> The NDSHS reports findings for people who identify as gay, lesbian or bisexual, or who are either not sure of their sexual orientation or who identify as something other than the response categories presented (such as transgender or intersex).

<sup>61</sup> Australian Government. Australian Institute of Health and Welfare. *National Drug Strategy Household Survey 2016: Detailed findings*. Canberra: AIHW; 2017. p 111. Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

Further, people using meth/amphetamine in the past 12 months were more likely than any other drug user to report being diagnosed with, or treated for, a mental health illness and their rate was three times higher than for non-illicit drug users (42 per cent compared with 13.9 per cent). This rate has increased almost one and a half times since 2013.

### 3.4.5 Methamphetamine and crime

There is substantial empirical evidence of an association between illicit drug use and offending. Criminological literature also reports that offenders are considerably more likely to use illicit drugs than the general population, and a large proportion of offenders attribute their criminal offending to their drug use. Methamphetamine use in particular has been associated with an increased risk of engagement in violent and property offences, although it is important to note that not all illicit drug users engage in crime.<sup>62</sup>

#### 3.4.5.1 Offending and methamphetamine use

Studies examining the motivation for offending across crime types have identified that offending among methamphetamine users appears to be primarily motivated by financial need. For example, a 2010 study found that 28 per cent of crimes committed by regular methamphetamine users were described by them as being committed to financially support their use of the drug. A 2013 study of injecting drug users reported 24 per cent of those who committed property offences were under the influence of methamphetamine at the time of offending.<sup>63</sup>

A 2016 study drawing on Drug Use Monitoring in Australia<sup>64</sup> data found:

- methamphetamine users reported intoxication and the need for money were the most common motivations for engaging in property crime;
- methamphetamine-using detainees in custody for drug offences (64 per cent) were more likely than other offender types to attribute their current offending to use of the drug; and
- high rates of attribution were also reported among violent offenders (58 per cent), property offenders (50 per cent) and breach offenders (44 per cent).

As shown in Figure 15, the same study reported that methamphetamine users were significantly more likely than non-users to be classified by most serious offence as a property or drug offender (26 per cent compared with 16.7 per cent), although there was no statistically significant difference between the proportion of methamphetamine users and non-users classified as violent offenders (25.7 percent compared with 30.1 per cent).

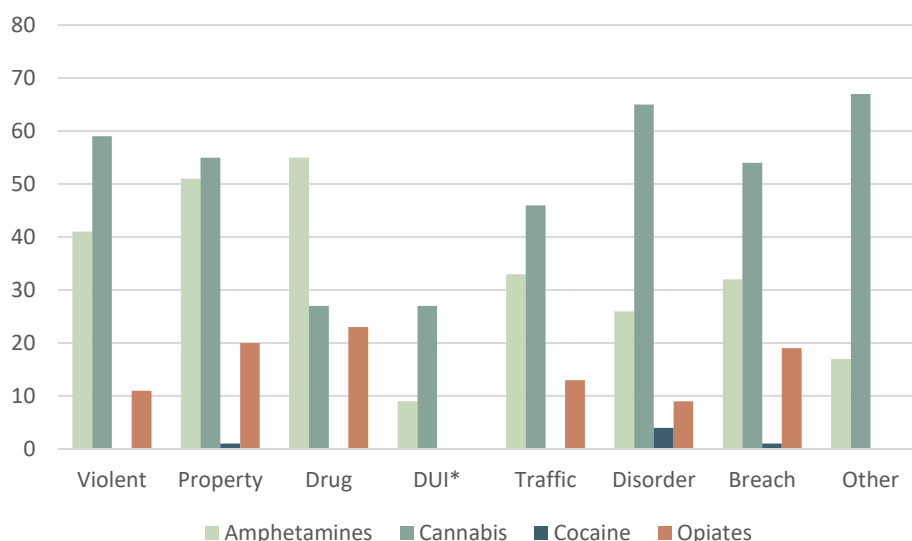
---

<sup>62</sup> Goldsmid S, Willis M. Methamphetamine use and acquisitive crime: Evidence of a relationship. Trends and issues in crime and criminal justice No. 516. Canberra: Australian Institute of Criminology; 2016. p. 1.

<sup>63</sup> Goldsmid S, Willis M. Methamphetamine use and acquisitive crime: Evidence of a relationship. Trends and issues in crime and criminal justice No. 516. Canberra: Australian Institute of Criminology; 2016. p. 9.

<sup>64</sup> In 1999, the Australian Institute of Criminology established the Drug Use Monitoring in Australia program which is now Australia's largest and longest-running ongoing survey of police detainees. In Western Australia, the Drug Use Monitoring in Australia program is conducted at the East Perth Watch House.

**Figure 15: East Perth Drug Use Monitoring in Australia sample, test positive result for four drugs by most serious offence category (per cent)**



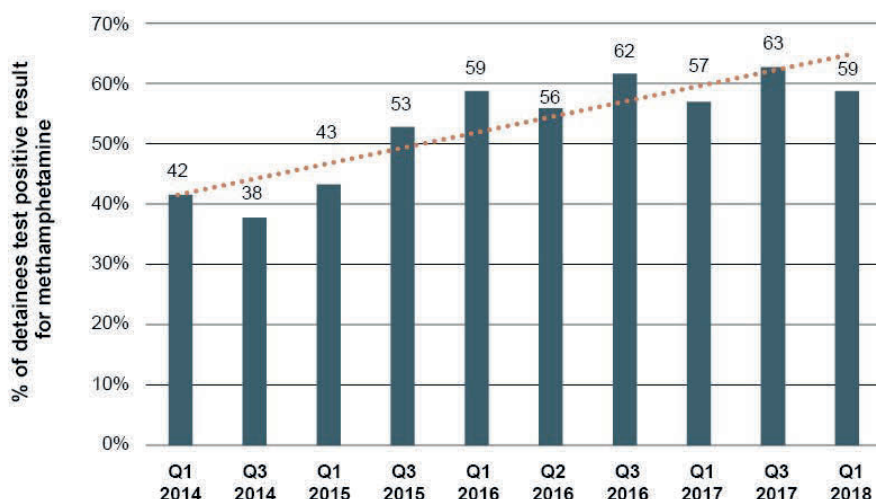
Source: AIC DUMA program 2013-14.

\*DUI drinking under the influence of alcohol or other drugs.

### 3.4.5.2 *Methamphetamine use among Western Australian police detainees*

Figure 16 shows the percentage of detainees testing positive for methamphetamine at the Western Australia Drug Use Monitoring in Australia test site has increased from 42 per cent in the quarter 1 of 2014 to 59 per cent in the quarter 1 of 2018. The 63 per cent test positive rate recorded in quarter 3 of 2017 was the highest reported level since the Drug Use Monitoring in Australia project began in 1999.<sup>65</sup>

**Figure 16: East Perth test positive results for methamphetamine Quarter 1 2014 to Quarter 1 2018**



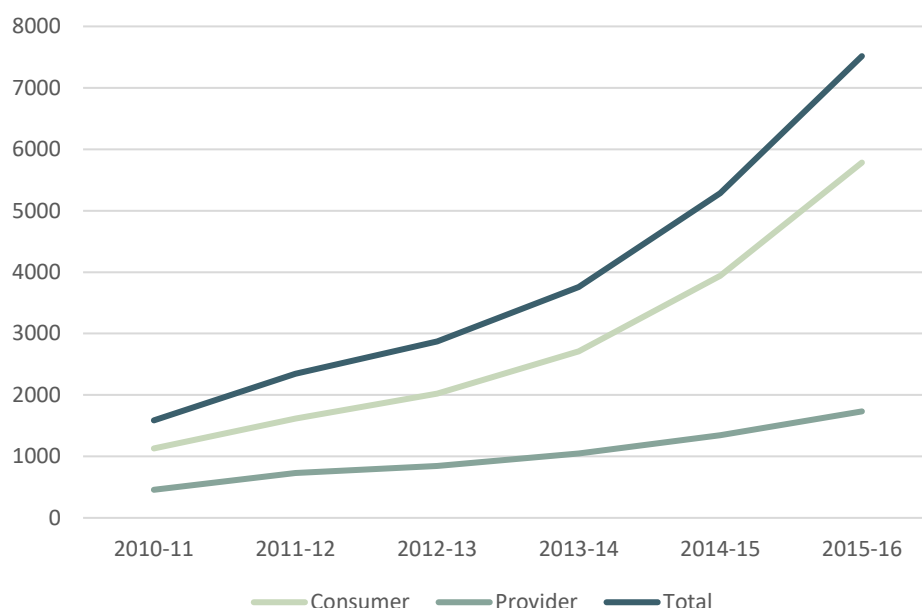
Source: Western Australia Police Force.

<sup>65</sup> It should be noted there was a lower number of detainees who provided samples for urinalysis in quarter 3 2017 (121 detainees) than quarter 1 2017 (145 detainees) and quarter 3 2016 (153 detainees).

### 3.4.5.3 Arrests related to the use and supply of methamphetamine

As seen in Figure 17 below, there has been an almost five-fold increase in the number of arrests for drug offences involving amphetamine-type stimulants in Western Australia between 2010-11 and 2015-16.<sup>66</sup> This reflects an increase in arrests for both consumers and providers. While not the highest rate of increase nationally (seven-fold was reported for the Northern Territory), this rate of increase is above the national rate of four-fold.

**Figure 17: Amphetamine-type stimulants consumer and provider arrests 2010-11 to 2015-16, Western Australia**



Source: Australian Crime Commission Illicit Drug Data.

### 3.4.5.4 Use by prison entrants

The rate of recent meth/amphetamine use among prison entrants in Western Australia is 16 times higher than the general population (44 per cent compared with 2.7 per cent, noting that the general population figure is 14+ years old, while the prison population is 18+ years old).<sup>67</sup>

For the first time in 2015, methamphetamine was reported nationally as the most common illicit drug used among prison entrants in the previous 12 months, overtaking cannabis (50 per cent compared with 41 per cent).<sup>68</sup>

The same trend is reflected in Western Australia with 47 per cent of entrants having reported use of methamphetamine in the previous 12 months compared with 40 per

<sup>66</sup> Australian Criminal Intelligence Commission, Illicit Drug Data Reports 2010-11 Table 23, p. 177; 2011-2012 Table 30, p. 205; 2012-2013 Table 40, p. 231; 2013-2014 Table 40, p. 205; 2014-2015 Table 42, p. 187; 2015-2016 Table 42, p. 196. [accessed 2018 Nov 7] Available from: <http://webarchive.nla.gov.au/gov/20160615100434/http://www.crimecommission.gov.au/publications/intelligence-products/illicit-drug-data-report>

<sup>67</sup> Australian Government. Australian Institute of Health and Welfare. The health of Australia's prisoners 2015. (cat no. PHE 207). Canberra: AIHW; 2015. Data Table S88. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/reports/prisoners/health-of-australias-prisoners-2015/data>

<sup>68</sup> Ibid., p. 101

cent reporting use of cannabis. This represents a significant reversal and increase on figures reported in 2010 (51 per cent reported use of cannabis, while 34 per cent reported use of meth/amphetamine).

Self-reported drug use while in prison is reported by 10 per cent of those discharged. In Western Australia this figure is more than double at 21 per cent. Of the 35 people discharged who reported using drugs in prison, all but one reported illicit drug use in the community prior to going to prison.<sup>69</sup>

### 3.5 Social and economic costs

“Children exposed to family violence, job loss, marriage breakdown, homelessness for myself and my son, family court issues, restraining orders against my ex-husband – the effects meth had on my family has been astronomical.”

*Online comment*

The social costs of methamphetamine are often measured by their impact on government services including ambulance, hospitals, police and child protection, as well as alcohol and other drug community services. Research suggests that the majority of costs of methamphetamine in Australia are expended at the acute end of responding to the impact of the drug, primarily within the criminal justice system.

#### 3.5.1 Findings of *The Social Costs of Methamphetamine in Australia 2013-14* report

In June 2016, the National Drug Research Institute at Curtin University released its report on *The Social Costs of Methamphetamine in Australia 2013-14*. The report notes that along with the rising concerns about methamphetamine use had come an interest in the total social burden and costs of the drug to the community. In part, this study was aimed at identifying high cost categories for targeting interventions and policy.

The study identified nine broad categories of cost and while noting the limitations of datasets and the multitude of sources of data used, the best estimate of total costs as shown in Table 1 was \$5,023.8 million, with a range from \$3,134.1 - \$7,016.8 million.

---

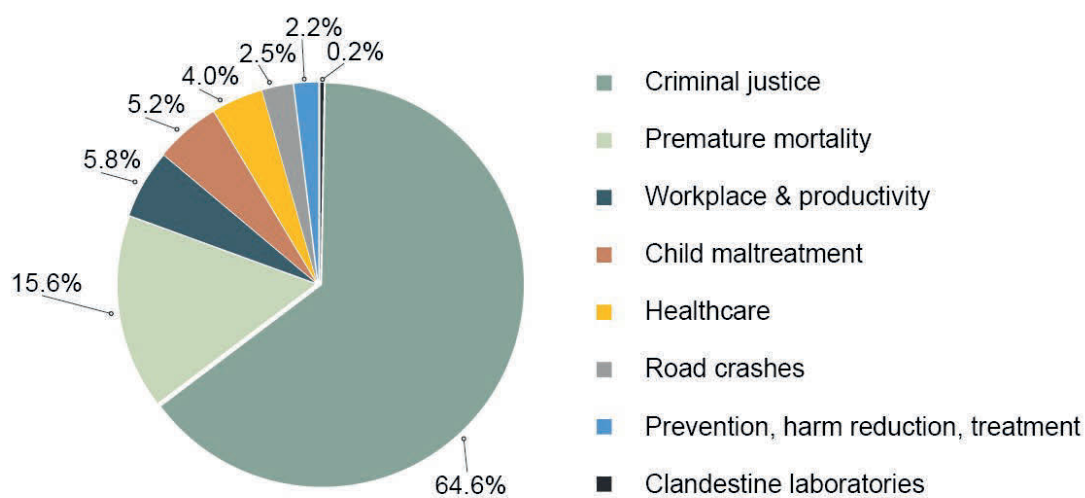
<sup>69</sup> Ibid. p. 102.

**Table 1: Summary of methamphetamine attributable costs**

Domain	Best estimate (\$'000,000)
Prevention, harm reduction and treatment	110.7
Health care (hospitals, ED, GP and ambulance service)	200.1
Premature mortality	781.8
Criminal justice (police, courts, prisons and victims of crime)	3,244.5
Child maltreatment and protection	260.4
Clandestine laboratories and production	11.7
Road crashes	125.2
Workplace accidents and productivity	289.4
<b>Total</b>	<b>5,023.8</b>

Source: NDRI. *The Social Costs of Methamphetamine 2013/14, 2017*, p.5.

Figure 18 shows the distribution of the estimated social costs of methamphetamine across these categories, with the majority of costs expended within the criminal justice system.

**Figure 18: Distribution of social costs of methamphetamine in Australia 2013-14**

Source: NDRI. *The Social Costs of Methamphetamine in Australia 2013/14, 2017*.

### 3.5.2 Methamphetamine and health care

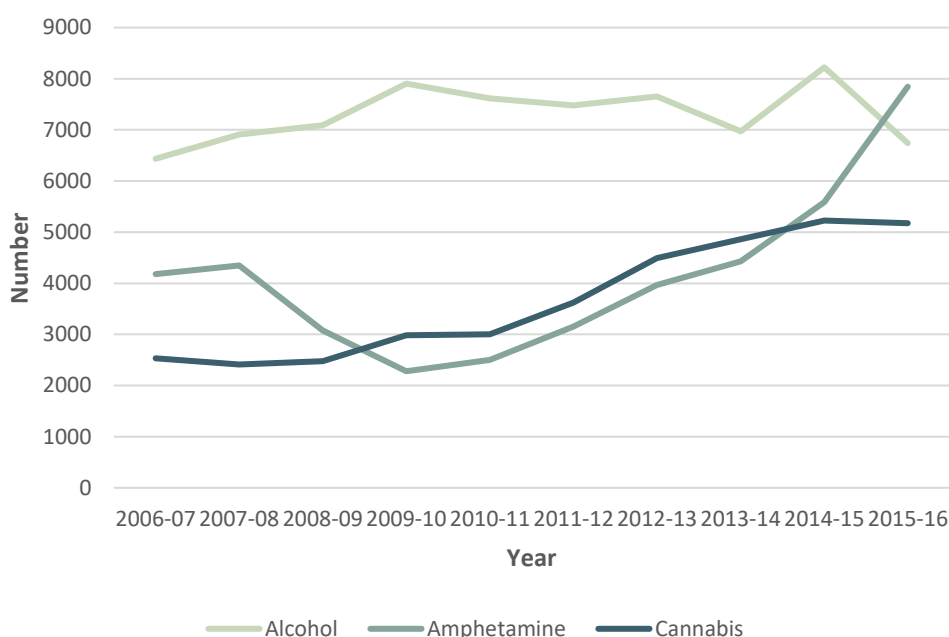
More people are requiring treatment for amphetamine-type stimulants indicated by the increase in drug and alcohol treatment episodes, emergency department attendances and hospital admissions for methamphetamine dependence and psychosis.



### 3.5.2.1 Drug and alcohol treatment episodes

Since 2014-15, in Western Australia amphetamines have overtaken alcohol as the most common 'principal' drug of concern in treatment episodes provided to clients for their own drug use (31 per cent of clients, and 35 per cent of episodes) as seen in Figure 19.<sup>70</sup> Between 2006-07 and 2015-16 the number of amphetamine treatment episodes rose by 88 per cent from 4,180 to 7,845.

**Figure 19: Closed treatment episodes in Western Australia for alcohol, cannabis and amphetamines 2006-07 to 2015-16**



Source: Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2015-16*, Table SE WA.10.

By comparison, nationally in 2015-16 amphetamines exceeded cannabis as the second most common drug of concern for all closed treatments (34 per cent compared with 23 per cent), but not alcohol, which remained the highest at 46 per cent of closed episodes. A closed treatment episode is a period of contact between a client and a treatment provider, or team of providers. An episode is considered closed when treatment is completed, there has been no further contact between the client and the treatment provider for three months, or when treatment is ceased.

### 3.5.2.2 Impact on the tertiary health care system

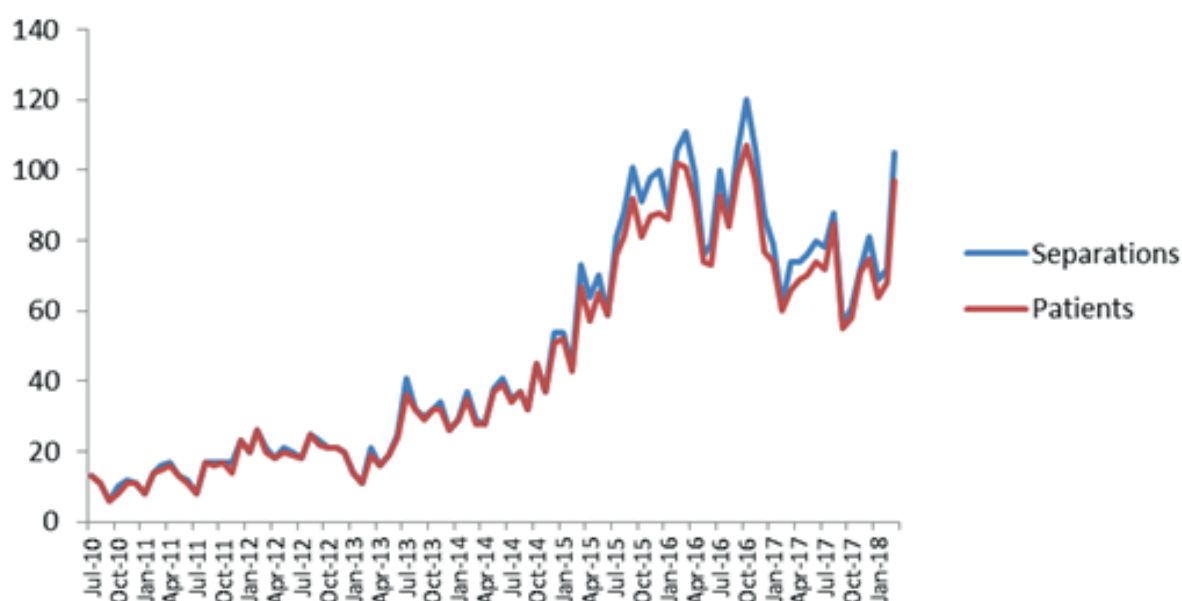
The negative effects experienced first-hand between methamphetamine users and health professions in hospitals, particularly in emergency departments have been well-documented.

The Taskforce has heard that the impact of methamphetamine on the tertiary health care system has been considerable and is increasing.

<sup>70</sup> Australian Government. Australian Institute of Health and Welfare. *Alcohol and other drug treatment services in Australia 2015-16*. Canberra: AIHWA; 2017. p.22. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/bf851ed5-673c-4f5a-8ff6-49f3a85bd95a/20799.pdf.aspx?inline=true>

Figure 20 shows there has been an upward trend in the number of meth-related hospital separations and patient counts in metropolitan hospitals (public and private) since July 2010.<sup>71</sup> From the period July 2010 to March 2018, there has been a seven fold increase in the number of patients ('unique patients' counted only once per month) where the principal diagnosis was methamphetamine related.

**Figure 20: Western Australian metropolitan hospital separations and patient counts where the principal diagnosis was related to methamphetamine July 2010 to March 2018.**



Source: Inpatient Data Collection, Department of Health.

The total number of methamphetamine related emergency department attendances at metropolitan hospitals (including Royal Perth, Sir Charles Gairdner, Fiona Stanley, Armadale/Kelmscott District Memorial, Rockingham General and Joondalup Health Campus) and Bunbury Hospital was 1,568 for the period July to September 2017. Royal Perth Hospital had proportionally the highest rate of methamphetamine related emergency department attendances, at 2.22 per cent of total emergency department attendances.<sup>72</sup>

### 3.5.2.3 *Methamphetamine-related ambulance attendances*

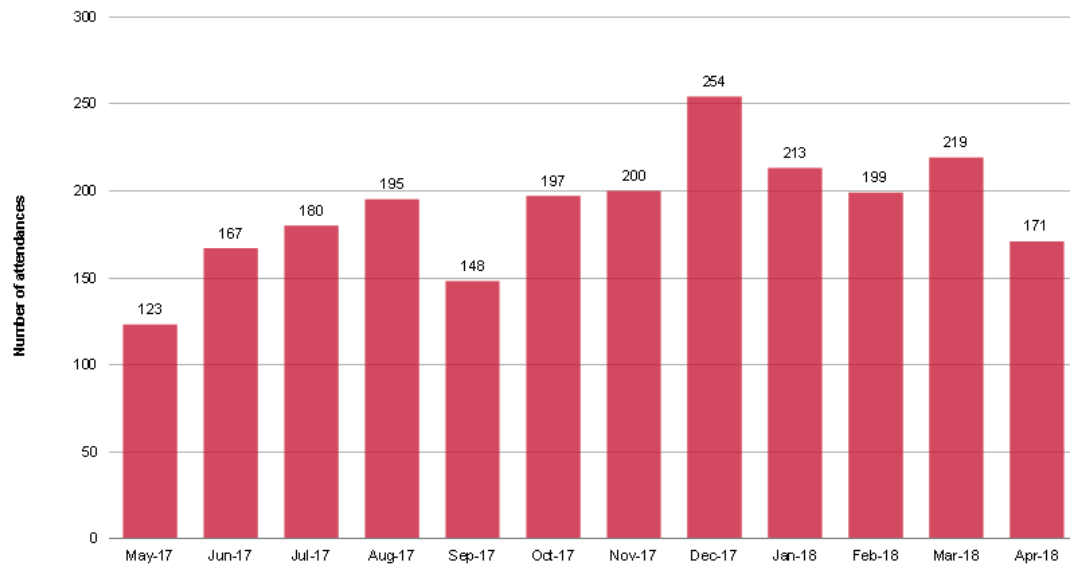
Between May 2017 and April 2018, St John Ambulance Western Australia recorded 2,266 methamphetamine related attendances in the metro area. Figures 21 and 22 show the number of methamphetamine-related ambulance attendances by month, age and gender.<sup>73</sup>

<sup>71</sup> Department of Health (March 2018). Hospital Morbidity Data System, Inpatient Data Collections, Purchasing and System Performance Division. Department of Health.

<sup>72</sup> Data provided by the Department of Health, 18 January 2018.

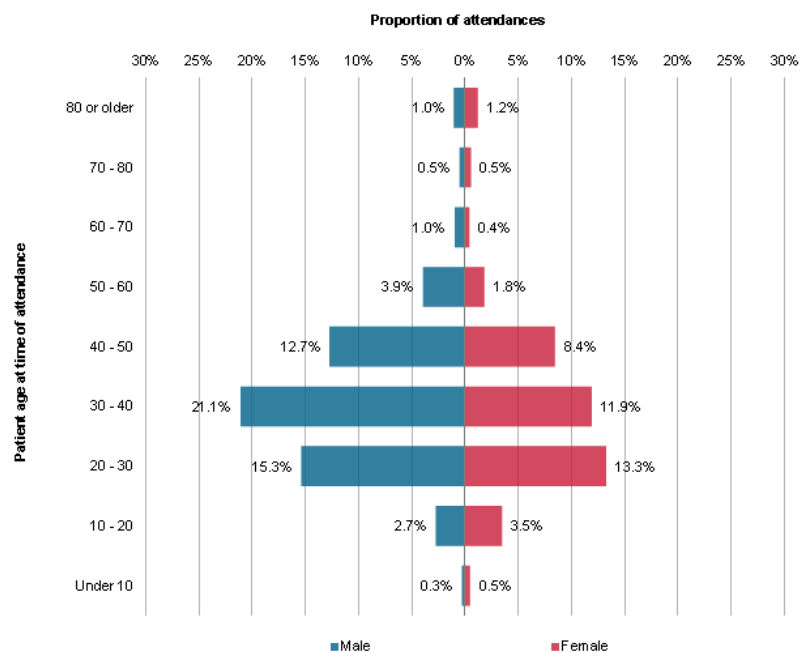
<sup>73</sup> Paramedics do not specifically code electronic Patient Care Records (ePCR) for methamphetamine. This data is drawn from scanning the narrative in the ePCR for key words. Booked calls, transfers and motor vehicle accidents are excluded.

**Figure 21: Metro methamphetamine related ambulance attendances May 2017 to April 2018**



Source: St John Ambulance Western Australia.

**Figure 22: Metro methamphetamine related ambulance attendances by age and gender May 2017 to April 2018**



Source: St John Ambulance Western Australia.

### 3.5.3 Methamphetamine and children and young people

There is a wealth of evidence that documents the harmful impacts of parental alcohol and other drug misuse on their children. While the National Ice Taskforce was careful to note that “poor parenting is not an inevitable outcome of drug use or misuse”<sup>74</sup>, parental alcohol and other drug misuse is a risk factor for neglect, maltreatment, physical abuse and sexual abuse by parents or drug using acquaintances. There are also major impacts on the enduring quality of life to infants and children raised in a neglectful setting.

While the impacts of alcohol and illicit drugs in general are well documented, the specific impacts of methamphetamine on children are less well documented. The Northern Territory’s Department of Children and Families Submission to the Northern Territory Legislative Assembly’s Ice Select Committee does document the more specific impact of methamphetamine misuse by parents on their children. It says, in part:

“Children growing up in families where ice is used are more likely to come to the attention of child protection agencies because:

- ice affected parents may have some level of cognitive damage and lack the judgment and impulse controls required for effective parenting including fulfilling children's basic care needs;
- sexual stimulation of the ice user may result in an increased risk of children being sexually abused, and children are at risk of physical and emotional abuse if a parent's response to intoxication or withdrawal symptoms is violent, reactive or punitive;
- children may witness violence or be forced to participate in violent acts;
- the chaotic lives that children experience in ice using families can affect their overall development, health and well-being including young children's brain development;
- older children may be required to take on a 'parenting' role of the other children and/or a caring role for the Ice affected parent; and
- financial difficulties may arise due to ice usage and parents may ignore buying household essentials such as food, clothes and paying bills in order to pay for drugs.”<sup>75</sup>

There are also risks to children exposed to the ingredients and process used to manufacture methamphetamine in homes, and the toxic residue left in the household environment from the smoking of methamphetamine.

While the exact effects of prenatal exposure to ice is dependent on frequency and intensity of use and the mother’s overall health and nutrition, the impacts on the unborn child’s exposure to methamphetamine from the mother’s use of the drug are

---

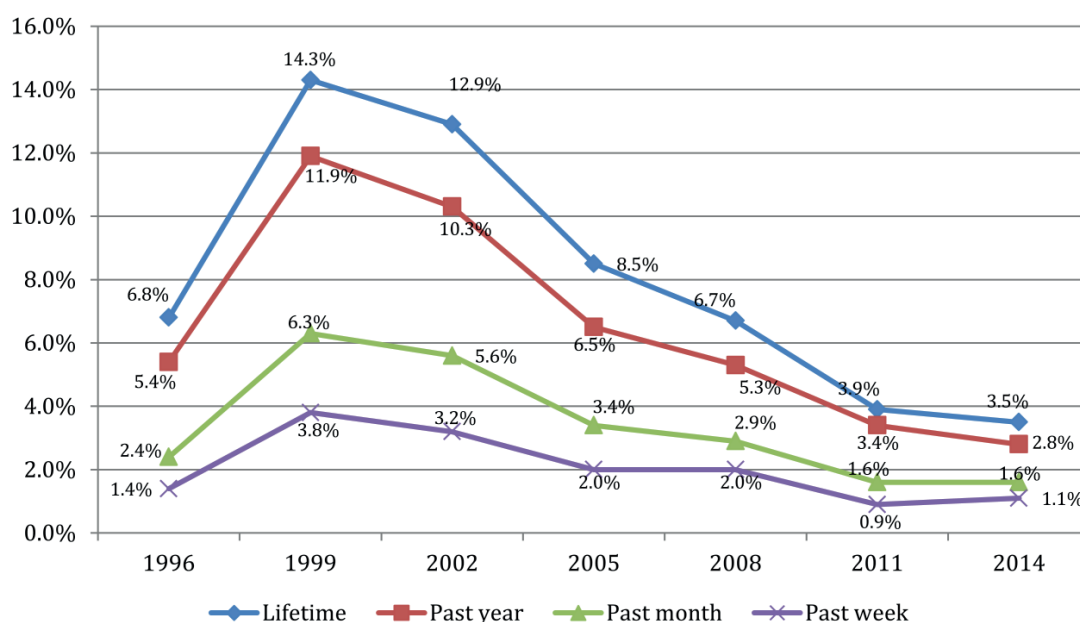
<sup>74</sup> Australian Government. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p.40. [accessed 2018 Nov 7] Available from: [https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

<sup>75</sup> Government of Northern Territory. Department of Children and Families Submission: ‘Ice’ Select Committee. Darwin: The Department; 2015 p. 5 –6. [accessed 2018 Nov 7] Available from: [https://parliament.nt.gov.au/\\_data/assets/pdf\\_file/0007/362797/Submission\\_No\\_33\\_NT\\_Department\\_of\\_Children\\_and\\_Families.pdf](https://parliament.nt.gov.au/_data/assets/pdf_file/0007/362797/Submission_No_33_NT_Department_of_Children_and_Families.pdf)

also risk factors for birth defects, growth retardation, pre-mature birth, low birth weight and brain lesions.<sup>76</sup>

It is important to note that Western Australian school-aged children's own use of amphetamines for non-medical purposes (which can include the use of prescribed pharmaceutical drugs such as dexamphetamine) has declined significantly in recent years. Since 1984 the Australian School Students Alcohol and Drug Survey has been conducted every three years. Students are asked about alcohol, tobacco and other drugs, how much they use, how they use and their attitudes towards alcohol and other drug use.<sup>77</sup> Figure 23 shows there has been a three to four-fold decrease in the prevalence of amphetamine use for students aged 12-17 years from 1999-2014 across the range of frequencies of use from lifetime (ever used) to use in the past week.

**Figure 23: Prevalence and recency of amphetamine use for students aged 12 to 17 years, 1996 to 2014**



Source: Mental Health Commission, Illicit drug trends in Western Australia: Australian school students alcohol and drug survey bulletin 2014.

<sup>76</sup> Government of Northern Territory. Department of Children and Families Submission: 'Ice' Select Committee. Darwin: The Department; 2015. p. 7. [accessed 2018 Nov 7] Available from: [https://parliament.nt.gov.au/\\_data/assets/pdf\\_file/0007/362797/Submission\\_No\\_33\\_NT\\_Department\\_of\\_Children\\_and\\_Families.pdf](https://parliament.nt.gov.au/_data/assets/pdf_file/0007/362797/Submission_No_33_NT_Department_of_Children_and_Families.pdf)

<sup>77</sup> Western Australian Government. Mental Health Commission. Illicit drug trends in Western Australia: Australian school students alcohol and drug survey bulletin 2014. Perth: MHC; 2015. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/media/1602/2014-assad-illicit-drug-bulletin.pdf>

### 3.5.4 Economic cost – methamphetamine and the workplace

The total workplace costs in Australia attributed to methamphetamine in 2013-14 was \$289.4 million with a high prevalence of use apparent in wholesale, construction, hospitality, mining and administrative services.<sup>78</sup> Of that cost, \$250.9 million relates to occupational injury, the remainder (\$38.5 million) relates to costs associated with absenteeism.<sup>79</sup> In 2013, methamphetamine users self-reported missing almost 125,000 days of work in Australia due to drug use.<sup>80</sup>

In June 2016, the Chamber of Commerce and Industry in Western Australia issued a special edition of its Business Pulse magazine *IcelandWA Workplaces Fight Deadly Drug*. This was published in response to a reported five-fold increase since 2012 in calls from business owners dealing with apparent ice use in their workplaces,<sup>81</sup> including industry sectors not traditionally associated with methamphetamine and ice use.<sup>82</sup>

The Chamber reported that based on figures provided by SafeWork Australia, which drug tests workers in the industries of agriculture, mining, manufacturing, utilities, construction and transport, on any given day about 7,000 workers turn up to Western Australian workplaces either under the influence of ice or suffering its after effects.<sup>83</sup> Effects can range in severity from lethargy, irritability and poor concentration to unpredictable outbursts and aggression. The figure does not take into account the many companies and industries that do not conduct testing.<sup>84</sup>

Figure 24 shows that when compared with the total workforce, prevalence of methamphetamine use is particularly high in wholesale, construction, hospitality, mining and administrative services.<sup>85</sup>

---

<sup>78</sup> Australian Government. Australian Institute of Health and Welfare. 2013 National Drug Strategy Household Survey: NCETA Secondary Analysis 2015. [accessed 2018 Nov 7] Available from: <http://nadk.flinders.edu.au/kb/methamphetamines/methamphetamine-and-employment/>

<sup>79</sup> National Drug Research Institute. The Social Costs of Methamphetamine in Australia 2013/14. Perth: Curtin University; 2017. p. 128.

<sup>80</sup> Ibid. p. 125.

<sup>81</sup> Wilmott D. Taking up arms against ice. A message from the Chief Executive Officer, *Business Pulse*, June 2016, p. 3.

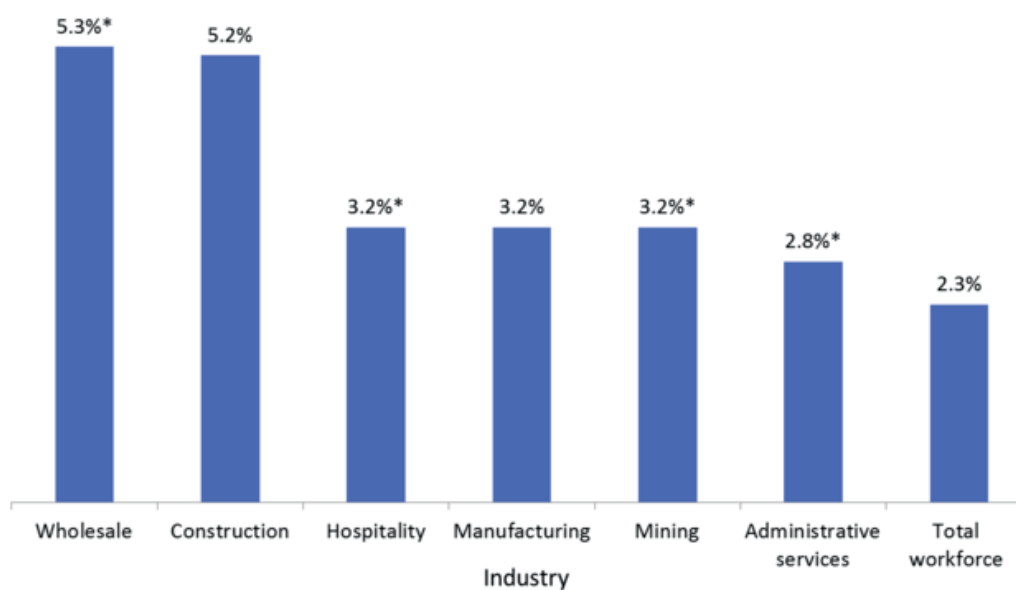
<sup>82</sup> Cox, C., Business's new battlefield, *Business Pulse*, June 2016, p. 12.

<sup>83</sup> Ibid., p. 13.

<sup>84</sup> Ibid.

<sup>85</sup> Australian Government. Australian Institute of Health and Welfare. 2013 National Drug Strategy Household Survey: NCETA Secondary Analysis 2015. [accessed 2018 Nov 7] Available from: <http://nadk.flinders.edu.au/kb/methamphetamines/methamphetamine-and-employment/>

**Figure 24: Proportion of employed Australians who use meth/amphetamine in the past 12 months by industry**



Source: Australian Institute of Health and Welfare 2013 National Drug Strategy Household Survey, NCETA Secondary Analysis 2015





## PART 2 OPPORTUNITIES TO IMPROVE SERVICES AND SUPPORT IN WESTERN AUSTRALIA

### Chapter 4 Helping people stay away from methamphetamine in the first place

#### 4.1 Reducing supply

“I could walk down the street [in a metropolitan suburb of Perth] and within fifteen minutes find three people who could sell me meth.”

“If you want it, you can get it, anywhere, anytime, with or without money. You just go into debt.”

“Meth is an acceptable part of life for FIFO workers now. Ten years ago, if you were involved in drugs people would look down on you. Now they talk about drugs as if they were beer.”

*Consumer and Family Forum*

“Staying away from meth is doable – if you really want to.”

“Education, education, education at schools please!”

*Online comments*

##### 4.1.1 What the Taskforce heard

Views expressed by those with lived experience suggested that in many communities the likelihood of being exposed to methamphetamine was high.

The Taskforce heard that methamphetamine is readily accessible in the community for those who want it. For those whose income was not sufficient to support their use of methamphetamine, turning to petty or more serious crime was a way to finance their use.

The Taskforce also heard that for those who make the decision to stay away from methamphetamine, it could require physical relocation to a new place or town, and cutting ties with friends and family if they use and/or supply the drug.

##### 4.1.2 What’s happening to reduce methamphetamine supply in Western Australia

The Western Australian Government is implementing the first stages of its State-wide, coordinated and targeted *Methamphetamine Action Plan*, which focuses on reducing demand, harm and supply.

The Western Australian Government has made a considerable and very necessary investment in reducing the supply of methamphetamine. Law enforcement measures play a vital role in combating the manufacture, importation and distribution of illicit drugs.

### **Methamphetamine Action Plan Initiative #8 – Establish a Meth Border Force within the Western Australia Police Force**

With 100 additional sworn officers and 20 specialised intelligence and support staff. Funding of \$18.3 million provided in 2017-18, with a further \$83.5 million from 2018-19 to 2021-22.

### **Methamphetamine Action Plan Initiative #9 – Increase the maximum penalty for meth traffickers to life imprisonment**

The Misuse of Drugs Amendment (Methylamphetamine Offences) Bill 2017 was passed by the Parliament on 16 August 2017.

### **Methamphetamine Action Plan Initiative #10 – Ensure Western Australia Police Force has the resources to significantly increase the volume of roadside alcohol and drug testing of Western Australian drivers.**

Funding of \$1.2 million provided in 2017-18 with a further \$3.6 million from 2018-19 to 2021-22.

The substantial seizures made by the Western Australia Police Force to date show that its efforts are preventing large amounts of methamphetamine making its way onto the market.

Since July 2015 the Western Australia Police Force has significantly increased its efforts to detect and reduce the supply of methamphetamine in Western Australia. The Western Australia Police operational plan the *Methamphetamine Enforcement Action Plan* provides a structure and capability to:

- reduce the methamphetamine supply into Western Australia;
- prosecute and remove methamphetamine dealers from our community and seize their cash; and
- introduce a multi-agency approach in partnership with other law enforcement agencies and our Commonwealth partners to detect, investigate and reduce methamphetamine imported into Western Australia.

To assist with these capabilities Western Australia Police Force increased its resources to provide the structure to support the intended capabilities with additional resources allocated to the Western Australia Police Force Serious and Organised Crime Division to implement operational teams to target and disrupt the supply of methamphetamine, including through:

- **Meth Transport Teams** – specialised investigation teams utilising the new Western Australian drug transit laws and drug detection equipment to increase the detection of methamphetamine entering Western Australia via parcels; entering or transiting Western Australia via roads, air and sea; and entering Western Australia at land borders;
- **Meth Investigation Teams** – specialised investigation teams to investigate methamphetamine dealers in metropolitan and regional districts;

- **Meth Money Team** – specialist team tasked with targeting methamphetamine dealers and money movers to seize meth cash profits;
- **Joint Organised Crime Taskforce** – the Taskforce established with Australian Federal Police, Australian Criminal Intelligence Commission, Australian Border Force and Australian Transaction Reports and Analysis Centre (Austrac) enables key agencies to share intelligence on drug importations, combine specialist capabilities and detect and disrupt methamphetamine importation into Western Australia, and to arrest those responsible;
- **Meth Investigation and Support Desk** – a dedicated support area tasked with providing increased investigative and intelligence support to the specialist teams. Maintains contact with Department of Communities and Department of Housing to protect children in meth environments and report meth dealers utilising Department of Housing residences; and
- **Meth Enforcement Taskforce** – specialised Taskforce working collaboratively with the Australian Criminal Intelligence Commission to disrupt and target established criminal networks and organised crime groups involved in the commercial distribution of methamphetamine.

The Joint Organised Crime Taskforce has made a number of significant seizures since inception, including the largest methamphetamine seizure in Australia's history, of 1.2 tonnes of methamphetamine in December 2017 in Geraldton. Despite these efforts, as the Methamphetamine Action Plan Taskforce heard, and as the evidence shows, methamphetamine is still readily available.

What the Taskforce also heard from a broad range of stakeholders including the community, health professionals, alcohol and other drug service providers, and law enforcement officers themselves, was that the problems of methamphetamine use for individuals and the community cannot be addressed solely through law enforcement measures.

*“Illicit drug use cannot be addressed by law enforcement alone – a multi-faceted approach is needed.”*

*Chris Dawson, Chief Executive Officer, Australian Criminal Intelligence Commission, Illicit Drug Data Report 2015-16.*

These views are also reported and supported by the Federal Parliamentary Joint Committee on Law Enforcement, the National Ice Taskforce, and Prime Minister Malcolm Turnbull who acknowledged “we cannot arrest our way out” of the illicit drug problem.<sup>86</sup>

The *Western Australian Drug and Alcohol Strategic Framework 2018-2022* is explicit in recognising the need to ensure a balance of supply, demand and harm reduction consistent with the national harm minimisation framework.

---

<sup>86</sup> Commonwealth of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 115 [5.57]. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

## Taskforce conclusions and recommendations

The Taskforce recognises that law enforcement measures are critical to reducing the supply of methamphetamine, and prosecuting and removing methamphetamine dealers from the community. The Taskforce supports ongoing efforts to disrupt the business model of organised crime and acknowledges law enforcement, targeting supply reduction, must remain a focus.

The Taskforce also recognises that given the complexity of illicit drug use and its impacts on individuals, families and the community, there are no simple solutions and that every lever available to government needs to be deployed to tackle the problems associated with methamphetamine use. Substantial effort and investment has already been focused on enforcement approaches and as a result, the Taskforce has not made recommendations in this area, as it is already covered substantially by the Western Australia Police Force *Methamphetamine Enforcement Action Plan*.

The Taskforce has formed the view that if additional resources are allocated to tackle methamphetamine use in the community, they would be best directed to prevention, harm reduction and treatment initiatives.

## 4.2 Reducing demand

Prevention strategies targeting individuals who do not currently use methamphetamine are a vital aspect of reducing the harms to individuals at risk of using and the wider community. They are universally supported by governments as socially and also economically effective as initial prevention costs are offset by 'downstream' savings in areas such as treatment.<sup>87</sup>

"Prevention means addressing the causes of use – people are filling gaps with drugs."

"People need to have interests, experiences and connections which are better, more interesting and more attractive than taking meth."

*Consumer and Family forums*

"There is so much misinformation about methamphetamine in the community."

"... I know it was a choice but if you ask any of them they will tell you 'I wished I never ever tried it'."

*Online comments*

### 4.2.1 What the Taskforce heard

One of the most common reflections heard by the Taskforce from current users or recovered users of methamphetamine was that 'if I had known then what I know now, I wouldn't have gone down that path'. A widely held view across a broad range of stakeholders was that accurate, evidence-based, publicly available information and education were key to preventing first use of methamphetamine.

---

<sup>87</sup> Jackson H, Shiell A. Preventive health: How much does Australia spend and is it enough? Canberra: Foundation for Alcohol Research and Education; 2017.

Two solutions offered by stakeholders to help people stay away from using methamphetamine in the first place were:

- recognising there are a variety of reasons people start using methamphetamine and addressing these underlying issues, to either prevent or reduce the risk they will use; and
- maintaining positive connections with, and being involved in, community activities can fill gaps that might otherwise be filled with methamphetamine use.

#### 4.2.2 What works to reduce demand

Research into what works to prevent harmful use of alcohol and other drugs has focussed on the risk and protective factors for alcohol and other drug problems, suggesting that the “most promising route to effective strategies for the prevention” is a “risk-focussed” approach.<sup>88</sup>

Risk factors are factors in a “person’s environment which increase susceptibility to social, behavioural and behavioural health problems”. Protective factors are factors in a “person’s environment which promote positive social development and decrease susceptibility to social, behavioural and health problems”.<sup>89</sup>

“Drug use is not simply an individual behaviour, but is shaped by a range of macro-environmental factors including the economic, social and physical environment (Spooner, Hall and Lynskey 2001). ... Communities and families at higher risk are those that face economic disadvantage, social or cultural discrimination, isolation, neighbourhood violence, population density and poor housing conditions, and a lack of facilities and services... People from lower-socio-economic status groups and the unemployed are at much greater risk of substance abuse, and are at risk of earlier initiation – itself a risk factor (Stuart and Price 2000).”<sup>90</sup>

Much of the work on a risk-based approach to alcohol and other drug prevention, particularly with adolescents, is based on the work of Hawkins et al. from the United States.<sup>91</sup> They report that the precursors of adolescent drug “abuse” are:

- “laws and norms favourable toward drug use;
- availability of drugs;
- extreme economic deprivation;
- neighborhood disorganisation;
- certain physiological characteristics;
- early and persistent behavior problems including aggressive behavior in boys, other conduct problems, and hyperactivity in childhood and adolescence;
- a family history of alcoholism and parental use of illegal drugs;
- poor family management practices;

<sup>88</sup> Victorian Government. Department of Human Service: Youth and Family Services Division. Improving the Lives of Young Victorians in Our Community, A Summary Report. Melbourne: The Department; 2000. p. 12.

<sup>89</sup> Ibid.

<sup>90</sup> Meyer L, Cahill, H. Australian Government. Department of Education, Science and Training. Principles for school drug education. Canberra: The Department; 2004. p. 34.

<sup>91</sup> Hawkins JD, Catalano RF, Miller JY. Risk and Protective Factors for Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention. Psychological Bulletin 1992; 112(1):64-105.

- family conflict;
- low bonding to family;
- academic failure;
- lack of commitment to school;
- early peer rejection;
- social influences to use drugs;
- alienation and rebelliousness;
- attitudes favourable towards drug use; and
- early initiation of drug use”.<sup>92</sup>

Hawkins et al. suggest “there is some evidence that certain factors including personal attributes and a social bond to conventional society may protect against drug abuse” and that evidence suggests “a viable prevention model would include simultaneous attention to a number of risk factors in different social domains” and that prevention efforts target populations at greatest risk of drug abuse because of their exposure to a large number of risk factors during development”.<sup>93</sup> Their research indicates that promising risk-focused approaches to be investigated for prevention effects are “early childhood education and early family support, parent training, school-based education social competence promotion, school based academic competence promotion, and school organisational change strategies”. Further, they found “coherent multi-component or comprehensive strategies [...]hold significant promise for preventing drug abuse and its attendant costs.”<sup>94</sup>

In 2000, the Victorian Government conducted a *Survey of Risk and Protective Factors* of young people based on a framework and survey adapted from the US Communities that Care program (which is founded on the work of Hawkins et. al.). The Survey documented for the first time evidence of the risk and protective factors of 9,000 young Victorians that affect their schools, families, communities and peer groups.<sup>95</sup>

Communities that Care is a training and technical assistance framework developed by Professors Richard Catalano and David Hawkins from the University of Washington.<sup>96</sup> It has been assessed as an effective strategy to address risk and protective factors,<sup>97</sup> beginning in Australia as a joint initiative of the Royal Children’s Hospital and the Rotary Club of Melbourne.

The Communities that Care process aims to identify the risk and protective factors that impact on the healthy development of children and adolescents in particular locations. Communities then plan to target their prevention efforts to reduce risk factors and strengthen protective factors in the four domains of community, family,

---

<sup>92</sup> Ibid. p.96.

<sup>93</sup> Ibid.

<sup>94</sup> Ibid. p.97.

<sup>95</sup> Victorian Government. Department of Human Service: Youth and Family Services Division. Improving the Lives of Young Victorians in Our Community, A Summary Report. Melbourne: The Department; 2000. p. 1.





<sup>96</sup> Kellock, P. Communities that Care. Review of implementation in three Australian Communities, Communities that Care Ltd. 2007. [accessed 2018 Nov 7] Available from: <https://www.communitiesthatcare.org.au/ctc-communities/australian-sites>

<sup>97</sup> For more information on U.S. trials and evidence of the effectiveness of Communities that Care see [accessed 2018 Nov 7] Available from: <https://www.communitiesthatcare.org.au/research/publications>



school and peer/individual. A community in Bunbury was an early adopter of the Communities that Care process.<sup>98</sup>

**Figure 25: Communities that Care Risk and Protective Factors Framework**

<b>RISK FACTORS</b> Risk factors increase the likelihood young people will develop health and social problems.	<b>DOMAIN</b>	<b>PROTECTIVE FACTORS</b> Protective factors help buffer young people with high levels of risk factors from developing health and social problems.
<ul style="list-style-type: none"> <li>• Low community attachment</li> <li>• Community disorganisation</li> <li>• Community transitions and mobility</li> <li>• Personal transitions and mobility</li> <li>• Laws and norms favourable to drug use</li> <li>• Perceived availability of drugs</li> <li>• Economic disadvantage (not measured in youth survey)</li> </ul>		<ul style="list-style-type: none"> <li>• Opportunities for prosocial involvement in the community</li> <li>• Recognition of prosocial involvement</li> <li>• Exposure to evidence-based programs and strategies (some are measured in youth survey)</li> </ul>
<ul style="list-style-type: none"> <li>• Poor family management and discipline</li> <li>• Family conflict</li> <li>• A family history of antisocial behaviour</li> <li>• Favourable parental attitudes to the problem behaviour</li> </ul>		<ul style="list-style-type: none"> <li>• Attachment and bonding to family</li> <li>• Opportunities for prosocial involvement in the family</li> <li>• Recognition of prosocial involvement</li> </ul>
<ul style="list-style-type: none"> <li>• Academic failure (low academic achievement)</li> <li>• Low commitment to school</li> <li>• Bullying</li> </ul>		<ul style="list-style-type: none"> <li>• Opportunities for prosocial involvement in school</li> <li>• Recognition of prosocial involvement</li> </ul>
<ul style="list-style-type: none"> <li>• Rebelliousness</li> <li>• Early initiation of problem behaviour</li> <li>• Impulsiveness</li> <li>• Antisocial behaviour</li> <li>• Favourable attitudes toward problem behaviour</li> <li>• Interaction with friends involved in problem behaviour</li> <li>• Sensation seeking</li> <li>• Rewards for antisocial involvement</li> </ul>		<ul style="list-style-type: none"> <li>• Social skills</li> <li>• Belief in the moral order</li> <li>• Emotional control</li> <li>• Interaction with prosocial peers</li> </ul>

Source: Communities that Care (<https://www.communitiesthatcare.org.au/how-it-works/risk-and-protective-factors>)

Victoria's *Survey of Risk and Protective Factors* found the three most prevalent risk factors for young people were poor family discipline, family conflict and availability of drugs in the community. The three most prevalent protective factors identified across

<sup>98</sup> For more information on Australian sites see <https://investinginouryouth.com.au/> and Kellock, P. June 2007, Communities that Care, Review of implementation in three Australian Communities, Communities that Care Ltd, [accessed 2018 Nov 7] Available from: <https://www.communitiesthatcare.org.au/ctc-communities/australian-sites>

Victoria were opportunities for positive community involvement, rewards for positive involvement in the family and belief in moral values.<sup>99</sup>

The findings from this survey were to be used to support and encourage prevention efforts, such as “community building planning and development across community services, including by organisations such as schools, health services, police, community agencies and local government”.<sup>100</sup>

### 4.2.3 School-based programs

#### 4.2.3.1 *What the Taskforce heard*

The Taskforce heard a number of observations from stakeholders about drug education generally, and methamphetamine education and information in particular, that:

- people should be provided with accurate information about methamphetamine, including the range of people it affects, as well as the varied impacts of use; and
- education and information delivered inappropriately can have unintended consequences, such as normalising use (by suggesting many people are using methamphetamine), or stereotyping users in ways that alienate and isolate them.

In general, stakeholders spoke about two main sources of education and information: school-based aimed at students and parents; and media campaigns aimed at the community more broadly.

On drug education in schools, the Taskforce heard:

- it should be mandatory for all students and schools;
- checks on the content and quality of information provided by external providers should be carried out;
- that having a classroom teacher provide drug education may not have the same impact as it might have if someone else, possibly with direct experience of drug use, delivered it; and
- turnout at drug education information sessions was often poor among parents, particularly in areas that could be considered at higher risk of exposure to drug use.

#### 4.2.3.2 *What works in schools*

Research undertaken by the U.S. National Institute on Drug Abuse highlights that education programs in schools work best when they: enhance protective factors and reverse or reduce the risk factors associated with future drug use; are long-term with repeated interventions; and employ interactive techniques, such as discussion groups and parent role-playing.<sup>101</sup>

---

<sup>99</sup> Victorian Government. Department of Human Service: Youth and Family Services Division. Improving the Lives of Young Victorians in Our Community, A Summary Report. Melbourne: The Department; 2000. p. 9.

<sup>100</sup> Ibid. p. 3.

<sup>101</sup> US Department of Health and Human Services. National Institute of Health. National Institute on Drug Abuse: Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders. Second Edition. Maryland: NIH Publications; 2003. p. 2-5.

The United Nations Office on Drugs and Crime, in its International Standards on Drug Use Prevention, advises that schools are one setting through which an effective prevention strategy should be delivered.<sup>102</sup> Other factors of importance in an effective strategy are the “support of children and youth through their development, particularly at critical transition periods when they are most vulnerable, e.g. [...] at the transition between childhood and adolescence” and to “target both the population at large [...] but also support groups [...] and individuals [...] that are particularly at risk”.<sup>103</sup>

The available literature also suggests that selective school education approaches, which target specific at-risk students, are most effective. These approaches are supported by the United Nations Office on Drugs and Crime, and were highlighted at the recent Commonwealth Government Parliamentary Inquiry into Crystal Methamphetamine.<sup>104</sup>

Prevention programs, such as the Montana Meth Project are intended to deter risky behaviour. The Montana Meth Project which uses graphic information on the negative consequences of methamphetamine use, including the personal stories, or ‘testimonial education’ from people who have recovered, or are in the process of recovery from drug dependence, has been shown not to be effective in drug prevention education.<sup>105</sup> Wider studies that have analysed published research evaluating substance use prevention programs have found some of this activity is not only ineffective in achieving its aims, but can also lead to negative effects including increasing substance use.<sup>106</sup> This points to the importance of measuring, monitoring and reporting the outcomes of prevention campaigns and ensuring that schools education are underpinned by evidence-based best practice.<sup>107</sup>

The literature highlights a number of school-based education services, aimed at preventing first drug use which embody the features shown to be effective. In particular:

- **Positive Choices** is an online portal to help school communities including parents, teachers and students to access accurate, up-to-date drug education resources and prevention programs. Funded by the Commonwealth Department of Health, the site provides access to interactive evidence-based drug education resources including recommended programs (with evidence ratings), fact sheets, videos, games, webinars, apps and quick activities. Positive Choices was developed in collaboration with the Centre of Research Excellence in Mental

<sup>102</sup> United Nations Office on Drugs and Crime. International Standards on Drug Use Prevention. Vienna: United Nations; 2015. p. 31. [accessed 2018 Nov 7] Available from: [https://www.unodc.org/documents/prevention/UNODC\\_2013\\_2015\\_international\\_standards\\_on\\_drug\\_use\\_prevention\\_E.pdf](https://www.unodc.org/documents/prevention/UNODC_2013_2015_international_standards_on_drug_use_prevention_E.pdf)

<sup>103</sup> Ibid.

<sup>104</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (Ice). Canberra: Parliament of Australia; 2016. p.21. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>105</sup> Anderson, D. Does Information Matter? The Effect of the Meth Project on Meth Use among Youth. Journal of Health Economics. 2010, September; 29(5): 732-742.

<sup>106</sup> Werch, C., and Owen D. Iatrogenic effects of alcohol and drug prevention programs. Journal of Studies on Alcohol. 2002; 63(5): 581-590

<sup>107</sup> Meyer, L., and Cahill, H. Australian Government. Department of Education, Science and Training. Principles for school drug education. Canberra: The Department; 2004. p. 16-17.

Health and Substance Use, the National Drug and Alcohol Research Centre at the University of New South Wales, and the National Drug Research Institute at Curtin University. It was also developed with input from teachers, parents and students.<sup>108</sup>

- **Preventure** was developed by the University of Montreal and aims to address adolescent drug and alcohol use in high-risk teenagers. The program commences in the classroom with a short questionnaire to identify high-risk personality profiles, and is followed some months later by two 90-minute group sessions with identified high-risk students. The underlying aim of Preventure is to enable at-risk students to participate in workshops which show them how to address specific emotional and behavioral problems. By holding the workshops months after the initial questionnaire, and not disclosing the reason for selection unless asked by students, it aims to limit the potential for labelling which is an inherent risk of selective school-based programs.<sup>109</sup> Preventure has been demonstrated through randomised controlled trials to reduce the likelihood of young people initiating alcohol and illicit drug use, as well as reduce frequency of illicit drug use.<sup>110</sup> The program was modified for use in Australia, to ensure the content and scenarios of Preventure were made relevant to Australia and fit within the Australian Curriculum.<sup>111</sup>
- **Climate Schools** was developed by the National Drug and Alcohol Research Centre's School of Psychiatry and the National Health and Medical Research Centre's Centre of Research Excellence in Mental Health and Substance Use at the University of New South Wales. The courses were developed in collaboration with teachers, students and education specialists and are online-based programs combined with classroom activities. The *Psychostimulant and Cannabis* module which covers methamphetamine is designed to be delivered by classroom teachers. Through the modules students learn different drug classifications and their effects, the short and long-term consequences of psychostimulants and cannabis, how to identify drug-related risk and stay safe, communication styles and being assertive, problem-solving skills, legal implications of drug use, and how to get help.<sup>112</sup> The benefits of the Climate Schools Psychostimulant and Cannabis module have been demonstrated in Australia.<sup>113</sup>

---

<sup>108</sup> Positive Choices. Information page: About Positive Choices. [accessed 2018 Nov 7] Available from: <https://positivechoices.org.au/information/about-positive-choices>

<sup>109</sup> Wagele, E. "Preventure" – A Program for Fighting Teen Addiction.' Psychology Today. 2016 November 15. [accessed 2018 Nov 7] Available from: <https://www.psychologytoday.com/au/blog/the-career-within-you/201611/preventure-program-fighting-teen-addiction>.

<sup>110</sup> Mahu, I.T., et al. Can cannabis use be prevented by targeting personality risk in schools? Twenty-four-month outcome of the adventure trial on cannabis use: a cluster-randomised controlled trial. *Addiction*. 2015; 110(10): 1625-33.

<sup>111</sup> Barrett, E.L., Newton, N.C., Teesson, M., Slade, T., Conrod, P.J. Adapting the personality-targeted prevention program to prevent substance use and associated harms among high-risk Australian adolescents. *Early Intervention Psychiatry*. 2015 Aug; 9(4):308-15. [accessed 2018 Nov 7]

<sup>112</sup> Positive Choices. Information page: Climate Schools: Psychostimulant & Cannabis Module. 2018. Available from: <https://positivechoices.org.au/teachers/climate-schools-psychostimulants-cannabis-module>

<sup>113</sup> Vogl, L.E., Newton NC, Champion KE, Teesson M. A universal harm-minimisation approach to preventing psychostimulant and cannabis use in adolescents: a cluster randomised controlled trial. *Subst Abuse Treat Prev Policy*. 2014; 9(24).

- **LifeSkills Training** has been shown through multiple evaluations to prevent the onset of adolescent substance abuse.<sup>114,115</sup> This classroom-based tobacco, alcohol, and drug abuse prevention program targets key risk and protective factors associated with alcohol and drug abuse behaviours. The program has been implemented in 39 countries including Australia, and can be adapted for primary and high school. The high school program is designed to be taught in a sequence over three years, with the first year's curriculum more intensive (with 15 class meetings) and booster sessions in the following two years providing a refresher and review for participants. The primary school program offers 24 classes that can be taught during years three to six.
- **Climate and Preventure study.** Australian researchers undertook the first-ever randomised control trial of a comprehensive prevention approach combining both universal and selective intervention techniques delivered to school students. The Climate and Preventure (CAP) study is a school-based prevention initiative targeting alcohol and drug use, comprising the Climate Schools program (a universal program delivered to all students) and the Preventure program. Results after three years show the effectiveness of universal and selective approaches, as well as a combined approach, in preventing harmful alcohol use among low- and high-risk adolescents.<sup>116</sup> However, the evaluation did not find that there was an advantage to the combined approach over universal or selective prevention alone.<sup>117</sup> A long-term follow-up is currently being conducted, which will follow the cohort beyond the completion of secondary school and into early adulthood.<sup>118</sup>

#### 4.2.3.3 *Western Australian drug education policies, frameworks, curriculum and plans*

The Commonwealth released the *Principles of School Drug Education* in 2004, to provide a framework of core concepts and values to support effective drug education practice within schools. The principles are a broad set of underpinning concepts that collectively describe an ideal of effective practice.

Of particular note is Principle 10: "Ensure teachers are resourced and supported in their central role in delivering drug education programs", which is based on the position that "[t]eachers are best placed to provide drug education as part of an ongoing school program".<sup>119</sup>

All schools in Western Australia, including government schools and those run by the Association of Independent Schools Western Australia and Catholic Education

<sup>114</sup> Velasco V. et al. Preventing Adolescent Substance Use Through an Evidence-Based Program: Effects of the Italian Adaptation of Life Skills Training. *Prev Sci.* 2017; 18(4); 394-405.

<sup>115</sup> Botvin G.J, Griffin K.W. Long-term outcomes from Blueprints model programs: Life Skills Training. Proceedings of the 2012 Blueprints for Violence Prevention Conference; 2012 April 11-14; San Antonio.

<sup>116</sup> Teesson M, Newton NC, Slade T, Carragher N. Combined universal and selective prevention for adolescent alcohol use: a cluster randomized controlled trial. *Psych Med.* 2017;47(10); p. 1761 – 1770.

<sup>117</sup> Ibid.

<sup>118</sup> National Drug and Alcohol Research Centre. UNSW. Information page: School-based prevention: A study into the benefits for young Australians of two drug prevention programs. [accessed 2018 Nov 7] Available from: <https://ndarc.med.unsw.edu.au/project/school-based-prevention-study-benefits-young-australians-two-drug-prevention-programs>

<sup>119</sup> Meyer L, Cahill, H. Australian Government. Department of Education, Science and Training. Principles for school drug education. Canberra: The Department; 2004.



Western Australia, are required to implement the current Curriculum which includes drug and alcohol education. Alcohol and other drug education content is prescribed within the Pre-Primary to Year 10 Western Australia Curriculum: Health and Physical Education Syllabus. The independent School Curriculum and Standards Authority is responsible for “setting the standards of student achievement and for the assessment and certification of students according to those standards”<sup>120</sup>; and for “developing an outline of curriculum and assessment in schools that, taking into account the needs of students, sets out the knowledge, understanding, skills, values and attitudes that students are expected to acquire, and the guidelines for the assessment of student achievement.”<sup>121</sup>

During its consultations the Taskforce heard that while alcohol and other drug education is required to be delivered under the Curriculum, how that happens varies between schools. The Taskforce heard from the Association of Independent Schools that within statutory requirements, school policies and practices were determined by individual schools. Both the Association of Independent Schools and Catholic Education Western Australia submitted the Health and Physical Education learning area in the Curriculum which covers alcohol and other drug education was a very broad area of learning that included a diverse range of topics. As not every topic could be covered, prioritisation was required.

The Western Australian Department of Education’s Student Behaviour Policy requires school principals to follow an established set of Student Behaviour Procedures and:

- document a whole school plan to support positive student behaviour;
- implement the plan to support positive student behaviour; and
- provide individual student behaviour support where the need is identified.

The whole school plan is required to cover a range of behavioural issues, including mobile phone use, presence of weapons and drug and alcohol misuse by students. The plans also provide a structure for the provision of classroom-based drug and alcohol education including naming education resources and the hours of drug education provided to students, and an incident management and intervention support protocol in circumstances where a student is thought to be drug-affected, in possession of a drug (legal or illicit) or where student drug use is identified through disclosure or staff concern.

The Department of Education does not systematically monitor school compliance with the Student Behaviour Policy and Procedures. In 2017, 57 schools were supported by the Western Australian Government through the School Drug Education and Road Aware (SDERA) organisation to develop plans, and 19 schools were scheduled for plan development assistance in 2018.

#### **4.2.3.4      *What’s happening in Western Australia***

School Drug Education and Road Aware (SDERA) is a not-for-profit organisation funded by the Western Australian Government through the Department of Education, the Mental Health Commission and the Road Safety Commission. It is overseen by a peak governance group comprising the Director General Department of Education, Executive Director Catholic Education Western Australia, Executive Director

---

<sup>120</sup> <https://www.scsa.wa.edu.au/about-us/about-scsa> [accessed 2018 Nov 7]

<sup>121</sup> <https://www.scsa.wa.edu.au/about-us/about-scsa> [accessed 2018 Nov 7]

Association of Independent Schools, and the Road Safety Commission. A Management Committee with representatives from the systems and sector of education in Western Australia and the Road Safety Council has oversight of all operational and strategic business.<sup>122</sup> Funding is administered by Catholic Education Western Australia. (The Taskforce has been advised by the Department of Education that these governance arrangements will change from the beginning of 2019, with School Drug Education and Road Aware staff becoming employees of Department of Education, rather than employees of Catholic Education Western Australia under the current arrangements. The Department of Education confirmed that regardless of these changes, School Drug Education and Road Aware will continue to provide services and support to schools across the public, Catholic and independent sectors).

School Drug Education and Road Aware provides the following services to the government and non-government education sectors:

- free professional development for teachers to deliver drug and road safety education and payment towards staff relief;
- classroom-ready resources mapped to the Western Australian curriculum;
- assistance in the development of policies, programs and plans in resilience, and drug and road safety;
- funding and support toward planning a whole school approach; and
- free parent education seminars.

School Drug Education and Road Aware offers assistance to primary and secondary schools to develop whole of school drug and alcohol plans. Examples of plans viewed by the Taskforce are consistent with the Commonwealth's *Principles of School Drug Education*, although this consistency is not mandated by the Student Behaviour Policy or the Student Behaviour Procedures.

School Drug Education and Road Aware also provides modified workshops for cultural and linguistically diverse, and Aboriginal families. School Drug Education and Road Aware has been delivering evidence-based or evidence-informed services to schools for some 20 years. School Drug Education and Road Aware's training and resources are aimed at enabling students to improve their ability to make safer choices, to build resilience, strengthen mental health and extend their social and emotional awareness.

In the 2017 school year, 122 schools were engaged in School Drug Education and Road Aware's whole-school approach to resilience, drug and road safety education: Changing Health Acting Together (CHAT).

In March 2015, the Child Health Promotion Research Centre at Edith Cowan University reported on the Changing Health Acting Together (CHAT) initiative. CHAT "aims to build the capacity of school communities to implement evidence-based practices that will improve student health and well-being, with a focus on resilience,

---

<sup>122</sup> <https://www.sdera.wa.edu.au/> [accessed 2018 Nov 7]



drug and road safety education.”<sup>123</sup> The evaluation found that “schools’ capacity to address resilience, drug and road safety is being strengthened through involvement in the CHAT initiative”, however, schools reported “lower levels of implementation of strategies that aimed to engage with parents, community and external agencies and strategies to encourage student voice”.<sup>124</sup>

The Mental Health Commission advised the Taskforce that between 1 July 2016 and 30 June 2018, as part of the State Meth initiative additional one off funding of \$500,000 was provided to School Drug Education and Road Aware. The funding was provided over two years to progress the expansion of school alcohol and other drug education programs, including provision of targeted information regarding methamphetamine use, with a focus on initiatives for at-risk students.

The funding agreement required that School Drug Education and Road Aware implement activities to develop methamphetamine-related education materials targeting non-mainstream students, student support staff and parents. Specifically, the activities that would be undertaken during the agreement term included the following:

- engage with target groups of at-risk students in a broad range of educational settings to identify and develop a range of resources and professional development programs to suit their specific student needs. This could include Engagement Centres, Curriculum and Re-engagement in Education (CARE) schools, and geographically-isolated and remote schools;
- develop a targeted methamphetamine education program that can be implemented in Year 11 and 12;
- continue to deliver parent education seminars, Talking Drugs, across the State, with emphasis on regions of high need as identified by School Drug Education and Road Aware regional consultants;
- develop a professional development program that informs student services and pastoral care staff (including psychologists, chaplains, nurses and regional office staff) on how to appropriately engage and work with students potentially affected by methamphetamines; and
- develop interactive, online curriculum materials and resources that aim to engage all students and particularly those identified in the target group.

In relation to the above activities, the below outcomes were also required to be achieved during the agreement term as part of the additional funding:

- increase the delivery of school alcohol and other drug education, with an emphasis on methamphetamine education, into specialist school settings;
- increase the delivery of school alcohol and other drug education, with an emphasis on methamphetamine education, to Year 11 and 12 students;
- increase parent understanding of alcohol and other drugs, including methamphetamines;
- improve the ability of student services and pastoral care staff to identify and appropriately engage with students affected by methamphetamines; and

---

<sup>123</sup> Child Health Promotion Research Centre, 2015, CHAT Evaluation Project, Final Report, Edith Cowan University [accessed 2018 Nov 7] Available from: <https://www.sdera.wa.edu.au/about-us/research-and-evaluation/>

<sup>124</sup> Ibid.

- develop interactive online materials.

The additional funding was also intended to support school pastoral care and student services staff working with at risk students requiring additional support and specific strategies due to disengagement from mainstream educational settings; learning styles or needs; language barriers; and/or geographic isolation/remote schools.

The Mental Health Commission reported to the Taskforce that overall, all outcomes from this additional funding have been met and the delivery of outputs have either been met, or are on track to be met over the duration of the two years of the project.

#### **Methamphetamine Action Plan Initiative #4 – Ensure up-to-date drug and alcohol programs for Western Australian schools**

Work with drug and alcohol education agencies to ensure Western Australian schools have the most up to date programs to better inform young people.

\$400,000 has been allocated to the Mental Health Commission in the 2018-19 Budget for the continuation of prevention initiatives, including school-based education programs. Education programs targeting at-risk young people are funded to December 2018.

Other groups providing alcohol and other drug education and support in schools include:

- Life Education, which is an Australian preventive health education organisation aiming to empower children and young people to make safer and healthier choices now and in the future, including through education and information on drugs. Their program consists of specially trained educators presenting age-appropriate curriculum-based classroom activities and resources to teachers and students and providing take home resources for parents from pre-primary to secondary levels.
- Sideeffect Australia, which is a Western Australian based not-for-profit charity that aims to educate young people about synthetic drugs and more recently has extended to corporate and mining workplaces and parent education. Its founder, Rob Bridge, is a parent whose son died after taking a synthetic form of LSD in 2013. Sideeffect delivers the Teen Drug Prevention program.

#### **Taskforce conclusions and recommendations**

As the Taskforce heard, it is not widely understood that the Western Australia Curriculum and the Department of Education's Student Behaviour Policy mandate that alcohol and other drug education is delivered from pre-primary to Year 10. While alcohol and other drug education is embedded in the Curriculum, and the Student Behaviour Policy states that drug and alcohol use by students will be responded to through health and education frameworks, there is a variable understanding of how this operates in practice. The Taskforce also acknowledges that the area of the Curriculum within which alcohol and other drug education is provided can be crowded, covering a number of diverse topics, and that schools prioritise the topics most relevant to their students.

### Recommendation 1:

The Department of Education and the Mental Health Commission liaise with the School Curriculum and Standards Authority to mandate a minimum level of alcohol and other drug education in all schools.

The actions below would create the conditions and context to improve school level programs and cause existing services (e.g. school psychologists, Schools of Special Educational Needs, Engagement Centres, school nurses) and initiatives (e.g. Full Service School pilot, expansion of mental health programs) to more explicitly build alcohol and other drug education into their work and seek ways to better coordinate/target their support to schools and their work with other agencies:

- Statements in future *Focus* documents (the Director General of Education's annual publication that sets directions for schools and the system) that promote best practice and targeted alcohol and other drug programs in schools. These statements may, for example, require:
- **Schools** to review their alcohol and drug education programs to ensure they align with the findings of the Department's evaluation;
- **Statewide Services** to build the capacity of its staff to meet the support needs of schools where large numbers of families are affected by alcohol and drugs; and
- **Central Office** to work with other agencies to identify communities most at-risk from alcohol and drug abuse, and targets resources and specialised support to schools accordingly.
- An evaluation of:
  - School Drug Education and Road Aware programs and classroom resources (their content, reach, targeting, and delivery);
  - the extent to which associated/potential support resources are appropriately equipped/ utilised in the context of alcohol and other drugs (student support teams, school nurses, school psychology service, staff in the Schools of Special Educational Needs); and
  - the capacity of the above to extend support beyond students and to include at-risk families (as deemed appropriate).

### Recommendation 2:

The Department of Education gives greater prominence to alcohol and other drug education in schools by including statements in future strategic documents and directions to schools that:

- positions the issue in the context of student health and well-being;
- addresses the impacts of not just student's own use, but also use of alcohol and other drugs by others;
- requires alcohol and other drug education programs to be based on best practice;
- takes a whole-of-school approach; and
- provides for both universal and targeted programs to meet the needs of individuals and/or groups of students at greater risk.

School-based drug and alcohol education in Western Australia has on the whole taken a universal (general provision of information), rather than a targeted approach. Additional funding provided to School Drug Education and Road Aware under the

2016 Methamphetamine Initiative recognised the need to take a more targeted approach, with populations of at-risk students, their teachers, pastoral care and student services staff and parents prioritised for development of methamphetamine-related materials and engagement.

The available literature suggests that selective school education approaches which target specific at-risk students are also effective.

During the course of its inquiry the Taskforce was not made aware of any school-based education programs in Western Australia that target individual at risk students, although this approach is taken in other States using evidence-based programs. The Taskforce considers these approaches could be examined for introduction to Western Australian schools, as part of a broader evaluation of the effectiveness of current school-based alcohol and other drug education programs and resources.

### **Recommendation 3:**

Recognising that schools are required to comply with a large number of policies, the Department of Education should highlight alcohol and other drug education as a priority through existing systems and communications that set directions and expectations for schools and school services (such as through the Director General's *Focus* document).

### **Recommendation 4:**

The Department of Education monitor and publicly report alcohol and other drug program delivery in public schools to ensure alignment with best practice and effective targeting of individuals and/or groups of students at greater risk.

### **Recommendation 5:**

The Department of Education undertake and publicly report on an independent evaluation of the effectiveness of its current school-based alcohol and other drug education programs and resources. The results of the evaluation will be used to inform improvements to alcohol and other drug education programs and resources.

## **4.2.4 Training and workplace education**

The National Drug Strategy Household Survey 2016 indicates fewer young people are taking up first use of drugs in their school years, with a growing number of first use delayed to age 19 to 29 years.<sup>125</sup> The Taskforce heard that for those who were disengaged from school, or who began using methamphetamine after leaving school, there may be fewer opportunities to be educated about the potential risks of methamphetamine use.

The Taskforce also heard from workplace stakeholders that training for employment or post school education may offer an opportunity to ensure drug prevention initiatives are continued into post-secondary education settings, particularly from a health and safety perspective.

<sup>125</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

#### 4.2.5 Community-based programs

Of particular concern to the Taskforce were stories where the living circumstances for some people were such that being educated about the most serious impacts of methamphetamine use would not have prevented their first use. These circumstances were environments where the availability and use of methamphetamine was widespread and seen as 'normal'. Seeing family members, friends and co-workers use methamphetamine regularly, combined with isolation (social and geographical), difficult socio-economic circumstances, and unemployment or lack of opportunities created circumstances where methamphetamine was a way of life.

Community-based programs play an important role in preventing the uptake of drugs, particularly among young people up to the age of 25. They also play an important role in empowering communities to identify and address local needs.

##### 4.2.5.1 *What's happening in Western Australia*

Local Drug Action Groups (LDAGs)

Current programs include those conducted by Local Drug Action Groups (LDAGs), funded by the Western Australian Government through the Mental Health Commission, which are volunteer groups working in primary prevention to deliver local preventative drug and alcohol support activities to young people and families. There are currently 62 LDAG's across Western Australia working across a range of program initiatives, including:

- **Margaret River LDAG.** In 2014, the Margaret River LDAG oversaw production of the film 'Above the Influence'. Made by and featuring local community members from Augusta and Margaret River, including those with lived experience of using alcohol and other drugs, the film aims to raise awareness about the risks and consequences of drug use. It presents the different reasons why young people make choices to use, and the effects on individuals, their families and wider community. The film aims to deter young people from taking illicit drugs and consuming excessive amounts of alcohol, and promotes healthier alternative pathways for people who are feeling stressed or tempted to experiment.
- **Mundaring LDAG.** In partnership with the Mundaring Arts Centre, Mundaring LDAG holds a number of 'Worn Out Worn Art' workshops leading up to the Darlington Arts Festival. Students create large sets, sculptures and costumes from recycled materials which depict the findings of their research of the effects of alcohol and other drug use on the body. The sets, sculptures and costumes look at the impacts of use at a cellular level, creating "monstrous forms" from the harmful effects drugs can cause. The Mundaring LDAG also supported the About YOUth Health Expo targeted at Year 10 students throughout the Perth Hills area, which aimed to help young people make informed positive choices about their lives. A Student Organising Committee was involved in the development of the day-long program which included workshops on mental health, sexual health and drugs and alcohol. Many community youth services groups also attended the Expo to provide information about services available in the Perth Hills area.

##### Local Drug Action Teams (LDATs)

The Commonwealth Government funds another set of groups called Local Drug Action Teams (LDATs) through its *National Ice Action Strategy*. These aim to support communities to work together to reduce the harms of alcohol and other



drugs. As at May 2018 there were 25 funded LDATs in Western Australia working across a range of initiatives, including:

- **Stirling Local Drug Action Team** is led by the City of Stirling and comprises 26 local organisations working together to deliver programs that aim to prevent and minimise harm from alcohol and other drug use, particularly methamphetamine, in the community. The team was formed in response to local concerns about the effects of methamphetamine use in the community and the high number of meth-related treatment episodes in the Stirling region. During May 2018, the Stirling LDAT used its local newspaper the Stirling Times to publish information in four instalments titled *Community Action on Meth*, to proactively provide the local community with non-stigmatised information. The articles presented information about action being taken by the Stirling LDAT organisations, including the Schools Drug Education and Road Awareness group's role in preventative education, treatment work by Cyrenian House and the North Metro Community Alcohol and Drug Service, and interviewed people within the City of Stirling community with lived experience of methamphetamine use. This initiative was developed in consultation with a Victorian LDAT which had undertaken a similar project.
- **Bunbury Geographe Aboriginal LDAT** was one of the original LDATs in Western Australia (along with Nannup and Kalgoorlie-Boulder) and its project delivery area covers Bunbury, Collie, Harvey and Manjimup. The LDAT is led by the Breakaway Aboriginal Corporation and since its inception in 2017, has undertaken a full community consultation and developed a Community Action Plan. Through its partner organisations, the LDAT has run a number of programs in the local community including a peer support program for Aboriginal people, weekly sport and life skills sessions with young people, and monthly cultural excursions. The Bunbury Geographe LDAT received extra funding at the end of 2017 to continue its work throughout 2018.

### Prevention through Community Alcohol and other Drug Services

The Western Australian Government, through the Mental Health Commission, funds Community Alcohol and Drug Services (CADS) to provide specialised alcohol and other drug counselling. The Mental Health Commission advised the Taskforce that Community Alcohol and Drug Services are also contracted to support prevention activities and build capacity within communities through supporting the development of alcohol and other drug management plans, supporting the implementation of State public information campaigns and providing training and building networks.

### Programs in sporting clubs

Sporting clubs have been identified as appropriate forums for educating young people on the effects and impacts of alcohol and more recently other drugs, including methamphetamine. The Good Sports program, conducted by the Australian Drug Foundation and funded by the Commonwealth Government, works with community sporting clubs to promote healthier, safer and family-friendly environments and behaviours and offers assistance to clubs to become better prepared to address drug-related issues through education and the development of policies to tackle illicit drug use.

The Australian Sports Drug and Education Consultancy provides sporting clubs with education, knowledge and advice on how to address drug-related issues and support cultural change. The Consultancy has identified athletes and sporting clubs as key

players in reducing drug-related issues, both within clubs and in the general community. It aims to have robust discussion and engagement with clubs on issues that are important to them, and offers services that focus on education, skills development, and design and implementation of peer support groups within sporting clubs.

### **Taskforce conclusions and recommendations**

The similarity of programs funded separately by the State and Commonwealth Governments raised questions for the Taskforce about possible duplication of effort, noting the Mental Health Commission submitted there was unnecessary duplication while the Alcohol and Drug Foundation submitted efforts were complimentary, as many State-funded Drug Action Groups were well placed to take advantage of Commonwealth funding allocated through the LDAT framework.

It is the view of the Taskforce that the current range of programs is more likely to support positive outcomes, with activity funded by the Commonwealth providing opportunities for Western Australia-based Drug Action Groups to continue to expand their program initiatives.

#### **4.2.5.2 Initiatives targeting community engagement**

As reported earlier, “community disorganisation” and “low community attachment” are risk factors that increase the likelihood of young people developing health and social problems. Protective factors identified to “help buffer” young people from these risk factors include “opportunities for pro-social involvement in the community” and “attachment to family”.<sup>126</sup>

One community-based model which targets these protective factors that the Taskforce considered was the Icelandic Model of Adolescent Substance Use Prevention. Developed by social scientists at the Icelandic Centre for Social Research and Analysis, it uses a data-informed approach to adolescent substance use prevention through community-based programs, involving a broad range of stakeholders.<sup>127</sup> Researchers collect and analyse data from secondary school students about their substance use, significant relationships and leisure time to understand the potentially modifiable community protective and individual risk factors present in the youth population.

A local community group comprised of policy makers, parents, school personnel, sport, recreational and youth workers uses the data and advice from the research to identify opportunities to reduce risk factors and strengthen school and community-level protective factors. The community group builds a network of support responding to the needs of their young people, including providing alternative opportunities for sport, cultural and other interests during non-school hours and opportunities for positive youth development and monitoring the outcomes.

However, literature on the effectiveness of the program is mixed. A 2010 study suggests that over time, parental monitoring and adolescent participation in

---

<sup>126</sup> Victorian Government. Department of Human Service: Youth and Family Services Division. Improving the Lives of Young Victorians in Our Community, A Summary Report. Melbourne: The Department; 2000. p. 9.

<sup>127</sup> Sigfúsdóttir ID, Thorlindsson T, Kristjánsson AL, Roe KM, Allegrante JP. Substance use prevention for adolescents: the Icelandic Model. Health Promot Int. 2009; 24(1); 16–25.



organized sports increased, and unmonitored idle hours and attendance at unsupervised parties decreased, in communities where the program was adopted, in comparison with communities not using the program.<sup>128</sup>

Data on the first 10 years suggested that alcohol use and being intoxicated during the last 30 days decreased more in the intervention than control communities<sup>129</sup> and that there was a 60 per cent decline in initiation of alcohol, tobacco and cannabis use<sup>130</sup>. However, recent research suggested that while alcohol use and trying cannabis use has declined in Iceland in the last 30 years, over this same period there has been a threefold increase in heavy users of cannabis and in this regard, Iceland is similar to its neighbouring countries.<sup>131</sup> This latest published research concludes that it is unlikely that increased parental monitoring will be successful at reaching the more vulnerable group of heavy adolescent cannabis users.<sup>132</sup>

In early 2016, Kununurra residents identified increased anti-social behaviour and a spike in youth crime over the school holiday periods as having considerable community impact. Anti-social and self-harming behaviours were peaking yet service/staffing capacity was reduced, leaving many at risk youth vulnerable. Kununurra lacked the resources to keep young people engaged in positively reinforced activities. As a result, a collaborative approach to programming and youth community services during the school holiday period was designed, targeting not only young people, but also their families.

This project, named the Kununurra Empowering Youth project (KEY), was developed by the East Kimberley District Leadership Group engaging representatives from across State, local and Commonwealth government, Aboriginal Controlled Community Organisations, not-for-profit agencies and community representatives. The methodology was based on Collective Impact design<sup>133</sup> principles with the underlying premise that no single organisation can create large-scale lasting social change alone. Its approach ensures that there is partnership and leadership in the design, planning and implementation of community specific solutions and outcomes.

To develop the program and calendar of events, advice was sought from the young people, local Aboriginal leadership, and service providers. Feedback was specifically obtained from the identified 'youth at risk', mostly aged between 10-15, who are generally disengaged from education and other mainstream activities.

Activities offered as part of the program included basketball, football, pool parties, weaving, discos, movie and skate nights, indoor soccer, street art, bush tucker trips back to country visits, make up evenings and performing arts events.

---

<sup>128</sup> Kristjánsson AL, James JE, Allegrante JP, Sigfusdottir ID, Helgason AR. Adolescent substance use, parental monitoring, and leisure-time activities: 12-year outcomes of primary prevention in Iceland. *Prev Med*. 2010; 51(2): 168–171.

<sup>129</sup> Arnarsson A, Kristofersson GK, Bjarnason T. Adolescent alcohol and cannabis use in Iceland 1995–2015. *Drug Alcohol Rev*. 2018;37(S1): S49-S57.

<sup>130</sup> Sigfusdottir ID, Kristjánsson AL, Gudmundsdottir ML, Allegrante JP. Substance use prevention through school and community-based health promotion: A transdisciplinary approach from Iceland. *Glob Health Promot*. 2011; 18(3): 23-6

<sup>131</sup> Arnarsson A, Kristofersson GK, Bjarnason T. Adolescent alcohol and cannabis use in Iceland 1995–2015. *Drug Alcohol Rev*. 2018; 37(S1): S49-S57.

<sup>132</sup> Ibid.

<sup>133</sup> For more information on Collective Impact see <https://aifs.gov.au/cfca/publications/collective-impact-evidence-and-implications-practice/what-collective-impact> [accessed 2018 Nov 7]

The calendar of events document used to promote the activities incorporates artwork by a young person from the local community, who won a competition run by the working group to design the logo for the KEY initiative.

Family participation is considered an essential element of the KEY initiative. Activities have been developed to attract not only young people but also their families. Work is undertaken continually to increase the level of family participation in events and also to continue to engage with families to identify what events they would like to see, and encourage volunteer support for the events that are held. The KEY program is resourced to operate solely on existing government and non-government agency funding. As such data collection to include collation of family participation rates are currently reliant on observation and anecdotal information.

Since its inception, the KEY initiative has contributed to a considerable decrease in both rates of offence and incarceration by young people:

Baseline prior to delivery of KEY activities 2015-16:

- A total of 37 young people were charged during this period.
- Seven (7) young people were in custody over the Dec/Jan school holiday period costing the state an estimated \$75,000.

First year of KEY activities 2016-17:

- 425 attendances by young people at 17 KEY activities over the Dec/Jan school holiday period.
- A total of 29 young people were charged during this period.
- An estimated 32 per cent of top 'prolific and priority offenders' attended KEY events.
- Two (2) young people were placed into custody during this time costing the state an estimated \$21,000 (a reduction from the year before of \$54,000).

Second year of KEY activities 2017-18:

- 2,765 attendances by young people at 46 KEY activities over the Dec/Jan school holiday period.
- A total of 23 young people were charged during this period (with the vast majority of offences occurring after 8pm, i.e. outside the hours of KEY activities).
- A total of 55 per cent of the Kununurra top 'prolific and priority offenders' attended KEY events.
- The numbers of young people placed into custody during this time is yet to be confirmed.

### **Taskforce conclusion and recommendations**

The Taskforce notes the success to date of the Kununurra Empowering Youth project which aims to build pro-social community involvement through a collaborative approach to programming and youth community services, targeting young people and their families. The Taskforce believes programs such as these should be evaluated over time for their ability to strengthen the protective factors that help safeguard young people from developing health and social problems. The Taskforce encourages communities to consider adopting programs such as the Kununurra Empowering Youth project.

**Recommendation 6:**

In order to strengthen community level protective factors aimed at young people and their families, the Department of Communities ensures existing evidence-based, best practice models for adolescent leisure or extracurricular activities are implemented more broadly in Western Australia.

**4.2.6 Media and information campaigns**

“Current ad campaigns on TV do not deter users. Seeing the ads just makes you want it again, encourages you to keep going. They also cause stigma.”

*Consumer and Family Members Forum*

“We need to open the conversation more. And there needs to be more discussion regarding users who aren’t the ‘typical’ addict we see advertised on TV. They aren’t all violent, stealing, crazed users. My Dad had a wife and 3 kids. He never stole for his habit, he would borrow money off family, including us kids, he would sell things etc. He wasn’t violent, he would be really happy and calm when on it. When he came down he would go to bed for a week or two straight with ‘a headache’ and be grumpy but never violent.”

*Online comment*

Public information campaigns have formed a significant part of government efforts to educate and inform people about the harms caused by methamphetamine, especially since 2015. In the main these campaigns have emphasised the most extreme effects of the drug on individuals and their families, and the severest impact on services that respond to them. However, while they may have a deterrent effect for some, the literature shows ‘fear’ campaigns do not encourage dependent users to seek help, and further isolate them and their families from getting the support they need. This is supported by what the Taskforce heard from people with lived experience of methamphetamine.

**4.2.6.1 What the Taskforce heard**

The Taskforce heard that while media campaigns showing extreme representations of the problems associated with methamphetamine (such as psychosis, stroke, violence, hallucination, facial sores) may deter some people from first using, for those who had already experienced some experimental or social use of the drug, these ads did not coincide with or reflect their often euphoric experience of methamphetamine, and was therefore not likely to deter future use. For those who had tried methamphetamine after seeing the ads the extreme representation they contained did not match their first use experience, so the warnings or consequences inherent in the campaign were given little weight. The Taskforce also heard (and evidence supports) that for those with problematic or entrenched use of methamphetamine, these ‘fear’ campaigns led to greater isolation and did not encourage them to seek help (see Section 5.2 on stigma for more on this).

Few evaluations have been conducted on the effectiveness of mass-media campaigns in preventing drug use, (although all Mental Health Commission campaigns are evaluated for awareness, understanding of their key messages, intentions to use and actions arising as a result; see below for more information).

Findings of individual evaluations vary considerably, likely due to variation in the types of mass-media interventions assessed.

One comprehensive meta-analysis of 19 mass-media campaign studies found no clear characteristic correlated with successful or unsuccessful campaigns, either regarding the campaigns' theoretical underpinnings or the specific communication strategies used. However, the analysis noted that two out of the four campaigns which were found effective in promoting the non-use of drugs positioned abstinence as a way to support the goals of autonomy and achievement of competence (i.e. non-use of drugs as a way to achieve important goals).<sup>134</sup>

A number of mass media campaigns have been found to result in harmful effects, indicating a need to proceed with caution with this kind of intervention. For example, the first version of the US Office of National Drug Control Policy's media campaign, called *My Anti-Drug*, appeared to increase drug use habits among the target population of young people. The campaign was based on a social marketing approach which emphasised resistance skills, self-efficacy, normative education and negative consequences of drug use.<sup>135</sup> This is suspected to have increased the perception of the prevalence of drug use, effectively 'normalising' use in the target population.<sup>136</sup>

#### **4.2.6.2      *What's happening in Western Australia***

Public education media campaigns aim to inform people who use drugs, their families and communities about the effects of methamphetamine use and, in doing so, discourage first and early use.

The Mental Health Commission's Drug Aware Methamphetamine Prevention Campaign was first developed in 2008 in response to an increase in methamphetamine-related harm being experienced by people in Western Australia. The Campaign was developed in partnership with Curtin University.

The Western Australian Government provided \$500,000 for the Drug Aware *Meth Can Take Control* prevention campaign launched in December 2015. The objectives of the campaign were to increase:

- awareness and knowledge of the health, social and legal consequences of methamphetamine use;
- the salience of the potential risks associated with methamphetamine use; and
- access to support services at an early stage.

The key messages of the campaign were:

- methamphetamine use can impact your whole life;
- there are mental health, physical health, social and legal consequences from methamphetamine use; and
- the Meth Helpline offers free counselling and advice 24/7.

---

<sup>134</sup> Allara E, Ferri M, Bo A, Gasparrini A, Faggiano F. Are mass-media campaigns effective in preventing drug use? A Cochrane systemic review and meta-analysis. *BMJ Open*. 2015;5. [accessed 2018 Nov 7] Available from: <http://bmjopen.bmj.com/content/bmjopen/5/9/e007449.full.pdf>

<sup>135</sup> Hornik R, Jacobsohn L, Orwin R, Piesse A, Galton K. Effects of the National Youth Anti-Drug Media Campaign on Youths. *Am J Public Health*. 2008;98(12); 2229–36.

<sup>136</sup> Allara E, Ferri M, Bo A, Gasparrini A, Faggiano F. loc. cit.

The primary target group for the campaign was 17-25 year olds at risk of using, or who are currently trialling the use of, methamphetamine. This group were targeted with the *Meth Can Take Control* messages. The secondary target group were parents, family and friends of methamphetamine users. This group were targeted with the Meth Helpline messages.

The Mental Health Commission process in conducting public education campaigns involves the application of evidence-based practice and relevant behavioural and epidemiological data, incorporating in-house experience combined with expert external advice in the development and execution of all campaigns.

The development of campaigns includes qualitative research with the target groups, guiding concept development and media production. Evaluations for a three-year campaign are conducted independently by expert social marketing researchers at the end of Year one and Year three. The evaluation then informs further development and refining of the campaign strategies and materials.

The Mental Health Commission advised the Taskforce that care was taken to ensure the Drug Aware *Meth Can Take Control* campaign messaging was salient, believable and trustworthy to those at-risk of using drugs, as well as occasional and regular users. This process included testing of concepts, and the use of an expert advisory group to assist with ensuring the campaign is evidence-based and does not stigmatise or normalise drug use.

The Mental Health Commission's process included an independent research agency conducting focus groups with young people at risk of methamphetamine use, their parents, and an expert advisory group. This involved an analysis of the proposed campaign content, concept and tagline to ensure credibility and believability of the content. The Mental Health Commission reported that testing found:

- it is beneficial to show a diverse range of impacts from using methamphetamine, as different impacts resonated with different participants; and
- showing a progression from milder effects to more extreme effects makes the entire collection of stories more believable.

The *Meth Can Take Control* campaign was first evaluated in 2016 and a final evaluation is scheduled for 2018. An interim evaluation of the Meth Helpline segment was conducted to inform advice to government at the time. At the time of writing this report, independent evaluation results reported by the Mental Health Commission indicate evaluation amongst methamphetamine users, found the majority of this group thought the campaign was believable and supported its continuation (62 per cent and 73 per cent respectively in 2016). The Drug Aware campaign evaluations have found consistent increases in intention not to use since 2014, with 91 per cent of young people surveyed in 2017 not intending to use meth.

"I liked the honesty of the ads, because from self-experience I know that a lot of what they were saying was true." (Drug Aware *Meth Can Take Control* 2016 evaluation quote provided by the Mental Health Commission.)

The only free-to-air television component of the campaign promoted the helpline for people, or people close to them, experiencing problems with methamphetamine use, wanting further information about methamphetamines. The Mental Health



Commission reported that its evaluations found call rates to the Meth Helpline, and website visits to the help pages on the Drug Aware website, increased in conjunction with the campaign.

The Mental Health Commission advised that its Drug Aware campaigns do not use television for prevention education, due to the risk of normalising illicit drug use and stigmatising users. The Drug Aware Methamphetamine Prevention Campaign used a range of media channels including online video, cinema, bus and train interiors and social media.

In 2015, the Commonwealth Government ran a \$9 million Australia-wide media campaign called *Ice Destroys Lives*, aimed at steering young people away from using crystal methamphetamine. The campaign primarily involved 15, 30 and 45-second videos, as well as social media posts on Facebook and Twitter that were widely shared and commented on. The ads depicted methamphetamine users assaulting doctors, health care workers and family members.

The *Ice Destroys Lives* campaign was shown through an independent evaluation (of 2,000 young people and 1,700 parents) to have prompted 94 per cent of people aged 14-25 who saw the campaign to take action by talking to peers or parents about drugs and change their thinking about ice, with 50 per cent responding that they would avoid using ice.<sup>137</sup> Further, 69 per cent of parents took some kind of action, with 36 per cent of parents talking to their child about the ad.<sup>138</sup> Nine per cent of young people surveyed who had used the drug responded that they had stopped using or reduced their use of ice after seeing the campaign.<sup>139</sup>

There were differences in the perceived relevance of the campaign between states, with 40 per cent of respondents in New South Wales finding it relevant, but only 27 per cent of those surveyed in Western Australia finding it relevant (the lowest rate in the country).<sup>140</sup>

The Mental Health Commission advised the Taskforce of the following, in relation to the different approaches taken between the State and Commonwealth Governments when it comes to public education and information campaigns:<sup>141</sup>

“It is important to note that the Commonwealth Government broadcast some public education addressing methamphetamines overlapping with the Western Australian campaign.

The Commonwealth has delivered campaigns infrequently since 2001; the most recent being ‘Ice Destroys Lives’ in 2015.

Research with the Western Australian target audience, and feedback from alcohol and other drug (AOD) experts, has found previous national (Commonwealth-run) drug campaigns have been seen as depicting unrealistic scenarios that are not representative of the experiences of the

---

<sup>137</sup> Stancombe Research and Planning. National Drugs Campaign 2015 Second Evaluation Research: Quantitative Research Report. Paddington: Stancombe Research + Planning; 2015.p 24-25. [accessed 2018 Nov 7] Available from:

<https://campaigns.health.gov.au/file/3346/download?token=nomK15Zk>

<sup>138</sup> Ibid., p. 25.

<sup>139</sup> Ibid., p. 24-25.

<sup>140</sup> Ibid., p.24.

<sup>141</sup> E-mail from Mental Health Commission to Department of Premier and Cabinet, 29 May 2018.

majority of individuals affected by drug use; and the messaging is not seen as believable or relatable by the target audience. It is possible these messages have worked to stigmatise drug use and further discourage individuals from seeking help and support.”

The Mental Health Commission stated that its feedback, provided through the Department of the Premier and Cabinet to the Commonwealth in preparation for the *National Ice Action Strategy*, pointed to the need for an evidence-based approach that:

- “is targeted using appropriate media. This includes avoiding the use of telecast media for low prevalence drug use and related problems;
- uses messaging that minimises the potential for stigmatising, including checking the target group through testing; and
- complements the State-based approach through a collaborative approach.<sup>142</sup>”

Further, the Mental Health Commission advised:

“Advice was provided to the Commonwealth stating that the use of more selected and targeted approaches based on (drug use) prevalence within the target group (is required) should be used when conducting mass reach public education. i.e. If the target group is a small minority of a population, there is a case to be made for not using mediums that talk to the entire population but a need to use those mediums (targeted media) that are more likely to reach the group of interest without any unintended consequences, such as normalising a behaviour that is not common (5%) within the mediums reach nor stigmatising those who use.

The Western Australian Meth Campaign used selected below-the-line mediums that addressed the target group for all communications other than that used to promote the Meth Helpline. There was no television used. However, the Commonwealth campaign that overlapped the Western Australian campaign used all main media broadcast mediums, including free-to-air and subscription television, newspapers and cinema advertising. The messaging was very different both in content and method of delivery. The State campaign can be characterised as targeted and selected and the Commonwealth campaign as universal in approach.

This overlap also increased the potential for confusion amongst the target audience in Western Australia. State research consistently finds that the target audience does not differentiate between state and national campaigns. Additionally, national terminology differs to that used in Western Australia. National efforts can undermine the credibility and believability of the State activity.

The Mental Health Commission received complaints about the televised (Commonwealth) methamphetamine advertisements.

---

<sup>142</sup> E-mail from Mental Health Commission to Department of the Premier and Cabinet, 29 May 2018.



The Commonwealth did not consult with the Western Australian Mental Health Commission in the development of their public education campaigns, nor their scheduling.”<sup>143</sup>

### **Taskforce conclusions and recommendations**

While governments have sought to ensure the messaging in public information campaigns is tested for credibility and evaluated for effectiveness, the Taskforce heard concerns about the unintended consequences that can result.

Some stakeholders suggested that resources used to fund universal public information campaigns would be better allocated to more targeted campaigns that met the information needs of particular groups, such as those used by the Mental Health Commission at music festivals and events on social media platforms.

At a national level the Parliamentary Joint Committee on Law Enforcement recommended “that the Commonwealth Government ensure future public awareness campaigns engender compassion towards drug users and are targeted at and inform those people, with the objective of encouraging them to seek treatment and support”.<sup>144</sup>

#### **Recommendation 7:**

The Mental Health Commission working with the Department of the Premier and Cabinet, liaise with other governments to ensure any future public information and education campaigns run in Western Australia are targeted to meet the needs of specific audiences, at risk groups, and/or local needs, and that campaigns focus on:

- seeing methamphetamine use as a health issue first and foremost;
- including the objective to encourage help seeking behaviour and support for those directly affected;
- supporting the de-stigmatisation of methamphetamine use; and
- ensuring all future public information campaigns are evaluated for their effectiveness against their objectives.

<sup>143</sup> E-mail from Mental Health Commission to Department of Premier and Cabinet, 29 May 2018.

<sup>144</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p xii. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

## Chapter 5 Intervening early to prevent entrenched use

“In my experience, when I used to take it, it was with friends and everybody had a good time. There was belief that you couldn’t do [over dose] on it so it was just a fun party drug. We need to get it out of the hands of the recreational users before they become addicts.”

*Online comment*

“Don’t stigmatise – see the drug as the problem, not the person.”

*Consumer and Family Members Forum*

“See drug users as human beings – we are fathers, mothers, someone’s child.”

*Consumer and Family Members Forum*

“One hint of judgement, through body language or words turns people off and away from seeking help.”

*Service Providers Forum*

### 5.1 What the Taskforce heard

The Taskforce heard from consumers of services and their families that they experienced a great deal of judgement when seeking help and support.

“Most people hear ‘ice addict’ and don’t want anything to help [sic]. They roll their eyes and judge you as if the addict can never be helped and that I’m wasting my time. Most people don’t want to know about it.”

*Online comment*

And further, that fear of judgement combined with the stigma associated with methamphetamine use was one of the main reasons users don’t seek help.

“Meth is [a] growing problem affecting everyone from housewives to nurses to friends and family. I think the stigma around it needs to be removed so that people struggling know they are not the only one and be more willing to access help.”

*Online comment*

The Taskforce also heard the widely expressed view that methamphetamine should be considered and treated as a health issue, rather than a criminal justice issue. Many felt strongly that substance dependence should be treated first and foremost as a health issue, and that offering compassion and understanding rather than judgement and discrimination was key to getting effective treatment.

“Health needs to be the primary focus for AOD responses. Without this, AOD will continue to be an increasing burden on other sectors...[We] can’t arrest our way out of alcohol and other drug issues.”

*Service Provider Forum*

The National Ice Taskforce's Final Report considered early intervention to be measures that engage people who are at risk of developing dependence or coming to greater harms, with the aim of reducing their use or changing their behaviour before it becomes problematic or entrenched.<sup>145</sup>

While early intervention comes in many different forms, the literature highlights two as prevalent: initiatives focused on reducing the stigma associated with drug use and encouraging help-seeking; and brief interventions. Brief interventions commonly involve short assessments aimed at identifying potential problems with substance use and motivating those at risk to change their methamphetamine use behaviour.

## 5.2 Reducing stigma

In its final report, the National Ice Taskforce noted that most users do not get the help they need early in their use cycle, only doing so once their dependence is severe. It also said stigma is a major barrier to problematic and dependent users seeking help.<sup>146</sup>

This is supported by:

- a recent meta-analysis of barriers to accessing methamphetamine treatment which found the most common barriers to help-seeking among methamphetamine users was embarrassment or fear of public stigma (around 60 per cent of users);<sup>147</sup> and
- research that indicates there is a time lag of about five years between first problematic use of methamphetamine and when a person first decides to seek help.<sup>148</sup>

### 5.2.1 What is stigma?

The World Health Organisation recognises that illicit drug dependence is the most stigmatised health condition in the world.<sup>149</sup> Health-related stigma is understood to be a “socio-cultural process in which social groups are devalued, rejected and excluded on the basis of socially discredited health conditions”,<sup>150</sup> with studies finding that substance use disorders are more highly stigmatised than other health conditions.<sup>151</sup>

---

<sup>145</sup> Australian Government. Department of the Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p 74. [accessed 2018 Nov 7] Available from:

[https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf).

<sup>146</sup> Ibid. p.123.

<sup>147</sup> Cumming C, Troeung L, Young JT, Kelty E, Preen DB. Barriers to accessing methamphetamine treatment: A systemic Review and Meta-analysis. *Drug and Alcohol Dependence*. 2016; 1(168): 263-273.

<sup>148</sup> Lee NK, Harney AM, Pennay AE. Examining the temporal relationship between methamphetamine use and mental health comorbidity. *Advances in Dual Diagnosis*. 2012; 5(1): 23-31.

<sup>149</sup> Corrigan et al. (cited in Western Australian Network of Alcohol and other Drug Agencies, Position Paper, Reducing Stigma and Discrimination Relating to Alcohol and other Drugs in Western Australia, June 2013).

<sup>150</sup> Weiss, et al. (cited in Livingston JD, Milne T, Fang ML and Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: as systematic review. *Addiction* 2012 Jan; 107(1): 39-50).

<sup>151</sup> Rao, Ronzani, Room, Corrigan and Schomerus (cited in Livingston *ibid*).

“Stigma may be understood in terms of the different ways it manifests at the self, social and structural levels [8-10]. Self-stigma is defined as a subject process that is ‘characterised by negative feelings (about self) maladaptive behaviour, identity transformation or stereotype endorsement resulting from an individual’s experiences, perceptions, or anticipation of negative social reactions’...Social stigma describes ‘the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatised group’ [8]. Structural stigma refers to the rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatised groups [8-11]. Examples of structural stigma are the negative attitudes and behaviours of representatives of public institutions, such as people who work in the health and criminal justice sectors.”<sup>152</sup>

### 5.2.2 The causes and impacts of stigma

Perceptions of why people take drugs are often based on the assumption that the person is “weak” or “immoral”, which categorises drug use as an individual problem to be solved, rather than a complex problem with social and environmental influences, as well as individual factors. Stigma is also caused by the association between criminal behaviour and drug use. The majority of people who use drugs do not engage in criminal activity, other than use of the drug, but some resort to crime in order to sustain their use. Drug use often disconnects people from the mainstream and connects them to “marginalised sub-cultures where crime is rife”. As the Taskforce heard, once people who use drugs have a criminal record, they find it challenging to find work, “thus making the illegal market and criminal activity among their only means of survival”.<sup>153</sup>

Perceptions of drug use are influenced by media, “which portray the effects of drugs as overwhelmingly negative”. In the main media coverage of the issue links drugs to crime and associates the use of drugs with inevitable “devastating consequences” for the individual.<sup>154</sup> Figure 26 shows the cyclical link between public perceptions of use, media portrayal of drug issues and drug control policies which contribute to and perpetuate the stigma associated with drugs and drug use.

---

<sup>152</sup> Livingston JD, Milne T, Fang ML and Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: as systematic review. *Addiction* 2012 Jan; 107(1): 39-50.

<sup>153</sup> Global Commission on Drug Policy. *The World Drug Perception Problem. Countering prejudices about people who use drugs.* 2017. p.8. [accessed 2018 Nov 7] Available from:

<http://www.globalcommissionondrugs.org/reports/changing-perceptions/>

<sup>154</sup> Ibid.

**Figure 26: The Vicious Cycle of Perceptions of People who use Drugs**



Source: Global Commission on Drug Policy.<sup>155</sup>

“Stigmatizing therefore has a perverse effect: the more society stigmatizes and rejects people who use drugs, the fewer opportunities for treatment will be on offer; at the same time, stigma drives individuals who need help away from those services that are available.”<sup>156</sup>

The impacts of stigma and discrimination on individuals who use drugs are reported as “wide ranging, including:

- low self-esteem and self-worth;
- feelings of isolation;
- development of self-hate;
- feelings of helplessness;
- disempowerment;
- exclusion from community life;
- physical and psychological distress;
- compromised quality of life;
- chronic stress;
- depressive symptoms;
- unemployment and loss of income;
- difficulty obtaining housing;
- problems accessing education;
- problems accessing insurance;
- limited social opportunity.”<sup>157</sup>

<sup>155</sup> Ibid. p. 28.

<sup>156</sup> Ibid.

<sup>157</sup> Link et al. and Australian Injecting and Illicit Drug Users League (cited in Western Australian Network of Alcohol and other Drug Agencies, Position Paper, Reducing Stigma and Discrimination Relating to Alcohol and other Drugs in Western Australia, June 2013, p. 5).

As recognised by the National Ice Taskforce, a key impact of stigma on individuals is to discourage access to alcohol and other drug treatment with “labelled’ groups seeking to distance themselves from the ‘label’ through forgoing or delaying treatment”.<sup>158</sup> The Western Australian Network of Alcohol and other Drug Agencies says: “Stigma is also reported to impact on early identification and screening for problematic use of alcohol and other drugs, which is a key priority for public health.”<sup>159</sup>

The literature suggests a number of promising interventions focused on achieving meaningful de-stigmatisation of alcohol and other drug disorders, including methamphetamine use. A recent literature review of 13 evaluations of substance use disorder stigma interventions indicates a number of interventions that may be able to positively impact on stigma-related outcomes. There is some evidence that self-stigma can be reduced through participation in therapeutic group-based interventions, such as group-based counselling. Addressing social stigma, or improving the attitudes of the general public may be best tackled by promoting positive stories and facilitating positive interactions between the public and people with the stigmatised condition. The research indicates that providing educational fact sheets does not achieve improvements in public perceptions of people who use drugs. Structural stigma has been shown to be improved through ‘contact-based’ approaches, such as programs that focus on educating medical students, police officers and alcohol and other drug counsellors by educating them about substance use problems and “exposing them to people with substance use disorders are likely to decrease their stigmatizing attitudes and increase comfort levels towards working with this population”.<sup>160</sup>

The Global Commission on Drug Policy argues that changing how we speak about drugs, and the language used, can help to reduce the stigma related to drug use and drugs. They note that there has been in recent times a move by medical associations,<sup>161</sup> editors of scientific journals,<sup>162</sup> government officials,<sup>163</sup> and the media<sup>164</sup> to provide guidance on better language. Figure 27 provides a ready guide for better language.

---

<sup>158</sup> Hopwood (cited in Western Australian Network of Alcohol and other Drug Agencies, Position Paper, Reducing Stigma and Discrimination Relating to Alcohol and other Drugs in Western Australia, June 2013, p. 5).

<sup>159</sup> Western Australian Network of Alcohol and other Drug Agencies, loc. cit.

<sup>160</sup> Livingston et al., loc. cit.

<sup>161</sup> American Medical Association, 2015 Patients with Addiction Need Treatment – Not Stigma, (cited in Global Commission on Drug Policy, op. cit., p.30.)


<sup>162</sup> International Society of Addiction Journal. 20015 Statements and Guidelines Addiction Terminology (cited in Global Commission on Drug Policy, op. cit., p.30.)

<sup>163</sup> Botticelli, M (cited in Global Commission on Drug Policy, op. cit., p.30.)

<sup>164</sup> Associated Press. 2017 The Associated Press Stylebook 2017: and Briefing on Media Law (cited in Global Commission on Drug Policy, op. cit., p.30.)



**Figure 27: Global Commission on Drug Policy Better Language Guide**

 <b>USE</b>	 <b>DON'T USE</b>
Person who uses drugs	Drug user
Person with non-problematic drug use	Recreational, casual, or experimental users
Person with drug dependence, person with problematic drug use, person with substance use disorder; person who uses drugs (when use is not problematic)	Addict; drug/substance abuser; junkie; dope head, pothead, smack head, crackhead etc.; druggie; stoner
Substance use disorder; problematic drug use	Drug habit
Has a X use disorder	Addicted to X
Abstinent; person who has stopped using drugs	Clean
Actively uses drugs; positive for substance use	Dirty (as in "dirty screen")
Respond, program, address, manage	Fight, counter, combat drugs and other combatant language
Safe consumption facility	Fix rooms
Person in recovery, person in long-term recovery	Former addicts; reformed addict
Person who injects drugs	Injecting drug user
Opioid substitution therapy	Opioid replacement therapy

Source: Global Commission on Drug Policy.<sup>165</sup>

### 5.2.3 What's happening in Western Australia

The Western Australian Government's current drug and alcohol stigma reduction efforts occur predominantly through the Social Inclusion Action Research Group (SIARG); a partnership between the Western Australian Network of Alcohol and other Drug Agencies, the Mental Health Commission and the wider Western Australian alcohol and other drug sector. The SIARG partnership aims to reduce alcohol and other drug-related stigma and discrimination, promote social inclusion and reduce stigma experienced by people who have problems related to their own alcohol and other drug use, as well as the stigma of family members, significant others, and people who work in the alcohol and other drug sector.

<sup>165</sup> Global Commission on Drug Policy, op. cit., p. 30.



The partnership undertakes a number of key activities related to stigma reduction including advocacy work, community-based education and communication, and place-based behaviour change interventions, which are location-targeted programs that aim to improve service access and experiences for alcohol and other drug consumers.<sup>166</sup>

The Australian Press Council has issued standards of practice on drugs and drug addiction, offering the following broad guidelines for consideration when reporting drug-related issues:

- “Responsibly report public debate about drug use and addiction;
- The harmful effects of any particular drug should not be exaggerated or minimized;
- Avoid detailed accounts of consumption methods, even though many young people are generally familiar with them;
- Outlining the chemical composition of a drug may be justified in some reports, but avoid providing any details which would assist its manufacture;
- Do not quote the lethal dose of any particular drug;
- Guard against any reporting which might encourage readers’ experimentation with a drug, for example, highlighting the ‘glamour’ of the dangers involved;
- Highlight elements of a story which convey the message that preventative measures against drug abuse do exist, and that people can be protected from the harmful consequences of their addictive behaviours;
- Bear in mind the arguments of those who point out that tobacco and alcohol use and addiction are another major aspect of the drug story.”<sup>167</sup>

### Taskforce conclusions and recommendations

The Taskforce recognises the importance of preventing occasional and problematic methamphetamine users from becoming more entrenched and dependent users.

The Taskforce heard from those with lived experience of methamphetamine use – users and their families – that stigma and judgement are key issues preventing people seeking help. Research confirms stigma has wide-ranging and significant negative consequences for people who take drugs and is a common and major barrier to people seeking help. A five to 10 year time lag has been reported from the time methamphetamine use becomes problematic to when users seek help through treatment. By this time problematic use has generally become chronic use, lives are no longer functional, jobs are lost, relationships destroyed, children removed into care, homes gone and the dependency is that much harder to break.

The Taskforce has formed the view that initiatives that would successfully reduce this time lag between problematic use and seeking treatment represent a significant under-recognised and under-utilised opportunity to address the problems associated

<sup>166</sup> Van der Beeke L. Western Australian Network of Alcohol and other Drug Agencies. Marketing for Change, Reducing Alcohol and Other Drug Related Stigma in WA. Perth: WANADA; 2014. [accessed 2018 Nov 7] Available from:

[http://www.wanada.org.au/index.php?option=com\\_docman&view=download&alias=110-aod-related-stigma-next-steps-marketing-for-change-december-2014&category\\_slug=stigma&Itemid=265](http://www.wanada.org.au/index.php?option=com_docman&view=download&alias=110-aod-related-stigma-next-steps-marketing-for-change-december-2014&category_slug=stigma&Itemid=265)

<sup>167</sup> The Press Council of Australia. Guideline: Drugs and drug addiction. 2001 July 1. [accessed 2018 Nov 7] Available from <https://www.presscouncil.org.au/document-search/guideline-drugs-and-drug-addiction/?LocatorGroupID=662&LocatorFormID=677&FromSearch=1>

with methamphetamine in our communities, and that reducing stigma is fundamental to reducing this time lag.

The Victorian Parliament has recently recommended the Government develop specific guidelines on the use of appropriate, objective and non-judgemental language regarding substance use disorders, addictions and those who use drugs for public policy-makers, law enforcement agencies and health care professionals. In addition, it has been recommended that the Government consult with the appropriate agencies to ensure the guidelines are implemented throughout the working practices of these identified groups and the guidelines be conveyed to the media and non-government agencies.

The Parliamentary Joint Committee on Law Enforcement has recommended that the Australian Press Council develops and implements media reporting standards for coverage of drug use. The Taskforce recommends the Western Australian Government adopt a similar measure to address the social stigma associated with methamphetamine use by encouraging the use of non-judgemental language across all areas of its related activity and encouraging the same in the media. In addition, in order to improve self-stigma and the attitudes of the general public, the Taskforce recommends promoting positive stories and facilitating positive interactions between the public and people with lived experience of methamphetamine.

**Recommendation 8:**

The Mental Health Commission should work to reduce the stigma associated with methamphetamine use, including:

- developing specific guidelines on the use of appropriate objective and non-judgmental language regarding substance use disorders, addictions and those who use drugs for health care professionals, law enforcement agencies and public policy makers;
- consulting with appropriate agencies to ensure the guidelines are implemented throughout the working practices of these identified groups;
- conveying these guidelines to the media; and
- involving people who have or have had lived experience of methamphetamine and their families in frontline workforce education and training.

**Recommendation 9:**

The Mental Health Commission promotes positive personal stories of successful treatment to the general public and to those experiencing problematic or dependent use of methamphetamine to address both social and self-stigma and promote help seeking behaviour.

### 5.3 Screening and brief interventions

Screening for the harmful use of alcohol and other drugs including methamphetamine has not routinely been carried out in primary health care settings. However, evidence suggests that the most commonly accessed service for methamphetamine use and/or related harms are general practitioners (GPs), positioning GPs well to screen and conduct brief interventions with at-risk clients.<sup>168</sup>

The Taskforce heard that many methamphetamine users seeking help from primary care and other allied health care professionals experience stigma. The AMA (College of General Practitioners Western Australia) reported the reluctance of many GPs to treat drug-affected patients, particularly those with high levels of dependence, because of the impact this may have on their other patients in a general practice setting.

“Health care providers may hold negative beliefs about people with substance use disorders, including that they overuse system resources, are not vested in their own health, abuse the system through drug-seeking and diversion and fail to adhere to recommended care [7, 48]. Such perceptions can contribute to inequitable and poor provision of care for people with these disorders. As such, individuals ...may choose to conceal their substance use problems to avoid stigma, which may result in care provision that does not attend to substance use related needs (e.g. while pregnant) [33].”<sup>169</sup>

Many people with early use and problematic use of methamphetamine are likely to come into contact with or seek help from primary health care and other allied health care professionals. Given this, it is considered important to ensure that this workforce is appropriately skilled to, in a non-judgemental way, screen for and deliver meaningful brief interventions and have the necessary information and support to refer patients to specialist services where appropriate.

From July 2016, under the *National Ice Action Strategy*, the Commonwealth Government allocated \$1.7 million over four years for The University of Adelaide to continue to expand the application of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and Brief Intervention (ASSIST-BI) across the primary health, mental health, and emergency care sectors, as well as in community correctional settings.

ASSIST is a tool that provides an accessible and user-friendly option for health professionals to assess potentially harmful use of alcohol and other drugs and support brief interventions, and for methamphetamine users to access information and monitor their own drug-use.

<sup>168</sup> Quinn B, Stooze M, Dietze P. Factors associated with professional support access among a prospective cohort of methamphetamine users. *J Subst Abuse Treat*. 2013; 45(2): 235-241. A study of 255 people 18 years or over using methamphetamine at least monthly found that 43.5 per cent had accessed the services of a GP at some point for the methamphetamine use or related harms.

<sup>169</sup> Livingston et. al., loc. cit.

## Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

ASSIST is a tool to screen for hazardous or harmful use of illicit drugs, tobacco and alcohol. It was developed by the World Health Organisation between 2002 and 2007 for use in primary health care settings where harmful substance use among patients may go undetected, or become worse.

ASSIST has been widely tested to ensure it is feasible, reliable, valid, flexible, comprehensive cross-culturally relevant and able to be linked to brief interventions. Presently, ASSIST – BI is the only screening instrument responsive to changes in drug use patterns as it screens for the use of alcohol, tobacco, amphetamines, cannabis, cocaine, inhalants, opioids, sedatives and hallucinogens.

The NIAS-funded [ASSIST Portal](#) developed by The University of Adelaide contains a specific ASSIST on Ice resource, along with a range of other resources and eLearning tools to help administer the ASSIST and linked brief intervention; links to the *ASSIST Community*, a learning environment for experts and practitioners using ASSIST, and *ASSIST Check-up* an ‘app’ that can be downloaded to mobile devices free that provides a confidential tool for people to:

- check their alcohol and other drug use and track their use in a diary
- receive personalised feedback to help minimise risk of harm
- access to detailed information about a variety of drugs
- hear advice about what to do in a crisis
- find tips for cutting down or stopping; and
- access links to help services.

ASSIST is available through an iOS or Android phone or tablet ‘app’ accessible here [ASSIST Checkup – ASSIST Portal](#)

The aim of brief interventions is to help people understand that their alcohol and other drug use is putting them at risk, and to encourage them to seek help to reduce or give up use. Brief interventions are generally most appropriate for early users, rather than individuals with entrenched methamphetamine dependency issues.

Brief interventions can range from five minutes of brief advice to 15-30 minutes of brief counselling. They can be performed by a range of individuals including primary health care professionals such as GPs and allied health professionals, as well as trained drug and alcohol workers and, in some cases, frontline workers such as police or emergency department staff. It should be noted that frontline staff are not always best placed to conduct brief interventions, as their focus is commonly on addressing an immediate crisis and their time with each patient is limited.

There is good evidence to suggest the effectiveness of brief interventions delivered in primary health care settings for users of amphetamines.<sup>170</sup> Regular (at least monthly) users of amphetamine were recruited to identify whether brief cognitive-behavioural interventions were effective overall and to pilot two and four session interventions. The brief interventions involved either: four sessions of cognitive-

---

<sup>170</sup> Baker A, Boggs TG, Lewin TJ. Randomised controlled trial of brief cognitive-behavioural interventions among regular users of amphetamine. *Addiction*. 2001; 96(9): 1279-87.

behavioural interventions, consisting of a motivational interview, skills training to avoid high-risk situations, cope with craving and prevent relapse; or two sessions consisting of a motivational interview and discussion of skills. The control group received a self-help booklet. The study found there was a significant reduction in amphetamine use among the sample as a whole, with inconclusive differences between the four and two session intervention sub-groups. The intervention group reported more than twice the reduction in daily amphetamine use as the control group, and significantly more people in the intervention group had abstained from amphetamine use at a six-month follow-up compared with the control group.

### 5.3.1 What's happening in Western Australia

Training of frontline workers to specifically address methamphetamine problems has been a key focus for both the Mental Health Commission and the WA Primary Health Alliance.

The Final Report of the National Ice Taskforce recommended a range of strategies to provide frontline workers with ongoing professional development, support, education, and training relating to crystal methamphetamine use; and establishing structures and systems that link frontline workers with services.

The Taskforce heard from the WA Primary Health Alliance that it is investing in increasing the uptake of screening and brief interventions by primary health care practitioners and specialists, allied health professionals and community health workers. The WA Primary Health Alliance notes in its submission to the Taskforce that increasing the prevalence of screening, brief intervention and support within the context of general health and well-being helps to reduce stigma associated with getting help, and acknowledges that issues can be complex and co-occurring.

WA Primary Health Alliance commissions activities to help support primary health care and allied health care professionals, including:

- a partnership between the Mental Health Commission, Edith Cowan University and the Royal Australian College of General Practitioners, involving the development and delivery of an Aboriginal Mental Health and Alcohol and other Drug training module targeted at GPs and other health professionals. The module aims to ensure Western Australia has a workforce better equipped to support Aboriginal people with problematic alcohol and drug use and/or mental illness. This module will be added to the Aboriginal Health Council of Western Australia's existing Cultural Safety Training package; and
- an Active Learning Module (accredited by the Royal Australian College of General Practitioners) involves development and delivery of alcohol and drug education and skills development to GPs. The activities will be developed with an expert reference group and delivered around the State in partnership with local service providers.

The Mental Health Commission funds the Clinical Advisory Service (CAS) which operates a 24/7 phone service for health professionals providing clinical advice on all issues relating to patient management involving alcohol and drug use.

This line is utilised by GPs, pharmacists, nurses, hospitals, alcohol and other drug agencies and other health professionals. During business hours the service is staffed by an experienced clinical team, with access to Addiction Medicine Specialists from Next Step Drug and Alcohol Services. During weekends and after hours, calls to the

service are answered by the Next Step on call doctor. During work hours, call enquiries to the service are managed according to the level of specialised advice required. Where the call relates to the clinical management of a patient the call will be referred to the Next Step duty doctor with a return call made at the earliest opportunity.

Given current resourcing, availability of the Clinical Advisory Service has not been widely promoted to primary care practitioners aside from those doctors and community pharmacists undertaking Community Program for Opioid Pharmacotherapy training for methadone and buprenorphine treatment. The service is also promoted by Next Step medical practitioners and clinical staff undertaking presentations or liaison with community service providers.<sup>171</sup>

#### **5.3.1.1 Response from general practitioners**

The Taskforce heard from the Australian Medical Association that there was reluctance among general practitioners (GPs) to have people affected by drug use attending their practices. It was advised that from a commercial perspective, private medical practices do not have a tolerance for 'no-shows' and that a GP practice does not have the structures in place to manage potentially violent people.

GPs have been identified as a likely point of entry to the system for people seeking assistance or information around methamphetamine use, and that it was important the GP was adequately equipped with the right information to be able to assist a patient.

The Taskforce heard that given the broad nature of their practice, GPs have information on a wide range of topics available to pass onto their patients. The Australian Medical Association advised that the most appropriate role for a GP, when asked for information around methamphetamine use, would be to refer them to the appropriate specialist services (which the Australian Medical Association identified as the Next Step Drug and Alcohol Service).

The Australian Medical Association advised that the advice of a GP around methamphetamine use would likely be requested in the following circumstances:

- a patient seeking general advice about the impacts of methamphetamine use (e.g. a parent seeking information about how to talk to their teenager about drug use);
- a concerned party (friend or family member) seeking advice about how to assist someone with issues relating to methamphetamine; and
- an individual with concerns about their own actions.

The Australian Medical Association also advised that for a GP to have an appropriate role in caring for a patient following treatment for methamphetamine use, they would need to receive details of that patient's drug use treatment, so they could provide informed support.

### **Taskforce conclusions and recommendations**

The Taskforce heard that many methamphetamine users seeking help from primary care and other allied health care professionals experience stigma and there is a reluctance on the part of many GPs to treat those with alcohol and other drug issues.

---

<sup>171</sup> Email from Mental Health Commission to MAP Taskforce, 21 June 2018.



The Taskforce believes it is important to ensure that this workforce has the skills to appropriately screen for and deliver meaningful brief interventions, and the necessary information and support to refer patients to specialist services where appropriate.

While the Commonwealth Government, through the *National Ice Action Strategy*, has invested in the development and implementation of ASSIST and ASSIST-BI by The University of Adelaide, the Taskforce is unclear about the extent of its use in Western Australia.

#### **Recommendation 10:**

The Mental Health Commission to work with the Department of Health, the WA Primary Health Alliance and the Australian Medical Association (Council of General Practitioners) Western Australia to better promote the use of the Next Steps Clinical Advisory Service to primary health and allied health care professionals.

#### **Recommendation 11:**

The Mental Health Commission to work with other relevant agencies to promote increased screening for alcohol and other drug conditions for people presenting to primary health care professionals and workers in child protection and community health; including increasing awareness and use of alcohol and other drug screening tools and referrals to appropriate services.

#### **Recommendation 12:**

The Department of the Premier and Cabinet and the Mental Health Commission, with the WA Primary Health Alliance and alcohol and other drug sector, to consult with the Commonwealth Government on measures to improve referral to alcohol and other drug specialist treatment services by GPs.

## **5.4 Early intervention in the workplace**

“When the mining companies brought in that people [would be] penalised if they have even 0.05 alcohol when tested, this led to an increase in meth using as miners came in to get fitpacks after work, shoot up and it was out of their system by the commencement of work”

*Online Comment*

“Workers use meth because it passes through the system quickly.”

*Service Providers Forum*

“There are penalties when workers disclose drug problems.”

*Service Providers Forum*

“[I want] an understanding of my obligations as an employer so I can best support my staff but also protect my business.”

*Workplace Forum*

### **5.4.1 What the Taskforce heard**

As previously noted, there are significant numbers of people who use methamphetamine who are employed. For most of these people, their use has not reached a point of entrenched use or high dependence. They are likely to be infrequent users, or people who may be starting to use more frequently and



beginning to experience problematic use (experiencing adverse effects on their health, sleep, relationships, housing, finances and employment). For that reason, workplaces represent an opportunity to intervene early to prevent entrenched use.

#### 5.4.2 What works in the workplace

As previously noted, methamphetamine was estimated to cost Australian workplaces \$289 million in 2013-14.

Workplace strategies generally include:

- alcohol and other drug policies – primarily a prevention strategy that communicates expectations, roles and responsibilities of the employer and employee;
- risk assessment and analysis;
- education and training programs – whole of organisation approach, frequency of education, delivery of education, rationale for testing if conducted;
- testing – there is little evidence that demonstrates the effectiveness of workplace testing for alcohol and drugs. Despite this, the perception is that workers see this intervention as a deterrent; and
- employee assistance programs.<sup>172</sup>

The National Centre for Education and Training on Addiction has provided a summary of the most common strategies utilised in Australian workplaces and their relative strengths and weaknesses.

**Figure 28: Strengths and limitations of workplace strategies for responding to alcohol and other drug-related issues**

Strategy	Strengths	Limitations
<b>1. Policy</b>	Necessary basis for any response	Not an intervention strategy per se Needs to incorporate other strategies
<b>2. Education/ training</b>	Necessary for response dissemination and implementation	Some workplaces may not have resources required to develop and deliver programs
<b>3. Counselling/ treatment</b>	Necessary as a 'treatment' strategy	Can be difficult for individual workplaces to access individual service providers Focus on individual 'problem' workers
<b>4. Employee assistance programs (EAP)</b>	Provides ready access to treatment/counselling services	Focus on individual 'problem' workers
<b>5. Testing</b>	Relatively easy to implement	Focus on illicit drugs Focus on individual 'problem' workers Can have unexpected negative outcomes
<b>6. Health promotion</b>	Focus on a range of health issues	Alcohol and other drugs not the main issue
<b>7. Brief interventions</b>	Relatively easy to implement	Needs to be part of additional strategy (e.g. health promotion, education program)

<sup>172</sup> Australian Drug Foundation. Effective workplace alcohol strategies. Melbourne: ADF; 2014. [accessed 2018 Nov 7] Available from: <https://adf.org.au/wp-content/uploads/2016/10/Effective-workplace-alcohol-strategies-Sheet.pdf>

Source: National Centre for Education and Training on Addiction<sup>173</sup>

The National Centre for Education and Training on Addiction has reported on the essential components of an effective response to alcohol and other drugs in the workplace based on research and best practice, which includes:

- a formal written alcohol and drug policy – the effectiveness of which depends on:
  - consultations;
  - feasibility study and risk assessment;
  - comprehensiveness;
  - dissemination; and
  - on-going implementation/evaluation process;
- education which is aimed at:
  - policy dissemination and acceptance;
  - preventing alcohol and drug problems in the workplace, including:
    - explaining roles and responsibilities of all employees;
    - providing health and safety in the workplace regarding of alcohol and drug use;
    - providing information on where and how to seek assistance; and
    - ongoing delivery of this through a variety of media;
- training which:
  - is targeted at key employees including supervisors, managers, workplace health and safety staff, and employee representatives;
  - enhances capacity to identify and manage alcohol and other drug-related harm;
  - builds communication, interview and supervision skills; and
  - is on-going and can adapt to changing circumstances;
- access to counselling and treatment services including voluntary confidential access (although according to the National Centre for Education and Training on Addiction there is less evidence of their effectiveness in identifying and treating employees with moderate alcohol and other drug problems is less evidence),<sup>174</sup> and provision of leave.<sup>175</sup>

Other effective strategies include:

- brief interventions – assessment followed by feedback on how this use may be affecting the worker's health and safety, which can be delivered by external health professionals, internal workplace health and safety staff, use diaries and self-help guides, or online interventions;
- health promotion – use of alcohol and other drug interventions embedded within a broader workplace health program;
- psychosocial skills training – provision of training that focusses on knowledge, attitudes and life skills, effective in changing attitudes toward use, reducing use that impacts the workplace, and improving teamwork; and

---

<sup>173</sup> Pidd K. National Centre for Education and Training on Addiction (NCETA). The workplace and AOD use: Research and best practice approaches. Melbourne: Office of the Federal Safety Commission AOD Forum; 2009 April 8. Available from: [http://www.fsc.gov.au/sites/FSC/Resources/AZ/Documents/Research\\_and\\_Best\\_Practice\\_Approaches.pdf](http://www.fsc.gov.au/sites/FSC/Resources/AZ/Documents/Research_and_Best_Practice_Approaches.pdf)

<sup>174</sup> Calogero et al. (cited in Pidd and Roche, loc. cit.).

<sup>175</sup> Pidd and Roche, loc. cit.

- peer intervention – use of trained peers (co-workers) to recognise and intervene with problem workers, particularly effective where there is a strong sense of identity among target group.<sup>176</sup>

The National Centre for Education and Training on Addiction has also developed *A Training Kit to respond to alcohol and other drug issues in the workplace*. The purpose of the training kit is to “provide participants with the knowledge, skills, and abilities required to facilitate the development and implementation of a comprehensive and effective workplace alcohol and other drug policy for their workplace”.<sup>177</sup>

#### **5.4.2.1 Drug testing in the workplace**

The main aim of drug testing is to eliminate drug-related risk to workplace health and safety by eliminating drug use. While research indicates there is evidence to support drug testing having a deterrent effect, the effect is small. Further, drug testing is often considered an inappropriate gauge for mitigating workplace safety risks as it only detects whether a person has used a drug, rather than testing their functional capacity to perform their job.<sup>178</sup>

For methamphetamine in particular, the drug may not be present in the system or detectable, but the after-effects of use (diminished executive function, decreased processing and response time due to lack of sleep, as well as depression and anxiety) have the potential to impact on the health and safety of both affected workers and their colleagues.<sup>179</sup>

Drug testing can mask risk in other ways. Instead of eliminating use, workers may simply change their behaviour to make their drug use less detectable without reducing the risk of drug-related harm, for example:

- abstinence for a sufficient time to avoid detection, and then resume use afterwards;
- utilise other medications to mask drug use; and
- contaminate or substitute samples at the time of collection.<sup>180</sup>

Of more concern is that changes in workers' behaviour directed at avoiding detection rather than reducing risk, may have serious consequences for the health and safety of workers. For example, due to the long window of detection (30 days) for cannabis, workers have moved from occasional use of marijuana to chronic but less detectable

---

<sup>176</sup> Pidd and Roche, loc. cit.

<sup>177</sup> The National Centre for Education and Training on Addiction. Flinders University. *A Training Kit to Responding to Alcohol and Other Drug Issues in the Workplace*. Adelaide: NCETA; 2006. [accessed 2018 Nov 7] Available from: <http://nceta.flinders.edu.au/files/6612/6466/1526/EN409%20Workplace%20Training%20kit%202006.pdf>

<sup>178</sup> Comer D. A Case Against Drug Testing. *Organization Science*. 1994; 5(2): 259-267.

<sup>179</sup> Pidd K, Roche A. National Centre for Education and Training on Addiction (NCETA). 'Ice' and the workplace. Adelaide: Flinders University; 2015. [accessed 2018 Nov 7] Available from: <http://nceta.flinders.edu.au/files/3014/3130/6035/EN593.pdf>

<sup>180</sup> Pidd K. National Centre for Education and Training on Addiction (NCETA). *The workplace and AOD use: Research and best practice approaches*. Melbourne: Office of the Federal Safety Commission AOD Forum; 2009 April 8. [accessed 2018 Nov 7] Available from: [http://www.fsc.gov.au/sites/FSC/Resources/AZ/Documents/Research\\_and\\_Best\\_Practice\\_Approaches.pdf](http://www.fsc.gov.au/sites/FSC/Resources/AZ/Documents/Research_and_Best_Practice_Approaches.pdf)

alcohol use or, as heard by the Taskforce, use of other illicit drugs with a shorter detectable period, such as methamphetamine.<sup>181</sup>

### 5.4.3 What's happening in Western Australia

Consultation with employers indicated that different businesses have varied capacity and resources to support workplace alcohol and drug interventions. For example, large mining organisations have the resources to contract services such as employee assistance programs and health awareness training, with some going so far as to offer amnesty periods and the option of holding employees' positions open for up to a year while they are supported to seek treatment. In contrast, the Taskforce heard that small businesses do not have the resources or the flexibility of a large workforce to be able to implement these types of approaches.

The range of measures available in Western Australian workplaces includes:

- specialised in-house management programs:
  - comprehensive in-house employee assistance and counselling programs;
  - using Chaplains to build relationships with staff and check in regarding any drug and alcohol and mental health issues they might be experiencing; and
  - amnesty programs, where employees could proactively seek counselling for issues, and their employment would be retained for them during that period.
- prevention strategies:
  - urine testing for detection of past use of a drug; with individual organisations determining their own alcohol and drug policy, including consequences of a positive test; and
  - other occupational health and safety assessments, to reduce the impact of methamphetamine in the workplace.

Employers also advised they may refer employees to external services, including peer-support programs or Employee Assistance Programs (EAPs). An EAP is a “work-based intervention program designed to enhance the emotional, mental and general psychological well-being of all employees and includes services for immediate family members. The aim is to provide preventive and proactive interventions for the early detection, identification and/or resolution of both work and personal problems that may adversely affect performance and well-being.”<sup>182</sup> Employers did raise concerns about whether consultants providing services under EAPs had the specialised knowledge to provide drug counselling and advice in relation to methamphetamine use.

#### 5.4.3.1 Small Business Owners Survey

The Small Business Development Corporation, the Stirling Business Association and the Regional Chamber of Commerce and Industry Western Australia conducted a survey to gather information on the issue of methamphetamine in the workplace from the perspective of small operators, for the Taskforce to consider. The survey received 17 responses which found:<sup>183</sup>

---

<sup>181</sup> Ibid.

<sup>182</sup> Employee Assistance Program Association of Australia. Information page: What is an Employee Assistance Program? 2018. [accessed 2018 Nov 7] Available from: <http://www.eapaa.org.au/site/>

<sup>183</sup> Results need to be interpreted with caution given the small sample size.

- more than 75 per cent of respondents believed the use of methamphetamine is an issue in their local area and that methamphetamine use is having a negative impact on their business;
- less than half (41.2 per cent) of respondents would know what to look for to identify if an employee was using methamphetamine;
- the majority of respondents (41.2 per cent were not aware of any services, and 35.3 per cent said they did not know) indicated they were not aware any of local services or initiatives to assist them as operators, or for their employees, to manage methamphetamine-related issues.

The majority of respondents believe they are responsible for ensuring a safe workplace (82.3 per cent), a drug-free workplace (76.5 per cent), and ensuring their workers act in a safe manner (76.5 per cent). However, all three employer groups advised the Taskforce that:

- small businesses are mostly not able to offer formal employee assistance programs to their employees;
- small businesses may not have a drug and alcohol policy, or be able to afford drug testing for their employees; and
- managerial oversight of small businesses may be done remotely, making it difficult to identify issues relating to methamphetamines until it results in productivity or performance issues.

All three groups stated they were committed to sharing information and resources on managing methamphetamine-related issues with their members and clients. However, they advised it was not reasonable for all small business operators to be expected to provide the same level of drug testing or employee support that large businesses do, without assistance. They suggested there was need for the Western Australian Government to develop more education and guidance materials for small businesses, to help operators identify if an employee was using methamphetamine and what rights operators have to manage these employees.

#### **5.4.3.2 Workplace Employer and Employee Forum**

The Taskforce convened a forum where it heard from a range of organisations including unions, not-for-profit groups, peak bodies, and large resource companies. The Taskforce heard:

- methamphetamine can have considerable economic implications for employers, particularly due to absenteeism and staff turnover;
- the size of the organisation impacts its ability to manage the impact or effects of methamphetamine use by employees; and
- there is a need for more consolidated information around the services and supports available for those impacted by methamphetamine use. It was suggested that the 'Green Book' (a listing of organisations providing alcohol and other drug services and mental health services in Western Australia) should be promoted and made available in workplaces.

#### **5.4.3.3 Western Australian Legislative Assembly Education and Health Standing Committee Report**

In 2015 the Education and Health Standing Committee delivered its final report into *The impact of FIFO work practices on mental health*. The Western Australian Government's response to Recommendation 4 (that independent research into the

mental health impacts of fly-in, fly-out (FIFO) work arrangements on workers and their families be commissioned) has resulted in the Mental Health Commission funding this further research to be carried out by The University of Western Australia's Centre for Transformative Work Design.

The research will seek to understand the range of workplace factors that contribute to mental health issues in FIFO workers, and identify positive strategies that can be used by individuals, families and organisations in the FIFO environment.<sup>184</sup> Findings and recommendations from the research are expected to be released at the end of 2018.<sup>185</sup>

### Taskforce conclusions and recommendations

The Taskforce considers the workplace represents a significant opportunity to implement brief and early intervention approaches to not only reduce risk with regard to workplace health and safety, but to improve a worker's home life and reduce the likelihood of further use or dependence.

While workplace drug testing is commonly used by employers to mitigate risks in the workplace, it is not an effective substitute for good management, and drug testing can mask risks.

The Taskforce heard that employees often find ways to get around drug testing, with one of the unintended consequences of this behaviour resulting in a preference to use methamphetamine because it exits the body faster than other drugs such as cannabis.

Research supports that drug testing, when used in isolation, has limited effectiveness in improving workplace safety and reducing drug use, but has a far greater impact when implemented in addition to strategies and training tailored for the specific working environment.

The Taskforce also heard about the impact that loss of employment can have on methamphetamine users, noting that the community is calling for employers to do more to support employees to manage their use and seek treatment while remaining employed.

### Recommendation 13:

Worksafe in collaboration with the Mental Health Commission to work with employer and employee peak bodies to develop a strategy to build the capacity of (particularly small business) employers to better manage and support employees with drug and alcohol conditions including the management of occupational health and safety risks.

<sup>184</sup> Parliament of Western Australia, Government Response to Legislative Assembly Education and Health Standing Committee Report No 5. The impact of FIFO work practices on mental health: Final Report, Table 13 October 2015.

<sup>185</sup> Parliament of Western Australia. Parliamentary Standing Committee on Health and Education. The Impact of FIFO work practices on mental health Final Report. Perth: Parliament of Western Australia; 2015. p 21. [accessed 2018 Nov 7] Available from: [http://www.parliament.wa.gov.au/Parliament/commit.nsf/\(Report+Lookup+by+Com+ID\)/2E970A7A4934026448257E67002BF9D1/\\$file/20150617%20-%20Final%20Report%20w%20signature%20for%20website.htaccess](http://www.parliament.wa.gov.au/Parliament/commit.nsf/(Report+Lookup+by+Com+ID)/2E970A7A4934026448257E67002BF9D1/$file/20150617%20-%20Final%20Report%20w%20signature%20for%20website.htaccess)





## Chapter 6 Providing treatment and support services for those seeking help

“Waiting for treatment, I’m like a sitting duck, I’m trying to do the right things but life doesn’t stop around you.”

*Consumer and Family Members Forum*

“I was addicted for 4 years and have been clean for over a year now but I had to do it without any help because there wasn’t anywhere to go.”

*Online comment*

“My 26 year old daughter and her partner both on meth. I have been raising there (sic) children for 19 months, my grandchildren now 2 and 4. My family have suffered so much and her children, we are lucky the boys can’t see her anymore...I cry myself to sleep many nights, I my family raised her well, we don’t drinks all (sic) touch drugs ever,.....I don’t know where my daughter lives... my husband and I have been married for 30 years this year, we wanted to go on a holiday, but our life is with our grandchildren they come first and always will,... and every day we give them love and affection. I know that ice is going to be around for years, but will my daughter be around for years. I seen (sic) pics of her she is about 40 kilos now so I know if I ever see her it will be at her funeral... so I hope we can all work together for myself and my family and others in my situation to get our children back?????”

*Online comment*

### 6.1 What the Taskforce heard

The Taskforce heard from many people seeking, or who had sought, help for their methamphetamine use. The Taskforce heard that in many cases they did not know where to go to get help, when they did locate services there were long waiting times to get treatment especially for residential rehabilitation, and there were challenges in accessing services when, where and how they were needed.

When considering treatment and support consumers, community members and service providers consistently identified that the system is complex and difficult to navigate, and often not able to respond when people are in crisis.

“You find services when you are at crisis point – you have to really want them.”

*Consumer and Family Members Forum*

“Often you are turned away when there is no room. Just taking the time to have a conversation with you and actually listening would make a big difference. Don’t just turn people away.”

*Consumer and Family Members Forum*

These issues are compounded when trying to find support in regional areas, and some consumers reported moving away from their place of residence to seek or access treatment. Often the reasons for this were to disconnect with drug-related connections and seek anonymity, in addition to a lack of services being available locally. Some consumers, family members and service providers were also concerned about the lack of accreditation and the unregulated nature of some private services.

A wide range of barriers to accessing treatment and support were reported, including:

- stigma and discrimination from GPs and hospitals towards people on drugs;
- not knowing where to go to get help;
- long travel times and distances to get to treatment;
- co-occurring mental health and addiction problems, getting 'ping-ponged' from one service provider to another;
- paying \$45 for a Police Clearance as part of rehabilitation entry requirements;
- not having appropriate documentation/identification – Medicare and Centrelink card numbers are required for access to services but often are not known;
- the high cost of paying rent and residential rehabilitation at the same time;
- no accommodation or care for dependent family members;
- personal feelings of shame; and
- lack of detox facilities.

Many consumers of services, family members and service providers felt strongly that problematic or dependent use of methamphetamine should be treated first and foremost as a health issue, and that offering compassion and understanding, rather than judgement and discrimination, was key to the effective treatment of methamphetamine dependence. Alternatively, there were some (although fewer) in the community who felt a harsher approach and penalties should be pursued.

*"Lock up every person caught with meth or dealing meth, don't just wait for the big time dealers."*

*Online comment*

Service providers, consumers of services and family members repeatedly identified the need for more rehabilitation services with reduced or no waiting lists.

Families dealing with the impacts of another's use identified the need for affordable/free counselling services and other forms of support for family members and children of parents who use methamphetamine, including financial support for school uniforms, lunch and extra-curricular activities.

Consumers of services identified the need for detox centres, especially in regional areas and many felt that pathways to treatment could be improved through GPs and primary health workers. They also felt lessons could be learned from investigating treatment models that are working well in other countries.

Consumers of services and their families felt strongly that more should be done to make it as easy as possible for people to get help, including developing mobile device 'apps' and online support.

## 6.2 What works when people need help

As discussed in Chapter 2 stimulant drugs, including methamphetamine, alter brain functions in ways that have important implications for treatment, including:

- the need to access support and treatment with no wait times, or within very short timeframes;
- physically detoxing from methamphetamine can take almost twice as long as other drugs (i.e. 10 – 14 days);
- memory, regulation and executive function may be impaired, requiring:
  - more frequent but shorter treatment sessions;
  - reminders;
  - memory aids;
  - assertive follow up; and
  - written instructions from treatment providers.

The Taskforce heard how vital it is for people seeking help to get it when they need it, and how challenging it can be to make that happen. This view is supported by testimony to the Parliamentary Joint Committee on Law Enforcement which said, in part:

“...cognitively, for many of them, they are absolutely unaware of the damage they are doing to themselves and to their families. So, a capacity to reflect and say, ‘I need to change this,’ for many people with an ice addiction is not going to happen. They have no concept and no insight in to what is going on. They need the motivation to change. When they have a window of opportunity – perhaps they have been well for a while and a critical incident happens and they realise that something has to change – at the moment we cannot get them quick help in Australia.”<sup>186</sup>

It is also often the case that treatment may need to be continued for many months before significant improvement is achieved, with the National Centre for Drug Education and Training reporting full recovery of all cognitive functions may take 12-18 months.<sup>187</sup> The chronic re-lapsing nature<sup>188</sup> of dependent methamphetamine use also means that post-treatment aftercare and support is important to sustain abstinence.

As previously discussed in Chapter 5 on early intervention, the research literature suggests that treatment utilisation among dependent methamphetamine users is

---

<sup>186</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 115 [5.57]. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>187</sup> Roche A. National Centre for Education and Training on Addiction (NCETA). Methamphetamine: Effects and Responses. Adelaide: Flinders University; 2015. p. 3. [accessed 2018 Nov 7] Available from: <http://nceta.flinders.edu.au/files/9014/3339/5938/EN597.pdf>

<sup>188</sup> Methamphetamine users are prone to relapse. One study of 350 methamphetamine users found that only 13 per cent achieved at least five years of continued methamphetamine abstinence, with 61 per cent relapsing within the first year following treatment. Brecht ML, Herbeck D. Time to relapse following treatment for methamphetamine use: longer-term perspective on patterns and predictors. Drug Alcohol Depend. 2014;139(1):18-25. doi: 10.1016/j.drugalcdep.2014.02.702.

low.<sup>189</sup> The Taskforce also heard from families and other support people that obtaining information and accessing treatment was difficult.

“More services, less waiting lists and more information to advise families what is available. Help for parents with children over 18 affected by Meth use.”

*Online comment*

The main reasons identified in the literature as to why dependent users do not seek treatment are:

- that they do not consider their drug use to be a problem<sup>190</sup>; and
- that they do not consider their drug use to be serious enough to warrant accessing professional support<sup>191</sup> or formal treatment.

Other barriers to users seeking treatment also include concerns regarding privacy and stigma, as well as a preference to withdraw from drugs alone.<sup>192</sup> Studies with dependent users have also confirmed there are concerns stemming from their perception of treatment effectiveness, as well as treatment accessibility and long wait lists.<sup>193</sup> This suggests that many methamphetamine users are not accessing treatment because they do not recognise their dependence and need for treatment. This perception exists despite the fact that clinically, they meet the criteria for dependence and they are experiencing significant harms from their drug use.<sup>194,195</sup> Real and perceived barriers regarding access to treatment and its effectiveness, as well as the fear of stigma is also stopping methamphetamine users from actively seeking help.

### 6.2.1 Factors for effective treatment

Throughout the Taskforce’s consultations, consumers of services asked for services to be designed recognising that methamphetamine dependency is a condition prone to ongoing risk of relapse. They said services needed to do more to actively support clients into treatment, once in treatment, and also after treatment. Research into the treatment of methamphetamine users supports this understanding and indicates the most effective treatment, measured by abstinence, includes the following characteristics:

---

<sup>189</sup> Quinn B, Stooze M, Papanastasiou C, Dietze P. An exploration of self-perceived non-problematic use as a barrier to professional support for methamphetamine users. *Int Drug Policy*. 2013; 24(6); 619-23.

<sup>190</sup> Kenny P, Harney K, Lee NK, Pennay A. Treatment utilization and barriers to treatment: Results of a survey of dependent methamphetamine users. *Subst Abuse Treat Prev Policy*. 2011; 6(3); 5. [accessed 2018 Nov 7] Available from: <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-6-3>

<sup>191</sup> Ibid.

<sup>192</sup> Cumming C, Troeung L, Young JT, Kelty E, Preen DB. Barriers to accessing methamphetamine treatment: A systemic Review and Meta-analysis. *Drug and Alcohol Depend*. 2016; 1(168); 263-273.

<sup>193</sup> Kenny P, Harney K, Lee NK, Pennay A. Treatment utilization and barriers to treatment: Results of a survey of dependent methamphetamine users. *Subst Abuse Treat Prev Policy*. 2011; 6(3); 5. [accessed 2018 Nov 7] Available from: <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-6-3>

<sup>194</sup> Ibid.

<sup>195</sup> Quinn B, Stooze M, Papanastasiou C, Dietze P. An exploration of self-perceived non-problematic use as a barrier to professional support for methamphetamine users. *Int Drug Policy*. 2013; 24(6); 619-23.

- residential rehabilitation, although it should be noted that residential rehabilitation on its own produces a large but time-limited reduction in methamphetamine use. Without other support measures in place, the research indicates there is no clear evidence of a significant benefit at three years after starting treatment;<sup>196</sup>
- a protracted treatment and rehabilitation period (up to 18 months), which is longer compared with other drugs such as alcohol and opioids;<sup>197</sup>
- reducing the wait time for entering treatment;
- higher rapport with treatment providers; and
- receiving individual counselling (resulting in a three to four-fold increase in the odds of continuous abstinence at one year after residential rehabilitation).<sup>198</sup>

Retention in treatment has been shown to improve with more flexible models of care for clients who leave residential rehabilitation early or who cannot stay in residential care for long periods of time because of personal commitments. These models include outpatient support such as individual counselling offered as day rehabilitation, or by phone and follow up support. Involving family and partners in the treatment process has also been demonstrated to improve retention.<sup>199</sup>

A study conducted with dependent users also reported that key features of a good alcohol and other drug service from users' perspectives include:<sup>200</sup>

- supportive, non-judgemental staff;
- staff personally experienced with drug use;
- case management;
- immediate/quick appointment (i.e. no wait lists);
- individually tailored treatment, with multiple treatment options and client input;
- location (i.e. accessible by public transport, not too far to travel);
- accurate information made available;
- suitable environment (i.e. calm, clean, quiet); and
- accessible opening hours (i.e. including outside of business hours, evenings and weekends).

<sup>196</sup> An Australian study reported 33 per cent of study participants were in continuous abstinence at three months when compared with study participants who received no treatment or detoxification only. However this benefit drops to 14 and six percentage points at one and three years respectively. McKetin R et al. Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES). *Addiction*. 2012;107(11); 1998-2008.

<sup>197</sup> Lee, N et al. Clinical Treatment Guidelines for Alcohol and Drug Clinicians No.14: Methylamphetamine dependence and treatment. Victoria: Turning Point Alcohol and Drug Centre; 2007. [accessed 2018 Nov 7] Available from: [http://nceta.flinders.edu.au/files/2814/3130/6037/Clinical\\_Treatment\\_Guidelines\\_for\\_Alcohol\\_Drug\\_Clinicians\\_No.\\_14.pdf](http://nceta.flinders.edu.au/files/2814/3130/6037/Clinical_Treatment_Guidelines_for_Alcohol_Drug_Clinicians_No._14.pdf)

<sup>198</sup> McKetin R, Kothe A, Baker AL, Lee NK, Ross J, Lubman DI. Predicting abstinence from methamphetamine use after residential rehabilitation: Findings from Methamphetamine Treatment Evaluation Study. *Drug Alcohol Rev*. 2018; 37(1); 70-8.

<sup>199</sup> Ibid.

<sup>200</sup> Kenny P, Harney K, Lee NK, Pennay A. Treatment utilization and barriers to treatment: Results of a survey of dependent methamphetamine users. *Subst Abuse Treat Prev Policy*. 2011; 6(3). [accessed 2018 Nov 7] Available from: <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-6-3>.

The same study suggested that a treatment setting specific to methamphetamine users was one way to accommodate the very different nature of methamphetamine dependence and withdrawal compared with other drugs such as opiates. This approach has been trialled in Australia through the establishment of four stimulant-specific treatment clinics including The Stimulant Treatment Program in Sydney and Newcastle, and Access Point specialist methamphetamine clinics in Fitzroy and St Kilda (see below).<sup>201</sup>

The study also notes that while establishing an entirely separate clinic is beyond the means of many drug treatment services, services can undertake small changes that could have a big impact on perceptions, such as allocating time each day in which only methamphetamine users are seen, or allocating specific staff or rooms to methamphetamine treatment and resources.<sup>202</sup>

### **Treatment specific to methamphetamine dependence**

#### **The Stimulant Treatment Program in Sydney**

The Stimulant Treatment Program established in New South Wales in 2006 provides a specialised treatment option for stimulant users, including methamphetamine users. The service is delivered through two clinics: in Darlinghurst at St Vincent's Hospital, and in Newcastle. The program is funded by the NSW Ministry of Health.

The clinic model is based on a harm minimisation philosophy and involves a stepped-care approach that modifies the intensity and nature of clinical intervention according to the severity of the problem and goals of the client. Paramount to the stepped-care approach is that treatments are individualised, evidence-based and the least restrictive option. The treatment approach of the service incorporates a range of interventions, including comprehensive assessment, brief intervention, counselling (group and individual) and pharmacotherapy.

The program includes a drop-in clinic which allows those seeking help to be seen by a counsellor without an appointment, open four mornings a week.

In 2012, a program evaluation found methamphetamine users entering the program showed significant reductions in stimulant use and related harm at both three and six-month follow-up. Overall, findings indicated that the model of care was successful in lowering amphetamine-type stimulant dependence and improving the health and social functioning of users. This included substantial decreases in psychotic symptoms, hostility, crime, injecting drug use and disability due to mental health.

#### **Access Point**

The Access Point model was designed to address some of the perceived or actual barriers to methamphetamine treatment, including providing timely service to combat waiting lists; providing a waiting area separated from other clients so methamphetamine users who didn't want to mix with heroin users didn't have to; and

---

<sup>201</sup> Ibid.

<sup>202</sup> Kenny P, Harney K, Lee NK, Pennay A. Treatment utilization and barriers to treatment: Results of a survey of dependent methamphetamine users. *Subst Abuse Treat Prev Policy*. 2011; 6(3). Available from: <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-6-3>.



providing specialised and tailored methamphetamine treatment which includes access to a counsellor, psychiatrist and medical practitioner.

An evaluation of these clinics over the first 12 months showed that Access Point clients differed demographically from clients receiving standard alcohol and other drug treatment, including being older, more likely to be employed, and more likely to be smoking methamphetamine than injecting. Access Point showed better outcomes in terms of treatment retention than standard treatment. In addition, Access Point clients showed good reductions in methamphetamine use and mental health problems.<sup>203</sup>

## 6.2.2 Treatment services in Western Australia

Planning for alcohol and other drug services including services to treat and support methamphetamine users and their families, is undertaken by the Mental Health Commission. *The Western Australian Mental Health, Alcohol and Other Drug Service Plan 2015 – 2025* (the Plan) was released in December 2015. Information provided by the Mental Health Commission states the Plan outlines the optimal mix and level of mental health, alcohol and other drug services required to meet the needs of Western Australians until the end of 2025. The Plan is the first of its kind in Western Australia where national modelling tools have been applied to show an optimal level and mix of services and where the imbalances and under-investment in the system are. It provides a guide for investment decisions and priority setting for all levels of government and non-government stakeholders, based on the most current evidence regarding population, prevalence and epidemiology in Western Australia.

The Plan uses the Drug and Alcohol Service Planning Model, commissioned in early 2010 by the Ministerial Council on Drug Strategy Alcohol and Other Drug Services, to estimate the number and type of services required for a comprehensive alcohol and other drug treatment system for people with mild, moderate and severe alcohol and other drug problems. Consultation with experts and other stakeholders ensured that the modelling of future demand was reflective of Western Australia's unique need, including those of Aboriginal people and for regional communities across the State.

The Plan acknowledges the alcohol and other drug system is a complex arrangement of public sector, not-for-profit and private services and supports. A key system reform service included in the Plan is the evidence-based telephone helplines designed to assist people to navigate the system, and to provide specific information and advice targeted to members of the public, individuals seeking advice reassurance and guidance on behalf of others, and people self-identifying particular issues. The helplines are also designed to assist with the provision of screening, assessment, triage and brief intervention and offer referral to specialist treatment services.

Mental health and alcohol and other drug problems, more often than not occur together and with other health and/or social issues (e.g. trauma, cognitive impairment, physical health problems, housing and accommodation problems). The Mental Health Commission advises there are some excellent examples of collaborative or integrated

<sup>203</sup> Kenny, P., Harney, K., Lee N.K., Pennay, A. Treatment utilization and barriers to treatment: Results of a survey of dependent methamphetamine users. *Subst Abuse Treat Prev Policy*. 2011: 6(3). [accessed 2018 Nov 7] Available from: <https://substanceabusepolicy.biomedcentral.com/articles/10.1186/1747-597X-6-3>.



work occurring in the mental health and alcohol and other drug sectors, but more often there is limited joint planning and communication between services. The Plan recognises that an integrated system requires new and effective ways of working together within and across traditional boundaries so that services are coordinated. Factors highlighted in the Plan as critical to the success of working in shared ways are:

- making available nominated people that assist people to navigate the system of services;
- clarity about shared roles and responsibilities;
- clarity around accountability;
- clear and established decision-making processes and agreed conflict resolution mechanisms;
- minimising bureaucracy and avoiding duplication of administration;
- having compatible information technology and sharing information appropriately;
- resolving service gaps and policy issues at the earliest opportunity;
- flexibility around service outcomes, including shared outcomes and reporting arrangements; and
- recognition that staff involved in working in an integrated fashion need to understand how they fit within their own organisation and within the larger system.

The Plan states: “The alcohol and other drug sector is considered more balanced across the optimal mix of services (i.e. community and hospital services) compared to the mental health sector. However, as demonstrated by Figure 29, the 2014 current level of service is well below the optimal level required to meet population demand in 2014. There is therefore a requirement to invest in services across the optimal mix (i.e. community through to hospital- based services).”<sup>204</sup>

---

<sup>204</sup> Government of Western Australia. Western Australian Mental Health Commission. Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth: Western Australian Mental Health Commission; 2015. p 20. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf>

**Figure 29: Western Australian Alcohol and drug treatment – optimal mix and level of service 2014**

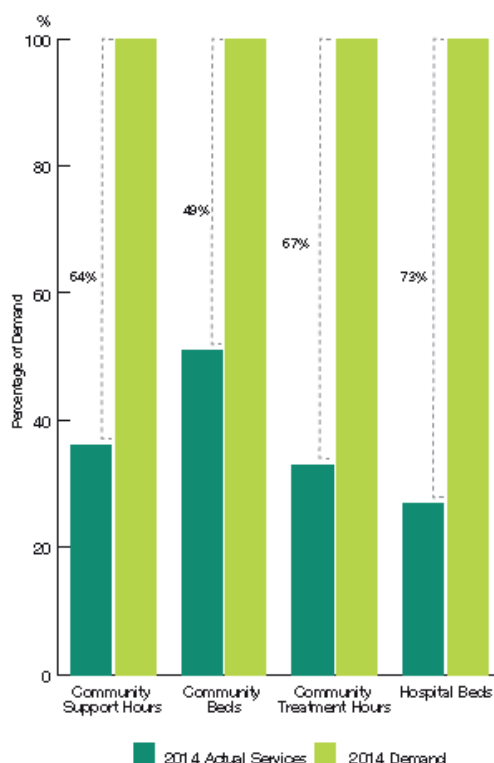


Figure 2: Current services as a proportion of 2014 demand (Alcohol and Other Drugs only)

Source: Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025, MHC, p. 20.

The Mental Health Commission is currently undertaking a review of the Plan to update the modelling of service provision and demand.<sup>205</sup> The Commission's assessment of unmet demand in Western Australia accords with findings at a national level of both the National Ice Taskforce and the Parliamentary Joint Committee on Law Enforcement.

In 2015, the National Ice Taskforce found “unmet demand is a long standing issue and supported further investment to strengthen the capacity of services to respond more effectively and ensure people are getting help and support when they need it.”<sup>206</sup> In recognition, the Australian Government provided \$13 million through the *National Ice Action Strategy* to introduce new Medicare Benefit Scheme items for addiction medicine specialists to increase treatment availability.

<sup>205</sup> Government of Western Australia. Western Australian Mental Health Commission. Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth: Western Australian Mental Health Commission; 2015. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf>

<sup>206</sup> Australian Government. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p 123. [accessed 2018 Nov 7] Available from: [https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

In 2018, the Parliamentary Joint Committee noted: “long waiting lists are largely due to the number of people seeking access to limited alcohol and other drug treatment services”.<sup>207</sup> In 2014 the National Drug and Alcohol Research Centre estimated, conservatively, that unmet demand (the number of people in any one year who need and would seek treatment) was between 200,000 and 500,000 people over and above those in treatment in any one year, representing substantial unmet demand for alcohol and other drug treatment in Australia.<sup>208</sup>

Below is a summary of the range of treatment and related support services that are available to people who use methamphetamine, their families and significant others in Western Australia seeking help:

- telephone and online support;
- peer support in treatment settings;
- specialised withdrawal or detox services;
- treatment for individuals while they still live in the community;
- treatment in residential settings; and
- comorbid treatment models.

#### **6.2.2.1 Telephone and online support**

The Mental Health Commission’s Alcohol and Drug Support Service (ADSS) provides free, 24-hour, seven-day-a-week telephone counselling, information, referral and support lines for alcohol and drug use, including the Meth Helpline. The Meth Helpline provides access to professional drug counselling and support for those using the drug as well as those who are concerned about another person’s use. Counsellors provide:

- information about methamphetamine use;
- emotional support;
- advice on treatment options;
- system navigation and referral to local treatment services that can provide ongoing support;
- interim support to people waiting for face-to-face treatment/counselling;
- ongoing call-back service to socially and geographically isolated clients; and
- support to health professionals working with individuals and families impacted by methamphetamine use.

In 2016-17, the Mental Health Commission’s Annual Report shows it provided more than “21,550 occasions-of-service to Western Australians through the four 24/7 telephone counselling, information, referral and support lines for AOD: the Parent and Family Drug Support line; Meth Helpline; Alcohol and Drug Support Line; and

---

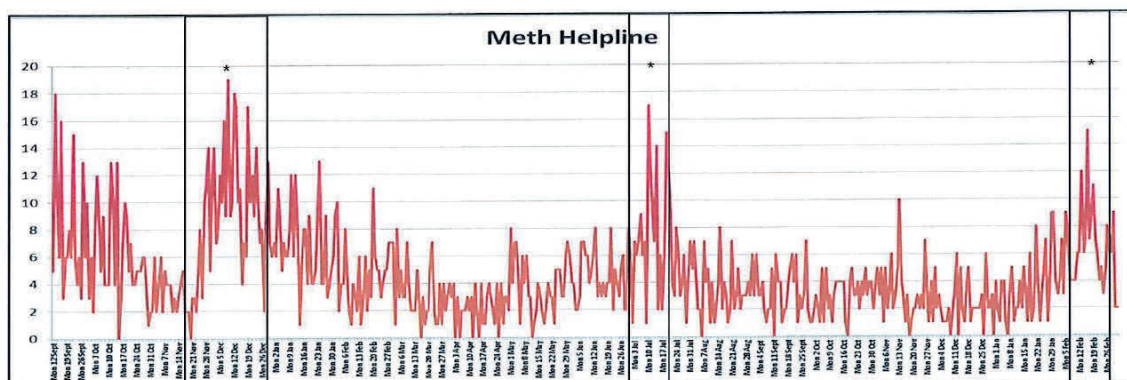
<sup>207</sup> Australian Government. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 19. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>208</sup> Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomez M. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW. New Horizons: The review of alcohol and other drug treatment services in Australia. Sydney: NDRAC; 2014, p. 13. [accessed 2018 Nov 7] Available from: <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf>

Working Away Alcohol and Drug Support Line. Of these, 21 per cent of contacts mentioned alcohol as the primary drug of concern, 21 per cent cannabis and 24 per cent methamphetamine.”<sup>209</sup>

Figure 30 below shows the volume of calls to the Meth Helpline between 12 September 2016 and 3 March 2018. Figure 30 also shows the increase in calls as a result of campaign activity.

**Figure 30: Daily average call rate to ADSS Meth Helpline 12 September 2016 – 3 March 2018**



\* Meth Helpline TV in market

Source: Mental Health Commission

The Mental Health Commission provided an analysis of the most recent campaign featuring a seven-week television media burst which ran from mid-January to early March 2018, which showed:

- a 241 per cent increase in calls to the Meth Helpline during the campaign period, with 282 calls during the campaign and 117 calls in the preceding seven-week period;
- the Meth Helpline daily contact rate increased from an average of 3.3 daily contacts when no campaign was running, to 7.0 contacts during a campaign period; and
- methamphetamine-related contacts to the Alcohol and Drug Support Service also increased, in addition to those to the Meth Helpline when the campaign was in market.

The Taskforce has been advised by the Mental Health Commission that funding for the Meth Helpline ceased on 30 June 2018. Callers with methamphetamine issues will be referred to the Alcohol and Drug Support Line.

Other services provide counselling online and by phone. Under the *National Ice Action Strategy*, in October 2016 Turning Point in Victoria launched an expanded Counselling Online service, to provide free counselling 24-hours-a-day, seven-days-a-week for people using alcohol and other drugs, their family and friends, anywhere in Australia. Support services are provided for people at all stages of help seeking, including:

<sup>209</sup> Government of Western Australia. Mental Health Commission. 2016/17 Annual Report. Perth: MHC; 2017. [accessed 2018 Nov 7] Available from <https://www.mhc.wa.gov.au/media/2151/mhc17-54463-final-approved-accessible-pdf-15-sept-2017.pdf>

- first time help-seekers;
- people waiting for treatment;
- people in treatment that require additional support, particularly after hours;
- people who have completed treatment and want to stay on track;
- people in recovery wanting to connect with others or prevent relapse; and
- people supporting a significant other with a drug and alcohol problem.

In 2017, Turning Point recorded more than 97,000 contacts to its telephone and online counselling services nationally. (Enquiries were made by the Taskforce to obtain data on the number of these calls that were received from Western Australia. The information was not provided at the time of finalising the report.)

The Commonwealth and the Western Australian Government also support the Kids Helpline and Headspace which provide telephone, web, and email counselling services to children and young people up to the age of 25. These services are not alcohol and other drug specific, but are available to people who may have alcohol and other drug issues.

#### **6.2.2.2      *Peer support in treatment***

Peer support services involve people with a lived experience of past alcohol and drug issues supporting those who are currently facing their own alcohol and other drug issues. The Ice Breakers program in Albany and Bunbury, and Palmerston support groups in Western Australia are examples of using peer support in treatment. These programs use the SMART program approach as the basis for their treatment methodology.

#### **Smart Recovery Australia**

SMART (Self-Management and Recovery Training) recovery is a group program assisting problematic behaviours, including addiction to drugs, guided by trained volunteer peers and, in some cases, professionals. Professional training courses are provided by SMART Recovery Australia to those wanting to become SMART Recovery facilitators and start new groups in the community, or their organisation.

Currently, there are 26 SMART Recovery groups (mostly open to anyone who wishes to attend) across Western Australia. SMART can be used as both a primary (stand-alone) or supplementary (in conjunction with professional treatment) recovery program. Individuals can access SMART face-to-face or online. SMART recovery involves a 90-minute weekly meeting which uses evidence-based tools and techniques, including cognitive behavioural therapy, to help people identify problematic behaviour, recognise triggers, beliefs and consequences, cope with cravings and urges, set achievable goals, and evaluate areas of importance.

Several SMART Recovery groups are run by non-government alcohol and other drug service providers. The Commonwealth, through the WA Primary Health Alliance, has funded Palmerston to build on its existing peer-support program to deliver the SMART program.

Other examples of peer-support groups include Holyoake's choir program – A Chorus Line, and Palmerston's Methamphetamine Support Group and Women's Art group.

### 6.2.2.3 *Withdrawal (or detoxification) services*

Withdrawal (or detoxification) management services help people manage the symptoms of withdrawal, either within the community, within specialised treatment units, or in a hospital setting. Withdrawal or detox is a requirement prior to entering specific residential rehabilitation centres.

The Mental Health Commission provides community-based treatment and prevention programs, including an inpatient withdrawal unit at the Commission's Next Step Drug and Alcohol Services facility in East Perth. The 17-bed unit delivers supervised medical treatment for adults requiring withdrawal from alcohol and other drugs, along with a range of other alcohol and other drug treatment services. During 2016-17, there were 636 admissions to the Next Step Inpatient Withdrawal Unit with 77 per cent of closed treatment episodes completed as planned.<sup>210</sup> The majority of clients are admitted for alcohol withdrawal, with the second highest number of patients being admitted for methamphetamine withdrawal. The number of clients presenting for an inpatient methamphetamine withdrawal has increased over the last two years. The waiting period for admissions is usually two weeks but may be longer depending on the availability of a long term rehabilitation bed should clients wish to transfer directly from the inpatient withdrawal unit to a residential rehabilitation service.

The Western Australian Government, through the Mental Health Commission, also funds 15 low medical withdrawal bed-based services in the community (eleven metropolitan beds and four regional beds. Eight of these were funded under the *Western Australian Meth Strategy 2016*). These services provide a 24-hour residential service, based on non-medical or low medical interventions, with support provided by a visiting doctor or nurse specialist. The Commission has advised that low-medical withdrawal beds can be suitable for the majority of methamphetamine users who do not generally require a high level of medical intervention.

Community-based withdrawal services are provided by the Drug and Alcohol Withdrawal Network (DAWN) in the metropolitan area. Funding is provided by the Western Australian Government, through the Mental Health Commission, to St John of God Health Care to deliver this service. The service is staffed by registered nurses who provide home visits to people undergoing drug or alcohol withdrawal, alongside the consumers' GP and a nominated support person.

Also funded by the Mental Health Commission are withdrawal services at the Salvation Army's Bridge House and private clinics, such as Perth Clinic, Fresh Start and Abbotsford Private Hospital.

---

<sup>210</sup> Government of Western Australia. Mental Health Commission. 2016/17 Annual Report. Perth: MHC; 2017. [accessed 2018 Nov 7] Available from <https://www.mhc.wa.gov.au/media/2151/mhc17-54463-final-approved-accessible-pdf-15-sept-2017.pdf>



### **Youth withdrawal and treatment services – DAYS**

The Drug and Alcohol Youth Service (DAYS) is a partnership between the Mental Health Commission's Next Step Drug and Alcohol Services and Mission Australia. DAYS, located in East Perth, provides a range of alcohol and other drug services to young people and their families, including clinical psychology, medical and nursing case management, counselling, withdrawal services, court diversion programs, residential rehabilitation and outreach.

The Youth Withdrawal and Respite Program provides 24-hour supervised care for young people requiring a low medical withdrawal and respite for up to three weeks.

The residential rehabilitation program provides young people with a friendly, supportive and structured environment to complete an AOD rehabilitation program. The three-month program provides both physical and emotional safety while young people engage in treatment to transition back into the community. Residents are required to pay rent during their stay.

The transitional program provides support to young people engaging in DAYS residential programs to transition into supported accommodation in the community.

DAYS aims to empower young people affected by alcohol and drugs to improve their health and well-being. Funding is provided by Western Australian Government and through community.<sup>211</sup>

The Department of Health introduced the Alcohol and Other Drug Withdrawal Management Policy in August 2017. It is a system-wide policy with the aim of ensuring that those requiring alcohol and other drug withdrawal treatment receive appropriate clinical care, including through referral pathways. This policy applies to the Child and Adolescent Health Service, metropolitan health services and WA Country Health Service, although it has yet to be implemented across the WA Country Health Service as they advised the Taskforce that additional investment in training and resources was required.

### **Taskforce conclusions and recommendations**

#### **Recommendation 14:**

Department of Health and WA Country Health Service ensure that its agreed State-wide detox policy, the 'Alcohol and other Drug Withdrawal Policy', is implemented by its health services as a priority.

#### **6.2.2.4 Community-based treatment**

Evidence indicates the majority (68 per cent) of treatment for people with amphetamine as a principal drug of concern occurs within a non-residential,

<sup>211</sup> Mission Australia. Information page: Service Directory, Drug and Alcohol Youth Service. 2018. [accessed 2018 Nov 7] Available from: <https://www.missionaustralia.com.au/services?categoryIDs%5B%5D=195>



community-based setting.<sup>212</sup> These community treatment services can be provided either by clinical health professionals, such as a GP or a nurse, or by drug support workers or counsellors. They can include a range of interventions, such as counselling using approaches like cognitive behavioural therapy, motivational interviewing and contingency management.

**Cognitive behavioural therapy** is a form of ‘talk therapy’ that is used to teach, encourage, and support individuals to reduce or stop harmful drug use. Cognitive behavioural therapy is intended to provide skills that are valuable in gaining initial abstinence from drugs (or in reducing drug use) and to help them sustain abstinence (relapse prevention). Cognitive behavioural therapy is a broad term that encompasses a range of interventions that may be quite different in application and focus.<sup>213</sup>

A recent (unpublished) systematic review of 12 eligible articles on psychological treatments for methamphetamine use suggests that while a variety of treatments are effective for methamphetamine use, “there is accumulating evidence that CBT [cognitive behavioural therapy] is more effective...in reducing MA [methamphetamine] use and co-occurring mental health symptoms compared to control conditions, during treatment and, in some studies, at follow-up”.<sup>214</sup>

**Motivational interviewing** is an intervention designed to increase the willingness to change behaviour within the client. This technique builds upon the information provided by a client during a personalised interview to convince them to discontinue their drug use. It focuses especially on the clients’ initial resistance and inability to properly assess their situation while in the early stages of recovery. However, motivational interviewing is a counselling strategy that can be used throughout recovery.

While the efficacy of motivational treatment for methamphetamine dependency has not been conclusively proven, there is evidence to suggest it is an emerging treatment option.<sup>215,216</sup> The literature further suggests motivational interviewing can

<sup>212</sup> Australian Government. Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia 2015-16: Canberra: AIHWA; 2017. p.15. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2015-16/notes>

<sup>213</sup> Hill R. Evidence-based practices for treatment of methamphetamine dependency: A review. Guelph, ON: Community Engaged Scholarship Institute; 2015. p 16-17. [accessed 2018 Nov 7] Available from: [https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/9267/Hill\\_MethamphetamineDependency\\_2015.pdf?sequence=4](https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/9267/Hill_MethamphetamineDependency_2015.pdf?sequence=4)

<sup>214</sup> Stuart A M, Baker AL, Denham AMJ, Lee NK, Hall A, Oldmeadow C, Dunlop A, Bowman J and McCarter K. Psychological treatment for methamphetamine use and associated mental health symptom outcomes: A Systematic Review and meta-analysis’. Unpublished. Cited with authors permission on 3 August 2018.

<sup>215</sup> Marsh A, O’Toole S, Dale A, Willis L, Helfgott S. Government of Western Australia. Drug and Alcohol Office. Counselling guidelines: Alcohol and other drug issues. 3<sup>rd</sup> Edition. Perth: Drug and Alcohol Office; 2013. p.29. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/media/1178/aod-counselling-guidelines.pdf>

<sup>216</sup> Hill R. Evidence-based practices for treatment of methamphetamine dependency: A review. Guelph, ON: Community Engaged Scholarship Institute; 2015. [accessed 2018 Nov 7] Available from: [https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/9267/Hill\\_MethamphetamineDependency\\_2015.pdf?sequence=4](https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/9267/Hill_MethamphetamineDependency_2015.pdf?sequence=4)

be particularly useful with clients who show initially low levels of motivation to change their behaviour.<sup>217</sup>

**Contingency management** involves using positive reinforcement to reward desired behaviour. It has been widely applied to drug dependency disorders in the USA but is not broadly used in Australia. Contingency management within the drug dependence context has four core principles:

- monitoring drug use to quickly identify an abstinent or substance-use period;
- in the case of methamphetamine use, drug screening should be planned in accordance with the half-life of the drug;
- using positive reinforcement when abstinence is identified; and
- emphasising the development of reinforcement.<sup>218</sup>

Typically, contingency management uses incentives such as vouchers exchangeable for goods or privileges and cash rewards for behaviours. In many cases, contingency management programs will incorporate mandatory attendance of 12-step meetings and use of a sponsor system, with rewards given for attendance.<sup>219</sup>

Evidence supports contingency management has been effective in reducing stimulant use among drug dependent populations in the U.S. (usually measured by a significant increase in methamphetamine-free urine samples taken from participants).<sup>220</sup> One study found that users were twice as likely to abstain from the use of stimulants during the study period, compared to those who received the control (treatment as usual).<sup>221</sup>

However, Australian research notes contingency management is difficult to implement given that its effectiveness is highly dependent on how strictly service providers adhere to the structured reward system involved, which can vary widely. Contingency management's effectiveness in sustaining abstinence and reduced drug use after the treatment has been completed, for example at three and six-month follow-ups, is also low.<sup>222</sup>

Community-based treatment is a good option when people seeking help don't need or want the intensity of residential rehabilitation or have commitments that mean it is not practical to be away from home for long periods, such as dependent children or work, or as a step down when residential treatment is finished.

---

<sup>217</sup> Hill, 2015, R, op. cit., p.14.

<sup>218</sup> Hill, 2015, R, op. cit., p.17.

<sup>219</sup> Hill, 2015, R, op. cit., p.18.

<sup>220</sup> Lee NK, Rawson RA. A systematic review of cognitive and behavioural therapies for methamphetamine dependence. *Drug Alcohol Rev.* 2008; 27(3): 309-17. [accessed 2018 Nov 7] Available from: <http://www.tandfonline.com/doi/abs/10.1080/09595230801919494>

<sup>221</sup> Rawson RA, McCann MJ, Flammiano F, Shoptaw S, Miotto K, Reiber C, Ling W. A comparison of contingency management and cognitive-behavioural approaches for stimulant-dependent individuals. *Addiction.* 2006;101(2): 267-74. [accessed 2018 Nov 7] Available from: <https://www.ncbi.nlm.nih.gov/pubmed/16445555>

<sup>222</sup> Lee NK, Rawson RA. loc cit.

“People with quite severe and complex problems can still do well in outpatient counselling, especially when they have good professional, community or family support.”<sup>223</sup>

There is a range of counselling services in the community which can provide treatment for alcohol and other drug issues provided by both not-for-profit service providers and private practices. Some counselling services specialise in alcohol and other drug treatment, while others treat a variety of issues including alcohol and other drug misuse. The Taskforce stocktake noted more than 65 service providers offered dedicated alcohol and other drug counselling, or counselling covering a variety of issues including alcohol and other drugs. However, this number is likely to be much higher as the stocktake took into account only the small number of private practices which actively promoted this counselling, and notes the nature of private services means many more are likely to be providing it.

The Western Australian Government, through the Mental Health Commission, provides funding for both specialised alcohol and other drug counselling and general counselling. Alcohol and other drug counsellors are funded through the Mental Health Commission’s Community Alcohol and Drug Services. The Metropolitan Community Alcohol and Drug Services are provided by Next Step Drug and Alcohol Services in partnership with non-government alcohol and other drug service providers. Regional Community Alcohol and Drug Services are provided in the Wheatbelt, South West, Great Southern, Mid-West, Goldfields, Pilbara and the Kimberley.

As part of its *Methamphetamine Action Plan*, Western Australian Government funding of \$4.5 million for the continuation of existing Community Alcohol and Drug Services alcohol and other drug counsellors was approved as part of the 2017-18 Mid-Year Review.

In 2016-17, Mental Health Commission alcohol and other drugs community-based services recorded 21,307 completed treatment episodes.<sup>224</sup> Waiting times for access to individual and family counselling services through the Community Alcohol and Drug Services is difficult to determine as this data is not centrally reported or monitored. At the time of writing this report, the Taskforce was advised by representatives of Cyrenian House that wait times to access their services were about one week. Community Alcohol and Drug Services advised that in the regions the wait can be longer – between one to three weeks for an individual counselling appointment in the Goldfields, up to three weeks for an appointment in the Mid-West, and three to four weeks for an appointment in the Kimberley.

The Western Australian Government, through the Mental Health Commission, also funds additional community treatment outside Community Alcohol and Drug

---

<sup>223</sup> Lee N. Drug rehab, what works and what to keep in mind when choosing a private treatment provider. The Conversation. 2018 May 2. [accessed 2018 Nov 7] Available from: <https://theconversation.com/drug-rehab-what-works-and-what-to-keep-in-mind-when-choosing-a-private-treatment-provider-95431>

<sup>224</sup> Government of Western Australia. Mental Health Commission. 2016/17 Annual Report. Perth: MHC; 2017.p 18. [accessed 2018 Nov 7] Available from <https://www.mhc.wa.gov.au/media/2151/mhc17-54463-final-approved-accessible-pdf-15-sept-2017.pdf>

Services, through a number of non-government alcohol and other drug service providers.

Under the *National Ice Action Strategy*, the Commonwealth Government also funds community-based methamphetamine treatment services in Western Australia. Funding is through the Primary Health Networks (PHNs). In Western Australia the WA Primary Health Alliance advised the Taskforce that \$20 million had been provided over four years to address methamphetamine use in Western Australia. Around 75 per cent of this funding (\$15 million) is dedicated to community-based treatment services (consistent with Commonwealth guidelines) with the remaining 25 per cent (\$5 million) dedicated to primary health sector training and capacity building.

The Commonwealth's WA Primary Health Alliance also provides funding for alcohol and other drug counselling services in both metropolitan and regional areas. Some funding is targeted at delivering counselling to young people and those presenting with both mental health and alcohol and other drug issues (co-morbidity). WA Primary Health Alliance has also provided funding to some metropolitan (North East and South) and regional Community Alcohol and Drug Services (Goldfields, Pilbara and Wheatbelt). Over 2016-2018 Palmerston, which delivers the South Metropolitan Community Alcohol and Drug Services, received \$100,000 to deliver a specialised service for methamphetamine users. Also over 2016-2018, St John of God Health Care outreach services received \$338,088 to include alcohol and other drug counselling in its peri-natal mental health service.

In addition to State and Commonwealth-funded community treatment services, a range of privately funded services are also available for individuals, including group and individual counselling (e.g. Ashcliffe Psychology, which is a private business delivering the MATRIX treatment model).

### **The MATRIX Program**

The Commonwealth government has funded a three-year trial of the intensive community-based Matrix model methamphetamine treatment program in Australia. The trial is running in South Australia at Adelaide suburban sites.

The Matrix Program is an intensive outpatient treatment program for addiction. The program is based on a model developed in the United States of America in the 1980s, but modified to incorporate Australian language and statistics, extra modules for male gender groups, online applications and lived experience mentors and extended from a 16-week program to a 20-week program. It is often targeted at treatment for stimulant dependence, in particular methamphetamine, cocaine and prescription stimulants, although it is also used in the treatment of alcohol and other drugs.

The Matrix Program in Perth is delivered by Ashcliffe Psychology, now part of The National Matrix Network, which is focussing on adapting the program further to meet the needs of individuals seeking treatment for methamphetamine here in Australia. In Perth the program is a 48-week program consisting of:

- individual/family sessions;
- early recovery skills groups;
- relapse prevention groups;
- family education groups;

- weekly random urine drug testing; and
- social support groups.

Initial results from the three-year trial show a significant decline in methamphetamine use for participants, with 55 per cent indicating remission during the intensive period, with future analysis required to determine the full effect of the program.<sup>225</sup>

#### 6.2.2.5 Residential rehabilitation

Residential rehabilitation services are longer-term treatment and counselling services provided within specialised live-in centres that deliver holistic, client-centred treatment to address substance use disorders, and provide psychosocial interventions to address the issues behind substance dependence. The Mental Health Commission website advises residential rehabilitation is voluntary, and that the average length of stay is 12-16 weeks but some people stay for more than 12 months.<sup>226</sup>

Residential rehabilitation is the most intensive type of treatment and requires a high level of commitment.

“Some people may be ready for treatment but not for the level of intensity that requires them to live and negotiate interpersonal relationships with people they don’t know; and to be without the day-to-day support of family and friends.

Residential rehab can be a good option for people who don’t have a stable home situation, or who need a complete break from their environment, or as a step up when less intensive treatments have not been effective.”<sup>227</sup>

The cost of government-funded residential treatment is estimated to be approximately \$117 per day. In addition, people attending treatment are asked to contribute to their day-to-day living costs (usually \$200-300 a week) through their government benefits or other income.<sup>228</sup>

A range of residential rehabilitation services are available in Western Australia, and are mainly operated by not-for-profit providers funded by the Western Australian Government and/or subsidised by residents’ Centrelink payments or fees.

<sup>225</sup> Ashcliffe Psychology, Matrix Program General Information, Black Q, Watson E, Black C. Introducing the Matrix Methamphetamine treatment program to Australia: The pilot, development of the Australian Matrix protocol, establishment of the national Matrix network and some preliminary research findings from South Australian multisite trials. In: Australian New Zealand Addiction Conference; 2018 May 28-30; Gold Coast.

<sup>226</sup> Government of Western Australia. Mental Health Commission. Residential rehabilitation for alcohol and other drugs. Perth: MHC; 2016. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/getting-help/residential-rehabilitation-for-alcohol-and-other-drugs/>

<sup>227</sup> Lee N. Drug rehab, what works and what to keep in mind when choosing a private treatment provider. *The Conversation*. 2018 May 2. [accessed 2018 Nov 7] Available from: <https://theconversation.com/drug-rehab-what-works-and-what-to-keep-in-mind-when-choosing-a-private-treatment-provider-95431>

<sup>228</sup> Lee, N., Drug rehab, what works and what to keep in mind when choosing a private treatment provider, *The Conversation*, 2 May, 2018



The Western Australian Government made commitments to increase the number of specialist drug and alcohol treatment beds available in Western Australia within residential rehabilitation settings originally as part of the *Western Australian Meth Strategy 2016*, now to be continued under the 2017 *Methamphetamine Action Plan* (see below). This provided mainly for an expansion of the number of specialist services provided by not-for-profit services in rural and regional areas.

The Mental Health Commission advised that the Western Australian Government funds a total of 236 beds in Western Australia; including 169 in the metropolitan area, 20 in the Wheatbelt, 22 in the Mid-West, 14 in the South West with up to 33 additional beds recently announced, and 11 beds in the Goldfields. In 2016-17, the Commission recorded 1,579 closed treatment episodes across its community bed-based funded services.<sup>229</sup>

### **Methamphetamine Action Plan Initiative #1 – Investing an additional \$2 million a year in treatment facilities**

Funding of \$16.1m over the forward estimates until June 2022 has been allocated to continue the operation of 52 existing residential rehabilitation beds and eight low medical withdrawal beds across metropolitan and regional Western Australia, previously funded under the *Western Australian Meth Strategy 2016*.

The Methamphetamine Action Plan Initiative #2 regarding specialist drug treatment in regional areas is discussed in Chapter 8.

Through the WA Primary Health Alliance, the Commonwealth has provided Palmerston with \$687,500 for the South West Therapeutic Community in Brunswick Junction. The funding is to provide therapeutic community services within a residential facility for treatment of co-morbid alcohol and other drug and mental health problems. WA Primary Health Alliance also provides funding for residential services to the Salvation Army for the Bridge Program (\$47,656), and Yaandina Family Centre Turner River Rehabilitation Centre in South Hedland (\$209,040), as well as for 22 beds in Broome at Milliya Rumurra, and 22 beds at Ngnowar Aerwah in Wyndham.

There are other private residential rehabilitation services available in the community, for example Perth Clinic, Tenacious House, Shalom House and Abbotsford Private Hospital.

The Taskforce noted that for many consumers of services, and particularly parents of people using methamphetamine, there is a perception that residential rehabilitation is the ideal form of treatment. For others, with the associated consequences for income, child care and housing arrangements, the practicalities of taking three months out of their lives to undertake residential treatment are not manageable.

A shortage of residential rehabilitation in particular was commented on by consumers of services at Taskforce community consultations. This is supported by service provider Palmerston reporting to the Parliamentary Joint Committee on Law

---

<sup>229</sup> Government of Western Australia. Mental Health Commission. 2016/17 Annual Report. Perth: MHC; 2017. p 18. [accessed 2018 Nov 7] Available from <https://www.mhc.wa.gov.au/media/2151/mhc17-54463-final-approved-accessible-pdf-15-sept-2017.pdf>



Enforcement that in 2015-16, 180 people participated in its residential program, representing an increase of 18 per cent from the previous year. It also noted an increase in the number of people seeking treatment for methamphetamine use more broadly, with the number of residents reporting methamphetamine as their primary drug of concern, increasing from 38 per cent in 2013-14 to 53 per cent in 2015-16. This was contrasted with alcohol which accounted for 47 per cent in 2013-14 and 28 per cent in 2015-16.<sup>230</sup>

In its submission to the Parliamentary Joint Committee on Law Enforcement, the Victorian Alcohol and Drug Association identified a lack of residential rehabilitation beds having a number of negative consequences, including:

- unmet demand being met by the expansion of unregulated private rehabilitation facilities;
- acute health issues due to untreated dependency resulting in preventable mortality; and
- demand on the justice system.

### Taskforce conclusions and recommendations

The Taskforce acknowledges the profound impact that dependent methamphetamine use has on families as well as users. The Taskforce supports the view that those most impacted by methamphetamine use have unique insights into what works to assist users and their families, and what doesn't.

The Taskforce recognises the Government's increased investment in methamphetamine treatment services, particularly in residential rehabilitation treatment services. The Taskforce notes, however, that this may not be sufficient to meet what is reported to be significant unmet demand for treatment services.

The Taskforce heard consistently from a broad range of stakeholders including service providers, researchers and consumers that demand for treatment services far exceeds supply. The Mental Health Commission's planning confirms the level of supply is inadequate to meet demand across all categories of service, including residential rehabilitation.

At the time of writing, the Office of the Auditor General was undertaking an audit on *The Availability, Accessibility and Effectiveness of Treatment for Methamphetamine Dependence in Western Australia*. The audit objective is to assess if public services for people with methamphetamine dependence are available, accessible and effective. The audit will focus on the following key questions:

- Does the Mental Health Commission understand the need for methamphetamine treatment services?
- Are appropriate treatment services in place?
- Do all people who require treatment services get them and are they effective?

---

<sup>230</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 30. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

**Recommendation 15:**

Once the outcome of the Office of the Auditor General audit on *The Availability, Accessibility and Effectiveness of Treatment for Methamphetamine* is available, the Mental Health Commission work with the Department of Treasury and the Department of the Premier and the Cabinet to develop recommendations for Government to prioritise funding of alcohol and other drug treatment services to address immediate and unmet demand.

The Taskforce also heard how challenging it is for people seeking treatment for methamphetamine use to access help in a timely way, and how vital this is. The Taskforce acknowledges residential rehabilitation is a very effective treatment service available to methamphetamine users, but notes it may not be suitable for all people seeking treatment despite a common community perception that it is the only successful treatment option.

The Taskforce endorses the provision of a diversity of treatment service types, and believes there is a need to provide consumers with a better understanding of the rehabilitation process and the treatment options available.

**Recommendation 16:**

The Mental Health Commission works with alcohol and other drug service providers to establish a centralised waitlist database in order to better identify and utilise existing treatment capacity.

**Recommendation 17:**

The Mental Health Commission, in consultation with service providers, prioritise additional strategies to further improve the responsiveness to users who wish to prepare for and undertake treatment, including:

- increasing the use of peer workers to 'bridge the gap' between when users decide to seek treatment and then commence treatment;
- introducing walk-in or no-wait services, based on models in other jurisdictions, for incorporation into existing services; and
- use of e-Health and other strategies that enable an immediate response to users during the small window in which users decide they want to change.

**Recommendation 18:**

The Mental Health Commission works with the alcohol and other drug sector to improve consumers' (including users and families) understanding of what the rehabilitation process involves, and rehabilitation options available for consumers and families beyond residential rehabilitation, including clarifying what is involved in planned detox, residential services, and community based services.

### 6.2.3 Better support for families

The Taskforce consistently heard from families dealing with the impact of another's methamphetamine use that they needed help across a wide range of services, including access to affordable or free counselling. As discussed previously in this chapter, the Mental Health Commission's Alcohol and Drug Support Service provides a range of professional counselling services for people using alcohol and other drugs, and their families. For parents of people of any age using alcohol and other drugs, the Alcohol and Drug Support Service can also provide access to a

Parent Peer Support volunteer. Parent Peer Support volunteers are trained parent volunteers who have experienced their own child's alcohol or drug use. This phone support is available from 8am-10pm daily, for volunteers to listen to parents' concerns, and share strategies to cope and help manage the caller's situation. Parent Peer Support volunteers also attend the Perth Drug Court every Monday morning offering the same support to parents attending court with their child or family member.

The Taskforce also heard that families dealing with the impact of another's methamphetamine use have very specific needs, and many want to be involved in the design of services to meet those needs, especially in regional communities. The Western Australian Government's Services Priority Review notes the merits of a place-based approach which frames needs based on a geographical location (rather than the needs of the majority of the State). Such arrangements can take into account the differences in demographics, geography, environment and the economy of regions. The Service Priority Review suggests place-based models can range from 'pooled funding based on location, to formal coordination and engagement mechanisms'.<sup>231</sup>

The Service Priority Review found strong support for co-design practices (illustrated in Figure 31) in service design and delivery from many stakeholders, including representatives from Aboriginal communities and the not-for-profit sector.

Stakeholders called for new ways of working together to deliver better services built on lasting partnerships, rather than services delivered to people in communities without their input.

---

<sup>231</sup> Government of Western Australia. Department of Premier and Cabinet. Working Together. One public sector delivering for WA. Service Priority Review Final Report. Perth: The Department; 2017. p 39. [accessed 2018 Nov 7] Available from: [https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/ServicePriorityReview/Documents/SPR\\_Report\\_FINAL-5-Dec.pdf](https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/ServicePriorityReview/Documents/SPR_Report_FINAL-5-Dec.pdf)

**Figure 31: The Co-Design Process**



Source: *Working Together One Public Sector Delivering for WA*, Service Priority Review Final Report to the Western Australian Government, October 2017 <sup>232</sup>

The review determined that co-designing services was resource intensive and time consuming, and while easy to support in theory was much harder to implement in practice. However, it found there was potential to replace services that were gaining minimal traction, and therefore a waste of resources, with initiatives that have a built-in legitimacy.<sup>233</sup>

### **Taskforce conclusions and recommendations**

The Taskforce acknowledges the profound impact that dependent methamphetamine use has on families, as well as individual users of the drug. People frequently using methamphetamine and their families are those in most critical need of care and support. Throughout the consultation, family and other support people regularly shared their sense of loss and dread, helplessness, and the emotional and financial burdens carried when dealing with the impacts of dependency.

#### **Recommendation 19:**

The Mental Health Commission works with alcohol and other drug service providers to ensure that service users, families and significant others are involved in the design and delivery of services, including training and professional development of service staff.

<sup>232</sup> Ibid pg 37

<sup>233</sup> Ibid. p.38.

**Recommendation 20:**

The Mental Health Commission works with alcohol and other drug service providers to ensure the outcomes of services referred to in Recommendation 19 specifically support and assist families and others who support methamphetamine users.

**Recommendation 21:**

The Mental Health Commission expands the Parent Peer Support volunteer service beyond the current level of service provision to provide more assertive outreach into, and presence, in the community, and provide greater support for families of methamphetamine users.

#### **6.2.4 Treatment of comorbid alcohol and other drug use disorders and mental health conditions**

The Taskforce heard from members of the community that:

- people seeking help with comorbid alcohol and other drug and mental health conditions are ‘falling through treatment service gaps’, or being ‘ping ponged’ between services;
- people seeking help are looking for holistic and integrated services to help them manage their co-occurring alcohol and other drugs and mental health issues.

These views are echoed by the Chief Psychiatrist of Western Australia, who submitted to the Taskforce that:

“Mental health care and treatment must be considered in the development of any action plan that addresses methamphetamine use in the Western Australian population... An action plan addressing methamphetamine without consideration of mental health care and treatment would only partially address the issues faced by the Western Australian community and methamphetamine users.”

*Chief Psychiatrist of Western Australia, 16 March 2018*

##### **6.2.4.1 What is comorbidity and why does it occur?**

The term ‘comorbidity’ refers to the co-occurrence of one or more alcohol and other drug use disorders with one or more mental health conditions. A mental health condition may be a diagnosed disorder or conditions where the symptoms of a disorder are evident but do not meet the criteria for a diagnosis.

Studies show that two thirds of people who use methamphetamine experience psychotic symptoms while using the drug, and up to one third experience psychotic symptoms for up to six months.<sup>234</sup> A 2013 study of people aged between 15 and 29 years admitted to a hospital in NSW with a first episode of psychosis found that almost half of these admissions had comorbid substance misuse, and in almost a third of those cases, a stimulant (or amphetamine) was the substance used. The

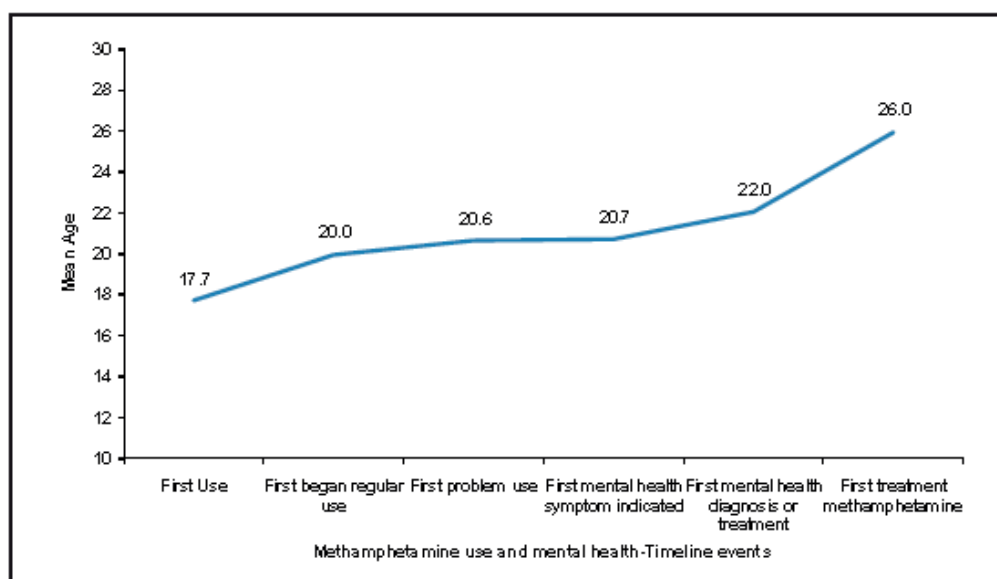
<sup>234</sup> Lecomte T, Mueser K, MacEwan W, Thorton A, Buchannan T, Bouchard V, et al. Predictors of Persistent Psychotic symptoms in persons with methamphetamine abuse receiving psychiatric treatment. J Nerv Ment Dis. 2013: 201(12); 1085 –9.

study also found that ‘stimulant disorders were associated with a greater likelihood of acute entry into mental health care’.<sup>235</sup>

There are typically three possible explanations for the relationship between mental health and drug use that can be applied to methamphetamine which focus on cause and effect. Two theories directly oppose each another; one considers that drug-use occurs in an attempt to manage pre-existing mental health issues, and the other considers that drug use occurs first which then contributes to the later development of mental health issues.<sup>236</sup> A third explanation suggests that there is an ‘indirect causal relationship’ whereby one condition has an effect on an intermediary factor that then increases the likelihood of developing the second condition.

In a study of dependent methamphetamine users in Melbourne, 22 per cent reported their mental health problems were identified prior to their first use of methamphetamine, and 72 per cent reported mental health problems after first use of methamphetamine. About 60 per cent of study participants experienced mental health symptoms at the same time or after methamphetamine use became ‘problematic’.<sup>237</sup> Figure 32 below taken from this study shows the short time period between first beginning regular use, first problem use and when mental health symptoms first appear. Mental health symptoms were first indicated about a year after first regular use of methamphetamine and about the same time as problematic use.

**Figure 32: Lifetime mental health and methamphetamine use**



Source: Lee, N., Harney, A. and Pennay, (2012) A. Examining the temporal relationship between methamphetamine use and mental health comorbidity, *Advances in Dual Diagnosis*, Vol. 5 Iss: 1 p27.

<sup>235</sup> Sara G, Burgess P, Malhi GS, Whiteford H, Hall W. (2013) Difference in association between cannabis and stimulant disorders in admission psychosis. *Schizophrenia Research*. 2016: 147(2-3); 216-22.

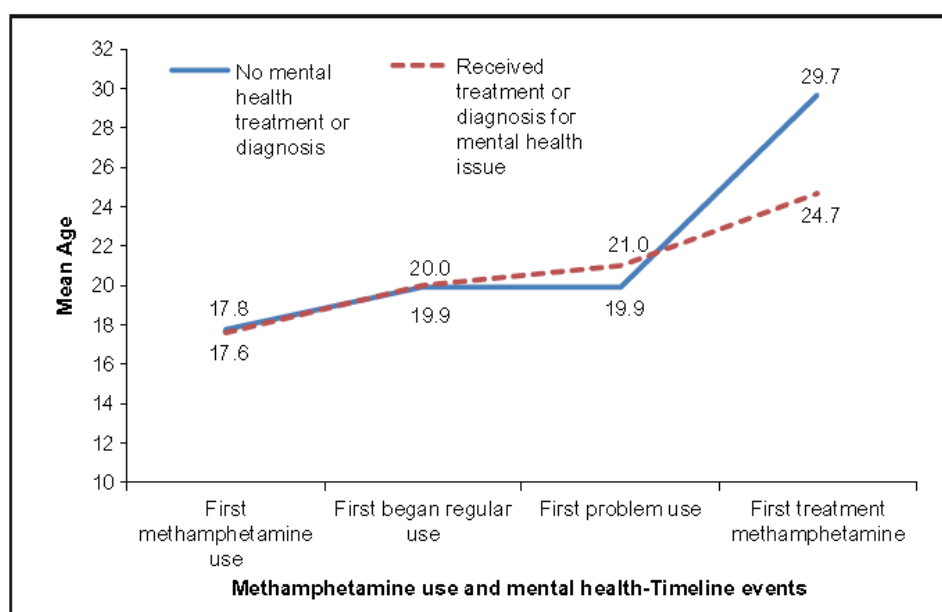
<sup>236</sup> Lee NK, Harney AM, Pennay AE. Examining the temporal relationship between methamphetamine use and mental health comorbidity. *Advances in Dual Diagnosis*. 2012;5(1); 23-31

<sup>237</sup> Ibid.



This study also indicates that those with mental health problems sought treatment sooner than those without mental health problems. The time lag between first problematic use and first treatment was five years on average for those who received treatment of diagnosis for a mental health condition, and 10 years for those who did not receive mental health treatment or diagnosis as shown in Figure 33.

**Figure 33: Lifetime methamphetamine use – timeline of impact of mental health treatment on diagnosis on first treatment**



Source: Lee, N., Harney, A. and Pennay, (2012) A. Examining the temporal relationship between methamphetamine use and mental health comorbidity, *Advances in Dual Diagnosis*, Vol. 5 Iss: 1.

#### 6.2.4.2 Treating comorbidity

In terms of treatment, regardless of how or when the comorbidity emerged, both conditions may maintain or make the other worse. The recommended strategies used to manage these conditions are the same irrespective of what order the comorbid conditions developed.

The Taskforce heard from consumers of services and their families that treatment for people with both mental health issues and drug addiction needed to be improved, with many identifying the need for a single point of service coordination across agencies to help manage their complex needs, including housing, child protection, and financial concerns. This observation is consistent with the literature which notes the management of people with comorbidity is challenging, especially because specialist mental health or alcohol and other drug services are usually separated from each other physically, administratively and philosophically within an already fragmented community service delivery environment.

A recent NSW review of effective models of care for comorbid mental illness and illicit substance use concluded that comorbid mental health and substance use disorders are one of health's most significant challenges, with the siloed structure of

the health care system “historically treating clients in sequence of disorder (based on which is considered primary), or in parallel by different treatment providers”.<sup>238</sup>

This would appear to occur despite national recognition supporting the integration of mental health and alcohol and other drug treatment in Australia. Such efforts include:

- [\*Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician\*](#) – first published in 2002 under a joint initiative of the National Drug Strategy and the National Mental Health Strategy, and updated in 2008 under the Australian Government’s National Comorbidity Initiative. This resource provides guidance to primary care clinicians on both general and specific comorbidity management approaches for different mental health disorders and common drug groups, including methamphetamine in the stimulants category;
- [\*Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings\*](#) – first published in 2009, also under the National Comorbidity Initiative, and updated in 2016. The purpose of these guidelines is to provide alcohol and other drug workers with up-to-date evidence-based information on the management of comorbid mental health conditions in alcohol and other drug treatment settings to improve treatment outcomes for comorbid clients. This resource is accompanied by a website and a free online training program.

Further, the literature on comorbidity identifies a number of useful and validated tools to assess and evaluate service capability to deliver integrated services:

- [\*Dual Diagnosis Capability in Addiction Treatment \(DDCT\) Toolkit\*](#) and [\*Dual Diagnosis Capability in Mental Health Treatment \(DDCMHT\) Toolkit\*](#) – created in 2003 and 2004 respectively, these resources have been developed as a standard or benchmark instrument to assess capability and guide substance use treatment providers and mental health providers in managing individuals with co-occurring mental health and alcohol and other drug disorders. Both the toolkits provide a program-level assessment, where information is gathered during a site visit and drawn from assessor observations, interviews, and review of materials. This data is then used to complete ratings on 35 benchmarks regarding policy, clinical practice, and workforce domains; and
- [\*Integrated Treatment for Co-occurring Disorders Evidence Based Practices Kit\*](#) – published in 2010, this resource details information on how best to evaluate integrated treatment programs. Two types of measures are recommended to evaluate a service – process measures and outcome measures.

The NSW Evidence Check of the existing evidence for effective models of comorbid treatment (referred to earlier) recommended a range of measures<sup>239</sup>, many of which

---

<sup>238</sup> Government of New South Wales. NSW Ministry of Health. Mental Health and Drug and Alcohol Office. Effective models of care for comorbid mental illness and illicit substance use – evidence check review. Sydney: NSW Health; 2015. p.3. Available from: <http://www.health.nsw.gov.au/mentalhealth/publications/Publications/comorbid-mental-care-review.pdf>

<sup>239</sup> Government of New South Wales. NSW Ministry of Health. Mental Health and Drug and Alcohol Office. Effective models of care for comorbid mental illness and illicit substance use – evidence check review. Sydney: NSW Health; 2015. p.3-5. Available from: <http://www.health.nsw.gov.au/mentalhealth/publications/Publications/comorbid-mental-care-review.pdf>

are consistent with other guidelines<sup>240</sup> for effective treatment of comorbidity, including:

- a *'no wrong door' approach* in which no client should be turned away from treatment; rather, it is necessary to establish where the client will receive the most appropriate care;
- *adopting a holistic approach* in order to either respond to or take into account, the broad range of issues that clients present with, including their mental health, medical, family, employment, housing, welfare and legal issues. Clients also need to be viewed in light of their age, gender, sexual orientation, culture, ethnicity, spirituality, socio-economic status and cognitive abilities;
- *adopting a client-centered approach*, including focussing treatment on the impairment and distress experienced by the client, rather than solely on diagnosis or primary/secondary substance use disorder;
- *recognising that comorbidity is common* and that all clients should be routinely screened for comorbid conditions;
- *screening tools to be brief and easy to administer* with assessment of all presenting conditions, and managing the most severe symptoms first;
- *adopt the principle of assertive care* where appropriate to increase retention in treatment and prevent clients 'falling through the gaps';
- *a care coordinator to coordinate the provision of care*, ensuring continuity of care from screening through to discharge/referral, and to manage effective communication between services and sectors;
- *orient all staff to basic comorbidity practices* including administration of screening tools, preliminary assessment and appropriate pathways for referral within and between services;
- *develop training/certification standards* to provide evidence of achievement of these skills; and
- *develop means for people with comorbidity, their families and carers to have input* into the planning, review and ongoing development of services and the training of staff in both sectors and primary care sectors.

Research also indicates that the use of e-Health services and treatment programs for addiction and mental health problems can help to foster stronger links between systems of care.<sup>241</sup>

---

<sup>240</sup> Marel C, Mills KL, Kingston R, Gournay K, Deady M, Kay-Lambkin F, Baker A, Teesson M Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings 2<sup>nd</sup> edition. Sydney: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre, University of New South Wales; 2016. p. 15-17. Available from: <https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf>

<sup>241</sup> Government of New South Wales. NSW Ministry of Health. Mental Health and Drug and Alcohol Office. Effective models of care for comorbid mental illness and illicit substance use – evidence check review. Sydney: NSW Health; 2015. p.3. [accessed 2018 Nov 7] Available from: <http://www.health.nsw.gov.au/mentalhealth/publications/Publications/comorbid-mental-care-review.pdf>

#### 6.2.4.3 *What's happening in Western Australia*

Comorbid treatment in Western Australia, at least in the mental health sector, appears to reflect that reported elsewhere. As the Chief Psychiatrist of Western Australia submitted to the Taskforce:

“Public health services in Western Australia do not have a consistent approach to managing comorbidity, nor do staff consistently see themselves as having a responsibility in this space... Practically care frequently fails because mental health clinicians consider the management of methamphetamine as a job for drug and alcohol services and the contrary regarding mental illness also exists... This is both a service structure as well as a cultural issue.”

*Submission to the Taskforce, 16 March 2018*

The Western Australian Network of Alcohol and other Drug Agencies has argued the situation is different in the alcohol and other drug sector, saying:

“The WA alcohol and other drug sector reports, and the WA mental health sector admits, that the alcohol and other drug sector has for a long time been building its capability/capacity to address high prevalence of mental health conditions. The mental health sector has not been commensurately supported to build capacity/capabilities to address co-occurring issues.”

*The Western Australian Network of Alcohol and other Drug Agencies presentation to the Taskforce, 20 February 2018*

In support of this claim, the Western Australian Network of Alcohol and other Drug Agencies in 2011 released a [Comorbidity Capacity Building Toolkit](#). This document reports the results and practical lessons learnt from an initiative piloting a consortia model to ‘pioneer’ comorbidity-centred partnerships among alcohol and other drug services in WA.

From the Western Australian Network of Alcohol and other Drug Agencies’ perspective the challenges of integrating mental health and alcohol and other drug services mirrors the challenges of having merged the Drug and Alcohol Office and the Mental Health Commission (in 2015):

“The merger/ amalgamation [of DAO and MHC] has not resulted in any significant service ‘integration’ developments beyond what was already in place, or that would have happened otherwise. It has also not improved the two sectors capacity or capabilities to address co-occurring issues.

The predominant service model applied to mental health is medical, the predominant service model in AOD is psychosocial / counselling. It is a different culture. The AOD sector is predominantly not for profit, where the majority of mental health services are government.”

*The Western Australian Network of Alcohol and other Drug Agencies presentation to the Taskforce, 20 February 2018*

#### **Taskforce conclusions and recommendations**

The Taskforce acknowledges that a considerable body of work has been undertaken in Australia to support comorbid treatment. However, it supports the view expressed by both consumers of services and the Chief Psychiatrist that an integrated model for best practice mental health services and alcohol and other drug services has not been realised.

**Recommendation 22:**

The Mental Health Commission collaborates with the peak bodies in mental health and alcohol and other drug sectors to ensure co-morbidity guidelines (set out in the *Co-morbidity of mental disorders and substance use: A brief guide for the primary care clinicians* and *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions*) are implemented, monitored and reported on in Western Australia.

**Recommendation 23:**

The Mental Health Commission works with the Department of Health and other key stakeholders to ensure a 'no wrong door' approach by making sure that service providers are applying the nationally developed and validated tools to assess and evaluate service capability to deliver integrated services (as set out in *Dual Diagnosis Capability in Addiction Treatment Toolkit*, *Dual Diagnosis Capability in Mental Health Treatment Toolkit*, and *Integrated Treatment for Co-occurring Disorders Evidence-based Practices Kit*.)

**Recommendation 24:**

The Mental Health Commission ensures that its commissioning policies, process and practices support and reinforce the application of the guidelines and tools referred to at Recommendations 22 and 23.

**6.2.5 Mandatory Treatment**

Treatment for people with alcohol and other drug dependence is not mandatory in Western Australia. The Taskforce heard that compulsory or mandatory treatment should be considered as a solution to the reported low numbers of methamphetamine dependent users seeking or in treatment. Some family members called for involuntary or compulsory treatment particularly as an alternative to incarceration for offenders who are drug dependent.

“Something that can force the offender into treatment before their lives are ruined by criminal charges.”

Online comment

**6.2.5.1 What's happening in Western Australia**

In September 2016, the Mental Health Commission undertook an extensive public consultation process to consider this option. Background and discussion papers on a proposed provision for compulsory alcohol and other drug treatment in Western Australia were released. Public consultation raised concerns about the lack of evidence of the effectiveness of compulsory alcohol and other drug treatment programs. In response, the Western Australian Government decided to wait for the release of an evaluation of a similar program in New South Wales (the Involuntary Drug and Alcohol Treatment Program) before further considering this approach in Western Australia. The evaluation is due to be finalised by the end of 2018.<sup>242</sup>

<sup>242</sup> Government of Western Australia. Mental Health Commission. Compulsory alcohol and other drug treatment program. Perth: MHC; 2018. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/about-us/acts-and-legislative-changes/compulsory-alcohol-and-other-drug-treatment-program/>

In its evidence to the Parliamentary Joint Committee on Law Enforcement, the WA Primary Health Alliance argued that people accepting they have a problem and wanting to change means treatment efficacy is much greater.

“I appreciate that many families who would feel that they are at their wits end would want that for the safety of their child and so forth, but the evidence about that [compulsory] type of treatment being successful is not strong. It is not to say that it will not work for some people, but for people willing to accept the issue will have greater treatment efficacy than being dragged against their will”.<sup>243</sup>

The Western Australian Network of Alcohol and other Drug Agencies also argued against mandatory treatment in its evidence to the Joint Committee, but for a different reason. The Western Australian Network of Alcohol and other Drug Agencies expressed the view that there is no point pursuing mandatory treatment before there is enough access to voluntary treatment, stating: “We need adequate voluntary services to start with, and then let us look at that [compulsory treatment] as an option.”<sup>244</sup>

### **Mandatory Treatment in Australia**

The National Ice Taskforce noted the following in its Final Report (2015):

“Mandatory treatment programmes for severe substance dependence operate outside the criminal justice system in Australia.

Four jurisdictions have legislated for mandatory treatment of people with alcohol and other drug dependence: New South Wales; Victoria; the Northern Territory; and Tasmania. These schemes have evolved from ‘Inebriates Acts’, in place since the early 1990s. The legislation in New South Wales, Victoria and Tasmania provides for mandatory treatment for people dependent on alcohol and other drugs, while the Northern Territory’s legislation applies only to alcohol and volatile substance misuse (such as solvents and petrol).

Under the New South Wales, Victorian and Northern Territory regimes, mandatory treatment can only be authorised where a person is at risk of serious harm, and less restrictive means are not available. There is also a requirement for substance dependence to be severe, and for treatment to be beneficial for the person. The objectives of the schemes include stabilising health and enhancing capacity to make future decisions about substance use and personal welfare.

The regimes all provide for detention periods varying from 14 days to up to six to 12 months. This decision is often informed by advice from an accredited medical practitioner. The regimes in New South Wales and Victoria authorise mandatory treatment only where people are incapable of making, or have lost the capacity to make, decisions about their substance use. In New South Wales the person must also have refused treatment.

---

<sup>243</sup> Parliamentary Joint Committee on Law Enforcement, Chrystal methamphetamine, Official Committee Hansard, 3 May 2018, p.19

<sup>244</sup> Parliamentary Joint Committee on Law Enforcement, Chrystal methamphetamine, Official Committee Hansard, 3 May 2018 p.30



A range of views and issues have been canvassed in relation to mandatory treatment, including in recent reviews of the New South Wales scheme in 2013 and the Victorian scheme in 2014. The high cost of mandatory treatment has raised questions about whether it is an appropriate treatment option, given limited resources and lack of a robust evidence base. Concerns have been raised that mandatory treatment may diminish the capacity for treatment to be delivered flexibly and in a manner that enables the individual to own their problem. Ethical and human rights concerns have also been raised about interfering with a person's civil liberties by imposing medical treatment without their consent.

Mandatory treatment is a complex area. Research suggests that, while there is some evidence mandatory treatment for short periods can be an effective way to reduce harm, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change.<sup>245</sup>

### Taskforce conclusions and recommendations

The Taskforce notes that on the matter of mandatory residential treatment the Parliamentary Joint Committee on Law Enforcement concluded:

"The committee understands why many people, often outside the AOD treatment sector – hold the view that mandatory residential treatment is a viable option for drug users. The committee has heard numerous accounts where families have reached the limits of their capacity to support loved ones through their drug addiction. In these circumstances it is not surprising that families and communities support mandatory treatment.

Evidence to the committee was largely critical of mandatory residential treatment, with many submitters and witnesses arguing it is not an effective response to problematic AOD use... many experts recognise that motivation to undertake AOD treatment must come from the individual, and cannot be enforced upon them... However, there may be a role for mandatory residential treatment in instances where a person is likely to harm themselves or others around them."<sup>246</sup>

The Taskforce also notes that neither the National Ice Taskforce nor the Parliamentary Joint Committee on Law Enforcement chose to make specific recommendations to either support or dismiss the matter of compulsory residential rehabilitation services.

Given its findings on the existing unmet demand for treatment services including residential rehabilitation, the Taskforce is particularly convinced by the common sense expressed by the Western Australian Network of Alcohol and other Drug Agencies in its evidence to the Joint Committee, that voluntary treatment needs should be met before giving any consideration to compulsory residential

<sup>245</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. pp 63-64. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>246</sup> Parliament of Australia. op. cit., p. 45.

rehabilitation treatment. The Taskforce therefore advises the Government accordingly.

### 6.2.6 Pharmacotherapy

Pharmacotherapy (treatments via medication) enables dependent drug users to stabilise their condition, allowing them to manage and repair their lives and either seek a drug-free existence or establish a maintenance program. There are currently no pharmacotherapies which have been proven to be effective in addressing methamphetamine dependence.

However, there are three relevant pharmacotherapy trials are currently underway in Australia:

- N-ICE, a randomised controlled trial into the safety and efficacy of N-Acetyl Cysteine (NAC) as a pharmacotherapy for methamphetamine dependence. The N-ICE trial is funded through a grant from the National Health and Medical Research Council, looking at the impact of NAC in reducing people's desire to continue to use methamphetamine (i.e. reduce cravings); as well as the severity of its psychiatric effects<sup>247</sup>;
- a clinical trial examining whether the drug lisdexamfetamine, currently used in the treatment of ADHD, shows promise in alleviating withdrawal symptoms and preventing relapse relative to placebo in recently-abstinent methamphetamine dependent individuals. Funded by the National Health and Medical Research Council; and <sup>248</sup>
- a clinical trial examining whether the drug baclofen is effective in suppressing methamphetamine cravings, funded by Western Australia Department of Health (State Health Research Advisory Council Research Translation Project 2015). This study is expected to conclude by the end of 2018.<sup>249</sup>

### 6.2.7 e-Health

The Taskforce heard that consumers of services and their families felt strongly that more should be done to make it as easy as possible for people to get help including by developing mobile device 'apps' and online support (i.e. e-Health services).

e-Health services generally offer information or therapy remotely through the internet or by telephone and have been found to not only provide effective care, but to be effective options for improving access to treatment and support.<sup>250</sup> In particular, e-Health services can help address access inequities associated with geographic location and demographic factors, as well as the cost of treatment, misperceptions

---

<sup>247</sup> National Drug Research Institute. Information page: The N-Ice Trial. 2018 July 18. [accessed 2018 Nov 7] Available from: <http://ndri.curtin.edu.au/research/research-specific-sites/the-n-ice-trial/>

<sup>248</sup> US National Library of Medicine. University of Arkansas and National Institute on Drug Abuse. Clinical Efficacy of Lisdexamfetamine for Methamphetamine Dependence. ClinicalTrials.gov. 2017 August 22. [accessed 2018 Nov 7] Available from: <https://clinicaltrials.gov/ct2/show/NCT02034201>

<sup>249</sup> Stafford A, Fatovich D, Bynevelt M, Licari M, Reynolds J, Christmass M, Quigley A. Methamphetamine Addiction: Is Baclofen effective in suppressing methamphetamine cravings? Functional MRI patterns of brain activation in Baclofen vs placebo treated methamphetamine addicts.

<sup>250</sup> Christensen H, Hickie B. Using e-health applications to deliver new mental health services. Med J Aust. 2010;192(11); S53 – S56. and Griffiths KM, Farrer L, Christensen H. The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials. Med J Aust. 2010; 192(11); S4 – S11.

about the quality and effectiveness of treatments, lack of information and general stigma.<sup>251</sup>

While they cannot exactly replicate face-to-face therapeutic contact, e-Health services have the potential to service as complementary options for delivering brief interventions, as first self-help steps in a stepped model of care<sup>252</sup> and to facilitate peer-support.<sup>253,254</sup> They have been found to be particularly effective in the domains of health promotion, prevention, early intervention and prolonged treatment, as well as for treating depression, addiction and anxiety disorders.<sup>255</sup>

Examples of effective e-Health services to support those managing drug dependency include PORTS (Practitioner Online Referral Treatment Services, covered in Chapter 9 on Regional Communities), and Breaking the Ice Support Program.

“Breaking the Ice is a free, confidential, online early intervention program for people who are using crystal methamphetamine (ice). The program is particularly recommended for young adults (aged 16-25) but can be used by people of any age. It is designed to help participants identify any problems associated with their use of ice, in areas such as health, work, relationships and money; and consider the impact of making changes to their ice use, like quitting completely, reducing use, or using in a less risky manner. Breaking the Ice is made up of two modules and uses motivational interviewing and cognitive behaviour therapy methods. Participants are required to register using an email address, password and phone number. The program can be completed over several sessions.”<sup>256</sup>

---

<sup>251</sup> Farvolden P, Cunningham J, Selby P. Using e-health programs to overcome barriers to the effective treatment of mental health and addiction problems. *J Tech Human Serv.* 2009: 27(1); 5-22.

<sup>252</sup> Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs.

<sup>253</sup> Farvolden P, Cunningham J, Selby P. Using e-health programs to overcome barriers to the effective treatment of mental health and addiction problems. *J Tech Human Serv.* 2009: 27(1); 5-22.

<sup>254</sup> Christensen H, Hickie B. Using e-health applications to deliver new mental health services. *Med J Aust.* 2010;192 (11); S53 – S56. and Griffiths KM, Farrer L, Christensen H. The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials. *Med J Aust.* 2010: 192(11); S4 – S11.

<sup>255</sup> Ibid.

<sup>256</sup> WA Primary Health Alliance. Information page: Alcohol and Other Drugs: Services. 2018. Available from: <http://www.wapha.org.au/primary-health-networks/alcohol-and-other-drugs/>

Many e-Health services are currently delivered through existing primary care or GP services. This runs the risk of becoming the preferred model of delivery and represents only one way in which e-Health services can be provided. The literature suggests an over-reliance on practitioner guided e-Health services could not only work to restrict access to care (the very problem which e-Health is supposed to solve) but runs contrary to the evidence which demonstrates that automated or self-help interventions can be effective.<sup>257</sup>

### **Taskforce conclusions and recommendations**

#### **Recommendation 25:**

The Mental Health Commission should promote the application of evidence based e-Health treatment programs or integrate e-Health treatment programs into established face-to-face models of care as a solution that may assist in: improving access to treatment for more people in general; the lack of available services in regional and rural Western Australia; and concerns about privacy in smaller communities.

---

<sup>257</sup> Christensen H, Hickie B, loc cit.

## Chapter 7 Reducing the harm associated with methamphetamine use

“Substance abusers need people to care about them and reach out to help. Everyone needs love in their lives, they want to fit in and feel less anxious.”

*Consumer and Family Members Forum*

“Provide safe houses where intoxicated people can go, where there are trained staff to provide support, and that won’t let you leave while you are in danger.”

*Consumer and Family Members Forum*

“When pharmacists give out clean needles they should also give a flyer about getting help.”

*Consumer and Family Members Forum*

“Teach people how to use drugs safely.”

*Consumer and Family Members Forum*

“I don’t know what the answer is but I do know one week off it makes all the difference if we could just provide help for that first crucial week they have a clearer head and maybe can make better choices.”

*Online comment*

Despite the best efforts of Government and service providers, some people will continue to use drugs in a way that is potentially harmful.

Harm reduction is one of three equally important pillars underpinning the Australian Government’s response to drug use, including methamphetamine, as identified in the *National Drug Strategy*.<sup>258</sup> The Strategy recognises that a balanced combination of demand, supply and harm reduction is the most effective way to minimise the social and economic consequences of drugs for individuals, their families and the wider community.<sup>259</sup>

Despite the recognised need for a balanced approach to demand, supply and harm reduction strategies, historically the majority of funding has been dedicated to supply reduction strategies. A 2013 analysis of government expenditure on illicit drug programs for 2009-10 estimated that the Commonwealth, State and Territory governments had spent approximately \$1.7 billion on illicit drug programs, 64 per cent of which was spent on law enforcement measures, with only 2.2 per cent spent on harm reduction measures.<sup>260</sup>

---

<sup>258</sup> Australian Government. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p 96. [accessed 2018 Nov 7] Available from: [https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf),

<sup>259</sup> Australian Government. Department of Health. National Drug Strategy 2017-2026. Canberra: The Department; 2017. p 1. [accessed 2018 Nov 7] Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/\\$File/National-Drug-Strategy-2017-2026.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/National-Drug-Strategy-2017-2026.pdf)

<sup>260</sup> Ritter A, McLeod R, Shanahan M. 2013. Government Drug Policy Expenditure

In Western Australia, the majority of funding for the Government's *Methamphetamine Action Plan* is focused on law enforcement. Of the \$131.7 million allocated in the 2017-18 State Budget for *Methamphetamine Action Plan* initiatives, \$83.5 million was allocated to the Western Australia Police Force for the establishment of the Meth Border Force.<sup>261</sup>

One study confirms the harm reduction response to amphetamine use remains underdeveloped when compared with the responses developed for opiate use and injecting-related harms.<sup>262</sup>

This observation is consistent with the findings of the *Final Report of the National Ice Taskforce*, and the evidence submitted by experts and communities which provided harm reduction support for methamphetamine users.<sup>263</sup>

The 2018 Victorian Parliamentary Inquiry into Drug Law Reform found that despite strong support for harm minimisation in the community, a commonly-heard criticism was that Australia's drug policy has 'gone backwards' in the past two decades after being a leader in needle and syringe programs in the 1980s, and that Australia is no longer considered a world leader in advocating for innovative harm reduction initiatives.<sup>264</sup>

## 7.1 What the Taskforce heard

The Taskforce heard from those with lived experience of methamphetamine about the importance of the quality, availability and accessibility of harm reduction services, as well as identifying opportunities for new and improved approaches. In particular, consultation participants identified that the system of services needs to be easy to navigate, ideally offering a single point of initial contact. The positive impact that peer-support services could offer was also highlighted; providing education and outreach services to people who currently use methamphetamine, as well as connecting them to clinical and therapeutic services.

Families and other support people consistently told the Taskforce there was a need for somewhere a person affected by methamphetamine could go when in crisis, when they posed an immediate threat to themselves, their families and the

---

in Australia – 2009/10. Drug Policy Modelling Program Monograph 24. Sydney: NDARC; 2013. [accessed 2018 Nov 7] Available from:

[https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/24%20Government%20drug%20policy%20expenditure%20in%20Australia%20-%202009\\_10.pdf](https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/24%20Government%20drug%20policy%20expenditure%20in%20Australia%20-%202009_10.pdf)

<sup>261</sup> Government of Western Australia. Media statement: \$131.1 million to implement Meth Action Plan to address ice scourge. 2017 September 7. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2017/09/131-point-7-million-dollars-to-implement-Meth-Action-Plan-to-address-ice-scourge.aspx>

<sup>262</sup> Pinkham S, Stone K. A Global Review of the Harm Reduction Response to Amphetamines: A 2015 Update. London: Harm Reduction International; 2015. p. 7. [accessed 2018 Nov 7] Available from: [https://www.hri.global/files/2015/10/18/AmphetaminesReport\\_Oct2015\\_web.pdf](https://www.hri.global/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf)

<sup>263</sup> Commonwealth of Australia. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p 169. [accessed 2018 Nov 7] Available from:

[https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

<sup>264</sup> Parliament of Victoria, Law Reform, Road and Community Safety Committee. Inquiry into drug law reform Summary Booklet. March 2018. p. xviii. [accessed 2018 Nov 7] Available at [https://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs\\_Report/LRRCSC\\_58-03\\_Full\\_Report\\_Text.pdf](https://www.parliament.vic.gov.au/images/stories/committees/lrrcsc/Drugs_Report/LRRCSC_58-03_Full_Report_Text.pdf).



community, which was an alternative to the current options of emergency department attendance, involuntary admission to a psychiatric hospital, or as a last resort, police detention.

Through its online comments the Taskforce also obtained feedback from the general public on how best to respond to a range of problems associated with methamphetamine use in Western Australia. There was a low number of responses related to harm reduction strategies with feedback limited to: the need for an alternative response when families were in crisis; opportunities for improving needle and syringe programs; and establishing supervised injecting facilities for people to consume methamphetamine in a safe and controlled environment.

In other consultations the Taskforce heard that the current reach of needle and syringe programs in Western Australia did not adequately meet people's needs, particularly in the outer-metropolitan suburbs such as Joondalup and Armadale, and in regional areas. Consultations also highlighted a need for the presence of needle and syringe programs in the prison system, which is discussed in further detail in Chapter 9.

The Taskforce recognises the need to ensure that services, in addition to attempting to reduce or stop drug use, also care for people who continue to use to ensure they don't cause harm to themselves or others.

## 7.2 Reducing harm among users

Harm Reduction International, a non-government organisation promoting support for harm reduction initiatives, defines harm reduction as:

“policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.”<sup>265</sup>

Harm reduction is a key focus of state and national drug strategies. The *National Drug Strategy* is a national framework for building “safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities”. The Strategy is based on a “balanced approach across the Three Pillars of Harm Minimisation”. Figure 32 illustrates the three pillars including harm reduction.<sup>266</sup>

<sup>265</sup> Harm Reduction International. Information page: What is Harm Reduction? 2018. [accessed 2018 Nov 7] Available from: <https://www.hri.global/what-is-harm-reduction>

<sup>266</sup> Australian Government. Department of Health. National Drug Strategy 2017-2026. Canberra: The Department; 2017. p 1. [accessed 2018 Nov 7] Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/\\$File/National-Drug-Strategy-2017-2026.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/National-Drug-Strategy-2017-2026.pdf).

**Figure 32: A Balanced Approach Across the Three Pillars of Harm Minimisation**



*Source: National Drug Strategy*

Current Western Australian Government support for harm reduction activities include targeted education (including peer-based education), advertising and media strategies, mobile health services, youth outreach services, sobering up centres, needle and syringe programs and night patrols.

It should be noted that there is no proven pharmacological-based treatment for dependence on amphetamines, like the successful use of methadone to treat people with opiate dependence. Pharmacological treatments for methamphetamine are still in trial phases with no approved programs available.<sup>267</sup>

### 7.2.1 What's happening in Western Australia

The Mental Health Commission currently provides targeted initiatives for at-risk young people via the Drug Aware and Safer Events and Venues “The Medix” campaign. The campaign commenced on 19 November 2017 and promotes evidence-based strategies to prevent harms including dehydration, over-hydration, overheating and poly-drug use. The campaign objectives are to:

- increase awareness of illicit drug harm reduction strategies;
- increase awareness of the signs someone is having physical or mental health issues associated with illicit drug use; and
- reduce fear of accessing medical assistance from event first aid and ambulance services.<sup>268</sup>

<sup>267</sup> Pinkham, S., Stone, K. A Global Review of the Harm Reduction Response to Amphetamines: A 2015 Update. London: Harm Reduction International; 2015. p. 15. [accessed 2018 Nov 7] Available from: [https://www.hri.global/files/2015/10/18/AmphetaminesReport\\_Oct2015\\_web.pdf](https://www.hri.global/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf)

<sup>268</sup> Mental Health Commission. [accessed 2018 Nov 7] Available from: <https://drugaware.com.au/about-us/current-campaigns/safer-events-and-venues/>.

The target group for this campaign is young adults 18 to 34 years who use illicit drugs at festivals, other music events and night venues. The campaign's key messages are:

- stay hydrated by drinking 500-600mls of water over each hour;
- take chill out breaks to prevent overheating;
- take care of your mates;
- don't mix drugs – mixing is risky and the effect can be unpredictable;
- first aid and ambulance services “The Medix” are here to help, not call police unless threatened or there is a death; and
- if experiencing illicit drug related physical or mental health issues, seek help from first aid or emergency services straight away.<sup>269</sup>

The Department of Health has produced *Guidelines for concerts, events and organised gatherings*. The Guidelines identify basic standards and safety measures for event organisers including dealing with alcohol and drug related issues.<sup>270</sup>

As part of the Taskforce consultation process, Peer Based Harm Reduction WA conducted a survey of awareness of available harm reduction services among its consumers, and asked for suggestions for improvement. The survey found:

- 40 per cent of respondents could not identify, or were not aware of any services other than those offered by Peer Based Harm Reduction WA, that support methamphetamine users;
- misrepresentation in the media, politicians demonising methamphetamine, hysteria, stereotypical concepts by police, medical staff or those needed in emergency situations, and stigma which is ‘unhelpful or negative for people who use methamphetamine’;
- concerns about a lack of services in the outer metropolitan area, lack of pharmacological treatments for methamphetamines compared to treatments like methadone for opioid addiction, lack of needle exchange programs available in prisons, and long waiting lists to get into treatment; and
- opportunities for improvement that include:
  - better 24-hour emergency help that is not police;
  - less discrimination and better understanding of why people use drugs;
  - more funding and more locations for needle exchange and treatment;
  - better support in hospitals and for homeless users;
  - shorter wait times to enter rehabilitation; and
  - methamphetamine use being reported more accurately in the media.

Many of the opportunities for improvement identified by Peer Based Harm Reduction WA were also articulated by other stakeholders. These have been taken into consideration by the Taskforce in formulating recommendations throughout this report.

---

<sup>269</sup> Ibid.

<sup>270</sup> Information available at

[https://ww2.health.wa.gov.au/~/\\_media/Files/Corporate/general%20documents/Environmental%20health/Concerts%20and%20Mass%20Gathering%20Guidelines.pdf](https://ww2.health.wa.gov.au/~/_media/Files/Corporate/general%20documents/Environmental%20health/Concerts%20and%20Mass%20Gathering%20Guidelines.pdf)

## Taskforce conclusions and recommendations

The Taskforce considers improving the visibility of harm reduction strategies to current users, and ensuring that harm reduction and other educational materials don't perpetuate the stigma associated with methamphetamine use, are important overarching principles that must be considered as part of the Government's harm reduction strategies to be implemented across Western Australia.

### 7.2.2 Needle and syringe programs

The most identifiably successful harm reduction strategy is needle and syringe programs (NSPs). The value of needle and syringe programs in reducing communicable diseases among injecting drug users is well established in the literature<sup>271-272</sup> and a large body of peer-reviewed studies have also demonstrated the health and economic benefits of such programs.<sup>273</sup> Beyond their role in reducing communicable disease such as HIV/AIDs, needle and syringe programs provide the most opportunities to connect with people currently injecting drugs who are not in treatment, thus providing the best opportunity to improve outcomes in this cohort through enhanced services. Although the support available for mitigating injecting-related harms is well established in Australia, it is important to note that this is just one form of harm reduction and assists only one sub-group (albeit one growing in numbers) of people injecting methamphetamine.<sup>274</sup>

#### 7.2.2.1 What's happening in Western Australia

Needle and syringe programs are available throughout Western Australia, through hospitals, health services, pharmacies and community alcohol and other drug organisations. A range of service delivery models are used including mobile outreach, vending machines and fixed-site services. Services can operate on a free distribution basis while others take a 'one-for-one' exchange approach (i.e. needle and syringe exchange programs) or charge a small fee. Needle and syringe equipment can generally be purchased by users directly from pharmacies, including one 24-hour pharmacy operating in metropolitan Perth.<sup>275</sup>

In regional Western Australia, there are currently two needle and syringe exchange programs, operating in fixed-site locations in Kalgoorlie and Geraldton. In the Kimberly and Pilbara needle and syringe programs are available through local

<sup>271</sup> Wilson D, Kwon A, Anderson J, Thein R, Law M, Maher L, et al. Australian Government Department of Health and Ageing, National Centre in HIV epidemiology and clinical research. University of NSW. Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia. Sydney: The Department; 2009. [accessed 2018 Nov 7] Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/A407CF4FECBDC715CA257BF0001F98B2/\\$File/return2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A407CF4FECBDC715CA257BF0001F98B2/$File/return2.pdf)

<sup>272</sup> Rhodes T, Hedrich D. European Monitoring Centre for Drugs and Drug Addiction. EMCDDA Monographs. Harm reduction: evidence, impacts and challenges. Luxembourg: EMCDDA; 2010. [accessed 2018 Nov 7] Available from: [http://www.emcdda.europa.eu/system/files/publications/555/EMCDDA-monograph10-harm\\_reduction\\_final\\_205049.pdf](http://www.emcdda.europa.eu/system/files/publications/555/EMCDDA-monograph10-harm_reduction_final_205049.pdf)

<sup>273</sup> Wilson D, Kwon A, Anderson J, Thein R, Law M, Maher L, et al., loc. cit.

<sup>274</sup> Pinkham S, Stone K. A Global Review of the Harm Reduction Response to Amphetamines: A 2015 Update. London: Harm Reduction International; 2015. p. 10. [accessed 2018 Nov 7] Available from: [https://www.hri.global/files/2015/10/18/AmphetaminesReport\\_Oct2015\\_web.pdf](https://www.hri.global/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf)

<sup>275</sup> Department of Health, 2018, Department of Health, Perth, [accessed 2018 Nov 7] [http://healthywa.wa.gov.au/Articles/U\\_Z/Where-to-find-needle-and-syringe-programs-in-WA](http://healthywa.wa.gov.au/Articles/U_Z/Where-to-find-needle-and-syringe-programs-in-WA)

hospitals and health services, or on a fee-for-service basis through vending machines and local pharmacies.

The Taskforce considers that these limited options may have unintended consequences for injecting drug users located in regional and remote communities, particularly Aboriginal people.

A previous Western Australian study indicated Aboriginal people may not patronise pharmacy-based needle and syringe programs because of limited opening hours and locations, privacy concerns and a fear of encountering negative staff attitudes.

Concern regarding vending machines is also a factor, stemming primarily from the risk of the machine not functioning or being empty, as opposed to cost.<sup>276</sup> Further work to understand how culturally appropriate current needle and syringe program service models are for Aboriginal people, particularly in regional areas, is required.

Although injecting drug use is less prevalent in Aboriginal communities, research indicates there is a higher incidence of unsafe injecting practices and higher rates of HIV among this group.<sup>277</sup>

#### **7.2.2.2 Service model of need and syringe programs**

The Taskforce noted findings which indicate the general set up of an alcohol and other drug service can determine its attractiveness to the consumer, indicating that users may be looking for more than just injecting equipment when accessing needle and syringe programs.<sup>278</sup> Although needle and syringe programs have their roots in blood-borne virus prevention (e.g. HIV and Hepatitis C), these services have evolved over time to include much broader harm reduction education and outreach, as they represent an opportunity for brief interventions with people currently injecting drugs.

Needle and syringe program service providers in Western Australia have themselves identified the value of providing more than just clean needles and syringes to people using drugs. They have also suggested a number of opportunities for ways in which their services could deliver greater impact, as part of the Department of Health's annual service provider review, including:

- maintaining training of coordinators and other needle and syringe program staff, including increasing use of video conferencing;
- on-site needle and syringe program development including more access hours, additional equipment, better needle and syringe vending machine maintenance, and installing additional needle and syringe vending machines and sharps disposal bins;
- increased development of, and access to, educational materials on harm reduction, needle and syringe program services, and support groups;

<sup>276</sup> Lilley G, Mak DB, Fredericks T. Needle and syringe distribution trends in Western Australia, 1990 to 2009. *Drug and Alcohol Review*. 2013; 32(3); 320-7.

<sup>277</sup> Stone K. *The Global State of Harm Reduction 2016*. London: Harm Reduction International; 2016. p. 114. [accessed 2018 Nov 7] Available from:

[https://www.hri.global/files/2016/11/14/GSHR2016\\_14nov.pdf](https://www.hri.global/files/2016/11/14/GSHR2016_14nov.pdf)

<sup>278</sup> Lilley G, Mak DB, Fredericks T., loc. cit.

- increasing awareness of the program to staff members and the general community.<sup>279</sup>

### Taskforce conclusions and recommendations

Lack of awareness and accessibility of needle and syringe programs were consistent themes which emerged through the Taskforce's consultations, suggesting that although these programs are well established in WA, there is an opportunity to improve particularly in regional areas.

In addition to providing improved service delivery for regional users, it may be that a more culturally appropriate service model is required for Aboriginal people. Further discussions with Aboriginal communities will be required to determine this.

#### Recommendation 26:

The Department of Health promotes greater awareness of needle syringe programs and needle syringe exchange programs in Western Australia to people who need these services.

#### Recommendation 27:

The Department of Health in consultation with Aboriginal Community Controlled Health Services and the WA Country Health Service to implement strategies to:

- provide a more culturally appropriate service for Aboriginal people delivered by Aboriginal people; and
- improve access to and the availability of needle syringe exchange programs particularly in regional areas.

#### Recommendation 28:

Department of Health to examine opportunities for needle syringe programs providers to expand their role beyond supplying clean needles and syringes to consumers of their services to include other harm reduction strategies including brief interventions.

### 7.2.3 Good practice approaches including peer support

Evidence supports the effectiveness of behavioural/cognitive interventions such as Cognitive Behavioural Therapy<sup>280</sup> and motivational interviewing<sup>281</sup> as effective ways of reducing harm. These interventions are outlined in greater detail in Chapter 6 on treatment and support. Good practice approaches and models of care for reducing harm to people who use amphetamines follow these principles:

- meet people who use amphetamines 'where they are';
- give people who use amphetamines information, means and opportunities for behaviour change to improve their health;

---

<sup>279</sup> Government of Western Australia. Department of Health. Communicable Disease Control Directorate. Needle and Syringe Program Annual Report 2015-16: Western Australia 1 July 2015- 30 June 2016. Perth: The Department; 2016. p 8. [accessed 2018 Nov 7] Available from: [http://ww2.health.wa.gov.au/~/\\_/media/Files/Corporate/general%20documents/Sexual%20Health/PDF/NSP%20Annual%20Report%202015-16.pdf](http://ww2.health.wa.gov.au/~/_/media/Files/Corporate/general%20documents/Sexual%20Health/PDF/NSP%20Annual%20Report%202015-16.pdf)

<sup>280</sup> Cognitive behaviour therapy is a type of psychotherapy that helps the person to change unhelpful or unhealthy habits of thinking, feeling and behaving.

<sup>281</sup> Motivational interviewing is a counselling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behaviour.



- organise harm reduction around their needs rather than imposing external demands;
- provide safer injecting supplies;
- provide mobile outreach services and workers to access people who are unwilling or unable to attend a harm reduction site;
- engage people with lived experience of drug use as staff members, volunteers and advisors; and
- connect people using amphetamines to other needed services such as cognitive behavioural therapy and motivational interviewing.<sup>282</sup>

The effectiveness of engaging people with lived experience of drug use (i.e. peer support workers) to support other people using drugs, to reduce drug-related harms, is well-established particularly with regard to supporting people injecting drugs.<sup>283 284</sup> Research indicates that while the social networks of people using drugs can function as generators of harm, networks which share health and social care information and build social support can function to oppose the risks of drug-related harm.<sup>285</sup> Meeting people who use methamphetamine 'where they are' through outreach-based service models in tandem with peer support workers is also considered good practice,<sup>286</sup> noting that peer support workers are uniquely positioned to help to reduce the demonisation and stigma that people who use drugs often experience, and which stops them from seeking help.<sup>287</sup>

### **7.2.3.1 Practical approaches to harm reduction**

Research shows there are many practical approaches that friends and family, service providers and police can take to help reduce methamphetamine-related harm. These include simple things like encouraging people who use drugs to eat balanced meals regularly and drink plenty of water, brush their teeth, plan for breaks from the drug to avoid 'binge use' and take rest periods in darkened rooms. The provision of clean injecting and smoking equipment, as well as condoms and lubricant, can also help to reduce harms that arise from methamphetamine use and associated risk-taking behaviours.

### **7.2.3.2 Alternative approaches**

Community consultations suggested supervised injecting facilities as an opportunity to better support harm reduction measures in Western Australia. Two exist in Australia: one was established in Kings Cross, Sydney in 2001; a second facility is currently being trialled in Melbourne having opened earlier this year. A review of the literature on the success of such facilities is mixed. Despite evidence the Kings Cross facility has been effective in reducing harm for people using drugs and

<sup>282</sup> Pinkham S, Stone K. A Global Review of the Harm Reduction Response to Amphetamines: A 2015 Update. London: Harm Reduction International; 2015. p. 10. [accessed 2018 Nov 7] Available from: [https://www.hri.global/files/2015/10/18/AmphetaminesReport\\_Oct2015\\_web.pdf](https://www.hri.global/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf)

<sup>283</sup> Jozaghi E, Lampkin H, Andresen MA. Peer-engagement and its role in reducing risky behaviour among crack and methamphetamine smokers of the Downtown Eastside community of Vancouver, Canada. Harm Reduct J. 2016; 13(1); 19.

<sup>284</sup> Allman D, Myers T, Schellenberg J, Strike C, Cockerill R, Cabvalieri W. Peer networking for the reduction of drug-related harm. Int J Drug Policy. 2006; 17 (5); 402-410.

<sup>285</sup> Ibid.

<sup>286</sup> Ibid.

<sup>287</sup> Ibid.

lessening the impact of public drug use on the local community,<sup>288,289</sup> research also indicates supervised injecting facilities are only warranted in cities where there is presently a well-established street-based “open drug scene”<sup>290</sup> and their success depends heavily on support from the local community.

Another alternative harm reduction strategy recently recommended in Victoria was the implementation of pill testing facilities at public events such as music festivals. This strategy was trialled for the first time in Australia in April this year, by the Australian Capital Territory Government, at the *Groovin’ the Moo* music festival in Canberra with some success. News reports at the time show a mix of drugs was found among substances voluntarily handed in, including ecstasy, cocaine, ketamine and the highly toxic drug N-Ethylpentylone or ephylone.<sup>291</sup>

Decriminalising drugs, specifically small quantities for personal use, is also considered a harm reduction strategy intended to: reduce the stigma of drug use; reduce the social costs of a criminal conviction or custodial sentence to individuals, their families and communities; reduce the economic costs to society associated with applying criminal law to personal drug use; and free up police and court resources to deal with more serious offences.<sup>292</sup>

### **7.2.3.3 What’s happening in Western Australia**

A number of service providers in Western Australia use peer-based approaches to service delivery and models of care to varying degrees and in different capacities.

The Western Australian Government, through the Mental Health Commission, funds the *Methamphetamine Peer Education Project*. The project is delivered by the Western Australian Aids Council and uses peer educators to provide health and harm reduction information to amphetamine users, or people at risk of using amphetamines through opportunistic brief interventions.

Peer Based Harm Reduction Western Australia (formerly known as the WA Substance Users’ Association) is staffed by people who have lived experience with drug use, utilising a peer-based approach to supporting people who use methamphetamine and other drugs in Western Australia. In addition to delivering a needle and syringe program, Peer Based Harm Reduction WA offers free Hepatitis C treatment, free vaccinations for Hepatitis A and B, free sexual health and blood-borne virus testing, harm reduction information and education (including responding to amphetamine induced psychosis) and advocacy services.

---

<sup>288</sup> van Beek I. The Sydney Medically Supervised Injecting Facility: A Clinical Model. *J Drug Iss Summer*. 2003; 33(3); 625- 638.

<sup>289</sup> Ibid.

<sup>290</sup> Green T, Hankins C, Palmer D, Boivin JF, Platt R. Ascertaining the Need for a Supervised Injecting Facility: The Burden of Public Injecting in Montreal, Canada. *J Drug Iss*. 2003;33(3); 713-731.

<sup>291</sup> Healy J, Sibthorpe C. Groovin the Moo pill test finds lethal stimulant, paint and toothpaste in drugs. ABC online; 2018 April 30. [accessed 2018 Nov 7] Available from: <http://www.abc.net.au/news/2018-04-30/groovin-the-moo-pill-testing-finds-lethal-product/9710112>

<sup>292</sup> Rolles S, Eastwood N. (2009). Drug Decriminalisation Policies in Practice: A Global Summary (2009) pp.157-165

### Holyoake Clinical Specialist Team

Holyoake established its Clinical Specialist Team project in Northam in early 2017, to address methamphetamine use. Initially funded to June 2018 by the WA Primary Health Network (Country), the pilot provided:

- a comprehensive service mix encompassing clinical case management, counselling, medical and peer support;
- a holistic focus including mental and physical health;
- support for individuals and their families, recognising that families are key to the change process;
- longer support timeframe to cover any periods of lapse and relapse;
- assertive follow-up to help keep people engaged; and
- case management to mobilise other services when needed.

The Clinical Specialist Team comprises a range of practitioners including a Senior Clinical Case Coordinator, General Practitioner, Clinical Nurse, Peer and Family Support Workers, working together to deliver the service model.

Service delivery has been carefully structured to avoid duplication with Holyoake's role as the Wheatbelt Community Alcohol and Drug Service. Rather, the Team aims to provide added value to that service.

Operating from a central location, the Clinical Specialist Team receives referrals from a variety of agencies and, increasingly, self-referred clients as it becomes known in the community. Some participants have identified the service location as a safe place where they can seek respite from negative influences. Because it is located in the community, participants are able to maintain contact with friends and family, keep their accommodation, and attend the service on a needs basis.

The value of the Peer and Family Support Workers is becoming increasingly apparent as a significant component of the success of the overall program, with assertive follow-up, providing support and resources to families, and acting as conduit to counsellors contributing to experienced recovery.

The initiative will be independently evaluated by the Curtin University's National Drug Research Institute (NDRI). Funding by the WA Primary Health Network has been extended to include people with other drug and alcohol issues in the treatment program.

'Ice Breakers' is a 12-week non-residential program run by Police & Community Youth Centres in Bunbury and Albany, that focuses on rehabilitating and supporting people who currently use methamphetamine and those who are recovering from it. In 2017, the Western Australian Government provided \$360,000 to support a two-year trial of the program in Albany. Ice Breakers uses the Self-Management and Recovery Training (SMART) program developed by psychologist Margaret Gordon, focussing on education and cognitive behavioural therapy, and facilitated by trained volunteers with lived experience of methamphetamine use. The SMART program is considered in further detail in Chapter 6 on treatment and support.

A number of peer support groups for people struggling with dependence and their friends and family, operate across Western Australia. Some examples include the Breakaway Aboriginal Corporation's Busselton peer support group for women, Cyrenian House's Family Matters group, and the Fresh Start Recovery Program for people in recovery.

### **Taskforce conclusions and recommendations**

The merit of peer-based approaches in harm reduction is well-established in the literature. The Taskforce considers the role of peer-support based approaches to be an opportunity to connect people using methamphetamine to other services which may help them access treatment and recovery from use in the longer term.

Further, the Taskforce has formed the view that peer-based approaches to reducing harm for people who use methamphetamine represents an under-utilised opportunity to improve health and well-being, avoid the acute tertiary health care impacts of methamphetamine use, and support longer-term help seeking behaviour.

With regard to community suggestions regarding safe injecting centres, after considering all of the available evidence the Taskforce is of the view that as Western Australia does not have a geographically localised drug-injecting culture among users, consideration of a safe injecting site is not currently warranted as a harm reduction priority.

#### **7.2.4 Emergency care interventions**

"It's very hard when its drug related. It's not always a criminal issue, so the police are unable to help. They can only put a three-day order on someone, which makes things a lot worse when the person being removed from their home is affected by meth. And it's not what the 'victim'/family wants either. I called the police numerous times for my partner because I wanted them to put him somewhere safe as he was experiencing psychosis. I wasn't getting beaten up or anything – I was scared FOR him, not OF him. Removing him from his home for three days at a time like that is devastating, not helpful. It got to the point where he was hospitalised involuntarily and then put in a mental hospital twice. There was no 'in between' service for help."

*Online Comment*

The Taskforce heard from families, friends and other support people that they are often the first responders for people who use drugs and are in crisis, particularly when they are experiencing methamphetamine-induced psychosis and/or self-harming behaviours.

Families, friends and other support people strongly indicated that in these circumstances they did not want to call police or an ambulance, or admit their loved one to a psychiatric ward involuntarily.

##### **7.2.4.1 What's happening in Western Australia**

The Western Australian Government provides funding through the Mental Health Commission for sobering up centres, which aim to provide a safe environment for people found intoxicated in public to sober up. A person being cared for in a sobering up centre can expect: access to bathroom facilities, a shower, bed, clean clothes, and a simple nutritious meal; non-discriminatory and non-judgemental care; and

referral to other agencies and services if required. Bridge House is the only sobering up centre located in the metropolitan area. Regional sobering up centres are located in Kalgoorlie, Port Hedland, Carnarvon, Derby, Broome, Wyndham, Kununurra and Roebourne. Sobering up centres are primarily patronised by Aboriginal people, particularly in regional areas. However, these centres are often unable to accommodate methamphetamine users in crisis due to the aggressive and violent behaviours they may exhibit.

Hospitals have also begun to establish services that better treat the needs of patients presenting in emergency departments with issues that might relate to mental health concerns or intoxication, including those affected by methamphetamine. For example, a Mental Health Observation Area at Joondalup Health Campus was opened in February 2018, catering for people presenting with psychiatric disorders by providing a specialised service in a more clinically appropriate and secure environment. However, the Western Australian Department of Health does not believe these areas are appropriate places to accommodate methamphetamine users who are in psychosis.

The Taskforce notes that the Western Australia Police Force has recently invested in improving its emergency response to people experiencing a mental health crisis and supports the ongoing use of mobile response teams, which include police officers and an authorised mental health clinician, to respond to serious mental health crises.

### **Western Australia Police Force Mental Health Co-Response Commissioning Trial**

In January 2016, the Western Australia Police Force implemented the Mental Health Co-Response Commissioning Trial in the metropolitan area in response to the growing demand for police to attend incidents involving mental health issues. The trial was developed in consultation with Western Australia Police Force, the Department of Health and the Mental Health Commission, and incorporates the following elements:

- a holistic approach to police response to, and management of, individuals experiencing a mental health crisis;
- incorporating mental health expertise at each stage of police response to crisis situations: at the point of dispatch, at the point of physical contact at the scene and post-arrest within the custody setting;
- a mental health clinician at the Police Operations Centre to triage calls for assistance when related to a mental health crisis;
- a mental health clinician at the Perth Watch House to facilitate early access to clinical assessment and interventions for detainees;
- a mobile response team, including police officers and an authorised mental health clinician, available to respond to the most serious mental health crisis in the community in a timely manner; and
- mental health training – to provide police with additional tools to assess and manage incidents that avoids escalation and minimises harm.

The trial operated Monday to Saturday from 2pm – 10pm.

A 2018 evaluation of the trial found: “Overall, the evaluation demonstrated the value of the Mental Health Co-Response model implemented by the W[estern] A[ustralia]



Police Force. Findings showed benefits in terms of resource allocation, the safety and well-being of officers and consumers, and integrated inter-agency collaboration at each stage of the model.”<sup>293</sup> The study recommended continuing and expanding the model<sup>294</sup>.

The service will continue through 2018-19 with a joint agency business case currently being prepared.

Hospital emergency department presentations are recognised as a critical point of care and intervention. Management of alcohol and other drug issues in the emergency department setting involves accurate assessment and the provision of a safe environment and careful monitoring. Alcohol and other drug clinical nurse liaison services provide specialist assessment, advice and recommendations regarding the management of patients with significant alcohol and other drug-related issues under the care of the emergency department team. Key services provided to individuals and families include:

- undertaking assessments of referred patients in emergency department settings with alcohol and other drug presentations;
- providing brief clinical interventions for referred alcohol and other drug patients in emergency department settings;
- participating in care coordination activities across treatment providers;
- providing advice regarding the ongoing treatment and intervention options for referred alcohol and other drug patients;
- identifying patients’ goals or expectations regarding their substance use and treatment;
- supporting discharge planning (including referral to relevant alcohol and other drug, medical and social services);
- offering support, advice and guidance to carers and family members of alcohol and other drug patients;
- participating in workforce development activities, including training and mentoring of general hospital staff; and
- contribution to development and review of hospital policy and procedure in the management of individuals with alcohol and other drug-related health and mental health issues.<sup>295</sup>

These services were provided at Joondalup Health Campus (1.0 Full-Time Equivalent [FTE] position), Peel Health Campus (1.0 FTE), Royal Perth Hospital (1.0 FTE), Bentley Hospital (1.0 FTE), St John of God Bunbury (1.4 FTE), and Rockingham General Hospital (1.0 FTE). Funding has also enabled Next Step Clinic to provide additional Clinical Nurse Liaison support at Royal Perth Hospital and specialist medical services at the Alma Street Clinic (0.4 FTE). Western Australian Government funding for this initiative ceased on 30 June 2018.

The Western Australian Health Royal Perth Bentley Group introduced the RAPID alcohol and other drug and mental health program to facilitate the provision of an alcohol and other drug service to patients at Royal Perth Hospital. The RAPID team

---

<sup>293</sup> Henry, Pamela and Nikki Rajakaruna. WA Police Force Mental Health Co-Response Evaluation Report. Edith Cowan University, Australia. 2018

<sup>294</sup> Ibid.

<sup>295</sup> Information provided by the Mental Health Commission.



provides alcohol and other drug contact numbers and assistance to access clinical pathways through other alcohol and other drug services.

In May 2018, the Urgent Care Clinic (Toxicology) opened at Royal Perth Hospital. The clinic is located within the emergency department and provides six specialised treatment spaces for people with behavioural disturbances, usually caused by drugs and alcohol.<sup>296</sup> Between 22 May 2018 and 8 July 2018, a total 209 patients attended the clinic. Attendance includes patients overflow from the Emergency Medical Ward.<sup>297</sup>

### **Methamphetamine Action Plan Initiative #3 - Mental Health Observation Area at Royal Perth Hospital**

As part of the *Methamphetamine Action Plan*, the Western Australian Government committed to introduce a Mental Health Observation area in Royal Perth Hospital's emergency department for people who require assistance and close supervision for up to 72 hours.

Mental Health Observation Areas provide an alternative and more appropriate clinical response to people experiencing psychiatric distress, including methamphetamine induced psychosis, as emergency departments are often not appropriate for managing mentally ill or intoxicated patients.

In February 2018, the Western Australian Government announced the opening of a \$7.1 million Mental Health Observation Area at Joondalup Health Campus as a joint initiative with privately owned Ramsay Health Care. As part of the 2018-19 State Budget, \$11.8 million has been allocated to establish a Mental Health Observation Area Plus Unit at Royal Perth Hospital to support inner city mental health needs. An acute psychiatric unit and a mental health short stay unit are also planned as part of the Geraldton Health Campus stage 1 redevelopment.

Graylands Hospital, the State-run specialist psychiatric hospital, will assess and treat patients who have methamphetamine-induced psychotic disorders.

The Taskforce heard from families and other support people that in some circumstances Police Orders, which are used in certain family and domestic violence incidents to provide for temporary (up to 72 hours) protection, care and safety for victims, are being used to respond to people who use methamphetamine and are in crisis. Families with experience of the use of Police Orders in these circumstances explained that without a safe place for their family member or loved one to be removed to, this was not necessarily a helpful response. Police Orders are designed and used to protect families as victims in the context of family and domestic violence incidents rather than, in this instance, make users of methamphetamine safe. This often puts the person affected by methamphetamine in a position of being unable to

<sup>296</sup> Government of Western Australia. Media Statement: Urgent Care Clinic opens at Royal Perth Hospital. 2018 May 22. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/05/Urgent-Care-Clinic-opens-at-Royal-Perth-Hospital.aspx>

<sup>297</sup> Government of Western Australia. WA Health Urgent Care Clinic (Toxicology). Unpublished data. 2018.

return home for up to 72 hours, causing significant distress for families who fear for the well-being of a loved one in crisis.

### **Taskforce conclusions and recommendations**

Families and loved ones of people severely affected by methamphetamine use did not want to contact police or other emergency services when they were in crisis, but were often left with no alternative. Instead, families have called for the development of an alternative option where their family member or loved one could be safely cared for on a short-term basis, to ensure their safety, the safety of their families and the community.

The Taskforce understands concerns regarding the present options (police detention, or admission to emergency department or a psychiatric facility) can result from fear these responses won't adequately meet someone's needs, as well as a fear of prosecution as a result of police intervention.

The Taskforce examined the current range of emergency care interventions to determine whether they were capable of delivering, or being modified to deliver, the kind of short-term crisis intervention that families are seeking. Agencies with responsibility for the services outlined above, each commented that their respective services were not designed to provide the kind of crisis response families were looking for.

This was the one issue that was consistently raised in each and every forum held with consumers and their families, as well as through online comments. The Taskforce has formed the view that more work is needed to consider innovative solutions to the problem identified.

#### **Recommendation 29:**

Within 12 months, the Mental Health Commission, Western Australia Police Force and Department of Health establish an appropriate alternative crisis intervention response that would provide a short-term place for methamphetamine users when they are in crisis that will keep them, their families and the community safe, including in the regions.

## Chapter 8 Regional communities

*The Australian Statistical Geography Standard divides Australia into five classes of remoteness based on relative access to services – major cities, inner regional, outer regional, remote and very remote.<sup>298</sup> For the purpose of this report, regional refers to inner regional, outer regional, remote and very remote areas, including regional cities. When remote is specified, remote refers to both remote and very remote.*

*The Taskforce notes there are other important definitions of regional Western Australia including that defined by the Regional Development Commissions Act 1993. The Taskforce also acknowledges Western Australia covers an area about one third of Australia's total land mass<sup>299</sup> and the challenges of delivering services across this area should not be underestimated.*

"The long wait times in rural areas due to satellite services makes the problem worse. If a person is ready to get help NOW you need to move with them NOW. In a month's time is no good, they are not in that space anymore."

Online Comment

"There are very long waitlists for services in regional areas."

"We want services that make connections. It is all about making contact and offering help."

Service Providers Forum

"There has been a lot said, but services are still scarce and regions are left out."

"Very little [by way of services] as it's a small country town. There is a drug service 50 kms away who send a counsellor over sometimes but recovery is not just about counselling... and if rehab is needed the wait list is SO long, it's almost an insurmountable barrier."

Online comments

### 8.1 What the Taskforce heard

The Taskforce met with communities in Broome, Port Hedland, Karratha, Exmouth, Geraldton, Kalgoorlie, Northam, Bunbury and Albany. The Taskforce also received online responses from people living in regional Western Australia. Of the 146 online respondents, 64 per cent were from regional areas.

Across its regional consultations, the Taskforce repeatedly heard the concerns of people living in regional Western Australia about impact of methamphetamine use on their families and friends, and on their communities.

The Taskforce spoke to many people who felt strongly that the high use of methamphetamine in regional Western Australia was due to social isolation,

<sup>298</sup> Australian Bureau of Statistics. Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2016. Canberra: ABS; 2018. [accessed 2018 Nov 7] Available from: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/1270.0.55.005>

<sup>299</sup> Australian Government. Geoscience Australia. [accessed 2018 Nov 7] Available from: <http://www.ga.gov.au/scientific-topics/national-location-information/dimensions/area-of-australia-states-and-territories>

boredom and limited social and employment options in regional communities. This concern was voiced particularly in relation to young people in regional communities. The Taskforce was moved by the significant efforts being made by individuals and groups at all levels to deal with the impact of methamphetamine use on their local community.

The Taskforce heard there were significant challenges for people living in regional Western Australia trying to tackle the effects of methamphetamine use.

Firstly, people in the regions were reluctant to seek advice for themselves, families or friends because they felt they weren't able to do so without the stigma and judgement of the local community. For people seeking treatment, some felt leaving their community was the only way to stop using, because they needed to leave both the environment and the people associated with their drug use behind. Others saw the ability to stay in their local community while receiving assistance and treatment as the best way to receive help. Individuals could be supported by family and friends, and would be (depending on the form of treatment) able to remain in their own accommodation and their employment.

*"I don't want to have to leave and go to Perth for help."*

*Consumer and Family Members Forum*

Secondly, overwhelmingly the Taskforce heard current services in regional Western Australia were not able to address the issues associated with methamphetamine use because they were not available or accessible to people when they needed them most. Concerns raised included:

- distances impacted access to services, particularly limiting options for early intervention and follow-up post treatment;
- long waiting lists for treatment;
- the transient nature of health care workforce and high turnover of staff made it difficult for people using services to develop and maintain relationships with service providers;
- health care staff posted to the regions were inexperienced and ill-equipped to deal with the often complex needs of individuals;
- regional hospitals were unable to provide specialist alcohol and other drug services as frontline staff were often not trained in these issues; and
- lack of local community involvement in service planning and commissioning.

Finally, the Taskforce also heard from people who believed there wasn't enough funding to provide enough services to deal with the magnitude of methamphetamine use in regional communities. For example, people in the Mid West told the Taskforce they believed their close proximity to Perth resulted in less funding and fewer services. People in the South West told the Taskforce that although funding there had increased, it did not take into account the wide distribution of the population across many small towns.

## 8.2 The extent of methamphetamine use in the regions

Results of the National Wastewater Drug Monitoring Program<sup>300</sup> from March 2018 showed significantly higher levels of methamphetamine in wastewater in regional areas of Western Australia, than in the regions of another any other Australian state or territory. It indicated the rate of consumption for methamphetamine in regional Western Australia was higher than anywhere else in Australia, except for metropolitan Adelaide.<sup>301</sup>

Consistent with the National Wastewater Drug Monitoring Program results, the National Drug Strategy Household Survey 2016 reported that across Australia, “people in remote and very remote areas were 2.5 times as likely to use meth/amphetamines as those in major cities”<sup>302</sup> and that people using the crystal/ice form of methamphetamine were more likely to live in outer regional, remote and very remote areas (22 per cent compared with 6.4 per cent).<sup>303</sup> A 2017 study of methamphetamine-related deaths found that nearly half occurred in rural and regional locations,<sup>304</sup> considerably higher than the percentage of the Australian population which resided outside the major capital cities.<sup>305</sup>

A 2017 study on the prevalence and patterns of methamphetamine use in rural Australia concluded:

- “there has been a disproportionately larger increase in methamphetamine, including crystal methamphetamine, use in rural [outer regional, remote and very remote] locations compared with other Australian locations;”<sup>306</sup> and
- “among rural 18 to 24-year-olds, life-time prevalence of methamphetamine use was significantly higher than for those in cities or Australia overall.”<sup>307</sup>

The Taskforce was unable to source a body of substantive literature specifically questioning why consumption of methamphetamine is so high in regional Western Australia. The literature suggests reasons for methamphetamine use generally being higher in regional and remote areas, compared to major cities, could be attributed to the additional health and social vulnerabilities faced by regional and remote

<sup>300</sup> Wastewater analysis is now a standard method for measuring population-scale use of a range of different chemical compounds, in particular selected substances of concern in most populated regions of Australia. In August 2017, a total of 22 wastewater treatment plants in capital cities and a further 32 regional sites participated in the project, covering a population of 14 million Australians. Australian Government. Australian Criminal Intelligence Commission (ACIC). Illicit Drug Data Report 2015-16. Canberra: ACIC; 2017.

<sup>301</sup> Australian Government. Commonwealth of Australia. Australian Criminal Intelligence Commission (ACIC). National Wastewater Drug Monitoring Program Report: Report 4. Canberra: ACIC; 2018. p.34. Available from: <https://acic.govcms.gov.au/sites/g/files/net3726/f/nwdmp4.pdf?v=1522809564>

<sup>302</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. p 96. [accessed 2018 Nov 7] [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

<sup>303</sup> Ibid.

<sup>304</sup> Darke S, Kaye S, Duflou J. Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study. *Addiction*. 2017; 1012(12); 2192-2201.

<sup>305</sup> Australian Bureau of Statistics. Australian Demographic Statistics, 3101.0. Canberra: Australian Bureau of Statistics; 2016.

<sup>306</sup> Roche A, McEntee A. Ice and the outback: Patterns and prevalence of methamphetamine use in rural Australia. *Aust J Rural Health*. 2017; 25(4); 200-209.

<sup>307</sup> Ibid.

communities, such as poorer health outcomes, lower incomes and levels of education, unemployment, social isolation and limited access to health services.<sup>308</sup>

Research shows people living in regional areas tend to experience poorer health and welfare outcomes than people living in major cities; and that access to health services is limited.<sup>309</sup> This is further exacerbated for people living in remote and very remote areas.<sup>310</sup>

Difficulty accessing health services is likely to impact people seeking methamphetamine treatment in outer regional and remote areas. Although methamphetamine use in these areas has increased, a recent study found that “services reported a smaller proportion of episodes of care for methamphetamine compared with services in cities and regions. This may reflect limited access to treatment facilities, lack of relevant expertise or greater concern with other drugs in rural locations.”<sup>311</sup>

### Taskforce conclusions and recommendations

It is clear to the Taskforce that regional communities are particularly vulnerable to the impacts of methamphetamine use. Based on wastewater analysis and other data, and what the Taskforce heard, regional Western Australia is significantly impacted by methamphetamine use.

What is unclear is exactly why the use of methamphetamine in regional Western Australia is the highest in the country. Without a clear understanding of the specific nature of the problem of methamphetamine use in regional Western Australia, the most effective solutions to appropriately address the problem will not be found. The Taskforce concludes more research to better understand the problem is required.

## 8.3 Service delivery in the regions

Chapter 6 on providing treatment and related support services for those seeking help, provides information on treatment services in both metropolitan and regional areas. Additional information is provided below on regional *Methamphetamine Action Plan* initiatives, the WA Country Health Service, regional Community Alcohol and Drug Services (CADS) and examples of community-based organisation initiatives.

---

<sup>308</sup> National Rural Health Alliance Inc. Fact Sheet 33 -June 2015: Illicit Drug Use in Rural Australia. Deakin: National Rural Health Alliance; 2015. [accessed 2018 Nov 7] Available from: <http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-illicit-drugs-0615.pdf>

<sup>309</sup> Australian Government. Australian Institute of Health and Welfare. Rural and Remote Australia. Canberra: AIHW; 2017. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/reports-statistics/population-groups/rural-remote-australians/overview>

<sup>310</sup> Australian Government. Australian Institute of Health and Welfare. Survey of Health Care: selected findings for rural and remote Australians (cat no. PHE 220). Canberra: AIHW; 2018. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/reports/rural-remote-australians/survey-health-care-selected-findings-rural-remote/contents/summary>

<sup>311</sup> Roche A, McEntee A. Ice and the outback: Patterns and prevalence of methamphetamine use in rural Australia. Aust J Rural Health. 2017; 25(4); 200-209.



## **Methamphetamine Action Plan Initiative #2 – Expand specialist drug services into rural and regional areas and open two specialised rehabilitation centres in the South West and Kimberley**

As part of the *Methamphetamine Action Plan*, the Western Australian Government committed \$18 million (2017-18 State Budget) to establish an alcohol and other drug residential rehabilitation centre in the South West. \$200,000 was also allocated to commence planning for alcohol and other drug services in the Kimberley.

\$9.3 million has been allocated in the 2018-19 Budget to contract services that will allow 33 residential rehabilitation and low medical withdrawal beds to become operational in the South West by January 2019.

### **8.3.1 WA Country Health Service**

The WA Country Health Service provides a network of public hospitals, health services and nursing posts across regional Western Australia and is funded to provide drug and alcohol services.

Under its current strategic plan, The WA Country Health Service prioritises “developing mental health and general staff expertise to help people who experience both mental health issues and alcohol and/or drug issues, [and] foster[ing] more collaboration and integration between alcohol and drug services and mental health services.”<sup>312</sup>

WA Country Health Service acute psychiatric units are currently provided in Bunbury, Albany, Kalgoorlie and Broome and provide treatment for people with drug-induced psychosis. The Western Australian Government has committed to expanding Geraldton Hospital to include an acute psychiatric unit and mental health short stay unit.<sup>313</sup>

Detox/withdrawal services are provided in some regional hospitals subject to bed availability. The system-wide Alcohol and Other Drug Withdrawal Management Policy is currently not implemented in all regional hospitals.

### **8.3.2 Community Alcohol and Drug Services**

Community Alcohol and Drug Services operate in each of the seven regions in Western Australia and depending on the region, are delivered by the WA Country Health Service or by a non-government organisation. These services are free and confidential, providing individuals and their families with alcohol and other drug treatment and support services in the community. Community Alcohol and Drug Services have offices in major regional towns and provide outreach services to other towns and outlying communities. A summary of regional Community Alcohol and Drug Services service areas, office locations and outreach services is provided in

<sup>312</sup> Government of Western Australia. WA Country Health Service. WACHS Strategic Directions 2015–2018: Healthier Country Communities through Partnerships and Innovation. Perth: WACHS; 2015. p 11. [accessed 2018 Nov 7] Available from: [http://www.wacountry.health.wa.gov.au/fileadmin/sections/purpose\\_and\\_strategy/Documents/Strategic\\_Plan\\_3\\_August.pdf](http://www.wacountry.health.wa.gov.au/fileadmin/sections/purpose_and_strategy/Documents/Strategic_Plan_3_August.pdf)

<sup>313</sup> Government of Western Australia. Media Statement: State budget delivers expanded services at Geraldton Hospital. 2018 May 10. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/05/State-Budget-delivers-expanded-services-at-Geraldton-Hospital.aspx>

Table 2. The Taskforce sought information on the volume of clients receiving services from Community Alcohol and Drug Services in each of the regions, however this information was not available. Data is represented as treatment episodes reported annually on a State and Territory basis by the Australian Institute of Health and Welfare.

**Table 2: Regional Community Alcohol and Drug Services**

Regional Community Alcohol and Drug Services <sup>314</sup>		
Service and provider	Hubs	Outreach Services
Kimberley Community Alcohol and Drug Services (WA Country Health Service)	Derby, Kununurra, Halls Creek, Fitzroy Crossing	Various outlying communities including Warmun and Wyndham
Pilbara Community Alcohol and Drug Services (Mission Australia)	Karratha, Newman, Roebourne, Tom Price, Port Hedland	Various outlying communities
Midwest Community Alcohol and Drug Services (WA Country Health Service)	Geraldton, Carnarvon, Meekatharra	Fortnightly service to: Kalbarri, Dongara, Northampton, Mullewa, Morawa, Three Springs, Eneabba Monthly service to: Yalgoo, Cue, Mt Magnet, Meekatharra, Wiluna Regular outreach to: Kalbarri, Mt Magnet, Wiluna, Mullewa, Exmouth
Wheatbelt Community Alcohol and Drug Services (Holyoake)	Northam, Narrogin, Merredin	Wyalkatchem, Gin Gin, Goomalling, Beverley
Goldfields Community Alcohol and Drug Services (Hope Community Services)	Kalgoorlie, Esperance, Leonora	Various outlying communities including regular outreach to Laverton
South West Community Alcohol and Drug Services (St John of God)	Bunbury	Weekly service to: Manjimup, Bridgetown, Collie, Margaret River Fortnightly service to: Busselton, Harvey
Great Southern Community Alcohol and Drug Services (Palmerston)	Albany, Katanning	Kojonup, Gnowangerup, Denmark, Mt Barker

<sup>314</sup> Government of Western Australia, Community Alcohol and Drug Services. 2018. [accessed 2018 Nov 7] <https://www.mhc.wa.gov.au/getting-help/community-alcohol-and-drug-services>. and information provided by the Mental Health Commission.

### 8.3.3 Community-based organisations

There is a broad range of non-government and community-based organisations providing services in and to regional communities. These organisations are predominantly based in regional town centres. They are funded through a variety of sources to deliver services ranging from prevention, education, alcohol and other drug counselling, support services (including peer support services), low medical withdrawal and residential rehabilitation.

Some support services available in regional Western Australia have developed through a community response to an identified local issue. An example is 'Doors Wide Open' in Bunbury, established by two local mothers affected by their children's methamphetamine use.<sup>315</sup> Recently the recipient of a \$100,000 Western Australian Government grant, the volunteer-run program provides access to a variety of services and resources to help people recover from dependence. The program works to strengthen support networks for individuals and give them the opportunity to learn new skills. The premises provide a 'safe space' for people recovering from dependence and for family members and friends seeking help and support.

### 8.3.4 National Ice Action Strategy and the WA Primary Health Alliance

Under the *National Ice Action Strategy*, \$241.5 million in funding was provided to Primary Health Networks to "commission further drug and alcohol treatment services to meet local needs, including a focus on culturally appropriate services for Aboriginal and Torres Strait Islander people."<sup>316</sup> Approximately \$20 million of *National Ice Action Strategy* funding was allocated to the WA Primary Health Alliance, which oversees commissioning activities of WA's three Primary Health Networks, including Country WA.<sup>317</sup>

Country WA Primary Health Networks has offices in all seven Western Australia regions. It invests in programs and initiatives delivered in regional communities for early intervention, treatment (including withdrawal and rehabilitation) and post-treatment support and relapse prevention including residential rehabilitation in the Kimberley and Pilbara. Some examples of specific initiatives funded by the Country WA Primary Health Networks include Practitioner Online Referral Treatment Services and the Specialist Methamphetamine Team in Northam.

Practitioner Online Referral Treatment Services is a virtual mental health service which aims to provide accessible care to people across Western Australia. GPs in regional Western Australia can refer a patient over 16 years who has alcohol and other drug use problems, depression or anxiety to the WA Primary Health Alliance-commissioned mental health service in each region. That service conducts an

<sup>315</sup> Government of Western Australia. Media Statement: Doors wide open for methamphetamine peer support in Bunbury. 2017 November 5. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2017/11/Doors-wide-open-for-methamphetamine-peer-support-in-Bunbury.aspx>

<sup>316</sup> Australian Government. The Department of Health. National Ice Action Strategy. Canberra: The Department; 2018. [accessed 2018 Nov 7] Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce>

<sup>317</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. An inquiry into crystal methamphetamine (ice): Answers to Questions on Notice Health Portfolio Crystal Methamphetamine. Canberra: Parliament of Australia; 2017. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Additional\\_Documents](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Additional_Documents)

assessment with the patient and, if appropriate, refers the patient to the Practitioner Online Referral Treatment Services. A Practitioner Online Referral Treatment Services therapist will contact the patient within one business day to discuss and/or begin treatment. Once enrolled in treatment, patients can access material 24/7 at their convenience, and therapists are available Monday to Friday. The Practitioner Online Referral Treatment Service will then provide the referring GP with progress reports, and will contact the GP if appropriate.<sup>318</sup>

The Holyoake Specialist Methamphetamine Team has been established in Northam, which includes a doctor, clinical nurse, case manager, peer workers, family support workers, and counsellors operating from one location. More information about this service can be found at Section 7.2.3.

## 8.4 Providing better services

The Taskforce heard consistently from regional communities across Western Australia there was a need to improve the availability of, and access to, services to respond to methamphetamine use. This was particularly a concern for people living outside the main regional centres, in smaller towns and remote communities.

The Taskforce heard a variety of suggestions to improve access to appropriate and timely alcohol and other drug alcohol services, including: more facilities, more upskilling in regional hospital emergency departments, such as the frontline worker training provided by the Mental Health Commission, more/broader outreach services, and more/broader online resources and mobile applications.

The literature suggests approaches that focus on the additional health and social vulnerabilities faced by regional communities may assist in addressing methamphetamine use. These approaches “should be aimed at promoting social inclusion, building individual and community resilience, enhancing protective factors, reducing risk factors and providing support to families affected by illicit drug use.”<sup>319</sup>

Regional Western Australia cannot be treated as a homogenous whole. The diversity between regions, and also between the major cities, towns and the outlying communities within each region, requires tailored approaches which consider the specific needs of different communities.

The literature suggests that state-wide approaches to addressing complex social issues generally do not take into account the specific needs of regional and remote communities. Adopting a place-based approach which focuses on the needs and characteristics of individual local communities and regions may create better outcomes for regional Western Australia. Place-based approaches address the collective problems of communities at a local level by using “local characteristics, organisations and partnerships to effectively and efficiently identify and prioritise needs, and develop and deliver programs and services.”<sup>320</sup> Research suggests empowering communities and creating local partnerships builds “a sense of

<sup>318</sup> Titov N. Practitioner Online Referral Treatment Service. Information page: PORTS. 2018. [accessed 2018 Nov 7] Available from: <https://ports.org.au/>.

<sup>319</sup> National Rural Health Alliance Inc. Fact Sheet 33 -June 2015: Illicit Drug Use in Rural Australia. Deakin: National Rural Health Alliance; 2015. [accessed 2018 Nov 7] Available from: <http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-illicit-drugs-0615.pdf>

<sup>320</sup> Yeboah DA. A framework for place based health planning. Aust Health Rev. 2005; 29(1); 30 – 36.

ownership at the local level and improves participation in the identification of needs and the development and delivery of programs to address them.”<sup>321</sup>

In evidence to the Commonwealth Parliamentary Joint Committee on Law Enforcement’s Inquiry into Crystal Methamphetamine (ice), a number of organisations submitted that *National Ice Action Strategy* funding was not being targeted to the areas with the most severe problems. Palmerston Inc., the Western Australian Network of Alcohol and Other Drug Agencies, and the National Drug Research Institute all submitted (to varying degrees) that known levels of drug use should be considered in the allocation of funding. Professor Steve Allsop of the National Drug Research Institute stated: “more consideration needs to be given to rural and remote communities.”<sup>322</sup>

The Commonwealth Department of Health states its overall drug and alcohol funding model (including *National Ice Action Strategy* Primary Health Network funding) “allocates funding according to 2011 Census data, and applies a cumulative weighting for rurality, socioeconomic disadvantage and Indigenous population.”<sup>323</sup> Based on this, Country WA Primary Health Network received 4.1 percent of available funding.<sup>324</sup> The breakdown is further stated as: “the period for the \$241.5 million funding to the PHNs commenced in 2016-17 and will end in 2019-20. A total of \$177.1 million was committed for AOD treatment programs for 2016-17, 2017-18 and 2018-19. The remaining \$64.4 million was allocated to the PHNs for 2019-20.”<sup>325</sup> The Commonwealth Department of Health advised it was “not currently considering changing the model used to allocate the final year of funding to PHNs in 2019-20.”<sup>326</sup>

The Parliamentary Inquiry concluded:

- it had “concerns that the funding for 2019-20 is informed by Census data from 2011. The most recent Census data for 2016 was released on 27 June 2017 and, for this reason, the committee suggests that the DoH considers using 2016 Census data to inform the allocation of the remaining NIAS funds, rather than the 2011 data”; and
- “in addition to the use of 2016 Census, the committee is of the view that the remaining NIAS funding could also be informed by data from the wastewater

<sup>321</sup> Ibid.

<sup>322</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 105. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>323</sup> Ibid., p.104.

<sup>324</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>325</sup> Ibid., p.101.

<sup>326</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Senate Community Affairs Committee Answers to Questions on Notice Health Portfolio Budget Estimates 2017 – 2018 (Ref No: SQ17-000589). 2017 May 30. [accessed 2018 Nov 7] Available from: [http://www.aph.gov.au/Parliamentary\\_Business/Senate\\_Estimates/claccte/estimates/bud1718/Health/index](http://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/claccte/estimates/bud1718/Health/index)



analysis. The use of wastewater analysis data should assist in allocating resources to areas with known higher methamphetamine use.”<sup>327</sup>

The Parliamentary Inquiry subsequently recommended the Commonwealth Department of Health consider using 2016 Census and National Wastewater Drug Monitoring Program data to determine the allocation of *National Ice Action Strategy* funding for 2019-20.<sup>328</sup>

### Taskforce conclusions and recommendations

The Taskforce recognises that diversity both within and between the very different regions of Western Australia requires a tailored approach for planning, delivery and evaluation of effective services to combat the issues of methamphetamine use. The Taskforce strongly believes the use of place-based models with significant community involvement should be utilised to improve services in regional Western Australia.

#### Recommendation 30:

In order to better meet regional needs, within 12 months the Mental Health Commission develops regional alcohol and other drug plans in consultation with the community and other key stakeholders to promulgate a place-based approach to planning, investment, delivery and evaluation of services.

The Taskforce supports the use of the latest Census data in concert with current wastewater analysis to inform allocation of remaining *National Ice Action Strategy* funding. This would provide additional funding from an appropriate source to target an already identified area of greatest need, and support methamphetamine initiatives in regional Western Australia.

#### Recommendation 31:

The Mental Health Commission works with the Department of the Premier and Cabinet to propose to the Ministerial Forum on Alcohol and Drugs that future Commonwealth Government resources allocated to address methamphetamine use should be apportioned based on the most recent census data and the relative 'need' or magnitude of the problem in each State, to enable appropriate levels of funding support to be provided to address use in regional Western Australia.

## 8.5 Place-based approaches to planning, commissioning and delivering services

The Taskforce heard repeatedly from regional communities about the potential of place-based (or local) service planning and delivery to better meet the heterogeneous needs and characteristics of their communities.

---

<sup>327</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 108 [accessed 2018 Nov 7]. Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>328</sup> Ibid.



The Productivity Commission's inquiry into human services reforms recognised that "Australia's federal system of government poses challenges to coordinating the planning and provision of human services and that 'place-based' approaches offer the potential to improve government responses to complex social problems, as they cut across government 'silos'".<sup>329</sup>

The Productivity Commission notes the involvement of the local community is a common feature of different place-based models. This involvement can range from consultation to active involvement in decisions and even delegating authority to local decision makers, giving community more control over the funding and design of local services.<sup>330</sup>

In Western Australia, Regional Services Reform takes a regional governance approach to place-based planning and delivery of services. Regional Services Reform aims to bring about long-term systemic change to improve the lives of people in regional and remote Western Australia.

In 2012, the Department of the Premier and Cabinet established Regional Managers Human Services Groups as a forum for Government to engage with non-government service providers, local governments and the community on an ongoing basis. The key mandate for these groups was to determine priorities and responses at a local level for specific target cohorts.

In 2015, to support Regional Services Reform, the East and West Kimberley, Pilbara, and Goldfields groups became District Leadership Groups. These District Leadership Groups meet monthly to discuss and explore operational issues and initiatives. Membership includes representatives from State and Commonwealth governments, local government, the community services sector, Aboriginal Community Controlled Organisations and industry.

The District Leadership Groups key activities involve:

- coordination of effort and resources on key local initiatives;
- provision of local advice to the Regional Services Reform Unit of the Department of Communities and relevant funding and policy agencies;
- fostering partnerships to link services, measuring impact and sharing expertise and resources; and
- ensuring timely and accurate flow of information with key stakeholders.

The Department of Communities is developing a District Leadership Group Strategy that will identify structures to support District Leadership Groups across the State. This will include proposals around governance, membership, terms of reference, operating frameworks and support from the Department of Communities.

---

<sup>329</sup> Australian Government. Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Productivity Commission Inquiry Report No 85, 27 October 2017. Canberra: The Commission; 2017. p 289. [accessed 2018 Nov 7] Available from: <https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf>

<sup>330</sup> Ibid.

### Kimberley District Leadership Group Initiatives

The Kimberley region will be the first region to move to a new Department of Communities integrated model of service delivery. The region was identified for its readiness and willingness to embrace change and because of the success of the District Leadership Groups there.

The East and West Kimberley District Leadership Groups developed a regional outcomes framework for the period 2018-2022, that identifies a collective commitment to aligning vision and outcomes across the region.

As part of this work they have also identified three regional priority areas to work on collaboratively to deliver responsive, integrated place-based solutions:

- **Collectively addressing family violence.** The District Leadership Groups will lead the implementation of the Kimberley Family Violence Regional Plan 2015-2020;
- **Supporting the early years.** The District Leadership Groups will provide leadership to early learning and development initiatives at key locations; and
- **Targeted support for vulnerable children and young people.** The District Leadership Groups will lead the development of integrated and tailored earlier support services for young people and their families.

Establishing a collective vision and mutual accountability is essential in developing community-driven solutions to increase the well-being of children and families in the Kimberley. The District Leadership Groups have proven to be a critical vehicle for leading on-ground responses and understanding complex, entrenched local issues. The success of and lessons learned from the Kimberley District Leadership Group will be used to create a framework for District Leadership Groups across the State.

The WA Primary Health Alliance notes that place-based approaches are particularly important in locations where local resources may be limited, such as regional and remote areas, but that this could also include outer suburban areas. For example, as part of the WAPHA funded Integrated System of Care program to support Aboriginal people with alcohol, drug and mental health issues, a series of community consultations and co-design workshops were held in specific locations across Perth to engage with local community members, identify local issues and support community-led responses.<sup>331</sup>

“Through supporting the development of relationships, building local capacity and truly enabling co-design of place based solutions, there is opportunity to build on what already works, as well as increase the chance for innovative design.”<sup>332</sup>

---

<sup>331</sup> WA Primary Health Alliance, March 2018, ‘Overview of approach to addressing harm from alcohol and drugs. Prepared for the Methamphetamine Action Plan Taskforce’, p.4.

<sup>332</sup> Ibid.

The WA Primary Health Alliance, in partnership with the Mental Health Commission, is currently working on what is potentially Western Australia's first comprehensive Mental Health Atlas, which maps and documents all government funded and not-for-profit services in the mental health and alcohol and other drug sectors across the State. The Mental Health Commission believes the Atlas could be used to support modelling and planning for services in Western Australia.<sup>333</sup>

### Taskforce conclusions and recommendations

While both the State Government (through Regional Services Reform) and Commonwealth Government (through the WA Primary Health Alliance) Governments are actively engaged in developing place-based approaches in their own spheres, the Taskforce is of the view that there is still more to be gained if place-based models involved joint planning, funding and action across all three levels of government, with local communities. The Taskforce notes that mechanisms are being developed that could underpin such an approach, such as the Mental Health Atlas which includes alcohol and other drug services.

A joint government approach to place-based planning, investment and commissioning of services would benefit users of services by ensuring they get the right support no matter where they entered the system. Such an arrangement could also include fewer and longer contract terms for service providers. This would also arguably benefit users by improving the funding security and sustainability of, and collaboration between, service providers by reducing the administrative burden and 'competition' between services. Workforce retention and development (a particular problem in regional Western Australia) would also flow from greater funding certainty.

While the Taskforce supports the need for change in this area, it notes the caution offered by the Productivity Commission. The Commission's Inquiry into Human Services' Reform notes that "initiatives like these hold promise, but will need time and patience from all stakeholders to achieve results... Place-based approaches are also highly resource intensive and would not be appropriate everywhere."<sup>334</sup> The Productivity Commission notes in relation to remote Aboriginal communities:

"... that constant changes to policy have caused ongoing disruption ... and that successful implementation of place-based approaches will depend on the capacity of government[s] and communities... Expanding too far too fast is a significant risk, and has been identified as a contributing factor to problems in previous reform processes."<sup>335</sup>

<sup>333</sup> WA Primary Health Alliance. Information page: Mental Health Atlas: shaping WA's mental health system for the future. 2018. [accessed 2018 Nov 7] Available from: <http://www.wapha.org.au/primary-health-networks/mental-health/mental-health-atlas/>

<sup>334</sup> Australian Government. Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Productivity Commission Inquiry Report No 85, 27 October 2017. Canberra: The Commission; 2017. p 289. [accessed 2018 Nov 7] Available from: <https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf>

<sup>335</sup> Ibid. p. 291.

However, the Taskforce heard there is a need for reform throughout regional Western Australia and holds the view that change, especially in the design and commissioning of services, is an urgent matter.

Western Australia is uniquely placed to trial place-based planning and investment for alcohol and other drug services. The Mental Health Atlas should be used as a tool to not only strategically plan, but also facilitate place-based investment and funding (through co-commissioning or pooling funds) to deliver services more effectively to meet local needs, both in metropolitan and regional Western Australia. For regional Western Australia, Regional Advisory Councils and District Leadership Groups should provide governance structure.

**Recommendation 32:**

Minister for Mental Health, through the Ministerial Drug and Alcohol Forum, proposes that a place-based planning and investment program be piloted in Western Australia within 12 months, supported by the Integrated Atlas of Mental Health, Alcohol and Other Drugs – Western Australia, when finalised.

## Chapter 9 Helping groups vulnerable to high rates of methamphetamine use

*The Taskforce recognises there are groups within the Western Australia community that are particularly vulnerable to the impacts of methamphetamine use. Addressing use within these communities will require targeted strategies and interventions to ensure information and services are appropriate.*

### 9.1 Aboriginal people

“Meth is blackfellas and whitefellas, mothers, fathers, sons, daughters, cousins and grandchildren. Everyone.”

*Aboriginal Consumer and Family Members Forum*

“We’ve had the Stolen Generation, now we are dealing with the Lost Generation [the *Meth Generation*].”

*Aboriginal Consumer and Family Members Forum*

“The conversation used to be about who is on meth, now it’s about who isn’t on meth.”

*Aboriginal Consumer and Family Members Forum*

“When Aboriginal people don’t get help for addiction, they die slowly. There are so many children just watching their parents deteriorate.”

*Aboriginal Consumer and Family Members Forum*

There is growing recognition, and the Taskforce acknowledges, that European colonisation disrupted the cultural well-being of Aboriginal people, and that it continues to have an impact in the form of Aboriginal people’s experience of intergenerational trauma, poverty and racism.<sup>336</sup> As a result, Aboriginal people are at higher risk of experiencing poorer social, health and well-being outcomes compared with non-Aboriginal people, including from the use of alcohol and other drugs.

For methamphetamine use, the 2016 National Drug Strategy Household Survey found that Aboriginal people were 2.2 times as likely to use meth/amphetamines than non-Aboriginal people.<sup>337</sup> The Taskforce heard there is a grave sense of concern and urgency within Aboriginal communities in Western Australia about the impact of methamphetamine use on families and children.

---

<sup>336</sup> Duggeon P, Milroy H and Walker R (eds) Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, 2<sup>nd</sup> edn, Commonwealth of Australia, 2014 [accessed 2018 Nov 7] Available at:

<https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf> and Haythornthwaite S and

Hirvonen T. 2015 ‘The relevance of trauma informed care to Aboriginal primary health care services’ Aboriginal Medical Services Alliance of the Northern Territory, presented at the 13<sup>th</sup> National Rural Health Conference [accessed 2018 Nov 7] Available from:

[http://www.ruralhealth.org.au/13nrhc/images/abs\\_Haythornthwaite%2C%20Sarah.pdf](http://www.ruralhealth.org.au/13nrhc/images/abs_Haythornthwaite%2C%20Sarah.pdf)

<sup>337</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

Western Australian Department of Health data from 2015 indicates approximately 60 per cent of the total Aboriginal and Torres Strait Islander population of Western Australia lives in regional and remote areas.<sup>338</sup> For this reason, many of the issues impacting regional and remote communities outlined in the previous chapter are experienced by Aboriginal and Torres Strait Islander people at proportionally greater rates. Those issues, as well as cultural issues specific to Aboriginal and Torres Strait Islander people, must be taken into account when considering approaches for dealing with methamphetamine use in this community.

### 9.1.1 What the Taskforce heard

“When you use meth, that becomes your culture. The people around you become your culture.”

*Aboriginal Consumer and Family Members Forum*

The Taskforce heard from Aboriginal people across metropolitan and regional Western Australia. It talked to people from different language groups, Elders, individuals, family and friends of those with lived experience of methamphetamine, service providers and peak bodies.

There was a high level of concern about methamphetamine use by Aboriginal people and the impact it has on families and communities, particularly remote communities. The Taskforce heard fears that entire remote Aboriginal communities are at risk, due to high levels of drug use among members.

Of particular concern to the Taskforce were fears expressed by Aboriginal people for the safety and well-being of their children, who are being born into and growing up within a family or a community where methamphetamine use is seen as normal. The Taskforce heard children as young as three years old were used as couriers between methamphetamine dealers and users.

The Taskforce also heard positive reflections on the importance of family as a strong source of support for those struggling with the impacts of methamphetamine. Older Aboriginal people expressed a strong desire to keep their families safe and assist affected family members across generations to receive treatment and rebuild their lives. Regaining the care of their children was a strong motivation to stop using methamphetamine for those who found themselves in those circumstances.

Because of the prevalence of use in their communities, some Aboriginal people felt they needed to remove themselves from that environment in order to seek help. They also acknowledged that returning to that environment carried significant risk of relapse.

The Taskforce heard that culturally appropriate interventions and treatment have a better chance of success than mainstream services. Some Aboriginal people with lived experience of methamphetamine use reflected on their period of use as a time

---

<sup>338</sup> Based on the WA Department of Health population dataset, which is based on the Census 2011 population estimates adjusted for WA births and deaths (excluding migration) and the Aboriginal Affairs Coordinating Committee (AACC) regions [accessed 2018 Nov 7] Available from: <https://catalogue.data.wa.gov.au/dataset/aacc-regions>



of disconnection with their culture, and found that their recovery was enhanced by reconnecting with their culture through treatment.

The Taskforce heard Aboriginal people were often deterred from seeking assistance or treatment for methamphetamine use if they were not familiar with the nature of the service, or did not feel welcome there. Some people, particularly in regional areas, felt discriminated against by frontline health care staff due to the double stigma of using methamphetamine and being Aboriginal. There was a call for more Aboriginal health care workers at all levels, from front desk staff to clinicians, to encourage more people to seek help; as well as the upskilling of all frontline staff in cultural awareness and culturally appropriate behaviours.

### **9.1.2 Aboriginal-specific services and culturally competent or secure approaches**

The increased risks Aboriginal people have of experiencing poorer social, health and well-being outcomes compared with non-Aboriginal people are, in part, caused by intergenerational trauma, poverty and racism.<sup>339</sup> Adopting trauma-informed approaches to the delivery of alcohol and other drug services which acknowledge, understand and respond to this particular underlying driver of use, is essential to ensuring the effectiveness of both Aboriginal-specific and mainstream services.

The literature suggests connection to culture is also key to recovery from alcohol and other drug problems.<sup>340</sup> This approach requires practitioners and organisations to ensure their ways of working with and across cultures are respectful and promote cultural security.<sup>341</sup> It is achieved through staff understanding Aboriginal culture and taking non-judgemental approaches to service delivery, as well as organisations embracing values, principles, policies and structures that enable them to work effectively across cultures.

The National Indigenous Drug and Alcohol Committee reported there was no definitive list of cultural values, spirituality and activities that should be used to provide culturally competent services, as these depend on an individual's specific needs. Rather, the intent of culturally competent service delivery is to stress "traditional cultural values, spirituality and activities that enhance self-esteem".<sup>342</sup> In practice, culturally competent service delivery may include the following approaches, tailored to individual needs:

- providing teachings on how to attain and maintain a connection with culture;

<sup>339</sup> Dudgeon, et al., and Haythornthwaite et. al., loc. cit.

<sup>340</sup> Munro A, Allan J, Shakeshaft A, Breen C. "I just feel comfortable out here, there's something about the place": staff and client perceptions of a remote Australian Aboriginal drug and alcohol rehabilitation service. *Subst Abuse Treat Prev Policy*. 2017;12 (1); 49. DOI 10.1186/s13011-017-0135-0

<sup>341</sup> Walker R, Schultz C, Sonn C. Cultural Competence- Transforming Policy, Services, Programs and Practice. In: Dudgeon P, Milroy H, Walker R, editors. *Working Together – Aboriginal and Torres Strait Islander mental health and well-being principles and practice*. Canberra: Commonwealth of Australia and Telethon Kids Institute; 2010. [accessed 2018 Nov 7] Available from: <https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf>

<sup>342</sup> Stokes J (ed.) Australian National Council on Drugs. National Indigenous Drug and Alcohol Committee. *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples*. Canberra: NIDAC; 2014, p. [accessed 2018 Nov 7] Available from: [http://www.healthinonet.ecu.edu.au/uploads/resources/27794\\_27794.pdf](http://www.healthinonet.ecu.edu.au/uploads/resources/27794_27794.pdf)

- grounding interventions in understanding of historical factors, including traditional family life and the ongoing effects of colonisation;
- involving the family and cultural traditions relevant to the person receiving treatment, and using the value of storytelling to share information;<sup>343</sup>
- use of an Aboriginal family systems approach to care, control and responsibility;
- supporting traditional ways of learning by watching, listening and trying things out;
- using traditional healing practices and medicines including bush tucker, healers and Elders; and
- going 'out bush' or 'on Country' to access culture and recognise the healing effects of the land.<sup>344</sup>

Additionally, the literature acknowledges the importance of services being delivered by Aboriginal staff with similar experiences of drug use cannot be underestimated. Further, that this is critical to developing and maintaining cultural connectedness and trust with Aboriginal people who use drugs during treatment.<sup>345</sup>

### 9.1.3 What works

The literature evaluating what works for Aboriginal people using alcohol and other drug treatments is limited.<sup>346</sup> However, the Taskforce heard from Aboriginal people that they are more likely to access and have success in alcohol and other drug treatment when:

- staff communicate respectfully and build good relationships;
- service providers adapt mainstream approaches to deliver them in a way that meets cultural needs, in particular for residential rehabilitation;
- staff are aware of underlying social issues, as well as having some understanding of culture; and
- Aboriginal people are engaged as part of the design and delivery of services.

#### 9.1.3.1 Aboriginal-specific alcohol and other drug services

The National Indigenous Council on Alcohol and Drugs (NIDAC) and the Australian National Council on Drugs both suggest interventions provided by mainstream services which are effective at addressing alcohol and other drug issues for the non-Aboriginal population cannot be assumed to be likely to have the same impact for the Aboriginal population.<sup>347</sup>

Evidence has shown that Aboriginal community-run services provide better access to care, make the health care provided more appropriate, provide a more holistic

---

<sup>343</sup> Nagel T, Robinson G, Condon J and Trauer T. Approach to treatment of mental illness and substance dependence in remote Indigenous communities: results of a mixed methods study. *Australian Journal of Rural Health*, Vol.17, No.4, 2009, pp.174-182.

<sup>344</sup> Stokes J. (ed.) loc. cit.

<sup>345</sup> Stokes J. Australian National Council on Drugs. National Indigenous Drug and Alcohol Committee. Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples. Canberra: NIDAC; 2014. [accessed 2018 Nov 7] Available from: [http://www.healthinonet.ecu.edu.au/uploads/resources/27794\\_27794.pdf](http://www.healthinonet.ecu.edu.au/uploads/resources/27794_27794.pdf) and Munro et. al., op. cit., p. 6.

<sup>346</sup> Stokes J. (ed) op. cit., p. 9 and Gray D, Stearne A, Wilson M and Doyle M. Indigenous specific alcohol and other drug interventions continuities, changes and areas of greatest need, Australian National Council on Drugs, 2010, p. 46. [accessed 2018 Nov 7] Available at [https://espace.curtin.edu.au/bitstream/handle/20.500.11937/10459/159535\\_159535.pdf?sequence=2&isAllowed=y](https://espace.curtin.edu.au/bitstream/handle/20.500.11937/10459/159535_159535.pdf?sequence=2&isAllowed=y)

<sup>347</sup> Ibid.

approach to better serve people with complex needs, and improve overall health outcomes of Aboriginal people.<sup>348</sup> However, there is also evidence supporting the effectiveness of culturally competent approaches when implemented by both mainstream alcohol and other drug services. It has been suggested that for Aboriginal people, the efficacy of mainstream alcohol and other drug services may either be “circumscribed (or in some cases enhanced) by:

- the extent to which Indigenous Australians perceive an intervention to be forced upon them by [the] non-Indigenous community;
- more frequent occurrence of co-morbid mental health problems;
- the settings in which services are offered; and
- individual or social barriers to compliance.”<sup>349</sup>

### 9.1.3.2 *Residential rehabilitation and ‘culture as treatment’*

Culturally competent residential rehabilitation is considered by the National Indigenous Council on Alcohol and Drugs to be “may be the best (or only practical) option” for Aboriginal and Torres Strait Islander people.<sup>350</sup> This approach is also reported to be the preferred option by Aboriginal people.<sup>351</sup> Specific features of culturally competent residential rehabilitation that work well for Aboriginal people include:

- receiving culturally specific services over an extended period;
- being in a drug and alcohol free environment and safe accommodation away from chaotic environments;
- having access to counselling; and
- having their nutritional needs met.

As discussed in Chapter 6 on treatment and support, methamphetamine dependency is a condition that is prone to relapse and studies have suggested that either length of stay and/or the progress made in treatment are significantly associated with positive post-treatment outcomes. For Aboriginal people, the effectiveness of treatment is significantly enhanced by a connection to culture facilitated by programs and staff, and is perceived as being critical to recovery. A study looking at the effectiveness of residential rehabilitation for Aboriginal people found that “the cultural component of Aboriginal residential rehabilitation programs is the point of difference between these programs and non-Aboriginal rehabilitation services” and, “culturally adapted treatment of Indigenous people had almost five times greater likelihood than any other treatment to engender remission from psychopathology.”<sup>352</sup>

### 9.1.3.3 *What’s happening in Western Australia*

Historically, Aboriginal health services have predominantly been the policy responsibility of the Commonwealth Government, with many Aboriginal alcohol and other drug programs being delivered as part of a broader primary health approach. However, both the Commonwealth and Western Australian Governments are

<sup>348</sup> Australian Government. Department of Health. Aboriginal and Torres Strait Islander Health Curriculum Framework. Canberra: The Department; 2014. [accessed 2018 Nov 7] Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/72C7E23E1BD5E9CFCA257F640082CD48/\\$File/Health%20Curriculum%20Framework.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/72C7E23E1BD5E9CFCA257F640082CD48/$File/Health%20Curriculum%20Framework.pdf) and Gray et al. op.cit. p. 46.

<sup>349</sup> Gray et al., op. cit., p. 46.

<sup>350</sup> Stokes J (ed), op. cit., p.13.

<sup>351</sup> Munro et al., op. cit., p. 2.

<sup>352</sup> Ibid.

involved in Aboriginal health service programming and delivery, having developed a number of policy and practice frameworks and funding initiatives, programs and services to support Aboriginal people's health and to address alcohol and other drug use.

Services and programs for addressing alcohol and other drug use in Aboriginal communities focus on prevention, early intervention, treatment and support, harm reduction, sector capacity building and support post recovery. These are generally provided by government agencies, Aboriginal Community Controlled Health Services, Aboriginal Corporations, and non-Aboriginal non-government service providers (mainstream services).

#### **9.1.3.4 Policy and Practice frameworks**

The State and Commonwealth Governments have produced a number of documents to guide the development of the health care system in relation to Aboriginal people, including:

- *Closing the Gap*: In 2008 the Council of Australian Governments (COAG) agreed to work together to achieve equality in health and life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by the year 2030. COAG implemented the *Closing the Gap* strategy setting six targets across the areas of health, education and employment to drive progress. Targets include halving the gap in child mortality by 2018; 95 per cent of all Indigenous four-year-olds enrolled in early childhood education by 2025; and closing the gap in life expectancy by 2031.
- *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*: The Plan provides a long-term, evidence-based policy framework as part of the overarching Council of Australian Governments' approach to *Closing the Gap* in Indigenous disadvantage. It adopts a strengths-based approach to ensure policies and programs improve health, social and emotional well-being and resilience for Aboriginal and Torres Strait Islander people, and promote positive health behaviours.
- *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health*: Prepared by the Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee, this commits all jurisdictions in Australia to embedding cultural respect principles into their health systems, from developing policy and legislation, to how organisations are run, through to the planning and delivery of services. It aims to guide and underpin the delivery of quality, culturally safe, and responsive health care to Aboriginal and Torres Strait Island People.
- *Western Australia Aboriginal Health and Well-being Framework 2015-2030*: The Framework identifies key guiding principles, strategic directions and priority areas for the next 15 years to improve the health and well-being of Aboriginal people in Western Australia. This Framework has a long-term agenda and encourages an approach for Western Australian Health, the health sector and other key stakeholders to adopt and guide future activities for Aboriginal people living in Western Australia. The Framework was developed for Aboriginal people by Aboriginal people and was informed by an extensive consultation program. It has a strong focus on prevention and acknowledges culture as a key determinant of health.
- *WA Health Aboriginal Workforce Strategy 2014–2024*: the Strategy aims to

develop a strong, skilled and growing Aboriginal health workforce across Western Australia Health including clinical, non-clinical and leadership roles within the sector. The Department of Health has set a goal of 100 additional Aboriginal staff each year. The Strategy aims to create a workplace which is culturally relevant and responsive to Aboriginal perspectives, and an environment in which Aboriginal staff will choose to stay and further their careers.

#### 9.1.3.5 *Prevention and harm reduction*

The Mental Health Commission Drug Aware *Strong Spirit Strong Mind* project provides Aboriginal-specific alcohol and other drug prevention and harm reduction messaging to young Aboriginal people, including their families and communities, in the Perth metropolitan area. The Project focuses on young people aged 12 to 25 years and “encourages Aboriginal people to develop the knowledge and attitudes to choose healthy lifestyles, promote healthy environments and create safer communities.”<sup>353</sup> Project activities include development of:

- prevention campaigns;
- an Aboriginal Youth Network Group; and
- targeted alcohol and other drug strategies for Aboriginal young people.<sup>354</sup>

It also provides:

- nationally recognised training programs (Certificate III & IV) in alcohol and other drugs courses to support the development of a skilled Aboriginal workforce to respond to the needs of Aboriginal people, their families and communities that are experiencing alcohol and other drug and social and emotional well-being related harm;
- capacity-building of non-Aboriginal workers in the alcohol and other drug and broader health services sector to better understand and work in ways that are culturally appropriate for Aboriginal people; and
- culturally secure consultancy and advice on policy, programs, campaigns and resources across service areas within the Mental Health Commission.

Supporting resources on the Drug Aware website outline how this approach can be applied in a therapeutic context and incorporate culturally secure cognitive behavioural therapy approaches.<sup>355</sup> Messaging was developed in consultation with Aboriginal youth groups and agencies. *Strong Mind Strong Spirit* is limited to the Perth metropolitan area because it was supported by the metropolitan Aboriginal Health Planning Forums. However, the model could be adapted for use in other parts of Western Australia.

**Wungening Aboriginal Corporation** (formerly known as the Aboriginal Alcohol and Drug Service) is a specialised alcohol and other drug support service for Aboriginal people. It operates in the Perth metropolitan area but provides services to Aboriginal people regardless of their usual location. Services are provided to Aboriginal youth,

<sup>353</sup> Drug Aware. Information page: Strong Spirit Strong Mind. 2018. [accessed 2018 Nov 7] Available from: <https://drugaware.com.au/about-us/strong-spirit-strong-mind/>

<sup>354</sup> Ibid.

<sup>355</sup> Stokes J. Australian National Council on Drugs. National Indigenous Drug and Alcohol Committee. Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples. Canberra: NIDAC; 2014. [accessed 2018 Nov 7] Available from: [http://www.healthinonet.ecu.edu.au/uploads/resources/27794\\_27794.pdf](http://www.healthinonet.ecu.edu.au/uploads/resources/27794_27794.pdf)



families, men, women (and their children), school and community groups and to clients in prison in the metropolitan area. Services respond to clients' needs by assessing holistically and providing culturally appropriate services. The principles of the Wungening service delivery model approaches include: empowerment; reducing risk; 'no wrong door'; non-judgmental; strengths-based; family inclusive; collaborative; promoting healthy choices; responsive; culturally secure; evidence-based; and holistic. Both the Western Australian Government and the Commonwealth provide funding to Wungening.<sup>356</sup>

Wungening is currently developing plans for a wellness hub in the Perth metropolitan area which will be a treatment and support facility that provides a range of culturally secure, holistic and best practice alcohol and other drug, and related, services for Aboriginal people. Key services will include:

- emergency accommodation for transiently homeless people;
- low medical withdrawal and respite service;
- range of alcohol and other drug services including individual and family counselling, and community engagement;
- residential assessment and preparation for long-term Therapeutic Community treatment; and
- post-exit residential support for people leaving the Therapeutic Community treatment program<sup>357</sup>.

#### **9.1.3.6 Aboriginal Community Controlled Health Services**

There are 22 Aboriginal Community Controlled Health Services in Western Australia which provide primary health care to Aboriginal people, and are managed by Aboriginal boards of governance with board members generally elected from relevant communities. Aboriginal Community Controlled Health Services staffing and service delivery arrangements vary widely from large multi-functional services employing several medical practitioners, to small services without medical practitioners which rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services.<sup>358</sup> Aboriginal Community Controlled Health Services provide an important role in health promotion and navigating the alcohol and other drugs system for Aboriginal people. It is unclear how many Aboriginal Community Controlled Health Services provide specialist alcohol and other drugs services in addition to their role providing primary health care.

Aboriginal Community Controlled Health Services are primarily funded by the Commonwealth Government.<sup>359</sup> The WA Primary Health Alliance funds the Aboriginal Health Council of Western Australia, the peak body for Aboriginal Community Controlled Health Services in Western Australia, to assist in cultural competency and capacity building of primary health care services to support Aboriginal people with problematic alcohol and other drug use and mental

---

<sup>356</sup> Wungening Aboriginal Corporation. Information page: Wungening Service Delivery Model. 2018. [accessed 2018 Nov 7] Available from: <http://www.wungening.com.au/aads-service-delivery-model-2/>

<sup>357</sup> Wungening Wellness Hub information published with permission of Wungening Corporation CEO, email 3 August 2018.

<sup>358</sup> National Aboriginal Community Controlled Health Organisation. NACCHO [home page on the Internet]. 2018. [accessed 2018 Nov 7] Available from: <https://www.naccho.org.au/>

<sup>359</sup> The Aboriginal Health Council of Western Australia. Information page: About AHCWA. 2018. [accessed 2018 Nov 7] Available from: <https://www.ahcwa.org.au/about>



illnesses.<sup>360</sup> This is currently delivered in the metropolitan area through a Perth North and Perth South Primary Health Network Alliance with the Mental Health Commission, Edith Cowan University and the Royal Australian College of General Practitioners. It has been developed as a module to be added to the Aboriginal Health Council of Western Australia's existing Cultural Safety training package and is also available online.

#### **9.1.3.7 Residential rehabilitation**

Dedicated Aboriginal residential rehabilitation facilities are available in the regions. Palmerston Association has six dedicated beds for Aboriginal clients at Palmerston Farm, a semi-rural location south of Perth, where Aboriginal staff are also available to provide advice and support;<sup>361</sup> while Cyrenian House has advised it has six dedicated beds for Aboriginal people at its Rick Hammersley Centre Therapeutic Community, a semi-rural location north of Perth. The Taskforce has been advised that while there are no dedicated residential rehabilitation beds for Aboriginal clients in the Perth metropolitan area, the Next Step inpatient withdrawal unit in East Perth is culturally safe and responsive to all patients' needs, including Aboriginal people. Information provided by the Western Australian Network of Alcohol and other Drug Agencies indicates the number of Aboriginal dedicated beds across Western Australia is dependent on individual service contracts, funded through a variety of State and Commonwealth bodies. The number of dedicated beds for Aboriginal clients currently available in Western Australia was not able to be identified.

### **Taskforce conclusions and recommendations**

The Taskforce acknowledges the work being done to deliver culturally secure alcohol and other drug services specifically for Aboriginal people, particularly those delivered by Aboriginal service providers. It also recognises efforts being made within the sector to ensure mainstream services are culturally secure. However, the Taskforce also acknowledges a lack of beginning-to-end treatment and support programs that include dedicated residential rehabilitation and low-medical withdrawal facilities specifically for Aboriginal people in metropolitan Perth. The Taskforce encourages the development of facilities, such as the wellness hub currently being planned by Wungening Aboriginal Corporation, that deliver holistic treatment and support for individuals, families and communities.

#### **Recommendation 33:**

Mental Health Commission works with the Aboriginal Community Controlled Health Services and Organisations to develop and deliver culturally appropriate models of residential rehabilitation.

#### **9.1.3.8 Other alcohol and drug services**

In addition to the Aboriginal Community Controlled Health Services the Western Australian Government funds Aboriginal services across Western Australia to

<sup>360</sup> WA Primary Health Alliance. WAPHA commissioned activities to support people with drug and alcohol issues - during 2016-2018. Rivervale: WAPHA; 2018. [accessed 2018 Nov 7] Available from: [http://www.wapha.org.au/wp-content/uploads/2018/02/1.-For-WEBSITE\\_ALL\\_DATS\\_Activities\\_FINAL.pdf](http://www.wapha.org.au/wp-content/uploads/2018/02/1.-For-WEBSITE_ALL_DATS_Activities_FINAL.pdf)

<sup>361</sup> Palmerston Association Inc. Information page: Aboriginal Support Services. 2018. [accessed 2018 Nov 7] Available from: <https://www.palmerston.org.au/for-you/aboriginal-and-torres-strait-islander-people/>

provide alcohol and other drug treatment, through the Mental Health Commission. These include four sobering up centres in Derby (through the Garl Walbu Aboriginal Corporation); Kununurra (through the Kununurra Waringarri Aboriginal Corporation); Broome (through Milliya Rumurra Aboriginal Corporation); Wyndham (through Ngnowar Aerwah Aboriginal Corporation); and one transitional housing and support program in Broome also provided by Milliya Rumurra. Milliya Rumurra (in partnership with Ngnowar Aerwah and Boab Health) received funding from the Commonwealth through the WA Primary Health Alliance for the Post-Rehab Continuing Care Service. The service will provide intensive support to individuals and families transitioning from residential rehabilitation in the East and West Kimberley back to community.

Other State-funded services across Western Australia include the Kalgoorlie Sobering Up Centre (Bega Garbirringu Health Services Incorporated) and Port Hedland Sobering Up Centre and Pilbara Community Treatment, both provided by Bloodwood Tree Association Inc.

The WA Primary Health Alliance has provided additional funding for a number of Aboriginal-specific programs which include peer support programs, alcohol and other drug treatment services, and programs focused on well-being, resilience and suicide prevention, including Yaandia Turner River. As Yaandia Turner River Centre's primary client base is Aboriginal people, funding was used to employ an Aboriginal Liaison and Advocacy Officer. The Officer advocates on behalf of the service in the community, supports people through the intake process, ensures applicants have all the information required for assessment, and assists with transport to the facility. The organisation has found there has been a marked increase in the number of referrals to the facility since the Aboriginal Liaison and Advocacy Officer was appointed.

#### **9.1.4 Adapting mainstream approaches**

The Taskforce heard in its consultations with Aboriginal people that culturally relevant and appropriate services were preferable to those that were not. The Taskforce also heard from Aboriginal people who had been through treatment which they did not consider to be culturally relevant and appropriate, and that people did not feel treatment assisted them in their eventual recovery from methamphetamine use. This is supported by the research indicating mainstream alcohol and other drug services can be successful for Aboriginal people when cultural adaptations of evidence-based mainstream interventions are implemented.

It should be noted that all Mental Health Commission funded services are required to deliver culturally secure services for Aboriginal people as part of the contract service requirements. In addition, the Mental Health Commission has identified Aboriginal people as a priority target for service provision. Under the quality standards outlined in contracts, all funded service providers are required to acknowledge and respect the history, cultural rights, values, beliefs and diversity of Aboriginal people and work towards embedding the principle of cultural security into the delivery of services. The Mental Health Commission notes that service providers must develop, refine and deliver alcohol and other drug services under the guidance of the *Strong Mind, Strong Spirit – Aboriginal Drug and Alcohol Framework for Western Australia 2011-2015*, and the *WA Health Cultural Respect Implementation Framework*.

The Taskforce considers it is essential for mainstream services to employ culturally competent service approaches and practices, and that a mix of both Aboriginal-specific and culturally competent mainstream services should be available to Aboriginal people to improve access and maximise the chance of treatment success.

As discussed in Chapter 12, the [\*Standard on Culturally Secure Practice \(AOD Sector\)\*](#) was launched in 2012 and is certified under JAS-ANZ to fall under ISO 9001 Human Services Standard as a recognised accreditation standard. The Mental Health Commission requires all its funded services to be accredited, or to be working towards accreditation against the Standard, or another appropriate accreditation standard.

The Taskforce considers that the Standard and similar accreditation standards provide a consistent foundation upon which the mainstream alcohol and other drug sector can continue to build capacity to deliver culturally competent services. The Taskforce notes that the Western Australian Network of Alcohol and other Drug Agencies is currently undertaking a review of the Standard and considers regular reviews, guided particularly by feedback from Aboriginal people, are essential to ensure this and similar standards remain contemporary and promote best practice.

#### **9.1.4.1      *Combatting racism as a barrier to treatment***

While Aboriginal Community Controlled Health Services and other Aboriginal organisations deliver holistic and culturally appropriate primary health and community-based alcohol and other drug support and treatment, many Aboriginal people in Western Australia also access support and treatment for methamphetamine use through mainstream services. Aboriginal people report a number of barriers to accessing mainstream treatment for methamphetamine use, and within the health system more broadly.

In Western Australia in 2011-12 and 2012-13, the proportion of Aboriginal people who were hospitalised and left against medical advice, or were discharged at their own risk, was five per cent. After adjusting for differences, the ratio for Indigenous and non-Indigenous Australians was ten per cent, compared with eight per cent nationally.<sup>362</sup> The literature suggests “the causal factors of discharge against medical advice are diverse and complex, and include institutionalised racism, a lack of cultural safety, a distrust of the health system, miscommunication, family and social obligations, and isolation and loneliness”.<sup>363</sup> In Western Australia, Aboriginal people are ten times more likely to discharge themselves from hospital against medical advice<sup>364</sup> with institutional racism identified as a contributor to this high rate.<sup>365</sup>

---

<sup>362</sup> Australian Government. Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander Health Performance Framework 2014: Western Australian (cat. No. IHW 165). Canberra: AIHW; 2015. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/reports/indigenous-health-welfare/indigenous-health-performance-framework-2014-wa/contents/table-of-contents>

<sup>363</sup> Shaw C. Deeble Institute Issues Brief: An evidence based approach to reducing discharge amounts Aboriginal and Torres Strait Islander patients explores the causes of and possible solutions to self-discharge among Aboriginal and Torres Strait Islander peoples. Issues Brief. no 14. Deakin: Deeble Institute; 2016. [accessed 2018 Nov 7] Available from: [http://ahha.asn.au/system/files/docs/publications/deeble\\_institute\\_issues\\_brief\\_caitlin\\_shaw\\_2\\_1.pdf](http://ahha.asn.au/system/files/docs/publications/deeble_institute_issues_brief_caitlin_shaw_2_1.pdf)

<sup>364</sup> Australian Government. Australian Institute of Health and Welfare., loc. cit.

<sup>365</sup> Shaw C., loc. cit.

The Taskforce heard from Aboriginal people during consultation that experiences of racism or discrimination from health care personnel, particularly in regional areas, was a major deterrent to seeking support and treatment. Racism and discrimination in the delivery of health services also contributes to low levels of engagement and compliance by Aboriginal people with treatment, thereby reducing its overall effectiveness.<sup>366</sup>

### **Taskforce conclusions and recommendations**

The Taskforce acknowledges there are many policies and practice frameworks that mandate the delivery of health and alcohol and other drug services to Aboriginal people in a culturally competent and non-discriminatory way and, wherever possible, by Aboriginal people with lived experience. However the implementation of these principles and values through both the practitioner's approach to engaging with Aboriginal people, as well as organisations' approaches to program design and delivery, is required in equal measure to ensure Aboriginal people feel safe accessing treatment and are given the best chance of success.

Noting that the Taskforce was told, and the research supports, that there is a legacy of systemic discrimination and cultural mismatch that has eroded the perceived and actual role of trust in mainstream service provision, the Taskforce believes that more Aboriginal-specific and culturally competent mainstream alcohol and other drug services are required to enable Aboriginal people to both access and successfully undertake treatment for alcohol and other drug use, including methamphetamine dependency.

#### **Recommendation 34:**

The Mental Health Commission works with Aboriginal community leaders, peak bodies and Aboriginal Community Controlled Health Services to incorporate the alcohol and other drug treatment needs of Aboriginal people in the regional alcohol and other drug plans in Recommendation 30.

Noting there is limited research available to indicate exactly what works for Aboriginal people with regard to alcohol and other drug treatment, the Taskforce considers the importance of sharing knowledge and learning more cannot be understated. In the short term, the practice of sharing lessons learned at community, organisation and practitioner levels is essential to more immediately inform frontline service delivery and to foster an environment of continuous improvement in culturally competent service delivery in the alcohol and other drug sector.

The Taskforce also considers that in measuring the success of treatment, governments, service providers and practitioners should adopt the National Indigenous Drug and Alcohol Council's more holistic approach. This suggests that success is not simply measured by abstinence of drug use, but incorporates an outcomes-based approach measuring improvements in aspects such as a person's quality of life, reconnection with family, success in employment, their level of interaction with the justice system, and the extent to which a person requires further medical care for an alcohol-related disease. The Taskforce considers this view

---

<sup>366</sup> Wofeso N. Racism: a major impediment to optimal Indigenous health and health care in Australia. Aust Indigenous Health Bulletin. 2011: 11(3); 1-13

should be universally applied to all alcohol and other drug services, however it has particular bearing for Aboriginal people.

### **Recommendation 35:**

The Mental Health Commission to work closely with the Western Australian Network of Alcohol and other Drug Agencies to establish regular opportunities for both mainstream alcohol and other drug service providers and Aboriginal Community Controlled Health Services to share information and lessons learned about how best to meet the needs of Aboriginal people. This could include enabling inter-organisational staff mobility and training opportunities.

### **9.1.5 Increasing the Aboriginal workforce**

Aboriginal people are greatly under represented in the Western Australian Department of Health workforce. In 2015, only 1.2 per cent of the Western Australian health system workforce was Aboriginal, compared to the Public Sector Commission's target of 3.2 per cent.<sup>367</sup> It is currently unclear the number of Aboriginal people who are employed or who work as volunteers in the mainstream alcohol and other drug sector.

Aboriginal people bring a diverse range of skills to the health and mainstream alcohol and other drug sectors, including the potential to break down barriers to access for other Aboriginal people, as well as bringing cultural perspectives which help meet the needs of Aboriginal people. The Western Australian Department of Health has developed the *WA Health Aboriginal Workforce Strategy 2014-2024* with the aim of developing a strong, skilled and growing Aboriginal health workforce across the Department, including clinical, non-clinical and leadership roles. Implementation of the plan requires involvement by a range of stakeholders relevant to government, including but not limited to Aboriginal Community Controlled Health Organisations, Aboriginal communities,<sup>8</sup> and other health service providers.<sup>368</sup>

The Mental Health Commission is a Registered Training Organisation and as previously noted in this chapter, provides Certificate III and IV courses to increase Aboriginal participation in the workforce, and offers a range of other workforce development initiatives and training.

The draft *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025* (Workforce Strategic Framework) provides a guide for all levels of government, non-government and private sectors in the commissioning, enhancement and delivery of workforce planning and development until 2025. Collaboration and coordination across service providers, organisations and sectors is essential for implementing the Workforce Strategic Framework.

The draft Workforce Strategic Framework recognises the Aboriginal workforce as an integral component of the mental health and alcohol and other drug workforce,

<sup>367</sup> Government of Western Australia. Department of Health. Workforce Directorate. Aboriginal and Torres Strait Islander Workforce Dashboard Report. East Perth: The Department; 2016.

<sup>368</sup> Government of Western Australia. Department of Health. *WA Health Aboriginal Workforce Strategy 2014-2024*. East Perth: The Department; 2014. [accessed 2018 Nov 7] Available from: [https://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Aboriginal%20health/PDF/workforce\\_strategy.pdf](https://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Aboriginal%20health/PDF/workforce_strategy.pdf)



noting it is a priority to support the growth and development of the Aboriginal workforce at all levels, including in leadership and senior management areas.

Strategies within the draft Workforce Strategic Framework include to support the workforce to deliver culturally secure services for Aboriginal people. It aims to ensure the percentage of Aboriginal and Torres Strait Islander people in the mental health and alcohol and other drug workforce is in line with, or exceeds, the target of the Public Sector Commission. Suggested actions to address these strategies include, but are not limited to:

- providing workplace leadership and mentoring opportunities for Aboriginal staff;
- promoting working in the mental health and alcohol and other drug sector to Aboriginal students;
- expand existing programs such as Aboriginal worker placements, cadetships, traineeships and scholarships; and
- promote the adoption of the *WA Health Aboriginal Workforce Strategy 2014-2024*.

### Taskforce conclusions and recommendations

The Taskforce believes there is a demonstrated need for more Aboriginal people working in both the health system and mainstream alcohol and other drug sector. While it is also important to develop a non-Aboriginal workforce that is both respectful and cognisant of Aboriginal people's perspectives, the increased presence of Aboriginal alcohol and other drug health care workers is essential at all levels of service delivery and in leadership roles. This will help Aboriginal people to access health and specialised alcohol and other drug services by breaking down barriers associated with stigma and lack of cultural security, and will improve overall successful treatment outcomes.

#### Recommendation 36:

The Mental Health Commission to work with Aboriginal community leaders, and peak bodies for Aboriginal health services and the alcohol and other drug sector to develop and implement a strategy to recruit, train and retain Aboriginal staff in both mainstream and Aboriginal-specific alcohol and other drug services.

## 9.2 Justice populations<sup>369</sup>

"Jailing people for drug use is creating long term problems that become lifelong barriers."

*Consumer and Family Forum*

"Going to jail made me want to get off meth. I really wanted to go to rehabilitation after I was released."

*Consumer and Family Forum*

As previously noted, the prevalence of methamphetamine use among people entering the justice system is higher than the general population. A 2013 survey of the mental health and substance use problems of prisoners who had recently arrived in Western Australia prisons found:

- three quarters of women (74 per cent) and men (77 per cent) fulfilled criteria

<sup>369</sup> Justice populations include all persons who have had formal contact with the criminal justice system (for example police, courts, or corrective services).



- for a clinically diagnosable alcohol and/or drug use disorder;
- more than 60 per cent of men had used amphetamines or methamphetamine in the previous 12 months; and
- 62.9 per cent of women and 51.4 per cent of men had ever injected amphetamine or methamphetamine.<sup>370</sup>

Justice services including prisons can often be the first time people using methamphetamine have contact with treatment services.<sup>371</sup>

## 9.2.1 Drug treatment diversion and support

### 9.2.1.1 *What the Taskforce heard*

The Taskforce heard from individuals who had been or were currently involved in the justice system and their concerned friends and families. Although their views differed on some subjects, a common theme emerged that not enough was being done to address drug use in justice (and especially prison) populations. Many agreed that an individual's involvement in the justice system is an opportunity to create a difference, not only for the individual but also for the broader community.

The Taskforce heard that criminal justice approaches which imprison people for non-violent drug-related offences do not help address the issues associated with drug use, and can make the situation worse. People supported drug diversion initiatives which allow alleged and convicted offenders to seek treatment in the community rather than going to prison. Many called for more drug diversion opportunities, including drug courts, in regional areas.

The Taskforce heard some people preferred to go to prison instead of being referred to alcohol and other drug diversion programs, such as the Perth Drug Court. The Drug Court Program has strict bail conditions including supervised urinalysis and police curfews which some participants struggle to comply with. One participant the Taskforce spoke to who was involved in the Drug Court but breached his conditions and was sent to prison, agreed. He believed it was easier to go to prison and serve a shorter sentence than continue with the Drug Court program which he found impossible to adhere to.

In its submission to the Taskforce, Legal Aid Western Australia (LAWA) stated:

“... the effectiveness of this program [the Perth Drug Court] can be hindered by the long wait times that clients experience waiting to access residential drug rehabilitation. This wait time can often occur in custody. The effectiveness of the Drug Court programs could be improved by providing more drug rehabilitation beds to reduce waiting times.”<sup>372</sup>

<sup>370</sup> Davison S, Fleming J, Butler T, Morgan V, Petch E, Morgan F et al. Report from the Health and Emotional Well-being Survey of Western Australian Prisoners, 2013. Perth: WA Department of Health; 2015. [accessed 2018 Nov 7] Available from:

<http://www.health.wa.gov.au/crc/outcomes/docs/MH%20Substance%20Use%20WA%20Prisons.pdf>

<sup>371</sup> Commonwealth of Australia. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p 136. [accessed 2018 Nov 7] Available from:

[https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

<sup>372</sup> Legal Aid Western Australia. Submission to the Methamphetamine Action Plan Taskforce 23 February 2018.

While recognising the Drug Court may be limited by the availability of appropriate services for alleged offenders, Legal Aid WA observed the potential benefits of expanding the model to other court jurisdictions:

“LAWA recommends the introduction of a Drug Court program in the family law and child protection context as this would be of great benefit to parents and their children. The development could be informed by programs such as the Family Drug Court program in the child protection jurisdiction of the Children’s Court in Victoria.”<sup>373</sup>

The Taskforce heard those involved in the justice system often faced a number of complex issues which may not be solely related to alcohol and other drugs. These issues can include a lack of stable housing, the need for mental health treatment, and no support networks. The community called for a more holistic approach that supports people involved in the justice system who have complex needs.

### **9.2.1.2      *What’s happening in Western Australia***

There are a number of alcohol and other drug and mental health diversion support programs which provide people apprehended by police or appearing in courts with a referral to specialist treatment in the community. They include: Western Australia Police Other Drug Intervention Requirement (ODIR); Pre-sentence Opportunity Program (POP); Indigenous Diversion Program (IDP); Supervised Treatment Intervention Regime (STIR); Cannabis Intervention Requirement (CIR); Young Person’s Opportunity Program (YPOP); and specialist courts such as the Mental Health Court (Start and Links) and the Perth Drug Court. Some of these are targeted specifically to assist young people and Aboriginal people.

Treatment associated with these programs is funded by the Western Australian Government through the Mental Health Commission, and provided by the metropolitan and regional Community Alcohol and Drug Services (CADS), non-government alcohol and other drug counselling Services, and non-government residential rehabilitation centres.

The Western Australia Police Force has the option of issuing an ODIR when small quantities of a drug are detected. This diverts individuals away from the court process and into drug treatment. Once issued with an ODIR by police, there is a requirement to complete three Other Drug Intervention Sessions (ODIS) within a 42-day period. An ODIR can only be issued to an adult, and only on a single occasion. Subsequent drug offences are prosecuted through the courts.

The Mental Health Court Diversion Program consists of the Start Court (for people aged 18 and older) and the Links Program (for people aged 17 and under) and allows individuals experiencing mental health issues to receive holistic support to address underlying causes of their offending behaviour. The Mental Health Court is a partnership between the Mental Health Commission and the Department of Justice which combines access to mental health supports and services including alcohol and other drug support.<sup>374</sup>

---

<sup>373</sup> Ibid.

<sup>374</sup> Government of Western Australia. Magistrates Court of Western Australia. Information page: Start Court. 2018. [accessed 2018 Nov 7] Available from: [http://www.magistratescourt.wa.gov.au/S/start\\_court.aspx](http://www.magistratescourt.wa.gov.au/S/start_court.aspx)

The Start Court is a specialist, solution-focussed mental health court operating in the Perth Magistrates Court, with dedicated staff including a Magistrate, judicial support officers, a psychiatrist, mental health clinicians, community corrections, duty lawyers, police prosecutors and peer and psychosocial supports. The program combines regular court appearances with access to mental health and alcohol and other drug services, and psychosocial supports. The Start Court also has a Drug and Alcohol Diversion Officer who provides assessments and referrals to appropriate alcohol and other drug services, and who can provide updates and facilitate reports to the Court as required. The Links Program is an assessment and referral program that provides clinical and psychosocial support to young people who appear before the Perth Children's Court.

The Drug Court operates in the Perth Magistrates Court and Perth Children's Court and accepts referrals from the District and Supreme Courts, as well as other Magistrates Courts around Western Australia. Offenders can be referred once charged with a criminal offence if they are experiencing alcohol and other drug issues. The Department of Justice says the Drug Court aims to:

- "support participants in addressing their drug related problems and associated lifestyle";
- "reduce imprisonment of those with drug related problems, by addressing those problems that are integral to offending behavior"; and
- "reduce post-treatment supervision requirements for participants by having them address relevant requirements at the earlier stage prior to final sentencing."<sup>375</sup>

Offenders referred to the Perth Drug Court are required to appear regularly in the Drug Court, undergo regular monitoring (including drug screen urine testing), and participate in treatment programs. A Drug Court program typically runs for between six and 12 months, depending on the program and individual circumstances. Final sentencing is deferred while the participant undertakes the agreed program. Upon successful completion of a program, the Magistrate will sentence the participant, taking into consideration the participant's performance in the program.<sup>376</sup> In 2016-17, a total of 1,168 offenders throughout Western Australia gained access to a court diversion program, including the Drug Court. This was 12 per cent less than the number for 2015-16.<sup>377</sup>

---

<sup>375</sup> Government of Western Australia. Department of Justice. Court and Tribunal Services. Information page: Drug Court. 2018. [accessed 2018 Nov 7] Available from:

[http://www.courts.dotag.wa.gov.au/D/drug\\_court.aspx?uid=5227-1163-1055-5774](http://www.courts.dotag.wa.gov.au/D/drug_court.aspx?uid=5227-1163-1055-5774)

<sup>376</sup> Government of Western Australia. Department of Justice. Court and Tribunal Services. Information page: Drug Court. 2018. [accessed 2018 Nov 7] Available from:

[http://www.courts.dotag.wa.gov.au/D/drug\\_court.aspx?uid=5227-1163-1055-5774](http://www.courts.dotag.wa.gov.au/D/drug_court.aspx?uid=5227-1163-1055-5774)

<sup>377</sup> Government of Western Australia. Department of the Attorney General. Final Report 2016/17. Pg. 13. Perth: The Department; 2017. Available from: [https://department.justice.wa.gov.au/files/annual-reports/DotAG\\_Final-Report-2016-2017.pdf](https://department.justice.wa.gov.au/files/annual-reports/DotAG_Final-Report-2016-2017.pdf)

### 9.2.1.3 *What works to treat and support alleged offenders*

#### **Drug diversion – drug courts**

Drug courts were first introduced into Australia in 1999 and can be found in the majority of Australian jurisdictions. There is no uniform drug court model, however the majority focus on reducing drug-related offending.<sup>378</sup>

In 2016 several evaluations of Australian drug courts were reviewed. The review found that overall, drug courts reduce recidivism more than conventional sanctions. This was consistent with similar international evaluations. However, the review found “some drug courts ‘work’ better than others, and characteristics of individual drug court models affect recidivism outcomes.”<sup>379</sup>

Two evaluations of the Perth Drug Court were included in the 2016 review. One was a 2003 Crime Research Centre Evaluation of the Perth Drug Court pilot project, which concluded “in regard to the central issue of recidivism, the current evaluation is not able to provide any substantial evidence of a reduction that can be attributed to the drug court program.”<sup>380</sup>

The other evaluation included in the review was the former Western Australian Department of the Attorney General (now Department of Justice) 2006 review of the Perth Drug Court which concluded that involvement in a Drug Court program “had a positive effect in reducing the level of re-offending among individuals charged with a drug-related offence... [and] ...was found to be associated with a net reduction in recidivism of 17.0% over prison and 10.4% over community corrections.”<sup>381</sup>

#### **Holistic approaches to treatment and support**

During its consultations the Taskforce heard individuals involved in the justice system often have a range of complex issues that influence their offending which may not be isolated to alcohol and drug use. On that basis, providing a more holistic approach to supporting individuals in the justice system may be more effective than only targeting their alcohol and other drug issues through mechanisms like specialist drug courts.

The Magistrates’ Court of Victoria introduced the Court Integrated Services Program (CISP) in November 2006. The rationale for introducing CISP was discussed in a 2009 economic evaluation conducted by PricewaterhouseCoopers:

“there is an over representation in the Magistrates’ Court system of defendants whose offences are directly related to one or a combination of drug and alcohol abuse, mental disorder, homelessness, social and economic disadvantage, poverty and isolation. An increasing number of defendants are presenting at court that have multiple and complex needs,

---

<sup>378</sup> Kornhauser R. The effectiveness of Australia’s drug courts. *Aust New Zea J Criminology*. 2016;51(1); 76-98.

<sup>379</sup> Ibid.

<sup>380</sup> Crime Research Centre. EVALUATION OF THE PERTH DRUG COURT PILOT PROJECT. 2003. [accessed 2018 Nov 7] Available from [http://www.parliament.wa.gov.au/publications/tailedpapers.nsf/displaypaper/4010923c794d6a896780c09a482581e800133453/\\$file/tp-923.pdf](http://www.parliament.wa.gov.au/publications/tailedpapers.nsf/displaypaper/4010923c794d6a896780c09a482581e800133453/$file/tp-923.pdf)

<sup>381</sup> Government of Western Australia. Department of the Attorney General. A review of the Perth Drug Court. Perth: The Department; 2006. [accessed 2018 Nov 7] Available from: [http://www.parliament.wa.gov.au/publications/tailedpapers.nsf/displaypaper/4010924c803ec5cfb0e6d479482581e800133459/\\$file/tp-924.pdf](http://www.parliament.wa.gov.au/publications/tailedpapers.nsf/displaypaper/4010924c803ec5cfb0e6d479482581e800133459/$file/tp-924.pdf)

for example the high prevalence of both mental illnesses and substance abuse problems. These factors lie at both the cause of their offending behaviour and are also preventing them from making long-term behavioural change.”<sup>382</sup>

The CISP provides:

“...a multi-disciplinary team-based approach to the assessment and referral to treatment of clients. It links clients to support and services such as drug and alcohol treatment, crisis accommodation, disability, mental health and acquired brain injury services. Support and services could range from providing referrals to community organisations with no further involvement in the program, to intermediate or intensive case management, depending on eligibility and the assessed needs of the client.”<sup>383</sup>

The aim of the CISP is to:

- “provide short term assistance before sentencing for accused with health and social needs;
- work on the causes of offending through individualised case management;
- provide priority access to treatment and community support services; and
- reduce the likelihood of re-offending.”<sup>384</sup>

Improving access to stable accommodation is an important part of the CISP, with the program having access to a number of transitional housing properties in the community.<sup>385</sup>

In 2015-16, 2,170 people were referred to the CISP. A snapshot of the CISP’s participants taken in June 2016 indicated that in 68 per cent of cases, methamphetamine was a contributing factor in the alleged offending.<sup>386</sup>

---

<sup>382</sup> PricewaterhouseCoopers. Department of Justice Economic Evaluation of the Court Integrated Services Program (CISP) Final report on economic impacts of CISP November 2009. Melbourne: PricewaterhouseCoopers; 2009. [accessed 2018 Nov 7] Available from: [https://www.magistratescourt.vic.gov.au/sites/default/files/Default/cisp\\_economic\\_evaluation\\_final\\_report.pdf](https://www.magistratescourt.vic.gov.au/sites/default/files/Default/cisp_economic_evaluation_final_report.pdf)

<sup>383</sup> The Magistrates’ Court of Victoria. Guide to Specialist Courts and Court Support Services. Melbourne: Magistrates Court of Vic; 2014. [accessed 2018 Nov 7] Available from: <https://www.magistratescourt.vic.gov.au/sites/default/files/Default/Guide%20to%20SCCSS%20-%202%20June%202014%20%28final%20version%29.pdf>

<sup>384</sup> Magistrates’ Court of Victoria. Information page: Court Integrated Services Program (CISP). 2018. [accessed 2018 Nov 7] Available from: <https://www.magistratescourt.vic.gov.au/court-support-services/court-integrated-services-program-cisp>

<sup>385</sup> The Magistrates’ Court of Victoria. Guide to Specialist Courts and Court Support Services. Melbourne: Magistrates Court of Vic; 2014. [accessed 2018 Nov 7] Available from: <https://www.magistratescourt.vic.gov.au/sites/default/files/Default/Guide%20to%20SCCSS%20-%202%20June%202014%20%28final%20version%29.pdf>

<sup>386</sup> Magistrates’ Court of Victoria. Magistrates’ Court of Victoria: Annual Report 2015/16. Melbourne: Magistrates’ Court of Victoria; 2016. [accessed 2018 Nov 7] Available from: <https://www.magistratescourt.vic.gov.au/sites/default/files/MCV%20AR%2015-16%20%28final%29.pdf>



The University of Melbourne also conducted an evaluation of CISP in 2009, concluding:

“...magistrates and other stakeholders showed a high level of support for the program and its outcomes; and, compared with offenders at other court venues, offenders who completed CISP showed a significantly lower rate of re-offending in the months after they exited the program.”<sup>387</sup>

The PricewaterhouseCoopers economic evaluation concluded there are “significant benefits associated with CISP”, with:

- “\$1.98m per annum in avoided costs of imprisonment as a result of the CISP program.
- \$16,826,420 estimated total benefits from reduced re-offending over a 30-year period.
- \$7,470,662 estimated total benefits from reduced re-offending over a five-year period.
- \$4,948,726 estimated total benefits from reduced re-offending over a two-year period (already achieved).
- \$5.90 worth of savings for the community for every 1 Dollar spent on the CISP.”<sup>388</sup>

### **Taskforce conclusions and recommendations**

The Taskforce heard support from the Western Australian community for drug diversion programs which allow people involved in the justice system to access alcohol and other drug treatment in the community.

The Taskforce cannot take a position on the current effectiveness of the Perth Drug Court as its last review occurred more than 10 years ago. The Taskforce notes the different approaches taken by the Perth Drug Court and the Mental Health Court Diversion Program. The Start Court appears to provide a more holistic approach to accessing the complex needs of individuals referred to the program.

The Taskforce believes because of the commonalities that often exist between mental health and alcohol and other drug issues, use of an integrated model such as CISP which provides wrap around services to address an individual’s needs holistically, should be investigated. The Taskforce holds the view that any integrated model investigated should include mechanisms to ensure the requirements of case-managed plans developed, are delivered by appropriate agencies.

The Western Australian Government should consider whether the cross-agency justice governance committee, the Justice Policy and Reform Committee, is an appropriate mechanism to support this recommendation. The Justice Policy and Reform Committee was established in July 2017 to provide strategic direction on development and implementation of a sector-wide reform plan.

---

<sup>387</sup> State Government of Victoria. Department of Justice. Court Integrated Services Program: Tackling the causes of crime: Executive Summary Evaluation Report. Melbourne. The Department; 2010. [accessed 2018 Nov 7] Available from: [https://www.magistratescourt.vic.gov.au/sites/default/files/Default/cisp\\_tackling\\_the\\_causes\\_of\\_crime.pdf](https://www.magistratescourt.vic.gov.au/sites/default/files/Default/cisp_tackling_the_causes_of_crime.pdf)

<sup>388</sup> Ibid.



**Recommendation 37:**

The Department of Justice and other relevant agencies introduce integrated approaches to the assessment and treatment of alleged offenders that provide a holistic, case-managed approach to treatment and support.

**9.2.2 Support for prisoners on remand****Court Integrated Services Program (CISP) Remand Outreach Pilot (CROP) – Victoria, Australia**

The Court Integrated Services Program (CISP) Remand Outreach Pilot (CROP) began in February 2014 and is an extension of the CISP. CISP Assessment and Liaison Officers have been introduced into prisons that accommodate prisoners on remand. These officers proactively identify remand prisoners who may be eligible for bail if appropriate community supports were put in place. They also assist remand prisoners to identify and address barriers to receiving these supports.

The Magistrates Court of Victoria's *Guide to Specialist Courts and Support Services* says: "Remand prisoners identified for the CROP will receive brief casework intervention by a Court Assessment and Liaison Officer, with a view to addressing current barriers to receiving bail. Barriers might include lack of a suitable bail address or the need for mental health and/or drug and alcohol support."<sup>389</sup>

In 2016-17, 547 people on remand were provided CROP assistance, with 269 receiving bail following CROP involvement.<sup>390</sup>

**9.2.2.1 What's happening in Western Australia**

During the court process if an alleged offender is denied bail they will be remanded in custody awaiting sentencing. In Western Australia, the number of adult prisoners in custody at 31 March 2017 was 6,776. Approximately 29 per cent of these prisoners were un-sentenced.<sup>391</sup> Alcohol and other drug support and treatment programs for sentenced prisoners such as the Drug and Alcohol Through-Care Service and the Criminal Conduct & Substance Abuse Treatment Program (Pathways), are not currently provided to un-sentenced prisoners/prisoners on remand.

The Department of Justice advised that Pathways is a criminogenic treatment program which targets changing offending behaviours. The program is therefore not suitable for remand prisoners as these prisoners haven't yet been convicted of any

<sup>389</sup> The Magistrates' Court of Victoria. *Guide to Specialist Courts and Court Support Services*. Melbourne: Magistrates Court of Vic; 2014. [accessed 2018 Nov 7] Available from: <https://www.magistratescourt.vic.gov.au/sites/default/files/Default/Guide%20to%20SCCSS%20-%2020June%202014%20%28final%20version%29.pdf>

<sup>390</sup> Information provided by the Magistrates' Court of Victoria.

<sup>391</sup> Government of Western Australia. Department of Corrective Services. *Adult Prisoners in Custody Quarterly Statistics March Quarter 2017*. Perth: The Department; 2017. [accessed 2018 Nov 7] Available from: <https://www.correctiveservices.wa.gov.au/files/about-us/statistics-publications/statistics/2017/quarterly/2017-quarter1-adult-custody.pdf>

offence and are assumed to be innocent, so there are no offending behaviours to target.<sup>392</sup>

The Office of The Inspector of Custodial Services 2015 *Western Australia's rapidly increasing remand population* report stated "the median length of time on remand for males was 26 days... [and for] females was 19 days."<sup>393</sup>

The Western Australian Auditor General's *Minimising Drugs and Alcohol in Prisons* 2017 report found that:

"Around 65% of prisoners cannot access Pathways because they have sentences of less than 6 months or are on remand awaiting sentencing. During the audit period, the proportion of prisoners who were ineligible increased by 7%. This likely reflects the 6% increase in the number of prisoners held on remand during the same time."<sup>394</sup>

### Taskforce conclusions and recommendations

The Taskforce acknowledges that providing a total of 100 program hours such as Pathways to prisoners on remand is not feasible, given the median time most people spend on remand. However, the Taskforce recommends that support should be provided to prisoners on remand to address alcohol and other drug issues on a voluntary basis. Support could include assessment, brief interventions, peer support, access to counselling and referrals to alcohol and other drug services in the community upon release. Support needs could be designed to accommodate the estimated length of stay for the person on remand.

The Taskforce believes an individual wanting to address an alcohol and other drug issue while on remand should not be seen as a presumption of guilt and should not impact the potential for convictions.

#### Recommendation 38:

The Department of Justice expands drug and alcohol through-care services to ensure that prisoners on remand who are released from custody are effectively connected to support and treatment services in the community.

### 9.2.3 Drug treatment and support for offenders with community based sentences

Once a court matter has been finalised a sentence may be imposed, including community-based orders. The Department of Justice Breaking Out program is a community-based program that targets the needs of offenders with a history of alcohol and drug use linked to their offending. The program aims to reduce alcohol and drug use and raise awareness of how emotions and thoughts underline alcohol

<sup>392</sup> Government of Western Australia. Department of Justice, Corrective Services. Response to MAP Taskforce Stocktake. Unpublished information. 2018.

<sup>393</sup> Government of Western Australia. Office of the Inspector of Custodial Services. Information page: Western Australia's rapidly increasing remand population: key findings. 2018. [accessed 2018 Nov 7] Available from: [http://www.oics.wa.gov.au/reports/western-australias-rapidly-increasing-remand-population/key-findings/?doing\\_wp\\_cron=1525232515.8739540576934814453125](http://www.oics.wa.gov.au/reports/western-australias-rapidly-increasing-remand-population/key-findings/?doing_wp_cron=1525232515.8739540576934814453125)

<sup>394</sup> Government of Western Australia. Office of the Auditor General. Minimising Drugs and Alcohol in Prisons Report 22: November 2017. Perth: Office of the Auditor General; 2017. [accessed 2018 Nov 7] Available from: [https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017\\_22-AlcoholDrug.pdf](https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017_22-AlcoholDrug.pdf)

and drug use and offending behaviour. It is based primarily on cognitive behavioural principles with elements of emotion focussed therapy. The program explores topics such as emotional management, empathy, dependency, harm minimisation, coping strategies and relapse management.<sup>395</sup>

## 9.2.4 Drug treatment and support for offenders sentenced to imprisonment

### 9.2.4.1 *What the Taskforce heard*

The Taskforce heard that for some people, going to prison made them want to address their alcohol and other drug issue, that being in a controlled environment away from outside influences allowed them to access treatment. One participant said he "...needed jail and the experience in there, it provided clarity." Another said "going to jail made [him] ...want to get off meth... [he] ...really wanted to go to rehabilitation after [he] ...was released."

Many people supported the Western Australian Government's plan to introduce two alcohol and other drug rehabilitation prisons, however, the Taskforce also heard more could be done to ensure prisoners across Western Australia's network of prisons have access to alcohol and other drug treatment, not just those incarcerated in the metropolitan area. Further, the Taskforce heard that any treatment programs should be based on contemporary best practice which addresses the individual needs of those accessing the treatment.

The Taskforce heard the current drug treatment program in Western Australia prisons, Pathways, is not meeting the needs of the diverse prison population. Although it had helped some people, the majority felt it was outdated, hard to access and involved a level of literacy which some prisoners do not have. Some people reported never being offered any treatment or rehabilitation opportunities while in prison. Many believed that treatment should be provided as soon as an individual enters the prison, with some mentioning lengthy delays in accessing treatment. The Taskforce heard there is a lack of psychological diagnosis for prisoners, as clinical assessments are deemed too expensive and people going through the prison system are not being diagnosed.

In its submission to the Taskforce, Legal Aid WA stated it had "received feedback from prisoners that there is often a lack of drug rehabilitation courses for prisoners and that prisoners are not aware of what is available."<sup>396</sup>

Many friends and families held the view that alcohol and other drug treatment in prison should be compulsory, with one mother urging:

"We should ignore the statement from alcohol and other drug counsellors that 'you can't help them until they are ready to be helped'. This statement has meant that my son has now been an addict for 22 years. It would have been much easier to fix the problem when it was an early addiction. None of them want to live like they do, but the drug forces them to continue. We need to use the same force to fight it."

<sup>395</sup> Government of Western Australia. Department of Justice, Corrective Services. Response to MAP Taskforce Stocktake. 2018.

<sup>396</sup> Legal Aid Western Australia. Submission to the Methamphetamine Action Plan Taskforce 23 February 2018.

#### 9.2.4.2 *What's happening in Western Australia*

##### **Methamphetamine Action Plan Initiative #5 – Alcohol and Drug Rehabilitation Prisons**

As part of the *Methamphetamine Action Plan*, the Western Australian Government committed to establishing two alcohol and other drug rehabilitation prisons with the aim of breaking the cycle of drug related crime. A prisoner triage unit in courts was also committed under the *Methamphetamine Action Plan* to assess prisoners for suitability to enter the alcohol and other drug rehabilitation prisons.

The Wandoo Reintegration Facility (previously a minimum security prison for young men) has been repurposed as a 77-bed prison targeting female offenders with alcohol and other drug needs. The facility opened in August 2018. The Taskforce has been advised the alcohol and other drug model of care will focus on lessons learned in other jurisdictions and that individual counselling will be a component of the wrap-around intervention, which will include a though-care component following offenders into the community or transfer to another prison for release.<sup>397</sup>

Casuarina Prison, the State's main maximum-security prison for men, will house the second alcohol and other drug prison, as part of a recently announced expansion.<sup>398</sup> The Department of Justice has advised that a number of options will be explored in developing the model of care of this facility, including the approach used at Wandoo. The Mental Health Commission will be involved in the co-design process. The facility is expected to open in 2019.

##### **Methamphetamine Action Plan Initiative #6 – Prisoner Triage Unit**

Complementing the above alcohol and other drug rehabilitation prisons, the Western Australian Government has committed to establishing a prisoner triage unit in courts to assess short term, non-violent prisoners for suitability to enter the alcohol and other drug rehabilitation prisons.

Pathways is a voluntary cognitive behavioural therapy based group program for prisoners who have co-occurring problems of alcohol and other drug abuse and criminal conduct. The program (a total of 100 hours) aims to prevent recidivism and prevent relapse into alcohol and other drug problems. To be eligible for the program a person needs to have a history of alcohol and drug problems that are inter-related with offending behaviour and a medium to very high risk of reoffending. Pathways is delivered across Western Australia by both internal Department of Justice staff and external non-government service providers.<sup>399</sup>

---

<sup>397</sup> Government of Western Australia, Department of Justice, Corrective Services. 2018. Response to MAP Taskforce Stocktake.

<sup>398</sup> Government of Western Australia. Media Statement: First of its kind alcohol and other drug treatment prison announced. 2018 March 9. Perth: WA Government; 2018. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/03/First-of-its-kind-alcohol-and-other-drug-treatment-prison-announced.aspx>

<sup>399</sup> Government of Western Australia, Department of Justice, Corrective Services. 2018. Response to MAP Taskforce Stocktake.

Information provided by the Department of Justice shows during 2017-18, 59 Pathways programs involving 692 offenders commenced across Western Australia. 470 people (68 per cent) successfully completed the program; 152 people (22 per cent) were still participating in the program at 30 June 2018; and 70 people (10 per cent) did not complete the program.<sup>400</sup> The Department of Justice is currently planning a review of the Pathways program.

Primary health care is available to all prisoners. Prisoners are assessed for their health needs and are provided primary care as required, including for health issues resulting from harm caused by drug and alcohol use. Prisoners suffering from the effects of alcohol, drugs or withdrawal are identified in an initial health assessment and provided with specific emergency treatment and medication.<sup>401</sup>

#### 9.2.4.3 *What's working*

The literature is mixed on the effectiveness of alcohol and other drug treatment programs in prisons on reducing criminal behaviour and drug use. In 2012 a systematic review summarised the findings of 74 studies from the USA, Canada, Australia, Taiwan and the UK on incarceration-based drug treatment programs which aimed to reduce substance abuse and other criminal behaviours. The review found that incarceration-based drug treatment programs are “modestly effective in reducing recidivism” with “the overall average effect of these programs is approximately a 15-17 per cent reduction in recidivism and drug relapse.”<sup>402</sup>

A 2015 study of drug treatment options in Australian prisons concluded that programs continue to be under-evaluated and the “effectiveness of the various forms of in-prison drug and alcohol treatment (e.g. counselling, Therapeutic Communities) on re-offending and re-incarceration are mixed. However, in a recent analysis of the costs and benefits of in-prison and aftercare substance abuse treatment for prisoners in America found benefits of enhancing in-prison substance abuse treatment.”<sup>403</sup>

There appears to be some consensus in the literature that programs focused on the Therapeutic Community model provide better outcomes. One meta-analysis which combined results from 66 published and unpublished evaluations of incarceration-based drug treatment programs found that “effective interventions... are most likely to find success with programs that focus on the multiple problems of... [the individual] ...in an intensive manner, such as Therapeutic Community programs.”<sup>404</sup>

Common features of Therapeutic Community programs in prison include: housing participants away from anti-social influences of the general prison population; having

---

<sup>400</sup> Ibid.

<sup>401</sup> Ibid.

<sup>402</sup> Mitchell O, Wilson DB, MacKenzie DL. The Effectiveness of Incarceration-Based Drug Treatment on Criminal Behavior: A Systematic Review. *Campbell Systematic Reviews*. 2006;11. DOI 10.4073/csr.2006.11

<sup>403</sup> Dolan K, Rodas A, Bode A. Drug and Alcohol use and Treatment for Australian Indigenous and Non-Indigenous Prisoners: Demand Reduction Strategies. *Int J Prison Health*. 2015; 11 (1); 30-8.

<sup>404</sup> Mitchell O, Wilson DB, Mackenzie DL. Does Incarceration-Based Drug Treatment Reduce Recidivism? A Meta-Analytic Synthesis of the Research. *J Experiment Crim*. 2007;3(4); 353-375.



participant activity involved in the program and supportive of others; and focussing on treating the individual's broader issues, not just drug use.<sup>405</sup>

The 2015 study of drug treatment options within Australian prisons also concluded alcohol and other drug programs "were not always culturally specific" which created barriers to accessing treatment, especially for Aboriginal prisoners.<sup>406</sup> The need for culturally appropriate alcohol and other drug treatment options for Aboriginal people has been previously discussed and extends to prison environments. Aboriginal people are significantly over-represented in the prison system. A 2015 Commonwealth prisoner health review found: "Indigenous people represent approximately 2% of the general adult population, but on 30 June 2014, represented 27% of the prisoner population."<sup>407</sup>

### **Findings from the Western Australian Auditor General *Minimising Drugs and Alcohol in Prisons* 2017 Report**

The Western Australian Auditor General's *Minimising Drugs and Alcohol in Prisons* 2017 Report detailed findings from an audit of 17 metropolitan and regional adult prisons in WA. The purpose of the audit was to "assess whether there are effective strategies in place to minimise drugs and alcohol in Western Australian prisons."<sup>408</sup> The report concluded there were "considerable improvements needed to prevent the supply of drugs, and to treat prisoners' addictions."<sup>409</sup>

In relation to alcohol and other drug treatment for prisoners, the Auditor General found:

- "Since 2010, the number of programs available to treat addiction based offending has narrowed from 4 to 1. The single therapeutic program, Pathways, is required to address the diverse needs of prisoners."
- "Two programs that catered for the needs of Aboriginal prisoners, who make up 38% of the prison population, were stopped in 2010 and 2015. There have also been no gender specific addiction treatment services for women since 2010."
- "Prisoners are not assessed for treatment within the required time period which delays their access to treatment programs, and impacted parole decisions. We found that 88% of prisoners were not assessed within the Department's 28-day target. On average, prisoners did not receive assessments for 70 days, with 28% taking more than 100 days."
- "When prisoners were assessed, more than half were recommended for Pathways. However, the Department does not provide enough places in Pathways to meet this need. During the audit period 1,382 prisoners recommended for Pathways were released. However, 310 (22%) were released before a place was available in the program."
- "The Department only monitors the number of prisoners enrolled in the Pathways treatment program. The program's effectiveness has not been assessed since

---

<sup>405</sup> Ibid.

<sup>406</sup> Dolan K, Rodas A, Bode A., loc. cit.

<sup>407</sup> Australian Government. Australian Institute of Health and Welfare. The health of Australia's prisoners. 2015. [accessed 2018 Nov 7] Available from <https://www.aihw.gov.au/getmedia/9c42d6f3-2631-4452-b0df-9067fd71e33a/aihw-phe-207.pdf.aspx?inline=true>

<sup>408</sup> Office of the Auditor General Western Australia. Western Australian Auditor General's Report Minimising Drugs and Alcohol in Prisons: Report 22 November 2017. [accessed 2018 Nov 7] Available from [https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017\\_22-AlcoholDrug.pdf](https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017_22-AlcoholDrug.pdf)

<sup>409</sup> Ibid.



2013 and its content has not been reviewed since 2010.”

- “Not delivering treatment programs has also contributed to parole being denied. We reviewed parole notes of prisoners who had not received their treatment by the time they were eligible for parole, despite being eligible and willing to participate. We found in 88.5% of cases, a failure to complete a treatment program was included as a contributing reason for denying parole.”<sup>410</sup>

In relation to alcohol and other drug treatment for prisoners, the Auditor General recommended that the Department of Justice:

- “review current treatment approaches to demand and harm reduction, to ensure they are up-to-date and able to meet the diverse needs of prisoners”; and
- “review current treatment programs, and establish measures to allow their effectiveness to be assessed.”<sup>411</sup>

The Department of Justice has advised that a Prisons Drug Strategy is currently being drafted and “work has also commenced on the whole of Department drugs strategy, taking into account Methamphetamine Action Plan [Taskforce] report and other key policy reviews.”<sup>412</sup>

### Taskforce conclusions and recommendations

The Taskforce acknowledges implementation of the State’s first dedicated alcohol and other drug rehabilitation prisons is progressing. This is an important step in improving prisoners’ access to alcohol and other drug treatment, and brings Western Australia in line with other jurisdictions.

However, the Taskforce believes the establishment of these facilities should be considered a first step to supporting prisoners to address their alcohol and other drug use, and that more must be done to make alcohol and other drug treatment programs available to all prisoners in Western Australia, on a voluntary basis.

The Taskforce believes the model of care used in the new rehabilitation prisons, which is currently in development, should be evidence-based and focus on the individual needs of the prisoner. Further, evaluation mechanisms should be considered, and ideally, finalised ahead of their operation. The Department of Justice has advised that an evaluation framework for alcohol and other drug rehabilitation prisons is also currently under development.

Criteria for entry to the current Pathways program is limiting and, combined with a lack of available places, means there is a missed opportunity here to create better outcomes for more people in the justice system. The Taskforce would like to see alcohol and other drug programs in prison address alcohol and other drug use holistically, as opposed to focussing only on the criminogenic aspects of use and/or whether the individual is at risk of reoffending.

The Taskforce acknowledges the challenges of delivering alcohol and other drug treatment services in a correctional setting, including managing an expanding prison

---

<sup>410</sup> Ibid.

<sup>411</sup> Office of the Auditor General Western Australia. Western Australian Auditor General’s Report Minimising Drugs and Alcohol in Prisons: Report 22 November 2017. [accessed 2018 Nov 7] Available from [https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017\\_22-AlcoholDrug.pdf](https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017_22-AlcoholDrug.pdf)

<sup>412</sup> Department of Justice email to MAP Taskforce, 12 July 2018.

population in a constrained fiscal environment. However, the Taskforce strongly believes that all prisoners willing to address their alcohol and other drug use should have access to these services. This is supported by the revised United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) that states prisoners should be given “the same standards of health care that are available in the community”.<sup>413</sup>

The Taskforce supports recommendations made by the Auditor General in the *Minimising Drugs and Alcohol in Prisons* 2017 Report. More can and should be done to ensure that all prisoners are assessed for substance use and provided with intervention and treatment to meet their needs.

#### **Recommendation 39:**

The Department of Justice ensures that all persons in custody, including remanded and sentenced offenders, are assessed for alcohol and other drug use, including methamphetamine, and are provided with intervention and treatment to meet the needs identified.

### **9.2.5 Drug treatment in juvenile detention**

There are a number of programs offered at Banksia Hill Detention Centre to help address young people’s alcohol and other drug concerns. The Drug Alcohol Youth Service (DAYS) brief intervention therapy program is for young people who have entrenched substance use issues and includes individual counselling on a weekly basis. Wungening Aboriginal Corporation provides two group programs, *Who’s ya mob?* and *180 Degrees*, designed to support young male Aboriginal offenders who present with a history of substance use and problematic behaviour.

Individual support is also provided by a Beyond Youth Justice Services youth worker, who focusses on emotional regulation, anger management and identifying future goals. The youth worker assists a young person to identify positive support networks (family and peers) and make plans for re-engagement in positive recreational activities within the community. Prior to release from Banksia Hill, ongoing support for the young person within the community is provided through a handover to a community-based Beyond Youth Justice Services youth worker.<sup>414</sup>

### **9.2.6 Drug treatment and support for offenders reintegrating to the community**

#### **9.2.6.1 What the Taskforce heard**

The Taskforce heard more should be done when reintegrating prisoners back into the community, with many facing barriers to accessing treatment services, safe accommodation, employment and training opportunities. When released from prison Aboriginal people, and men in particular, often have no safe accommodation to return to, are refused places in residential rehabilitation facilities due to their criminal records, and face waiting periods of three to four weeks before they can access

<sup>413</sup> United Nations Economic and Social Council. Commission on Crime Prevention and Criminal Justice 2015. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules). [accessed 2018 Nov 7] Available from [http://www.unodc.org/documents/commissions/CCPCJ/CCPCJ\\_Sessions/CCPCJ\\_24/resolutions/L6\\_Rev1/ECN152015\\_L6Rev1\\_e\\_V1503585.pdf](http://www.unodc.org/documents/commissions/CCPCJ/CCPCJ_Sessions/CCPCJ_24/resolutions/L6_Rev1/ECN152015_L6Rev1_e_V1503585.pdf)

<sup>414</sup> Government of Western Australia, Department of Justice, Corrective Services. Response to MAP Taskforce Stocktake. 2018.

other types of alcohol and other drug services and/or mental health services. Many people called for transitional support plans to be established prior to release from prison.

#### **9.2.6.2      *What's happening in Western Australia***

In 2016 the Department of Justice reviewed adult rehabilitation and reintegration services to improve “outcomes for offenders, ensuring that services are targeted to their specific needs in an integrated and individualised through-care approach.” The new Adult Rehabilitation and Reintegration Services commenced in April 2018 and aim to achieve the following service outcomes for offenders:

- effective transitional planning and support services for successful reintegration into the community;
- opportunities to address alcohol and other drug issues;
- increased motivation to establish and maintain pro-social lifestyles;
- increased access to meaningful and stable engagement in employment, education, training or other vocational activities in the community;
- improved access to suitable and sustainable housing;
- improved family relationships and personal networks;
- increased skills and knowledge to improve their emotional control and self-regulation to keep their families safe;
- support and opportunities to reconnect to their communities and culture; and
- increased understanding and awareness of how to maintain good physical health and well-being.<sup>415</sup>

Through-care services offered under the previous rehabilitation and reintegration contract were available through Cyrenian House and Holyoake, and only in the metropolitan area. The Department of Justice is introducing a new reintegration assessment in 2018 to complement the new rehabilitation and reintegration services.<sup>416</sup>

### **Taskforce conclusions and recommendations**

The Taskforce heard more should be done when reintegrating prisoners back into the community, with many facing barriers to accessing treatment services, safe accommodation, and employee and training opportunities.

The Taskforce supports the introduction of a new system of Adult Rehabilitation and Reintegration Services, noting previous through-care services were only available in the Perth metropolitan area. As methamphetamine consumption is highest in regional Western Australia, the Taskforce believes there is merit in investigating the feasibility of extending the new services to Western Australia's regional prisons.

#### **Recommendation 40:**

The Department of Justice expands drug and alcohol through-care services to sentenced prisoners in regional prisons.

<sup>415</sup> Ibid.

<sup>416</sup> Government of Western Australia. 2018. Prison to Work Report - Western Australian Government Action Plan.

## 9.2.7 Harm minimisation in prison

### 9.2.7.1 *What the Taskforce heard*

The Taskforce heard that despite a ban on illicit drugs in prison, the reality is that prisoners are injecting drugs and, due to a lack of clean needles, used syringes are shared among prisoners. This puts them at greater risk of a range of health-related harms, particularly blood-borne diseases. The lack of clean needles for prisoners was a common concern expressed by the community and many people said they'd like to see the introduction of needle syringe exchange programs in Western Australian prisons.

### 9.2.7.2 *What works to minimise harm*

A 2015 Australian Institute of Health and Welfare study found 45 percent of prison entrants reported injecting drug use.<sup>417</sup> Injecting drug use places prisoners at higher risk of blood-borne viruses such as Hepatitis B, Hepatitis C and HIV. The 2016 National Prison Entrants' Blood-borne Virus and Risk Behaviour Survey which sampled 431 participants found: the overall prevalence of Hepatitis C antibody was 22 per cent; Hepatitis C antibody prevalence was much higher among those with a history of injecting drug use compared with those who had not injected (50 per cent versus 1 per cent); among Indigenous people who had a history of injecting drugs, the prevalence of Hepatitis C antibody increased from 54 per cent in 2013 to 66 per cent in 2016; and 16 per cent of those tested were positive for Hepatitis B core-antibody.<sup>418</sup>

Detailed evaluations of needle exchange programs in prisons in Germany, Spain and Switzerland have shown positive results including a reduction in equipment sharing; a reduction in Hepatitis C infections; and equipment not being used as weapons against staff. These findings have led to the World Health Organization (WHO) and United Nations Programme on HIV/AIDS (UNAIDS) supporting the introduction of prison-based needle exchange programs.<sup>419 420</sup>

In 2003, the Australian Capital Territory (ACT) Legislative Assembly's Standing Committee on Health recommended "the Government, in line with its harm minimisation approach, adopt the policy of injecting equipment exchange in the ACT corrections system."<sup>421</sup> The position was subsequently supported through a 2006

<sup>417</sup> Australian Government. Australian Institute of Health and Welfare. The health of Australia's prisoners 2015. (cat no. PHE 207). Canberra: AIHW; 2015. p. 54. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/9c42d6f3-2631-4452-b0df-9067fd71e33a/aihw-phe-207.pdf.aspx?inline=true>

<sup>418</sup> Butler T, Simpson M. Kirby Institute (UNSW Sydney). National Prison Entrants' Blood-borne Virus Survey Report 2004, 2007, 2010, 2013, and 2016. 2017. Sydney: Kirby Institute; 2017. [accessed 2018 Nov 7] Available from: [https://kirby.unsw.edu.au/sites/default/files/kirby/report/JHP\\_National-Prison-Entrants-Report-2004-2007-2010-2013-2016.pdf](https://kirby.unsw.edu.au/sites/default/files/kirby/report/JHP_National-Prison-Entrants-Report-2004-2007-2010-2013-2016.pdf)

<sup>419</sup> Rutter S, Dolan K, Wodak A, Heilpern H. National Drug and Alcohol Research Centre (UNSW). Prison-Based Syringe Exchange Programs: A Review of International Research and Program Development. NDARC Technical Report No. 112. Sydney: NDARC; 2001. [accessed 2018 Nov 7] Available from: <https://ndarc.med.unsw.edu.au/resource/prison-based-syringe-exchange-review-international-research-and-program-development>

<sup>420</sup> Mogg D, Levy M. Moving beyond non-engagement on regulated needle-syringe exchange programs in Australian prisons. Harm Reduct J. 2009; 4(6); 7. DOI:10.1186/1477-7517-6-7.

<sup>421</sup> Legislative Assembly for the Australian Capital Territory. Access to needles and syringes by intravenous drug users. Report No. 5 Standing Committee on Health August 2003. Canberra:

and 2007 review of the ACT's correctional facilities by the ACT's Human Rights Commission.<sup>422</sup> The program was later rejected by prison officers who, after a year of consultation and negotiation (2015-2016) voted against a needle exchange proposed for the ACT's Alexander Maconochie Centre.<sup>423</sup> Concerns stemmed from how the program would be administered in prisons, and the risks arising from needles potentially being used as weapons by prisoners.<sup>424</sup>

More recently, there have been renewed calls for a prison needle and syringe program in the Australian Capital Territory with the release of the ACT Health Services Commissioner's March 2018 review of the *Opioid Replacement Treatment Program at the Alexander Maconochie Centre*. The review recommended "the Justice and Community Safety Directorate, Corrective Services and ACT Health undertake further work to progress the implementation of the ACT Government policy of a needle syringe program in the Alexander Maconochie Centre, consistent with services available in the ACT community, to reduce risks of blood borne virus transmission."<sup>425</sup>

### 9.2.7.3 What's happening in Western Australia

The Western Australian Government, through the Department of Health, funds a two-part mandatory *Health in Prisons, Health Outta Prisons* (HIP HOP) education program to educate prisoners about the dangers of blood-borne viruses resulting from unprotected sex, unclean tattooing and needle sharing. The program is delivered by Hepatitis Western Australia in metropolitan prisons, and by the WA Country Health Service in regional areas.

The program aims to: increase awareness among prison populations about blood-borne viruses and sexually transmissible infections; increase understanding of the concept of harm reduction in relation to blood-borne viruses; increase awareness about blood and health and safety issues; decrease stigma around people living with blood-borne viruses; and increase awareness of the blood-borne virus and sexually transmissible infection testing and treatment services available to prisoners.<sup>426</sup>

---

Legislative Assembly for the ACT; 2003. [accessed 2018 Nov 7] Available from:

[https://www.parliament.act.gov.au/\\_data/assets/pdf\\_file/0010/375598/h05accessstoneedles.pdf](https://www.parliament.act.gov.au/_data/assets/pdf_file/0010/375598/h05accessstoneedles.pdf)

<sup>422</sup> ACT Government. Human Rights Commission. Human Rights Audit on the Operation of Correctional Facilities under Corrections Legislation. Canberra: ACT Human Rights Commission; 2007. [accessed 2018 Nov 7] Available from:

<http://www.hrc.act.gov.au/res/Corrections%20Audit%202007.pdf>

<sup>423</sup> Connery G. Jail needle exchange veto shows unions 'dictating' public health policy: researchers. The Canberra Times. 2016 September 24. [accessed 2018 Nov 7] Available from:

<https://www.canberratimes.com.au/national/act/jail-needle-exchange-veto-shows-unions-dictating-public-health-policy-researchers-20160922-grlzg4.html>

<sup>424</sup> Mogg D, Levy M. Moving beyond non-engagement on regulated needle-syringe exchange programs in Australian prisons. Harm Reduct J. 2009; 6(7). DOI:10.1186/1477-7517-6-7.

<sup>425</sup> Toohey K, McKinnon G, Osmond I. ACT Human Rights Commissioner. Review of the opioid replacement treatment program at the Alexander Maconochie Centre: Report of the ACT Health Services Commissioner. Canberra: ACT Human Rights Commission; 2018. [accessed 2018 Nov 7] Available from: <http://hrc.act.gov.au/wp-content/uploads/2018/03/ORT-Report-Final-Ready-to-Print.pdf>

<sup>426</sup> Australian Indigenous Health Info Net. Information page: Health in Prisons, Health Outta Prisons (HIP HOP) program. 2017. [accessed 2018 Nov 7] Available from: <https://healthinfonet.ecu.edu.au/key-resources/programs-and-projects/?id=3139>



The Western Australian Government's *Western Australia Hepatitis C Strategy 2015–2018* acknowledged the need of prison populations, noting “people in, or who have recently exited, custodial settings” are a particular priority, and calls for “increased availability, access to, and use of, sterile injecting equipment among people who inject drugs” in Western Australia.<sup>427</sup>

However, there are currently no needle syringe exchange programs in Western Australian prisons, and the Department of Justice HIP HOP program, although compulsory, is not being accessed by all prisoners.<sup>428</sup> The Auditor General's 2017 review found:

- “The Department is not delivering its harm reduction program. The third part of the Department's expired strategy was harm reduction, which is delivered through the Health in Prison, Health Outta Prison (HIP HOP) education program. While the Department intends to deliver this program to all prisoners, only a small number of prisoners actually receive the program, and the Department does not assess delivery of the program against its set timeframes.”
- “We found that only 35% of prisoners received the first portion of the program and only 5.6% received the second portion. We were not able to assess delivery timeframes as the Department does not record this information. Opportunities to help prisoners reduce the harm from dangerous practices are being missed.”

### Taskforce conclusions and recommendations

The Taskforce acknowledges the seemingly contradictory message of sending people to prison for drug-related offences and then giving them injecting equipment to assist in their drug use, could be difficult to reconcile. However, the reality is that drugs are in prisons and they are being injected.

Based on the evaluations of prison-based needle and syringe exchange programs in other international jurisdictions, the Auditor General's findings, the Western Australian Government's support for reducing blood-borne virus transmission, morbidity and mortality, and what the Taskforce heard, the Taskforce recommends introducing a needle and syringe exchange program in Western Australian prisons. The potential impact of any program on the safety of prison staff should be investigated.

#### Recommendation 41:

The Department of Health and the Department of Justice introduce needle syringe exchange programs in Western Australian prisons, as part of the response to the Auditor General recommendation that “The Department of Justice review current treatment approaches to demand and harm reduction, to ensure they are up-to-date and able to meet the diverse needs of prisoners”.

<sup>427</sup> Government of Western Australia. Department of Health. *WA Hepatitis C Strategy 2015–2018*. East Perth: The Department; 2015 [accessed 2018 Nov 7]. Available from: <http://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents/Sexual%20Health/PDF/wa-hepatitis-c-strategy-2015-2018.pdf>

<sup>428</sup> Government of Western Australia. Office of the Auditor General. *Minimising Drugs and Alcohol in Prisons Report 22: November 2017*. Perth: Office of the Auditor General; 2017 [accessed 2018 Nov 7]. Available from [https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017\\_22-AlcoholDrug.pdf](https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017_22-AlcoholDrug.pdf)



## 9.2.8 Reducing supply in prison

### 9.2.8.1 *What the Taskforce heard*

The Taskforce heard access to drugs in prison and juvenile detention was easier than getting them in the community, with one participant stating “it is easier to get drugs in prisons than cigarettes.” One forum participant said that due to the availability of drugs in prison, they “came out of prison with a habit.” Some participants also spoke about the social opportunities prison offered, where they were able to catch up with relatives and friends, and meet new drug contacts.

The Taskforce heard efforts to reduce the supply of drugs in prison should be increased with many recommending more, and more thorough, drug screening and testing, including that all visitors and staff (family, friends, official visitors, prison guards, administration staff and service providers) should be thoroughly searched. Families and friends visiting people in prison raised also concerns about the probity of the process when drugs were found on individuals during drug screening checks.

### 9.2.8.2 *What’s happening in Western Australia*

#### **The Western Australian Auditor General *Minimising Drugs and Alcohol in Prisons* 2017 Report**

The Western Australian Auditor General concluded “the Department does not have a clear understanding of the extent of drug and alcohol use in prisons” and made a number of recommendations relating to reducing the supply of drugs in Western Australia prisons.<sup>429</sup> These include that “the Department should:

- develop a new drug and alcohol strategy that includes targets and measures of success;
- review the DPT [Drug Prevalence Testing] program, to ensure that it gives a more accurate and complete view of drug and alcohol use in prisons;
- consider other information it collects, such as security reports, incident reports, and search results to present a more holistic view of drug use in prisons;
- review gatehouse searching requirements, and ensure that all prisons have processes in place to select targets in a non-predictable way;
- review prison compliance with key supply reduction procedures to ensure they are carried out consistently and correctly;
- formalise processes and standard operating procedures for all areas, including its intelligence team, ensure that staff are suitably trained, and prisons have timely access to intelligence information;
- compile a data dictionary for TOMS [Total Offender Management Solution], and review controls in critical data systems to improve data accuracy and reliability; and
- assess whether prisons have access to the security devices they need to reduce the entry of drugs and alcohol into prisons.”<sup>430</sup>

The Department of Justice welcomed the findings of the report and accepted all recommendations made. It said: “The Department will be considering recommendations within cost and resource parameters and against other

<sup>429</sup> Government of Western Australia. Office of the Auditor General. *Minimising Drugs and Alcohol in Prisons* Report 22: November 2017. Perth: Office of the Auditor General; 2017. [accessed 2018 Nov 7] Available from [https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017\\_22-AlcoholDrug.pdf](https://audit.wa.gov.au/wp-content/uploads/2017/11/report2017_22-AlcoholDrug.pdf)

<sup>430</sup> Ibid.

Department and Interagency alcohol and other drug strategies that are currently in development.”<sup>431</sup>

The Department of Justice has increased its focus on drug detection and search strategies to reduce the supply of drugs in prisons. Examples of these initiatives include increased security measures and use of drug detection technologies, recruitment of additional staff, staff alcohol and other drug testing, and wastewater testing.<sup>432</sup> Additional information on further initiatives was provided to the Taskforce, however because of operational sensitivities this information cannot be publicly released.

### 9.3 LGBTIQ <sup>433</sup> (lesbian, gay, bisexual, transgender, intersex and questioning)

Rates of drug use among people identifying as homosexual or bisexual<sup>434</sup> are considerably higher than the national averages. The 2016 National Drug Strategy Household Survey found:

- “use of illicit drugs in the last 12 months, daily smoking and risky drinking were far more common among people who identified as being homosexual or bisexual than people who were heterosexual”; and
- “the largest differences in use among homosexual/bisexual people were in the use of ecstasy and meth/amphetamines; use was 5.8 times as high as heterosexual people for both.”<sup>435</sup>

Research has identified “two discrete but overlapping psychosocial determinants of increased drug use among LGBT people and communities: the first is tied to an LGBT individual’s experiences of heterosexist discrimination; the second to the normalisation of drug use on the commercial gay scene.”<sup>436</sup> A review of the literature published by the National Drug and Alcohol Research Centre in Sydney in 2012, around prevalence of and interventions for mental health and other drug problems in this community, found factors which may put members of the LGBT community at greater risk of drug use include abuse and victimisation, stigma and minority stress,

---

<sup>431</sup> Government of Western Australia. Office of the Auditor General. Information page: Response from the Department of Justice. 2017. [accessed 2018 Nov 7] Available from:

<https://audit.wa.gov.au/reports-and-publications/reports/minimising-drugs-alcohol-prisons/response-department-justice/>

<sup>432</sup> Government of Western Australia, Department of Justice, Corrective Services. Response to MAP Taskforce Stocktake. 2018

<sup>433</sup> LGBTIQ is the acronym used throughout the report, except where a source is referenced or quoted.

<sup>434</sup> The National Drug Strategy Household Survey only presents findings on people who identified as gay, lesbian or bisexual as the survey does not capture information on people who are transgender or intersex.

<sup>435</sup> Australian Government. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2016: Detailed findings. Canberra: AIHW; 2017. p 109. [accessed 2018 Nov 7] Available from: <https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/21028a.pdf.aspx?inline=true>

<sup>436</sup> Leonard W, Lyons A, Bariola E. The Australian Research Centre in Sex, Health & Society. A Closer Look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians. Monograph Series No. 103. Melbourne: La Trobe University; 2015. p32. [accessed 2018 Nov 7] Available from: <http://apo.org.au/system/files/53996/apo-nid53996-34376.pdf>

and uncertain self-identification. Although some of these factors are relevant for both LGBT and non-LGBT people, many of these factors are experienced to a greater extent by LGBT people.<sup>437</sup>

One recent study indicated that rates of drug use among LGBTIQ Australians, especially among gay men and other homosexually active men<sup>438</sup>, are considerably higher than the national averages, making them particularly vulnerable to the effects and harms associated with drug use. LGBT people have reported markedly higher rates of alcohol and other drug use in a party/recreational setting, including ecstasy, meth/amphetamine, cocaine and ketamine. Rates of amphetamine and ecstasy use among LGBT Australians are more than four times the national averages.<sup>439</sup>

Gay men and other homosexually active men represent a distinct subgroup of methamphetamine users who have specific usage patterns and motivations for use. Research suggests that drug use among this group can be seen as “a social practice that [is] embedded in relationships and not just an individual behaviour”<sup>440</sup> and that a “primary motivation for methamphetamine use [...] is the enhancement of sexual pleasure, including greater sexual endurance, higher libido and reduced sexual inhibitions.”<sup>441</sup>

The 2012 National Drug and Alcohol Research Centre literature review also found:

- “prevention is a priority principle with LGBT people; both alcohol and other drug and mental health problems are preventable. Youth are clearly a central target in prevention efforts [and] supportive counselling provided during adolescence is likely to substantially reduce the risk of later mental health or substance misuse problems”<sup>442</sup>;
- “preventing discrimination and stigma is an essential aspect of any comprehensive approach to reducing alcohol and other drug and mental health problems”<sup>443</sup>;
- LGBT people appear to access treatment for alcohol or drug problems at a higher rate than non-LGBT people and that “this is a compelling argument for ensuring

<sup>437</sup> Ritter A, Matthew-Simmons F, Carragher N. National Drug and Alcohol Research Centre Monograph No. 23: Prevalence of and interventions for mental health and alcohol and other drug problems amongst the gay, lesbian, bisexual and transgender community: A review of the literature. DPMP Monograph Series. Sydney: NDARC; 2012. [accessed 2018 Nov 7] Available from: <https://dpmp.unsw.edu.au/sites/default/files/dpmp/resources/DPMP%20MONO%2023.pdf>

<sup>438</sup> ‘Gay men and other homosexually active men (GHAM)’ is the term used by the WA Aids Council.

<sup>439</sup> Leonard W, Lyons A, Bariola E. The Australian Research Centre in Sex, Health & Society. A Closer Look at Private Lives 2: Addressing the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) Australians. Monograph Series No. 103. Melbourne: La Trobe University; 2015. p32. [accessed 2018 Nov 7] Available from: <http://apo.org.au/system/files/53996/apo-nid53996-34376.pdf>

<sup>440</sup> Dowsett GW, Wain D, Keys D. Good gay men don’t get “messy”: Injecting drug use and gay community. Sexual Research Social Policy. 2005; 2(2); 22-36.

<sup>441</sup> Lea T, Limin M, Bath N, Prestage G, Zablotska I, de Wit J, Holt M. Injecting drug use among gay and bisexual men in Sydney: prevalence and associations with sexual risk practices and HIV and hepatitis C infection. AIDS Behav. 2013; 17(4); 1344-51. DOI:10.1007/s10461-013-0409-0

<sup>442</sup> Ritter A, Matthew-Simmons F, Carragher N. National Drug and Alcohol Research Centre Monograph No. 23: Prevalence of and interventions for mental health and alcohol and other drug problems amongst the gay, lesbian, bisexual and transgender community: A review of the literature. DPMP Monograph Series. Sydney: NDARC; 2012. p. 130. Available from: <https://dpmp.unsw.edu.au/sites/default/files/dpmp/resources/DPMP%20MONO%2023.pdf>

<sup>443</sup> Ibid.

that services receive appropriate training and are well placed to provide care to this population group”<sup>444</sup>;

- “research has shown some superior outcomes with LGBT-specific services, especially for methamphetamine dependent users ... [and that] ...LGBT-specific services provide positive role models, strategies for coping with stigma, tailored interventions for alcohol and other drug and mental health issues and are largely staffed by LGBT practitioners”<sup>445</sup>;
- “a variety of treatment interventions such as cognitive behavioural therapy, motivational interviewing, 12-step programs and the community reinforcement approach have all been shown to be effective with LGBT individuals”<sup>446</sup> in the context of a non-LGBT-specific service; and
- a diversity of service types is required because “not all LGBT clients want a[n] LGBT service”; and
- all alcohol and other drug and mental health services should be LGBT sensitive with “an adequately trained workforce, culturally appropriate services and a non-judgmental attitude by all staff across a service”<sup>447</sup>.

The need for tailored prevention communication to the LGBTIQ community was acknowledged in the 2015 *Final Report of the National Ice Taskforce* which recommended that prevention communication, particularly social media, could be used more effectively in targeting particular audiences, such as the LGBTI community.<sup>448</sup> These methods should be evaluated for effectiveness, as research into social marketing campaigns directed towards healthy lifestyles for LGBT people has not been sufficiently evaluated to draw conclusions about efficacy.<sup>449</sup>

### 9.3.1 What’s happening in Western Australia

Current approaches to addressing methamphetamine use among the LGBTIQ community in Western Australia include peer support, targeted health promotion and harm reduction information. The Department of Health is currently developing the Western Australia Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy in conjunction with the LGBTI community. The strategy will provide a framework to raise awareness of the specific health and mental health challenges of LGBTI people.<sup>450</sup> It is not yet clear if the strategy will include a focus on alcohol and other drug use and its impact on health among the LGBTI community.

The Taskforce consulted with the Western Australian AIDS Council which has been supporting gay men and other homosexually active male clients to address their

---

<sup>444</sup> Ibid. p. 119

<sup>445</sup> Ibid. p. 130

<sup>446</sup> Ibid. p. 119

<sup>447</sup> Ibid. p. 130

<sup>448</sup>Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 116. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>449</sup> Ritter A, Matthew-Simmons F, Carragher N. loc. cit.

<sup>450</sup> Government of Western Australia. Department of Health. Information page: Contributions invited for WA LGBTI Health Strategy. 2018 March 22. [accessed 2018 Nov 7] Available from: <http://ww2.health.wa.gov.au/News/Contributions-invited-for-WA-LGBTI-Health-Strategy>

alcohol and other drug use, particularly when it intersects with their sexual health outcomes.

The Western Australian AIDS Council's M Clinic is a sexual health clinic for men who have sex with men. M Clinic works on a peer-based model, combining integrated health promotion with clinical service provision, with the aim of reducing acquisition of HIV and other sexually transmissible infections at a population health level. The clinic can assist men with referral to other health and related services, such as alcohol and other drug treatment.<sup>451</sup>

M Clinic clients are reporting low levels of methamphetamine use, with the majority of clients using alcohol. Clients also reported that crystal methamphetamine or ice use cannot be assumed to be always problematic or cause significant risk. Many clients who do use methamphetamine say they limit and control their use. Among this group, smoking methamphetamine is considered an acceptable way of using, whereas injecting is considered a sign of addiction and those who use methamphetamine in this manner face stigma from others. The Taskforce heard M Clinic clients will typically report concerns about their use when their habit reaches the point of injecting.

Recommendations to the Taskforce from the Western Australian AIDS Council include:

- targeted health communication including harm reduction messaging;
- training for service providers on specific issues relating to gay men and other homosexually active men;
- that Taskforce findings intersect with the Western Australian Department of Health LGBTI Health Strategy; and
- Rainbow Tick Accreditation is adopted by service providers and included in commissioning processes.<sup>452</sup>

The Mental Health Commission advises it is already delivering targeted health communication including harm reduction messaging.

The Rainbow Tick Accreditation Program supports organisations to understand and implement LGBTIQ inclusive service delivery, and provides national recognition for those that meet the Rainbow Tick Standards.<sup>453</sup> Currently, Richmond Wellbeing is the only Western Australia organisation to receive Rainbow Tick Accreditation.

Living Proud LGBTI Community Services of WA (formerly Gay & Lesbian Community Services of WA Inc.) is a non-profit organisation which aims to promote the well-being of LGBTIQ people in Western Australia. Services provided include a peer counselling phone line, health and well-being initiatives, and community capacity building.

<sup>451</sup> WA Aids Council. Information page: M Clinic. 2018. Available from: <https://waaidcs.com/item/15-m-clinic.html>

<sup>452</sup> WA AIDS Council Submission to the MAP Taskforce. 2018.

<sup>453</sup> Quality Innovation Performance. Information page: Rainbow Tick Accredited Organisations. 2018. [accessed 2018 Nov 7] Available from: <http://www.qip.com.au/standards/rainbow-tick-standards/rainbow-tick-accredited-organisations/>



The objectives of the association are to:

- provide a range of quality services, support and resources which promote the health and well-being of lesbian, gay, bisexual, transgender and intersex and other sex, sexuality and gender diverse people (collectively LGBTI);
- provide advocacy and leadership aimed at reducing disadvantage and discrimination among LGBTI people;
- encourage and empower LGBTI people to actively participate within the Association, partner organisations and the community;
- provide consultancy, information, education and training to a range of professionals and service providers which promotes access to services and improves the quality of services for LGBTI people; and
- develop the capacity of groups, organisations, businesses and other institutions to be inclusive of LGBTI people.<sup>454</sup>

Living Proud is the Western Australia partner of QLife, a national LGBTI confidential telephone and web-based service providing early intervention, peer support, counselling and referral services to people of all ages. The service is also available for friends and family of LGBTIQ people and service providers seeking accurate information and referral options for their relatives, friends or patients. The service is available from 3pm to midnight every day of the year.<sup>455</sup>

### Taskforce conclusions and recommendations

The Taskforce welcomes the development of a LGBTI Health Strategy and believes alcohol and other drug use issues, including those associated with methamphetamine use, and appropriate responses should be considered as part of the new strategy.

#### Recommendation 42:

The Department of Health in consultation with the Mental Health Commission and representatives from the LGBTIQ community, include in the development of the Western Australian Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Health Strategy – the impact of illicit drug use on the LGBTI community (including methamphetamine); relevant approaches to addressing illicit drug use, and consideration of the Rainbow Tick Accreditation Program.

## 9.4 Culturally and linguistically diverse (CaLD) communities

People from culturally and linguistically diverse (CaLD) communities have been highlighted as one of seven priority populations under the Commonwealth's *National Drug Strategy 2017-2026*, as some populations "have higher rates of, or are at higher risk of, alcohol, tobacco and other drug problems."<sup>456</sup> Reports suggest this is

<sup>454</sup> Living Proud LGBTI Community Services of WA. Information page: About Living Proud LGBTI Community Services of WA. 2017. [accessed 2018 Nov 7] Available from: <http://www.livingproud.org.au/about-living-proud-inc/>

<sup>455</sup> Living Proud LGBTI Community Services of WA. Information page: QLife Counselling. 2017. [accessed 2018 Nov 7] Available from: <http://www.livingproud.org.au/qlife-counselling/>

<sup>456</sup> Australian Government. Department of Health. *National Drug Strategy 2017-2026*. Canberra: The Department; 2017. p 29. [accessed 2018 Nov 7] Available from:



due to language barriers, unemployment, family stressors, lack of awareness of programs available, and limited access to programs that are culturally appropriate. Individuals may also have experienced torture, trauma, grief and loss, putting them at greater risk of alcohol and other drug issues.<sup>457</sup>

Specific barriers individuals from CaLD communities may face include:

- language, resulting from limited understanding or use of English, use of professional jargon and misinterpretation of body language;
- cultural norms that prohibit seeking extra-familial support, especially for women and children;
- traditional gender roles that prevent men from engaging with services or discussing family difficulties; and
- fear of authorities, such as child protection, police, courts, taxation, immigration and housing departments.<sup>458</sup>

These barriers may impact on CaLD communities accessing appropriate health services, including support for alcohol and other drug issues. Research indicates strategies which address these barriers are critical to improving the health of CaLD communities.<sup>459</sup> Enablers for improved CaLD individual and community participation in health services can include; increased cultural competency, accessible and appropriate language services, building relationships between individuals and health services, providing accessible health information, increasing diversity in the workforce, and adopting a whole-of-community approach.<sup>460</sup>

The literature notes CaLD communities are not homogenous and alcohol and other drug issues are not uniformly experienced by CaLD communities, or indeed individuals. Further, the notion that “solutions can be developed for the entire nation is detrimental.”<sup>461</sup>

It must be stated that the Taskforce’s engagement with members from CaLD communities to better understand the impact of methamphetamine use in Western Australia was limited. One forum was held with community leaders from one CaLD community. The findings and outcomes from this forum were consistent with those evident in the literature, particularly relating to culture barriers to accessing help.

The Taskforce heard that young CaLD people are mostly impacted by methamphetamine use in Western Australia, with some both using and dealing. The Taskforce heard young CaLD people are targeted by organised crime groups to sell

---

[http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/\\$File/National-Drug-Strategy-2017-2026.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/55E4796388E9EDE5CA25808F00035035/$File/National-Drug-Strategy-2017-2026.pdf)

<sup>457</sup> Ibid.

<sup>458</sup> Australian Government: Australian Institute of Family Studies. Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia. AFRC: Issues No.3. Canberra; AIFS; 2008. [accessed 2018 Nov 7] Available from: <https://aifs.gov.au/cfca/publications/enhancing-family-and-relationship-service-accessibility-and/barriers-service>

<sup>459</sup> Henderson S, Kendell E. Culturally and linguistically diverse peoples’ knowledge of accessibility and utilisation of health services: exploring the need for improvement in health service delivery. *Aust J Prim Health*. 2011; 17(2): 195-201. DOI: 10.1071/PY10065

<sup>460</sup> Romios P, McBride T, Mansourian J. Participation with Culturally and Linguistically Diverse Communities in Health Services - What Helps and What Hinders? *Health Issues*. 2008 [cited 16 May 18]. No. 95(Winter 2008); 27-31.

<sup>461</sup> Henderson S, Kendell E. loc. cit.

methamphetamine. Due to language and literacy issues, some parents can have a limited understanding of the impact of drugs on their children's lives, and often do not know they are involved with using and/or selling drugs until there is a problem.

#### 9.4.1 What's happening in Western Australia

Western Australia is the most culturally diverse state or territory in Australia. Data from the 2016 Australian Census shows:

- since 2011 there has been a 16.5 per cent increase in the number of people in Western Australia born overseas and their share in the total population increased from 30.7 per cent to 32.2 per cent;
- for the first time in history, the number of people born in non-main English speaking countries was larger than those from main English speaking countries; and
- 17.7 per cent of Western Australians speak a language other than English at home.<sup>462</sup>

Current approaches to address alcohol and other drug use, including methamphetamine use among CaLD groups in Western Australia that were captured in the Taskforce stocktake include: targeted online prevention material; alcohol and other drug forums; CaLD-specific health and resources centres, which may assist in linking individuals to mainstream alcohol and other drug services; and improving mental health approaches.

The Department of Local Government, Sport and Cultural Industries' Office of Multicultural Interests will provide an alcohol and other drug forum to CaLD groups upon request from non-government or local government representatives. Four forums have been held since 2014.

As part of the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, the Mental Health Commission states the need to further develop transcultural mental health services by increasing consultation and liaison to mainstream services, assist with access to multi-lingual information and services, and assist with the establishment of partnerships with local CaLD services.<sup>463</sup>

A Healthway research grant of \$617, 661 was provided to Curtin University in May 2018, to undertake two intervention research projects promoting refugee and migrant health outcomes. This includes one involving a peer mentoring program to prevent social isolation and improve the mental health of refugee women seeking employment.

---

<sup>462</sup> Government of Western Australia. Department of Local Government, Sport and Cultural Industries, Office of Multicultural Interests. Cultural and Linguistic Diversity in Western Australia (WA) 2016 Census. Perth: The Department; 2016. [accessed 2018 Nov 7] Available from: [https://www.omi.wa.gov.au/StatsInfoGuides/Documents/Cultural%20and%20Linguistic%20Diversity%20in%20Western%20Australia%20\(WA\)%202016%20Census.pdf](https://www.omi.wa.gov.au/StatsInfoGuides/Documents/Cultural%20and%20Linguistic%20Diversity%20in%20Western%20Australia%20(WA)%202016%20Census.pdf)

<sup>463</sup> Government of Western Australia. Western Australian Mental Health Commission. Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth: Western Australian Mental Health Commission; 2015. p 80. [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf>

### Taskforce conclusions and recommendations

The use of illicit drugs, including methamphetamine, among CaLD communities in Western Australia is difficult to establish, due to data limitations<sup>464</sup>. Further direct engagement, consultation and research is clearly required to understand the nature of the problem within such a diverse cohort.

#### **Recommendation 43:**

The Mental Health Commission in consultation with the Office of Multicultural Interests and CaLD communities, within 12 months, undertake and report on further research and consultation on drug use, its impact on CaLD communities and approaches to address issues identified.

---

<sup>464</sup> Parliament of Victoria, Law Reform, Road and Community Safety Committee. Inquiry into drug law reform Summary Booklet. March 2018. p. 139.



## Chapter 10 Helping to rebuild a person's life after methamphetamine

"... they need support to build lives again. Life skills – help finding study or work, housing, away from abusive relationships etc. Once my sister realised what she could do with her life she really made a positive change."

*Online comment*

"Volunteering allowed me to show my worth. It was a good stepping stone and let me give back rather than just taking."

*Consumer and Family Members Forum*

"I got involved, began sharing and lost the shame."

*Consumer and Family Member Forum*

*"I got a job through a friend after I got out of prison and did not have to declare my criminal conviction. I worked successfully in this job, got a good reference and then got offered a better job."*

*Consumer and Family Member Forum*

"I surrounded myself with positive people, new relationships, a healthy lifestyle."

*Consumer and Family Member Forum*

### 10.1 What the Taskforce heard

The Taskforce heard how difficult it was for people to re-establish their lives when they stopped using methamphetamine. There were many challenges, including just finding joy in everyday life, as well as getting a job, finding housing, repairing relationships with family and friends, and getting children returned from the care of others.

The Taskforce heard people recovering from their methamphetamine use:

- need support and the skills to (re)build personal relationships. Learning to interact with people is key to breaking feelings of isolation and destructive cycles of behaviour, integrating into the community and building resilience so people feel they are accepted;
- need access to employment, training and voluntary work opportunities. Many noted the challenges of trying to find employment with a criminal record, others talked about wanting to give back to society and help others in an attempt to make amends for the harms they had caused;
- understand relapse when recovering from methamphetamine addiction is probable at some stage, and feel more could be done to plan adequately to prevent this. People need access to long-term, reliable support that will be available when they have an emergency;
- need to (re)learn the basic skills of living, including how to care for themselves and others, and engage in other meaningful activities. Appropriately assessing where people are at in their recovery is essential in developing any plan for moving forward post-treatment; and
- need realistic hope for the future, which is helped by developing resilience and a

sense of self-worth, to help people to deal with life challenges.

Practical solutions to assist people to rebuild their lives offered by groups the Taskforce consulted, included to:

- fund treatment service providers to deliver active post-treatment support, with regular ongoing contact and follow-up;
- provide people exiting treatment with transition support plans;
- provide transitional accommodation options for people exiting treatment;
- actively promote local community engagement opportunities;
- offer incentives to employers to provide job opportunities for people post-treatment;
- create community connectedness through providing volunteer and work experience opportunities for people post-treatment;
- teach people how to establish relationships; and
- offer education/vocational training opportunities while people are in treatment.

## 10.2 What is ‘recovery’ from problematic or substance use dependency?

In 2008, the UK Drug Policy Commission<sup>465</sup> defined recovery as “voluntarily sustained control over substance use which maximises health and well-being, and participation in the rights, roles and responsibilities of society”, with the term “control over substance use” inclusive of both abstinence and maintenance approaches to recovery.<sup>466</sup>

The Commission recognised recovery will differ for individuals and that for some, it is an ongoing process from which they will never consider themselves fully ‘recovered’, while for others, they may get to a point where they no longer feel at risk of relapse and do therefore consider they have recovered from their substance use dependency.<sup>467</sup>

The Commission notes:

“...it is very important to recognise that recovery is more than reducing or removing harms caused by substance misuse as it must also encompass the building of a fulfilling life. Above all, the [consensus] group recognised that the individual must be placed at the heart of recovery but their relationship with the wider world (family, peers, communities and wider society) is an intrinsic part of the recovery process”.<sup>468</sup>

A discussion on what constitutes ‘recovery’ was considered by the Commission as a necessary step towards further consideration of what recovery-oriented services look

---

<sup>465</sup> The UK Drug Policy Commission operated between 2007 and 2012 as an independent charitably funded body established to stimulate informed evidence-based debate about drug policy.

<sup>466</sup> UK Drug Policy Commission. Recovery Consensus Group. A vision for recovery: Policy Report July 2008. London: UK Drug Policy Commission; 2008. p. 6. [accessed 2018 Nov 7] Available from: [http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20A%20vision%20of%20recovery\\_%20UKDPC%20recovery%20consensus%20group.pdf](http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20A%20vision%20of%20recovery_%20UKDPC%20recovery%20consensus%20group.pdf)

<sup>467</sup> Ibid. p.5.

<sup>468</sup> Ibid. p.6.



like, encouraging service providers to recognise and enhance their role in the recovery process for their clients.<sup>469</sup>

In relation to recovery, The Mental Health Commission noted that due to the chemical changes in the brain that are associated with long-term heavy use of methamphetamine, people are likely to experience a protracted period of chemical imbalance which often manifests itself as anhedonia, or an inability to feel pleasure in normally pleasurable activities. Anhedonia, while present in other drug withdrawal, is significant in methamphetamine and can take up to 18 months to lift. Further, this increases the risk of relapse, due to feeling flat, joyless or disconnected. People can appear as though they are disengaged and “trying not” to recover.

A 2012 analysis of the literature on recovery/remission from substance use outcomes notes that efforts to measure recovery are hampered by the lack of consensus on its definition and the widely variable methodologies and units of measurement (e.g. follow-up periods and rates).<sup>470</sup> However, a comprehensive review of literature which attempts to evaluate recovery outcomes from alcohol and other drug substance use disorders, provides the following insights:

- point in time studies of alcohol and other drug problems can mask the complex course of these problems, with “both addiction and recovery best viewed as fluid rather than fixed states[...]. This fluidity underscores the need for sustained and assertive recovery management”<sup>471</sup>;
- relapse usually occurs in the first days and weeks after treatment. This highlights the need for and value of assertive approaches to post-treatment monitoring, support and early re-intervention;
- long-standing family and social support has a greater effect on long-term recovery outcomes than short-term professional interventions;
- scientific studies of the long-term resolution of alcohol and other drug problems are limited, whereas much could be gained from studying the lived solutions to alcohol and other drug problems at personal, family, organisational, community and cultural levels;
- the challenges of definition and measurement of recovery should be overcome to create data to support planning, resource allocation and to better understand program and system-wide performance;
- those who have recovered or are recovering from alcohol and other drug dependency are an under-utilised resource that could be mobilised to support both treatment and recovery programs; and
- public perception of recovery is pessimistic, arising from high profile examples of relapse, whereas the data suggests this is not the norm over the long-term with a natural progression towards recovery for the majority.<sup>472</sup>

This chapter considers three key areas important to helping achieve recovery, identified through the Taskforce’s consultations with the community, and the literature:

- access to housing that supports recovery and assists clients to successfully

---

<sup>469</sup> Ibid. p.8.

<sup>470</sup> White W. Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 414 Scientific Reports, 1868-2011, Philadelphia Department of Behavioural Health and Intellectual Disability Services and the Great Lakes Addiction Technology Transfer Centre, p.1. 2012.

<sup>471</sup> Ibid., p. 3

<sup>472</sup> Ibid., pp. 3, 4.

- transition back into the community;
- returning to work or study; and
- ongoing support to sustain treatment outcomes post treatment.

The Taskforce notes that recovery from problematic or dependent methamphetamine use was not an issue examined by the National Ice Taskforce and, as a consequence, actions to assist people to rebuild their lives are not a feature in the *National Ice Action Strategy* or the National Drug Strategy. Nor does it appear that issues related to recovery have been considered by other similar exercises in other Australian jurisdictions. This suggests this is an under-developed or emerging area that would benefit from further examination, in order to minimise the costs of, and optimise outcomes from, treatment for alcohol and other drug dependency for individuals, their families and the community.

### 10.3 Housing for people recovering from methamphetamine use

As with alcohol and other drug dependence, it is not unusual for people undergoing treatment for their methamphetamine use to experience multiple episodes of relapse, resulting in cycles of treatment, recovery, relapse and repeated treatments.<sup>473</sup>

The literature (predominantly from North America) reports, and the Taskforce heard, that maintaining treatment outcomes is frequently undermined by the lack of a drug-free living environment that can sustain treatment outcomes post treatment, and is most challenging for clients who do not have a stable living environment or social support that encourages sustained recovery.<sup>474</sup> Findings indicate “clients who are homeless or lived in substance using environments during or after treatment were more prone to relapse than clients living in environments supportive of sobriety”.<sup>475</sup>

Further: “Having a home or a stable and safe place to live is recognised as fundamental to recovery from both mental health and substance use disorders. However, being homeless, as well as having unsafe or otherwise untenable housing, is common among individuals with serious mental illness (Folsom et al., 2015) and substance use disorders (Eyrich-Garg et al., 2008) and may present challenges to initiating and/or sustaining recovery (Castleow et al., 2015; Laudet & White, 2010).”<sup>476</sup>

#### 10.3.1 What works

The topic of housing has only relatively recently received focus in dependence research and literature. Nevertheless, there is quite extensive literature relating to housing provision outcomes for homeless people, many of whom experience alcohol

---

<sup>473</sup> Lubman D, Manning V, Best D, Berends L, Mugvin J, Lloyd B, et al. A study of patient pathways in alcohol and other drug treatment: Patient Pathways National Project. Fitzroy: Turning Point; 2014. p. 3. [accessed 2018 Nov 7] Available from: [http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/\\$File/Patient%20Pathways%20National%20Project.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/$File/Patient%20Pathways%20National%20Project.pdf)

<sup>474</sup> Polcin D. Communal Living Settings for Adults Recovering from Substance Abuse. J Groups Addict Recover. 2009; 1 (4&AMP); 7-22. DOI: 10.1080/15560350802712355

<sup>475</sup> Ibid.

<sup>476</sup> Mericle A, Grella C. Integrating Housing and Recovery Support Services: Introduction to the Special Section. J Dual Diagn. 2016; 12(2); 150-2. doi: 10.1080/15504263.2016.1176408

and other drug use and mental health issues.<sup>477</sup> The literature on supportive housing for the homeless is of particular interest when considering outcomes and models of service provision for people recovering from problems related to alcohol and other drug use.

Supportive housing has become an important element in recent efforts to reduce and prevent homelessness in Australia. It is presented as a measure to meet the needs of people with health and social problems in addition to homelessness,<sup>478</sup> with one evaluation of the nature and effectiveness of the models stating:

“Supportive housing combines affordable housing and services that help people who face the most complex challenges to live with stability, autonomy and dignity.”<sup>479</sup>

The aims and objectives of supportive housing are usually directed towards mental health consumers and most of the literature evaluating its outcomes relates to this group. It is an intervention aimed at enabling residents to return to work, school, volunteering and reconnecting with family and other social circles.<sup>480</sup> While there is a large body of evidence that reports on the outcomes attributed to supportive housing, the inconsistent use of definitions for supportive housing programs means that broad statements about what the evidence says are problematic. What can be said from the literature is “the provision of affordable housing with some form of voluntary support services is a successful means to enable people with experiences of homelessness and mental health to sustain housing.”<sup>481</sup>

There are generally two models for supportive housing, the congregate forms of housing with onsite support services or scattered site housing with an outreach model of support. The scattered site form of supportive housing is the predominant form of response to homelessness in Europe and is aimed at normalising living conditions. There are a variety of forms of congregate supportive housing including: independent units/apartments in the one apartment building, and full or partial shared facilities. Some models involve participants having lease arrangements in place or where their accommodation is dependent on program participation. There is not a consensus view on which of these two models leads to the most effective outcomes.<sup>482</sup>

---

<sup>477</sup> The 2007 National Survey of Mental Health and Well-being found that almost 16 per cent of people who had been homeless had a co-existing substance use disorder and other mental disorder and over 6 per cent had a substance use disorder only. Australian Government. National Mental Health Commission. A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC; 2013. p. 31. [accessed 2018 Nov 7] Available from: [http://www.mentalhealthcommission.gov.au/media/94321/Report\\_Card\\_2013\\_full.pdf](http://www.mentalhealthcommission.gov.au/media/94321/Report_Card_2013_full.pdf)

<sup>478</sup> Parsell C, Moutou O. Australian Housing and Urban Research Institute. An evaluation of the nature and effectiveness of models of supportive housing, AHURI Positioning Papers No 158. Melbourne: AHURA; 2014. p.2. [accessed 2018 Nov 7] Available from: [https://www.ahuri.edu.au/\\_data/assets/pdf\\_file/0014/2741/AHURI\\_Positioning\\_Paper\\_No158\\_An-evaluation-of-the-nature-and-effectiveness-of-models-of-supportive-housing.pdf](https://www.ahuri.edu.au/_data/assets/pdf_file/0014/2741/AHURI_Positioning_Paper_No158_An-evaluation-of-the-nature-and-effectiveness-of-models-of-supportive-housing.pdf)

<sup>479</sup> Ibid. p. 9.

<sup>480</sup> Ibid. p. 14.

<sup>481</sup> Ibid. p. 16.

<sup>482</sup> Ibid. p. 22.

While there is a substantial history in Australia and overseas in providing temporary communal living environments for people recovering from problems associated with alcohol use, the literature indicates a growing need for affordable 'sober living environments' that include drug-free housing.<sup>483</sup> A 2009 study on communal living for adults recovering from substance abuse from the U.S. notes:

"Although a variety [of] different communal housing models have been used to provide alcohol and drug free housing to individuals suffering from addiction, none are currently more popular or widespread than the Oxford House model. Oxford Houses have the advantages of being financially independent, peer managed, and easily replicable. Outcomes studies have shown they can be effective for a variety of individuals."<sup>484</sup>

Oxford Houses, founded in 1975 by Paul Molloy, is a form of self-run, self-supported recovery accommodation providing drug-free housing in community settings. At 31 December 2017, there were 2,287 Oxford Houses world-wide (in the U.S., Canada and Australia) providing 18,025 beds.<sup>485</sup> The model is as follows:

- the house is democratically self-run;
- the house members are responsible for all household expenses (average cost/per person per week in 2017 was \$123)<sup>486</sup>;
- a person can live in an Oxford House as long as they do not drink alcohol, use drugs and pay an equal share of the house expenses (the average length of stay in 2017 was 8.3 months)<sup>487</sup>;
- houses are single-sex dwellings, although some allow parents with minors to be resident (in 2017, 29 per cent were women only houses and 71 per cent were men only houses);
- any person in recovery from alcohol or other drugs can apply to get into any Oxford House with selection determined by existing members of the house with a minimum vote of 80 per cent in favour;
- a new Oxford House can be started by any group or individual recovering from alcohol or other drug dependence by finding a suitable house to rent and applying to Oxford House Inc for a charter; and
- Oxford Houses must have between six and 10 residents in order for them to be financially sustainable.<sup>488</sup>

---

<sup>483</sup> Polcin D. Communal Living Settings for Adults Recovering from Substance Abuse. *J Groups Addict Recover*. 2009; 1 (4&AMP); 7-22. DOI: 10.1080/15560350802712355

<sup>484</sup> Ibid.

<sup>485</sup> Oxford House, Inc. Annual Report Fiscal Year 2017. Maryland: Oxford House, Inc; 2018. p. 2. [accessed 2018 Nov 7] Available from: <https://www.oxfordhouse.org/userfiles/file/doc/ar2017.pdf>

<sup>486</sup> Ibid.

<sup>487</sup> Ibid.

<sup>488</sup> Jason L, Olsen B, Ferrari J, Sasso A. Communal housing settings enhance substance abuse recovery. *Am J Public Health*. 2006;96(10): 1727-1729. doi: 10.2105/AJPH.2005.070839

In 2017, the Oxford House resident profile was:

- average age of 37.2 years;
- 87 per cent were working;
- 79 per cent had both alcohol and drug use problems;
- 68 per cent reported prior homelessness;
- 77 per cent reported prior incarceration; and
- average weekly attendance at Alcoholics Anonymous or Narcotics Anonymous was 5.2 meetings.

The Oxford House model also:

- is readily replicable as it involves application of The Oxford House Manual (2006);
- offers a community where residents live without professional treatment staff and length-of-stay restrictions;
- residents receive abstinence support from peers, however, there is no single or set course for recovery, with residents free to decide whether to seek and choose (if any) treatment or support, including from groups such as Alcoholics Anonymous. (In 2017, 45 percent of Oxford House residents were going to counselling plus Alcoholics Anonymous or Narcotics Anonymous.<sup>489</sup>); and
- involves sanctions for destructive behaviour (in 2017, 21.9 per cent of 37,852 residents were expelled from Oxford Houses for relapse).

One study sought to evaluate the effectiveness of the Oxford House model in comparison with 'usual after-care' arrangements post-treatment for alcohol and other drug dependence. In this study, 150 individuals were randomly assigned to either an Oxford House or 'usual-care condition' which consisted of out-patient care or self-help groups. At the 24-month follow-up, Oxford House participants when compared with usual-care participants had significantly lower substance use (31.3 per cent versus 64.8 per cent), significantly higher monthly income (\$989.40 versus \$440.00) and significantly lower incarceration rates (3 per cent versus 9 per cent).<sup>490</sup>

Other key findings from the study were:

- "Given the high costs of substance use disorder to society in general, and to the health care delivery system in particular, the results of this randomised test of the efficacy of a low-cost, self-help housing intervention compared with the usual services provided after inpatient substance abuse treatment have major public health implications.
- Because residents pay all expenses, these types of self-governed settings have important public policy implications for stabilising individuals with substance abuse histories, especially in an era of cutbacks in funding for a variety of social service programs."<sup>491</sup>

<sup>489</sup> Oxford House, Inc. Annual Report Fiscal Year 2017. Maryland: Oxford House, Inc; 2018. p. 2. [accessed 2018 Nov 7] Available from: <https://www.oxfordhouse.org/userfiles/file/doc/ar2017.pdf>

<sup>490</sup> Jason L, Olsen B, Ferrari J, Sasso A. Communal housing settings enhance substance abuse recovery. *Am J Public Health.* 2006;96(10): 1727-1729. doi: 10.2105/AJPH.2005.070839

<sup>491</sup> Ibid.

In terms of community perceptions and impact the study found:

- “Oxford House residents are often considered good neighbours, particularly by those who lived next to an Oxford House”;
- “Property values for individuals living next to recovery homes were not significantly different from those living a block away”;
- “There were no significant differences between the crime rates around Oxford Houses and the control houses” suggesting that “well-managed and governed recovery homes pose minimal risks to neighbours in terms of criminal behaviour”; and
- “Oxford House members reported participating in the community for about 10.6 hours per month.” The majority of participants were involved in activities around their recovery and the recovery of others, including mentoring, administering and running support groups, informing or advising agencies or local leaders, involvement in anti-drug campaigns, working with youth, fundraising and volunteering with community organisations.<sup>492</sup>

In Australia, the Self Help Addiction Resource Centre and Mind Australia, community-based, not-for-profit organisations, run the Oxford Houses Australia Program. The Self Help Addiction Resource Centre was established to promote and provide peer-led, mutual-aid approaches to recovery from severe substance related issues for individuals and families.<sup>493</sup>

In 2017, Turning Point was commissioned to conduct a six-month study of the impact of the Oxford Houses Australia program. Its purpose was to evaluate the key outcomes of the program, to inform recommendations about the efficacy and sustainability of the program and areas for potential improvement, and to extend the evidence-base on the effectiveness of Oxford Houses in Australia.<sup>494</sup>

Oxford Houses Australia operates on the same principles as Oxford Houses in North America; single-sex dwellings (with the exception of those houses where residents are allowed to live with their minor children); four to six bedroom rental properties leased by Oxford Houses Australia; democratically administered by the residents, who are required to contribute equally to the upkeep of the household by paying rent, completing chores and fulfilling particular roles in the house. As long as residents conform to these requirements, maintain abstinence and don't engage in disruptive behaviour, there is no prescribed length of stay.<sup>495</sup>

The 2017 Turning Point study involved a self-completed survey of 16 participants who completed both a baseline survey and a residential follow-up survey. Participants were asked to compare their experience in Oxford Houses with active 'addiction'. The sample had an average residency period at the time of follow-up of 21 months. While the researchers acknowledged some limitations to their study, the

---

<sup>492</sup> Ibid.

<sup>493</sup> Thorn P, Savic M, Campbell S, Manning V. Turning Point Alcohol and Drug Centre. Oxford Houses Evaluation Findings. Fitzroy: Turning Point; 2017. p. 5. [accessed 2018 Nov 7] Available from: <http://www.sharc.org.au/wp-content/uploads/2013/11/Oxford-Houses-Evaluation-2017-%E2%80%93-Full-Report.pdf>

<sup>494</sup> Thorn P, Savic M, Campbell S and Manning V. 2017. Oxford Houses evaluation findings. Turning Point, Eastern Health, Fitzroy, p.5.

<sup>495</sup> Ibid.



study's outcomes were similar to those reported by large scale analysis of Oxford Houses in the U.S.:

“Compared to their time in active addiction, clients experienced considerable improvements in a range of well-being and life areas after entering Oxford Houses program – including in health, finances, legal issues, meaningful activities and family and social connectedness. Not only did they report improved well-being, they also reported decreased substance use and decreased usage of costly health care services and the criminal justice system.”<sup>496</sup>

### 10.3.2 What's happening in Western Australia

The Mental Health Commission oversees the Transitional Housing and Support Program. It began in 2011-12 and has received an investment of \$4 million dollars to 30 June 2019.

The Transitional Housing and Support Program aims to support person-centred recovery by providing community-based independent living in residential housing for clients exiting alcohol and other drug residential rehabilitation services, who require ongoing support and/or are at risk of homelessness. There are 15 properties that provide 55 beds allocated to eight existing residential treatment support providers, funded until 30 June 2019. Nine of these dwellings are located in the metropolitan area and six are located in regional Western Australia. The accommodation service is primarily short- to medium-term (three to six months), however, some cases warrant longer stays of up to 12 months.

The Transitional Housing and Support Program houses are either sole use, or shared with other participants or with the client's family. Clients can include mixed cohorts or programs for specific populations, such as mixed gender, women and children, youth or Aboriginal people and families. Clients can include those with severe and long-term dependency on alcohol or other drugs, a history of unsuccessful treatment, a home or a social environment unsupportive of treatment and/or clients who are homeless or at risk of homelessness.

A feature of the Transitional Housing and Support Program is ongoing support for clients to help with recovery and relapse prevention. Programs usually include counselling and support; assistance to integrate back into the community including education, training, employment; independent living skills; and assistance to identify suitable long-term housing.

Information provided by the Mental Health Commission notes that over the period 2011 to 2017, there were 227 episodes of care delivered through the Transitional Housing and Support Program with an average length of stay of 145 days. Of those 227 episodes of care, 63 were in regional locations and 164 were delivered in the metropolitan area. From 2011-12 to 2014-15 the primary drug of concern was alcohol, however, in 2015-16 and 2016-17 this changed to the primary drug of concern being amphetamine-type stimulants.

Through the implementation of the *Methamphetamine Action Plan*, the Western Australian Government has committed to expand services into areas of need and to increase access to alcohol and other drug residential rehabilitation beds. The

---

<sup>496</sup> Thorn P, et al., loc. cit.

Transitional Housing and Support Program aims to reduce the number of people exiting residential rehabilitation services into homelessness, and increase the number of people successfully transitioning into independent living. The increase in residential rehabilitation beds through the *Methamphetamine Action Plan* will further increase the need for access to transitional housing.

The Mental Health Commission undertook an evaluation of the Transitional Housing and Support Program in 2013. The scope of the evaluation focussed on program outputs, short-term outcomes and process issues that could be improved such as the impact on support service providers and the impact on the local community and other external stakeholders. The evaluation concluded that there were a range of positive outcomes for clients, with significant reductions in relapse rates, improvements in well-being, increased life skills and independent living and reduced levels of homelessness observed.

*The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* identifies the requirement for a strategy to address the housing needs of people with mental health and alcohol and other drug issues, while also increasing access to community support services that will assist with daily living tasks and sustaining tenancy. This includes appropriate housing and support for people who have mental health and/or alcohol and other drug issues and are homeless.

The Mental Health Commission, in consultation with a range of stakeholders, is currently developing a mental health, alcohol and other drug accommodation strategy to ensure that Western Australians with mental health and/or alcohol and other drug issues will have timely access to a range of appropriate accommodation and support options to meet their personal and cultural needs. The draft *Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025* (Accommodation and Support Strategy) establishes a framework to guide stakeholders in the development of appropriate accommodation and support for people with mental health and alcohol and other drug-related issues. It recognises the need for the collective efforts of stakeholders to achieve change. The draft Accommodation and Support Strategy illustrates the key features of a quality accommodation and support system to enable people with mental health and alcohol and other drug issues to sustain their accommodation in a community of their choice. It is underpinned by the principles of: individual rights; personalised, inclusive communities, effective system-wide partnerships, and continuous improvement.

The final Accommodation and Support Strategy is planned to be released in late 2018 or early 2019. The Mental Health Commission's 10-year plan has identified the need to continue and expand the range of accommodation services for clients engaged with specialist alcohol and other drug services.

### **Taskforce conclusions and recommendations**

The Taskforce heard from consumers and families that there is a need to provide a range of transitional housing options following treatment. The Taskforce recognises the work being done here by the Mental Health Commission through its Transitional Housing and Support Program and believes the Program should continue. The Taskforce has been advised by the Mental Health Commission that it is in the process of developing a business case to continue funding for the Program.

**Recommendation 44:**

The Mental Health Commission, working with the Department of Communities, continues to be funded for transitional housing and support for people exiting treatment for alcohol and other drug dependency, including treatment in prisons.

**10.4 Getting back to work****10.4.1 What works**

The Taskforce heard that getting back into work is an essential part of rebuilding lives for many people recovering from methamphetamine dependence. Findings from the Illicit Drug Reporting System indicate that in Western Australia, 72 per cent of people surveyed (those who injected drugs [including methamphetamine which was 30 per cent of the sample] six or more times in the six months preceding the survey) were unemployed.<sup>497</sup>

“Meaningful employment can be an important part of a problem drug user’s reintegration into society; it can have positive benefits to self-esteem and self-confidence and may provide a sense of purpose and self-worth... Employment also provided opportunities to demonstrate their commitment to being drug-free and so was an outward sign of intentions. It was evidence of their recovery and was an element that facilitated the reconnection with children, family and significant others. All of this was important in establishing, and being seen to lead a drug-free lifestyle.”<sup>498</sup>

The UK Drug Policy Commission undertook an Evidence Review in 2008 to examine the issues relating to the (re-)entry of problem drug users to the labour market, focussing on both the barriers to employment and on effective support structures and mechanisms. The Review explored the issues from the perspective of employers, service providers and people with problematic drug use. The executive summary of its findings is extracted below:<sup>499</sup>

**10.4.1.1 Getting ‘job ready’ – primary issues**

- Individuals who have experienced problematic drug use need to be motivated to begin the process of getting ready for addressing their primary needs before considering employment itself.
- Primary needs are often interwoven and need to be addressed together.
- Accommodation must be appropriate to the individual’s stage of treatment. This is critical in providing supportive and stable environment that is conducive to moving towards employment.
- Health issues, including but not restricted to those that are directly drug-related, need to be stabilised.

<sup>497</sup> Stafford J, Breen C. Australian Drug Trends 2016: Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trend Series no.145. Sydney: National Drug and Alcohol Research Centre, UNSW Australia; 2017.

<sup>498</sup> Spencer J, Deakin J, Seddon T, Ralphs R. UK Drug Policy Commission. Getting Problem Drug Users (Back) Into Employment. London: UK Drug Policy Commission; 2008. p 67. [accessed 2018 Nov 7] Available from: [http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Getting%20problem%20drug%20users%20\(back\)%20into%20employment\\_%20employer,%20provider%20and%20service%20user%20perspectives.pdf](http://www.ukdpc.org.uk/wp-content/uploads/Evidence%20review%20-%20Getting%20problem%20drug%20users%20(back)%20into%20employment_%20employer,%20provider%20and%20service%20user%20perspectives.pdf)

<sup>499</sup> Ibid. p.5-6.

- Practical and emotional support from a variety of sources, both formal and informal, is felt by problem drug users to be essential at this preliminary stage.

#### **10.4.1.2      *Seeking employment***

- There are differing views across all groups concerning whether abstinence or alternatively stabilisation through ‘maintenance prescribing’<sup>500</sup> are necessary for moving into employment. These views in turn link to the options for employment that are available.
- There is a process of matching the expectations of people who have experienced problematic drug use and service providers regarding suitable employment. Health and drug status play a fundamental role in determining the types and number of job opportunities available.
- Developing a positive and realistic attitude to work, through building confidence and motivation (e.g. undergoing training, volunteering etc.) is an important task for service providers and will ease the transition to a ‘mainstream’ lifestyle.
- Service providers found it difficult but vital to locate willing local employers. The fragility of some of these links often made service providers cautious about recommending placements for some higher-risk individuals.

#### **10.4.1.3      *Employer perspectives***

- Employers are generally reluctant to take on potentially ‘risky’ job applicants. Recruitment processes are used in different ways to manage these perceived risks. This can range from ‘blanket’ recruitment policies that rule out employing drug users through to a more discerning individual approach.
- A central concern is whether an individual is ‘fit for the job’ in terms of being reliable, capable and punctual. How fitness is ‘perceived’ varies for different employment sectors and company sizes. These perceptions are sometimes mediated by stereotypes and prejudices about drug users.
- Some employers identified support needs (e.g. updates on an employee’s rehabilitative progress), while for others it was not relevant.
- Regional variations between the case-study sites were minimal among employers but local differences in drug treatment ideologies (e.g. abstinence orientation) could be significant from the perspective of employers.

#### **10.4.1.4      *Conclusion and implications for policy and practice***

- Meaningful employment can be an important part of reintegration into society, bringing with it positive benefits to self-esteem, self-confidence and self-worth.
- People with problematic drug use can be employable across a range of sectors.
- Service providers should recognise that the search for employment is a significant step towards rehabilitation. Once employment is obtained, support must be provided to maintain motivation and to enhance the ‘distance travelled’; this will increase chances of avoiding relapse.
- Different types of accommodation provision need to be available for individuals at different stages of this process.
- A range of volunteering opportunities should be made available.
- A locally tailored employer engagement strategy should be developed.

---

<sup>500</sup> Noting there are currently no pharmacological treatments for methamphetamine available.

Sutton et al. provide a checklist for successful employment projects for people who have experienced problematic drug use from their review of the international literature, although they note the overall weakness of the evidence base. They suggest the following:

- close partnerships between drug services and employment service providers;
- customised, flexible, intensive and diverse one-to-one support services;
- well-trained support staff; and
- close links with local employers.<sup>501</sup>

Evidence points towards the importance of effective interagency partnerships, including with agencies that span wider fields such as housing.<sup>502</sup> Individualised and tailored support, including work focussed on basic personal development (e.g. self-esteem and confidence), have also been found to be important. The literature further highlights the value of post-employment support designed to ensure that a job is sustained.<sup>503</sup>

An example of a structured program in Australia that assists people who are engaged in treatment being supported to gain employment is the Second Step Program. The program operates as a partnership between the Toll Group and the First Step Program in Victoria. First Step is a multi-disciplinary, not-for-profit medical clinic in St Kilda offering treatment to patients with complex, coexisting alcohol and other drug and mental health issues. Beginning in 2001, Second Step provides employment opportunities for people transitioning into mainstream employment following treatment. Program participants are employed as trainees for a limited time (12 to 24 months) with no guarantees of ongoing employment after this period. Participants have been helped into ongoing employment with Toll as information technology specialists, welders, clerical workers, forklift drivers, receptionists and drivers. There are random drug tests once a week, trainees receive four hours of counselling a week and are provided with a mentor. Personal histories are kept confidential, with the exception of managers and mentors.<sup>504</sup> Toll reports that 500 people have been helped into ongoing employment from this program,<sup>505</sup> and more than 95 per cent have been retained in employment post the program.<sup>506</sup>

---

<sup>501</sup> Sutton L, Cebulla A, Heaver C, Smith N. Loughborough University. Institutional Repository. Drug and Alcohol Use as Barriers to Employment: A review of the literature. Loughborough: University of Loughborough; 2004. [accessed 2018 Nov 7] Available from:

<https://pdfs.semanticscholar.org/ce47/1f862ed221a8cd75dcb110d546b8fa759ad7.pdf>

<sup>502</sup> Richards N, Morrison A. Moving On: Education, training and employment for recovering drug users. Edinburgh: Effective Interventions Unit/Scottish Executive; 2001. p.40-41. [accessed 2018 Nov 7] Available from: <http://www.gov.scot/Resource/Doc/158882/0043156.pdf>

<sup>503</sup> Ibid. p.45-46.

<sup>504</sup> Gettler L. Toll deal swaps drugs for work. The Age online; 2005 June 23. [accessed 2018 Nov 7] Available here: <https://www.theage.com.au/news/business/toll-deal-swaps-drugs-for-work/2005/06/22/1119321789418.html>

<sup>505</sup> TOLL Corporate Social Responsibility – Community Programs [accessed 2018 Nov 7] Available from: <https://www.tollgroup.com/about/corporate-social-responsibility/our-community-programs>

<sup>506</sup> Booker C. Former drug addicts are 'outstanding employees', says ex-Bombers chairman. The Age online; first published 2016 May 8, updated 2016 May 10 [accessed 2018 Nov 7]. Available here: <https://www.theage.com.au/national/victoria/former-drug-addicts-are-outstanding-employees-says-exbombers-chairman-20160508-gop0wn.html>



### 10.4.2 What's happening in Western Australia

The Taskforce heard from one large employer in Western Australia about an initiative that supported its employees back into employment after treatment for alcohol or other drug dependence. The comprehensive employee support program included:

- the appointment of a chaplain to build relationships with staff and provide pastoral care and support to promote employee health and well-being;
- offering employees an amnesty from penalties if they self-disclosed problematic alcohol and other drug use so they could undertake treatment; and
- holding an employee's position open for them to return to, following successful completion of treatment for their problematic alcohol or other drug use.<sup>507</sup>

While there are alcohol and other drug services providing support to gain employment, the Taskforce is not aware of any other programs or initiatives in Western Australia that are specifically directed at supporting people back into employment through a structured program.

### Taskforce conclusions and recommendations

The Taskforce heard how getting back into work is an essential part of rebuilding lives for many people recovering from methamphetamine dependence. The literature provides guidance on the benefits, barriers and characteristics of successful employment projects for people recovering from alcohol and other drug dependence.

#### **Recommendation 45:**

The Mental Health Commission in consultation with the Western Australian Network of Alcohol and other Drug Agencies and peak employer bodies broker a partnership between a willing and capable treatment provider and employer to establish a suitable pilot structured return to employment program in Western Australia.

## 10.5 After treatment support

The Taskforce heard how challenging it was for people not to relapse following treatment for methamphetamine use. A previously cited Australian study<sup>508</sup> (in Chapter 6 on treatment and support) reported the short-term effectiveness of treatment for methamphetamine use indicating that without other supports in place, there is no clear evidence of a significant benefit (when measured by methamphetamine use status) at three years after starting treatment.

A 2014 North American study was the first to examine the time to relapse, or duration of continuing abstinence for methamphetamine users, beyond three years, in this case averaging five years post treatment. In this study a random sample of 350 people were selected for retrospective self-reporting approximately three years after treatment for methamphetamine use, and a follow-up interview was conducted two to three years after that. Relapse was defined as any methamphetamine use

<sup>507</sup> Information sourced from employer at the Workplace Stakeholders Forum, 7 December 2017.

<sup>508</sup> McKetin R et al. Evaluating the impact of community-based treatment options on methamphetamine use: findings from the Methamphetamine Treatment Evaluation Study (MATES). *Addiction*. 2012;107(11); 1998-2008.



with time as the number of months of continuous methamphetamine abstinence after treatment discharge.<sup>509</sup> The study found:

- 23 per cent of the sample maintained methamphetamine abstinence during the entire follow-up period (with abstinence durations of 22-90 months);
- 77 per cent of the sample relapsed to methamphetamine use within the follow-up period (ending periods of abstinence ranging from 0-79 months);
- 61 per cent of the sample relapsed within one year after treatment and 25 per cent relapsed during years two to five; and
- of the 61 per cent that relapsed within the first year after treatment, 36 per cent did so in the first month.<sup>510</sup>

In spite of the high early relapse rates reported, many of those who took part in the study had subsequent periods of abstinence. The data on 'point in time' abstinence status from this study showed; 66 percent of the sample were abstinent at 12 months post treatment, 75 per cent were abstinent at 24 months; 77 per cent were abstinent at 36 months, 80 percent at month 48, and 79 per cent at month 60. This confirms the cyclic nature of problematic and dependent substance use.<sup>511</sup>

This study also identified two significant risk factors for shorter time to relapse; parental drug use and ever having sold methamphetamine. Protective factors predicting longer time to relapse included:

- having experienced three serious problems perceived to relate to methamphetamine use (paranoia, hallucinations, violent behaviour);
- more months in the treatment episode; and
- participation in self-help and/or additional substance use disorder treatment during the abstinence period. (This protective factor had the strongest effect on time to relapse.)<sup>512</sup>

The Australian and North American studies on methamphetamine-related relapse rates point to the need for early post treatment and long-term continuing care and relapse prevention services.

"The multiple and disparate needs of AOD clients must be met through a comprehensive package of care that integrates specialist AOD treatment with non-specialist services supporting recovery and community reintegration through housing, employment and family support (Hesse et al., 2007)... The mismatch between client severity and treatment intensity, as well as the mismatch between client complexity and extensity and service integration, results in serial episodes of acute care as they

<sup>509</sup> Brecht ML, Herbeck D. Time to relapse following treatment for methamphetamine use: longer-term perspective on patterns and predictors. *Drug Alcohol Depend.* 2014;139(1):18-25. doi: 10.1016/j.drugalcdep.2014.02.702

<sup>510</sup> Ibid.

<sup>511</sup> Ibid.

<sup>512</sup> Brecht ML, Herbeck D. Time to relapse following treatment for methamphetamine use: longer-term perspective on patterns and predictors. *Drug Alcohol Depend.* 2014;139(1):18-25. doi: 10.1016/j.drugalcdep.2014.02.702

encounter crisis situations whilst cycling in and out of AOD treatment, resulting in a significantly higher cost to society (AIHW, 2013).<sup>513</sup>

### 10.5.1 What works

The Australian Study of Patient Pathways in Alcoholic and Other Drug Treatment undertaken in 2014 confirmed and extended the findings related to the need for post-treatment and long-term continuing care to help prevent relapse.

Patient Pathways was unique in the field of outcome studies in that it went beyond an examination of the client's particular experience of a treatment episode, mapping and analysing their path through treatment systems including through both specialist and linked services. The study recognised clients of alcohol and other drug treatment services present with complex life problems and as a result often must engage with a diverse range of professional services and supports in order to successfully complete treatment and re-establish themselves in the community post-treatment.<sup>514</sup>

The Patient Pathways study recruited 796 clients between January 2012 and January 2013 from 20 alcohol and other drug specialist services in Victoria and Western Australia. Of these study participants, 20 per cent reported meth/amphetamine as their primary drug of concern, 29 per cent of participants were in long-term residential treatment when recruited, 44 per cent were in acute withdrawal services, and 27 per cent were in outpatient-delivered treatment. Most participants had previous experience of specialist alcohol and other drug treatment reflecting the non-linear path to longer-term abstinence.

The Patient Pathways study found only half the participants reported they had received alcohol and other drug specific follow-up post treatment. For some this involved withdrawal treatment followed by residential rehabilitation, for others it involved a treatment exit plan and outpatient counselling following residential rehabilitation. Some, particularly rural-based participants, reported post-treatment support was facilitated by a key worker. Few participants who received outpatient treatment reported receiving any follow-up contact from the service following their treatment, although many indicated they were encouraged to re-engage with the service for further support if needed.<sup>515</sup>

Other qualitative findings of the study included:

- family and close friends were viewed by study participants as a significant source of support post-treatment;
- involvement in mutual aid (peer support) groups was an important source of support for some; and

---

<sup>513</sup> Lubman D, Manning V, Best D, Berends L, Mugvin J, Lloyd B, et al. A study of patient pathways in alcohol and other drug treatment: Patient Pathways National Project. Fitzroy: Turning Point; 2014. p. 3. [accessed 2018 Nov 7] Available from:

[http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/\\$File/Patient%20Pathways%20National%20Project.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/$File/Patient%20Pathways%20National%20Project.pdf)

<sup>514</sup> Ibid.

<sup>515</sup> Lubman D, Manning V, Best D, Berends L, Mugvin J, Lloyd B, et al. A study of patient pathways in alcohol and other drug treatment: Patient Pathways National Project. Fitzroy: Turning Point; 2014. p. 69. [accessed 2018 Nov 7] Available from:

[http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/\\$File/Patient%20Pathways%20National%20Project.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/$File/Patient%20Pathways%20National%20Project.pdf)

- involvement in community, or non-alcohol and other drug specific support groups, such as churches or clubs, provided other participants with support and social connection. These activities also allowed participants to feel they could make a positive contribution and provided a sense of belonging.<sup>516</sup>

The Patient Pathways study recommended:

- Promoting continuity of care, recognising consumers of services frequently present with complex and severe problems, and with previous experience of treatment. The study notes that “most funding systems currently focus on discrete, activity-based episodes of care, with little investment in structures to support continuity of care across treatment modalities and over time”. Rather, funding models should accommodate and promote treatment pathways that involve multiple treatment modes and greater follow-up care.<sup>517</sup>
- Encouraging services to engage in assertive follow-up of clients. Assertive follow-up of clients following treatment promotes continuity and re-engagement with the treatment system when needed. An example offered by the study was services introducing a routine telephone follow-up call four to eight weeks after completing treatment.<sup>518</sup>
- Specialist alcohol and other drug services develop and promote interventions and pathways to aftercare. Aftercare options cited included supportive community groups, including mutual aid (peer support) groups such as Alcoholics Anonymous and SMART Recovery. The study notes that workforce training is required to support staff to introduce such arrangements.<sup>519</sup>

### 10.5.2 What’s happening in Western Australia

The Mental Health Commission has advised that agencies routinely complete exit plans for clients and that some service providers offer specific aftercare treatment measures or interventions and pathways to aftercare, including through the Transitional Housing and Support Program referred to earlier in this chapter. However, the views put to the Taskforce and a review of relevant literature indicate these measures are only available to, or accessed by, some people seeking to recover from problems associated with their methamphetamine use.

### Taskforce conclusions and recommendations

The Taskforce heard how difficult it was for people to re-establish their lives when they stop using methamphetamine, and that active post-treatment support helps to prevent relapse. The Taskforce also heard that despite there being aftercare measures or pathways to aftercare available, only some people seem able to access them. The Taskforce believes more work is needed to ensure appropriate aftercare is available to all those who wish to access it.

---

<sup>516</sup> Ibid. p. 73.

<sup>517</sup> Ibid. p. xvi.

<sup>518</sup> Ibid.

<sup>519</sup> Lubman D, Manning V, Best D, Berends L, Mugvin J, Lloyd B, et al. A study of patient pathways in alcohol and other drug treatment: Patient Pathways National Project. Fitzroy: Turning Point; 2014. p. xvii. [accessed 2018 Nov 7] Available from: [http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/\\$File/Patient%20Pathways%20National%20Project.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/C51C9F3326D93748CA258082001232CB/$File/Patient%20Pathways%20National%20Project.pdf).

**Recommendation 46:**

The Mental Health Commission to work with the Western Australian Network of Alcohol and other Drug Agencies and consumer groups to introduce a system and practices that support post-treatment transition planning and after-care interventions for people exiting treatment, particularly for those in outpatient treatment.

**Recommendation 47:**

The Mental Health Commission to specifically fund specialist alcohol and other drug services to develop and promote interventions and pathways to aftercare for clients.

## PART 3 OPPORTUNITIES FOR CROSS SECTOR COLLABORATION

### Chapter 11 Cross-sector collaboration and coordination

“There are a lot of services – what do they do?”

*Service Providers Forum*

“Getting help needs to be easily accessible.”

*Online comment*

“Make it REALLY easy for us to know where to go for support and help.”

*Online comment*

“There seems to be competition and disagreement between services. There needs to be more cohesion to work and [complement] each other... Families and people do not need the extra drama.”

*Online comment*

“Alcohol and other services [should] take a collaborative approach. Including [to] mental health.”

*Online comment*

The Terms of Reference for the Methamphetamine Action Plan Taskforce include providing advice on opportunities for Government, the community sector and/or business sector to collaborate to reduce methamphetamine harm, supply and demand; and to identify opportunities for the community and business sectors to contribute to these objectives in their own right.

#### 11.1 What the Taskforce heard

Consumers of services commented:

- the siloed way in which services operate does not help them get the support and treatment they need, when they need it;
- gaining access to, and the availability of, treatment and support services needs to be improved, including making it easier for people who use methamphetamine, their families and friends to locate information and navigate a confusing system;
- it would help to have a single point of contact to access information and services and to coordinate the multiple services that are needed to meet consumers’ needs holistically (treatment, housing, financial, child protection and care etc.); and
- services need to focus on meeting the needs of their clients, rather than focussing on what works for the service.

Service providers identified the need:

- for a cohesive cross-sector (alcohol and other drug, health and mental health) approach to addressing methamphetamine use;
- to provide coordinated and integrated alcohol and other drug services;
- to support development and delivery of comprehensive, integrated multi-

- disciplinary services particularly in regional areas;
- for better information sharing between service providers and funding bodies/government agencies;
- to improve referral pathways into treatment;
- to address the financial instability of service providers which comes from having multiple funding sources and multiple and short-term contracts, all of which divert effort and detract from delivering services to clients, and also undermines developing the capacity and capabilities of the alcohol and other drug workforce (especially in regional communities); and
- to consider alternative models of funding where service providers are not 'competing' for limited resources across multiple funding streams, which is inefficient.

The Taskforce also heard that when funding rounds are imminent, informal collaboration arrangements that do exist between service providers sometimes dissipate, and that the current system of tendering for service delivery works against collaboration and coordination.

Solutions offered by service providers included:

- planning, designing and delivering services at a local level to meet local needs ('place-based' approach);
- consumer involvement at all levels of service design;
- tendering processes that enhance regional service delivery capacity, including recognition that distance increases costs and reduces available resources; and
- a single point of entry to services through more collaborative measures.

## **11.2 What the Taskforce observed**

The Taskforce is comprised of community leaders who all have considerable expertise in their respective fields. The following points are their observations on collaboration, coordination and system-level issues.

### **11.2.1 On collaboration and coordination**

- Examples of real cross-sector collaboration and coordination that go beyond information sharing are limited. Examples include the already described Western Australia Police Force Mental Health Co-Response Commissioning Trial (refer to section 7.2.4), the Western Australian Alcohol and Drug Interagency Strategy and the Western Australia Police Child Protection and Housing Referrals Project (refer to section 11.2.2).
- For all the rationality and content written in support of collaboration and coordination by all levels of government and the non-government sector, it is difficult to achieve.
- Current policies and processes, particularly government procurement and contracting policies, actively work against collaboration, coordination and a system that is capable of responding to the needs of the community at a local level, that is based on a collaborative effort.
- Poor coordination between and within governments has resulted in:
  - fragmentation of services and funding priorities;
  - gaps in service provision in some places and possibly duplication in others; and
  - barriers to accessing services, that are made even greater for consumers by



having to navigate a highly complex and confusing system of service delivery.

### 11.2.2 On issues with the system

- The system that currently exists is founded on historical precedent (i.e. legacy decisions of government, as well as the decisions and activity of third parties such as charitable institutions), rather than what is the most effective and efficient model to meet contemporary needs.
- System development and response is slow when compared to the expeditious and efficient changes in the drug market and drug use trends.
- Funding priorities of governments with a focus on a program-level response do not necessarily address the needs of communities at a local level, or the user holistically.
- The system needs reform, with meeting the needs of consumers of services as the key driver and priority for change.

### **DRAFT Western Australian Alcohol and Drug Interagency Strategy 2018 - 2022.**

Published on 31 July 2017 for public comment, the *Draft Western Australian Alcohol and Drug Interagency Strategy* builds on a review of other drug issues and trends, identified gaps in program and service provision, new and emerging evidence, and the achievements of the *Drug and Alcohol Interagency Strategic Framework for Western Australia 2011-2015*.

Developed in consultation with key stakeholders and the community, the Strategy captures the individual efforts of key human and social service Western Australian Government departments to collectively prevent and support those who need assistance to address the impacts of harmful alcohol and drug use. The Mental Health Commission leads the implementation, monitoring and review of the Strategy, in collaboration with other Western Australian Government agencies through the Western Australian Drug and Alcohol Strategic Senior Officers' Group.

The Strategy is aligned to key national and state policies and strategies to ensure consistency and complementary action. These include, but are not limited to, the *National Drug Strategy*, the *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* and the *Methamphetamine Action Plan*. There are five key strategic areas for action and identified drug and target groups:

1. Focussing on prevention
2. Intervening before problems become entrenched
3. Effective law enforcement approaches
4. Effective treatment and support services
5. Strategic coordination and capacity building.

### **Western Australia Police Force Child Protection and Housing Referrals Project**

In September 2017, the Western Australia Police Force commenced a project to work collaboratively with other government agencies to address child protection and public health issues that arise from the execution of search warrants under the *Misuse of Drugs Act 1981*.

Through this project, Western Australia Police Force works with the Department of Communities (Child Protection and Family Support and Housing), the Department of Health and local government authorities to refer matters that lead to the assessment of risks to children resulting from their exposure to drug-related offending, and the risk to occupants and public health from dwellings that have unsafe levels of residue, resulting from either the manufacture or the smoking of methamphetamine. This integrated approach is intended to contribute to better outcomes for the community.

During the period 1 September 2017 to 20 March 2018, 19 families were referred to the Department of Communities – Child Protection and Family Support. There were 33 children involved in the 19 referrals, 14 were aged between birth and six years, and 19 were aged between seven and 18 years.

Between the period 1 September 2017 and 20 April 2018, 114 houses were tested for drug contamination. Of the 114, 65 (57 per cent) tested positive for illicit drug contamination and of those 40 (61 per cent) were methamphetamine contaminated dwellings.

## **11.3 Why collaborate and coordinate**

Calls for better collaboration and coordination in the delivery of government services are long-standing and wide-ranging. The reasons are usually cited as a need for:

- better management of scarce or limited resources (more efficient services); and
- delivering better outcomes for clients and the community (more effective services).

The need for greater collaboration and coordination of service delivery has been central to several recent and influential reviews that examine how government could improve its effectiveness and efficiency, including the following:

- *Working Together One Public Sector Delivering for Western Australia – Service Priority Review* (2017). Established to examine the functions, operations and culture of the public sector, with the aim of driving lasting reform, the Review identified significant structural and systemic weaknesses across the Western Australian public sector requiring a commitment to comprehensive and sustained reform. The Review noted:
  - “The need for services designed to break cycles of disadvantage is higher in many regional and remote areas. Such services are often uncoordinated, expensive and difficult to deliver and do little to support individual and family

- success”<sup>520</sup>; and
- “A lack of effective coordination and integration between State and Commonwealth Governments, local government and non-government organisations is a key factor contributing to poor outcomes. A focus on funding and investment, to the exclusion of effective engagement, has evidently not led to better outcomes.”<sup>521</sup>
  - *Sustainable Health Review (current)*. Established to guide the direction of the Western Australian health system to deliver patient-first, innovative and sustainable health care into the future;
  - *Resilient Families, Strong Communities – a roadmap for regional and remote Aboriginal communities* (2016). A plan for reform to address the complex challenges to reduce the significant gap between the life outcomes of Aboriginal and non-Aboriginal people in Western Australia, with a particular focus on the Kimberley and the Pilbara in the first instance. The regional reforms agenda included the need for system level reform such as; outcomes focused government funded services that are more responsive to place based and community needs;
  - *Location Based Expenditure Review* (2014). A review of services delivered in Roebourne and the surrounding remote communities aimed at identifying opportunities to bring about efficiency and effectiveness in service delivery for these communities. A key finding from this review was the poor outcomes for Aboriginal people despite high levels of spending. In Roebourne, there are 63 government and non-government providers delivering more than 200 services to about 1,400 people; and
  - *Aboriginal Youth Expenditure Review* (2013). A review of targeted expenditure on Aboriginal youth programs and services which found that less than 15 per cent of services reviewed could demonstrate effectiveness. This was attributed in part to poor articulation and measurement of outcomes or objectives, limited program evaluation, and poor or patchy community engagement.

Despite their varied scope and remit, these reviews shared the following findings:

- a lack of evidence about the effectiveness of existing expenditure;
- evidence of fragmented and short-term funding which hinders effective service delivery;
- a complex and poorly coordinated policy and service delivery environment;
- poor or patchy service design, including limited effective community engagement in the design process;
- a siloed approach to service delivery, and poor linkages between related services delivered by different agencies; and
- significant wasted effort.

Each of these reviews also recognised the need for system level reform, with many of the following shared elements of reform identified:

- community needs must sit at the center of the Western Australian Government's

<sup>520</sup> Government of Western Australia. Department of Premier and Cabinet. Working Together. One public sector delivering for WA. Service Priority Review Final Report. Perth: The Department; 2017. p 54. [accessed 2018 Nov 7] Available from:

[https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/ServicePriorityReview/Documents/SPR\\_Report\\_FINAL-5-Dec.pdf](https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/ServicePriorityReview/Documents/SPR_Report_FINAL-5-Dec.pdf)

<sup>521</sup> Ibid. p.55

- operations, including involving community, family and individuals in identifying funding priorities, as well as service design and delivery;
- information and data should be harnessed and shared for better planning and performance measurement;
  - approaches to funding service provision should be more sophisticated, including:
    - funding for collaboration and a focus on outcomes; and
    - consolidating control of government resources and expenditure at a local level;
  - governance, accountability and transparency should be improved, including more effective coordination between and within governments; and
  - the impact of service delivery at both an individual program and collective level would be improved by reviewing the measurement and evaluation of service delivery.

These elements of reform have been captured in the Western Australian Government's *Supporting Communities Policy*. This policy recognises that the delivery of community services in Western Australia (like alcohol and other drug services) is principally centred on a relationship between Western Australian Government and the not-for-profit sector (88 per cent of alcohol and other drug services are delivered by the not-for-profit-sector in Western Australia <sup>522</sup>). The *Supporting Communities Policy* identifies actions to improve the delivery of community services in the following areas:

- breaking down barriers between government departments and stakeholders to ensure funding reaches those in need;
- improving procurement processes by:
  - streamlining procurement processes across departments;
  - procuring services based on outcomes, not outputs;
  - improving funding security to service providers by aligning the duration of contracts across departments;
  - providing flexibility to accommodate increased demand;
  - trialing a collaborative funding model;
- measuring outcomes based on an agreed-upon framework across the sector, ensuring the framework: measures the effectiveness of the Western Australian Government's funding; and promotes opportunities for more targeted, flexible and innovative services, as well as cooperation and data sharing between services and the Western Australian Government; and
- producing a biennial Our Communities Report to provide a snapshot of the health of the community.

At a national level, the need to put users at the centre of service delivery was a focus of the Productivity Commission's *Introducing Competition and Informed User Choice into Human Services: Reform to Human Services* inquiry report in 2017.<sup>523</sup>

---

<sup>522</sup> WANADA Submission to the MAP Taskforce, 20 February 2018.

<sup>523</sup> Australian Government. Productivity Commission. *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*. Productivity Commission Inquiry Report No 85, 27 October 2017. Canberra: The Commission; 2017 [accessed 2018 Nov 7]. Available from: <https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf>

The Productivity Commission found in relation to government-funded family and community services intended to improve the well-being of people at risk or hardship or harm, services were not delivering the best outcomes possible for either the users or the governments that fund them. “Poor coordination between and within government has resulted in a patchwork of funding priorities, gaps in service provision in some places, duplication in others, and barriers to accessing services that are made even higher due to the difficulties of navigating a complex system of service delivery”.<sup>524</sup>

One of the issues the report highlighted was that short-term contracts for service providers were detrimental to the users of those services, because providers spent too much time seeking short-term funding, which was a “costly distraction from delivering and improving their services.”<sup>525</sup> The Productivity Commission found “short-term contracts can also be an impediment to service providers developing stable relationships with service users, hindering service provision and the achievement of outcomes for users.”<sup>526</sup>

The Productivity Commission recommends governments move to a seven-year default contract term, rather than the three years which currently exists, to provide stability and a chance to focus on better user outcomes. This would extend to a 10-year default contract term for services to remote communities to enable extra time to establish community trust and invest in staff, capital and delivery models. It also determined the four to six weeks generally allowed for service providers to respond to tender opportunities was “not long enough for providers to develop a high-quality proposal, or for providers to formalise collaborative arrangements to take advantage of synergies. Much longer periods should be allowed in tenders for potential providers to develop bids (three months should be the default).”<sup>527</sup>

This is an issue the Taskforce noted particularly in relation to regional service provision, where service providers told the Taskforce they found the current system of procuring services so competitive it worked against them trying to collaborate across the sector.

The Productivity Commission also found that interactions between governments and providers continue to dominate the design and delivery of services. It found “governments tend to focus on the cost of service delivery and the ‘quality’ of the tender applications rather than the ability of providers to deliver outcomes for the users [...] service providers are required to deliver the (sometimes prescriptively defined) services in their contract, regardless of whether those services are the best way to produce outcomes for users”.<sup>528</sup>

The Productivity Commission determined there were sound efficiency and equity reasons for governments to fund human services, as “markets left to their own devices would not deliver the appropriate level, or distribution, of human services

---

<sup>524</sup> Ibid. p21.

<sup>525</sup> Ibid. p24.

<sup>526</sup> Ibid.

<sup>527</sup> Australian Government. Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Productivity Commission Inquiry Report No 85, 27 October 2017. Canberra: The Commission; 2017. p 23. [accessed 2018 Nov 7] Available from: <https://www.pc.gov.au/inquiries/completed/human-services/reforms/report/human-services-reforms.pdf>.

<sup>528</sup> Ibid. p 85.

across the community”.<sup>529</sup> Further, “Governments should always have the role of system stewards [...] responsible for the range of functions that both determine what human services should be made available and the effectiveness of those services.”<sup>530</sup> Noting that stewardship was a core part of the reform and delivery process, the report highlighted the following areas where governments need to improve:

- “greater coordination: government silos and poor planning have led to gaps and duplication, services with competing objectives and stewards [governments] losing sight of the users’ overall well-being. Better planning and coordination are needed within and across governments. Greater efforts, for example, are needed to coordinate services for people with multiple and complex needs;
- more transparency: providing information to improve accountability and facilitate performance assessment can benefit all parties within human services system. Equipped with improved information, users can assess providers, providers can plan their services, and governments can evaluate how providers or systems are performing; and
- smoother transitions: policy reform in human services is a complex task. Reforms can be large, costly and disruptive to users and providers, take considerable time to fully implement, and affect the lives of many (sometimes vulnerable) users [...] transitioning between providers can also be disruptive as users find new providers and build a relationship of trust with them. Governments should plan and prepare for change in order to preserve continuity of outcomes and minimise any negative effects on users from the transition.”<sup>531</sup>

What the Taskforce heard from stakeholders and the findings of several recent, significant government inquiries and reports, confirms the need to collaborate and coordinate in order to more effectively deliver services and better meet the needs of users.

### 11.3.1 What’s happening in Western Australia

Building on the principles of the Western Australian Government’s *Delivering Community Services in Partnership Policy*, the *Supporting Communities Policy* acknowledges that “central to the role of the delivery of community services is the relationship with government”.<sup>532</sup> Both policies focus on improving government procurement practices and processes with a view to ensure the delivery of quality services to the community. Key focus areas for improvement include streamlining procurement processes and breaking down barriers between government agencies procuring based on outcomes instead of outputs, exploring opportunities to establish collaborative funding, and developing flexibility to ensure government agencies can support individualised models of care. The Supporting Communities Forum was established in December 2017 to support the implementation of the *Supporting Communities Policy*. The Forum reports to the Community Safety and Family Support Cabinet Sub Committee.

---

<sup>529</sup> Ibid. p 7.

<sup>530</sup> Ibid. p 8.

<sup>531</sup> Ibid.

<sup>532</sup> Government of Western Australia Supporting Communities policy document [accessed 2018 Nov 7] Available from: <https://www.dpc.wa.gov.au/Councils-and-Committees/Supporting-Communities-Forum/Documents/Supporting%20Communities%20Policy.pdf>



## 11.4 Delivering a more effective system to better meet people's needs

The Taskforce is mindful of the State's current fiscally constrained environment and recognises the value and necessity of ensuring services are delivered efficiently. However, its primary interest (in the collaboration and coordination of service delivery and system reform more generally) is to ensure that services more effectively meet the needs of users.

For this reason, the Taskforce has focused on four key overarching areas for reform:

- taking primarily a health and community response to methamphetamine use;
- alternative models of drug regulation and control in the community;
- integrating health, mental health and alcohol and other drug services; and
- looking to the future.

### 11.4.1 Taking primarily a health and community response to methamphetamine use

"Help people through treatment, not punishment."

*Online comment*

"Consider compulsory rehabilitation rather than automatically criminalising users."

*Online comment*

The Taskforce consistently heard two principal, opposing views about how the impact of methamphetamine should be dealt with. Firstly, and overwhelmingly, that methamphetamine use should be treated as primarily a health and community issue.

Some stakeholders and people with lived experience of methamphetamine, including people who use methamphetamine and their families, went so far as to suggest the Government reconsider its drug policy settings as other countries have done, or are doing:

"In my opinion the Government needs to take on attitudes towards drug abuse/addiction like countries like Portugal or The Netherlands and treat this epidemic as a health issue rather than a criminal issue. Until this happens, my local area, and Australia as a whole, is doomed [to] keep struggling with this issue."

*Online comment*

"I believe if marijuana had been decriminalised then you would have seen the decline in ice users. Point in case... most FIFO workers are ice users as they can use it continuously on their break and be clean when returning to work, but the poor guy that has a smoke of a joint once pays for it for a month.....stupidity."

*Online comment*

Alternatively, the Taskforce heard strong calls for harsher penalties for people who use, and people who supply methamphetamine.

"Go hard on the users and dealers. [Person] has been caught drug driving so much he is going to lose his licence for life. But that is no big deal to

them. He will drive without it. Lock them up. Be smarter on how to catch them. His house got raided the other week and they found nothing. Put them under regular raids. Follow them. He is obviously hiding it somewhere.”

*Online comment*

“Harsher penalties – to many a court date/prison sentence or overnight in the lockup means nothing to them. There is no shame or consequence for doing meth.”

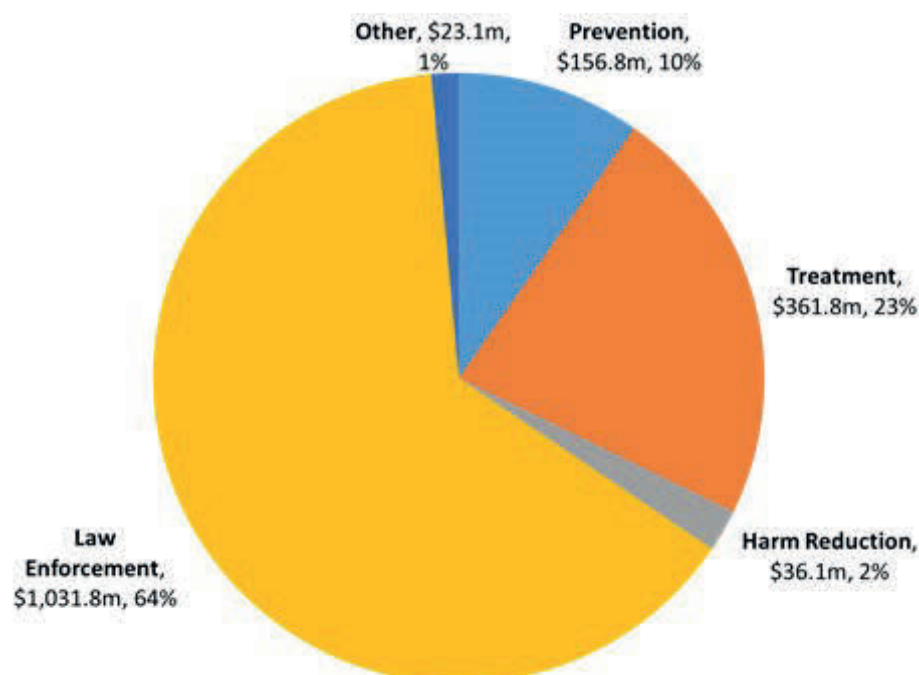
*Online comment*

#### **11.4.1.1      *The need to balance health, community, and law enforcement approaches***

What these divergent views represent is a growing debate occurring internationally as well as in Australia about the need to balance health, community and law enforcement approaches to illicit drugs. An extension of that discussion is the need to look at alternative models of regulation and control of drugs in the community.

One illustration of the relative areas of priority for governments in responding to illicit drugs is the proportion of expenditure on its different areas of activity. A 2013 examination of Australian governments’ expenditure on illicit drugs in 2009-10 estimated that \$1.7 billion is spent across all domains of activity, with 69 percent of that expenditure by states and territories. As can be seen in Figure 33, by far the largest category of spending at 64 per cent on law enforcement, with prevention (10 per cent) and treatment (23 per cent) together accounting for one third of total estimated expenditure.

**Figure 33: Total government expenditure estimates (proportion) across four policy domains (2009/10)<sup>533</sup>**



Source: Ritter, Alison, Ross McLeod and Marian Shanahan, 2013, *Government Drug Policy Expenditure in Australia – 2009/10*, Drug Policy Modelling Program Monograph 24, NDARC, June 2013, Addendum 20/8/13

The most recent exploration of these issues has been undertaken by the Parliament of Victoria Law Reform, Road and Community Safety Committee. It's *Inquiry into Drug Law Reform* report, released on 27 March 2018, sought to provide “a platform for genuine debate about drug law reform”,<sup>534</sup> recognising this is “an incredibly complex area of public policy”.<sup>535</sup>

The Parliament of Victoria's inquiry captures the reality of Australia's present situation:

“While Australia's official approach to drugs is based on harm minimisation, the predominant focus is law enforcement to reduce the supply of illicit drugs in the community. There is overwhelming evidence, however, that the focus on law enforcement is not having the intended impact. Despite the continued position of prohibition over the last 50 years, in reality drug consumption is endemic and the drug market is more volatile than ever. This is reflected in the emergence of new and more

<sup>533</sup> Ritter A, McLeod R, Shanahan M. 2013. *Government Drug Policy Expenditure in Australia – 2009/10*. Drug Policy Modelling Program Monograph 24. Sydney: NDARC; 2013. [accessed 2018 Nov 7] Available from:

[https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/24%20Government%20drug%20policy%20expenditure%20in%20Australia%20-%202009\\_10.pdf](https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/24%20Government%20drug%20policy%20expenditure%20in%20Australia%20-%202009_10.pdf)

<sup>533</sup> Parliament of Victoria, op. cit., p. 1

<sup>533</sup> Ibid. p. xv

<sup>534</sup> Ibid. p. 1

<sup>535</sup> Ibid. 2018, p. xv

potent drugs, the resurfacing of old drugs, and an increasing number of overdose deaths. This is not a criticism of law enforcement agencies, whom the Committee strongly believes operate as effectively as possible, but rather it reflects the constantly evolving nature of drug use and production.”<sup>536</sup>

As documented earlier in this report, this conclusion by the Parliament of Victoria’s inquiry is consistent with what the Taskforce has found in Western Australia. Despite considerable effort, investment and success with the number and weight of methamphetamine seizures in Western Australia, the drug is readily available and relatively cheap to obtain.

Given the current approach is not proving to be effective many people consulted by the Taskforce, and much of the evidence presented to the Parliament of Victoria’s inquiry, called for a revised approach pointing to the “need for open and frank conversations about drugs in order to help the community understand why people use them and to work towards a more compassionate and balanced response to drug issues”.<sup>537</sup>

As previously discussed, the reasons for problematic drug use are complex. The concept of the social determinants of drug use emerges from studies of human development and the social determinants of health. These studies conclude that drug use behaviours are the result of a complex interplay of individual and environmental factors across a life course:

“A variety of factors contribute to drug use and other problem outcomes, both individual and environmental. While drug prevention and treatment have traditionally focused on changing individual behaviours, such efforts can have only limited impact when changes are not made to the environment, that is, to the social determinants of drug use. These include the social and cultural environment, the economic environment and the physical environment.”<sup>538</sup>

The risk factors for determining drug use include social alienation, isolation and marginalisation, prolonged or chronic stress which impact on mental and physical health, economic hardship and related social disadvantage and trauma, and the impact of which is sometimes transmitted across generations. For Aboriginal people the risk factors are exacerbated as a result of a long history of dispossession of their lands, active disruption of Aboriginal society and cultural practice, discrimination and intergenerational trauma caused by government policy and interventions that have ranged from brutal to misguided or poorly conceived.<sup>539</sup>

The complexity of issues arising from these social determinants of drug use leads to several key conclusions:

- “Any single intervention, single sector or single worker can have only a limited

---

<sup>536</sup> Parliament of Victoria, op. cit., p. 2

<sup>537</sup> Ibid. p. 4

<sup>538</sup> Spooner C, Hetherington K. Social Determinants of drug use, Technical Report Number 228. Sydney: National Drug and Alcohol Research Centre; 2004. p. iv. [accessed 2018 Nov 7] Available from: <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf>

<sup>539</sup> Ibid. p. v - xiii

impact on drug-use problems. No person, agency or sector by itself can ‘fix’ an individual or a community. Comprehensive and sustained actions is needed for effective prevention and treatment”<sup>540</sup>; and

- what is required is investment in human development across life, including:
  - structures for child and youth development;
  - early interventions and safety nets across the life course for those who begin problematic trajectories; and
  - greater assistance (rather than marginalisation and punishment) for those who are not managing.<sup>541</sup>

#### 11.4.1.2 Addressing underlying drivers of use

The Taskforce is aware of recent efforts by the Western Australian Government to take a cross-agency and cross-sector approach to address complex social problems (that include the impacts of alcohol and other drug misuse) by tackling the underlying causes of these problems. Below are two such initiatives:

- **Armadale Senior High School Full Service School** pilot. ‘Full-service schools’ provide a range of services and activities, often beyond the school day, to help meet the needs of children, their families and the wider community. Working with the departments of Communities, Justice, Health and the Western Australia Police Force, the Department of Education intends to introduce services such as “after-school activities, vacation care, life-skills training (e.g. parenting support, prevention of teenage pregnancy and substance abuse, and social and relationship skills), vocational education and training services, specialist health services, classes to reintegrate early school leavers and part-time community based projects”<sup>542</sup>; and
- **Target 120** is a Government initiative to prevent young people reoffending and to improve community safety. A dedicated case worker will work with a young person and their family providing targeted interventions to address the issues that increase a young person’s likelihood of offending including substance abuse, lack of secure housing, domestic violence, trauma, mental health issues and poor attendance at school. Target 120 will take a cross-government coordinated and flexible approach to ensure young people and their families receive timely access to effective services. The Target 120 initiative is in the early stages of implementation, but is designed to be targeted, person-centric, flexible, culturally responsive and, importantly, moves away from individual agency responses to achieve a common, coordinated and collaborative outcome for participants and their families.<sup>543</sup>

<sup>540</sup> Ibid. p. xiii

<sup>541</sup> Spooner C, Hetherington K. Social Determinants of drug use, Technical Report Number 228. Sydney: National Drug and Alcohol Research Centre; 2004. p. xvi. [accessed 2018 Nov 7] Available from: <https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.228.pdf>

<sup>542</sup> Government of Western Australia. Media statement: Armadale Senior High School to pilot Full Service Schools program. 2017 December 6. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2017/12/Armadale-Senior-High-School-to-pilot-Full-Service-Schools-program.aspx>

<sup>543</sup> Government of Western Australia. Media statement: State Government youth crime initiative to start in Bunbury. 2018 May 11. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/McGowan/2018/05/State-Government-youth-crime-initiative-to-start-in-Bunbury.aspx>

In addition to taking a cross-agency and cross-sector approach at a service level, the Government has established governance arrangements that structurally support this approach. The Government established the Community Safety and Family Support Cabinet Sub Committee in April 2017 to direct and oversee the implementation of:

- the Government's social policy election commitments including the *Methamphetamine Action Plan*; *Stopping Family and Domestic Violence* policy; the *Target 120* initiative to reduce juvenile reoffending; the *Supporting Communities* policy; and
- responses to other social policy issues that require integrated across-government approach and implementation by a range of agencies working collaboratively.

### **Taskforce conclusions and recommendations**

The Taskforce has heard calls for methamphetamine use to be treated as primarily a health and community issue, rather than as a criminal issue. It has also heard calls to increase the punitive approach to both users and suppliers of the drug. These views reflect a broader debate both in Australia and internationally on the most effective approach to addressing the increasing rates of problematic drug use in our communities, given best efforts and current strategies haven't worked.

Such a debate requires an examination of some of the fundamentals that underpin our current approach including community understanding of and attitudes towards illicit drugs and the people who use them, as well as the policies, laws, procedures and regulations relating to illicit drugs. The Taskforce is of the view that community understanding of, and attitudes towards, illicit drugs and the people who use them would be greatly enhanced if there was greater appreciation of the reasons why people take drugs in general, and methamphetamine in particular.

Recommendations necessary to address the social determinants of drug use are beyond the scope of the Taskforce's Terms of Reference, but are fundamentally important to the longer term and most effective solutions not only for methamphetamine use, but alcohol and other drug misuse more broadly. For that reason, the Taskforce is of the view that initiatives that seek to tackle other but related complex social problems taking a cross-agency, cross-sector approach, should be supported and if possible their impact on addressing the social determinants of drug use should be integrated.

The Taskforce supports the Government's efforts to address the problems associated with methamphetamine use by taking a sustained, cross-government coordinated and comprehensive approach.

#### **11.4.2 Alternative models of drug regulation and control in the community**

The need to re-examine the approach to an effective response to methamphetamine and drug use more broadly, requires some examination of the laws that underpin the current policy and system response.

Along with the Parliament of Victoria's Inquiry into Drug Law Reform, the Commonwealth Parliamentary Joint Committee on Law Enforcement's Inquiry into Crystal Methamphetamine (ice) considered Australia's current drug policies and illicit drug laws. The Parliamentary Joint Committee Inquiry discussed decriminalisation and compared that with legalisation. It also looked at developments in other countries including the United States, Uruguay, Canada and Portugal.



Portugal is of particular interest to many working in the alcohol and other drug field and has been referred to as a model of best-practice. The Portuguese model maintains criminal sanctions against individuals and organised crime groups responsible for trafficking drugs, but Portugal's drug users are treated with compassion. They are supported by police and the Commission for Dissuasion of Drug Addiction to receive education about the harms of drug use without fear of criminal sanctions, and attend voluntary treatment.

The Commonwealth Parliamentary Joint Committee was careful to note there are differing views on the success of the model and that Portugal's decriminalisation model was largely a response to heroin use, not methamphetamine. The availability of pharmacotherapy to treat heroin use makes treating problematic use of that drug a different proposition to methamphetamine.<sup>544</sup>

The Parliamentary Joint Committee concludes:

- while decriminalised drug policies have demonstrated a positive impact on health outcomes for drug users, decriminalisation is not a 'silver bullet';
- reform to decriminalise drug use must occur in conjunction with investment in treatment services to ensure drug users are able to transition into treatment without delay;
- successful implementation of decriminalisation in Australia would require the engagement and commitment of the Commonwealth and state and territory governments, with political will and leadership essential to building public understanding of and support for such approaches; and
- the success of research into pharmacotherapies for methamphetamine users, (as discussed earlier) would have to be a key consideration in the appropriateness of decriminalisation of methamphetamine.<sup>545</sup>

The Parliamentary Joint Committee:

"...urges Australian governments to implement the recommendations in this and the committee's first report. Improvements can and must be made in addressing methamphetamine use in Australia; in the Committee's opinion, this should be done by shifting the focus on methamphetamine from a law enforcement problem to a health issue within an environment where treatment and support are readily available and without stigmatisation."<sup>546</sup>

Other jurisdictions in Australia and other countries are considering or have in some cases already reformed some aspects of their drug laws and regulation. The success of the reforms that have taken place is still being debated.

### Taskforce conclusions and recommendations

It is the Taskforce's view that Australia has a strong track record of taking an evidence-based approach to alcohol and other drugs and that it should continue to

<sup>544</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 157. [accessed 2018 Nov 7] Available from:

[https://www.apph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.apph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>545</sup> Ibid. p. 157 and 158.

<sup>546</sup> Ibid. p. 158.

do so; taking advantage of the inevitable ongoing evaluation of drug law reforms in other jurisdictions and only implementing reforms when they have proven to be effective.

The Taskforce agrees the lack of a recognised pharmacotherapy for methamphetamine and the very nature of the drug itself makes it a very different proposition for investigating alternative models for regulation and control in the community, than other drugs such as heroin. However, it is possible that reforms for other drugs (such as the decriminalisation of cannabis for personal use) may have a beneficial flow-on effect on trends in methamphetamine use, such as reducing the uptake of methamphetamine in the first place.

The Taskforce is of the view that there needs to be a comprehensive public consideration of the ways we treat currently illegal drugs in our community which recognises the limitations of criminalisation and imprisonment of drug users and considers alternative non-prohibition models for drugs including those which are being trialled and implemented in other countries. The Taskforce believes the best way to do this is through a bipartisan Parliamentary Committee.

**Recommendation 48:**

A Parliamentary Committee inquire into and report on alternative models for drug regulation, regulatory systems and controls in other jurisdictions, including both prohibition and non-prohibition models, their effectiveness in addressing the costs and harms to individuals, families and the community and, their suitability for introduction into Western Australia. This inquiry should:

- be bipartisan in structure and composition;
- be subject to specific reporting time-frames;
- involve consultation across the alcohol and other drug sector;
- be open to and engage with the public; and
- be required to report to the Parliament of Western Australia on the outcomes of the inquiry.

### **11.4.3 Integrating health, mental health, and alcohol and drug services**

The Taskforce heard about the difficulties faced by consumers who needed to access a range of services and supports that could help them turn around their circumstances. The effects of prolonged use of methamphetamine on the brain makes this particularly challenging for those seeking help. This is exacerbated for those who no longer have the support of family or friends. The range of services often needed to address the impacts of methamphetamine on some people's lives include not only treatment, but also support to deal with housing, child care and protection, income and benefits, and transport.

#### **11.4.3.1 *One point of contact to coordinate and support holistically***

In addition to the Target 120 initiative described at 11.4.1.2, the Taskforce is aware of two other initiatives that seek to address the challenge of providing a single, coordinated point of contact for access to all services that might be required. The Armadale Youth Intervention Partnership (AYIP) pilot and the Commonwealth's Partners in Recovery (PIR) initiative.

Evolving from a collaboration of several place-based diversionary programs, the Youth Partnership Project (YPP) (which conducts the AYIP pilot) was initiated in the

south east corridor of Perth in 2014 with funding support from the Department of Communities. The Project was a direct response to significant youth issues, including youth crime and anti-social behaviour. The project adopted a 'collective impact' early intervention approach for young people with complex needs through facilitating the collaboration of services and the coordination of resources that already existed, and identifying and filling gaps. To achieve this, AYIP was established in 2016 to demonstrate how a targeted, collaborative and place-based approach, with resourced leadership, could support better outcomes for young people with complex needs.<sup>547</sup>

"The YIP [Youth Intervention Partnership] model... is not 'another program'; it rethinks service system and changes the way it operates... [it] enables a cross-sector of partners to move beyond programs with isolated impact, to a collaborative approach with a common goal.

It is premised on the theory that if we get the right support, to the right young people, at the right time, we will not only create significant savings in expenditure on tertiary services, but more importantly, young people will thrive in their communities."<sup>548</sup>

The model works as follows:

- identification – partnership organisations identify young people who would benefit using a shared definition of young people with complex needs;
- building relationships – young people engage with mentors and youth workers during intensive engagement program;
- consent – partnership coordinators engage family and seek consent;
- assessment of needs – through observational assessment, cognitive and emotional assessment and functional assessment of cognitive, literacy and educational abilities; and
- coordinated and holistic support – the partnership provides a range of support for the young person and their family, coordinated by the YIP Coordinator and supported by youth workers from partner organisations.

Commencing in 2012, Partners in Recovery (PIR) is a funding program that contracts an organisation to facilitate better coordination of existing clinical and other support and services for people with persistent mental health illness and complex needs. The initiative aims to deliver 'wrap around' care that is individually tailored to the person's needs that may include coordination and integration of services such as: public and private specialist mental health services; primary (e.g. GPs), secondary (occupational therapists, optometrists, dental) and tertiary (hospitals, specialists) health care services; alcohol and other drug treatment; disability services; income support services; supported accommodation and public housing services; parenting support services, education and employment services; and child protection, domestic violence and justice services.<sup>549</sup>

<sup>547</sup> Youth Partnership Project, *Youth Intervention Partnership Model*, 2017, p. 6. [accessed 2018 Nov 7] Available at <http://www.youthpartnershipproject.org.au/publications>

<sup>548</sup> Ibid.

<sup>549</sup> Australian Government. Department of Health and Ageing. Partners in Recovery Program Guidelines for the engagement of PIR Organisations 2012-13 to 2015-16. Canberra: The Department; 2012. p. 4-5. [accessed 2018 Nov 7] Available from:

### Taskforce conclusions and recommendations

Target 120, YIP and PIR models provide useful examples of systems reform that are person-centric, coordinated, address the needs of both the affected individual and their family, and are holistic in their approach. The Taskforce is of the view that these models may prove promising for application in dealing with people with complex needs in the alcohol and other drug sector. Given the relatively recent development of the Western Australian-based initiatives, the Taskforce considers further examination of these models would be worthwhile.

#### **Recommendation 49:**

The Mental Health Commission works with other government agencies and the alcohol and other drug sector to integrate a case-management approach, which meets the multiple and complex needs of individuals and families, into its service delivery model.

#### **11.4.3.2 Systems level integration of Western Australia's mental health and alcohol and drug services**

As previously reported, the Taskforce has heard there are challenges accessing the right support for people with co-occurring mental health and alcohol and other drug substance use disorders. This was heard from consumers of services, and acknowledged by the Chief Psychiatrist (see section 6.2) and the Western Australian Network of Alcohol and other Drug Agencies.

The Taskforce has made recommendations to support improvements to treating people with co-occurring mental health and alcohol and other drug substance use conditions in section 6.2, but recognises there may be opportunities to look at systems level reform that would better support integration of the State's mental health and alcohol and drug services.

On 1 July 2015, the Western Australian Government announced the merger of the Mental Health Commission and the Drug and Alcohol Office. The objective of the merger was stated as improvement in services for Western Australians with mental health, drug and alcohol or co-occurring problems.

"Combining the functions of both agencies will provide a more holistic approach to care for people experiencing challenges with their mental health, alcohol or drug use, or both. The new Mental Health Commission will steer transformation and growth across both sectors consistent with the directions outlined in the *Mental Health, Alcohol and Other Drug Services Plan 2015-2025*."<sup>550</sup>

---

[http://www.health.gov.au/internet/main/publishing.nsf/content/7C73764C94CDDC02CA257BF0001A8D3D/\\$File/Partners%20in%20Recovery.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/7C73764C94CDDC02CA257BF0001A8D3D/$File/Partners%20in%20Recovery.pdf)

<sup>550</sup> Government of Western Australia. Media Statement: Agency to tackle drug issues and mental health. 2015 July 1. Perth: WA Government. [accessed 2018 Nov 7] Available from: <https://www.mediastatements.wa.gov.au/Pages/Barnett/2015/07/Agency-to-tackle-drug-issues-and-mental-health.aspx>

The Western Australian Network of Alcohol and other Drug Agencies, in its submission to the Taskforce, questioned whether the objective of the merged service integration had been realised.

“The merger/amalgamation between government bodies (MHC [Mental Health Commission] and DAO [Drug and Alcohol Office]) has not resulted in any significant service “integration” developments beyond what was already in place, or that would have happened otherwise. It has also not improved the 2 sectors capacity or capabilities to address co-occurring issues.”<sup>551</sup>

The Western Australian Network of Alcohol and other Drug Agencies submitted there are a range of barriers to effective integration including:

- cross-sector language issues;
- a loss of corporate alcohol and other drug specific knowledge and expertise in the merged agency impacting on procurement, policy, sector planning etc. and “negative perceptions or attitudes towards alcohol and other drug consumers and alcohol and other drug services”;
- differences in service models between mental health (medical) and alcohol and other drug services (psychosocial/counselling); and
- the alcohol and other drug sector is predominantly not for profit, while mental health services are predominantly government.<sup>552</sup>

The Western Australian Network of Alcohol and other Drug Agencies reported that since the merger, the sector has seen an increase in funding for alcohol and other drug service provision, noting: “although we were starting at a seriously low base of services to meet demand”. It submitted to the Taskforce that the alcohol and other drug sector is “the poor cousin in the amalgamation”, “having an overall budget of just 10 per cent of the mental health budget”.<sup>553</sup>

### **Taskforce conclusions and recommendations**

The Taskforce heard from consumers of services and key stakeholders in the mental health and alcohol and other drug sectors that more needs to be done to deliver services to people experiencing co-occurring conditions. Measures already discussed elsewhere include building the capacity and capability of both sectors. The Taskforce acknowledges the peak body for the alcohol and other drug sector has raised questions about whether the desired results of the functional merger of the Western Australian Government agencies responsible for mental health and alcohol and other drugs have been realised.

In order to properly address the questions raised by the sector and give greater confidence to consumers of alcohol and other drug services, the Taskforce considers it timely to undertake a review of results of the merger.

---

<sup>551</sup> WA Network of Alcohol and other Drug Agencies, 20 February 2018, Presentation to the Methamphetamine Action Plan Taskforce.

<sup>552</sup> Ibid.

<sup>553</sup> Ibid.

**Recommendation 50:**

The Western Australian Government, as part of the Machinery of Government changes, consider how the State's alcohol and other drug response can be given greater priority across all portfolios and how it can be most effectively positioned within the public sector to maximise efficiency, effectiveness and engagement with the community. In particular, the Government should commission an independent body/investigator to determine the extent to which the objectives of the amalgamation of the Mental Health Commission and the Drug and Alcohol Office in 2015 have been achieved with the view to improving accountability and transparency of service delivery.

**11.4.3.3 Easier access to information and support**

The Taskforce has documented the recurring frustration of consumers regarding a lack of accessible information on methamphetamine, including information about treatment and support.

People who work in the sector have responded with surprise and frustration when these views were reported to them, pointing to the considerable effort and resources deployed to provide this information to consumers.

Some of the key sources of information available in Western Australia include:

- the Mental Health Commission's Alcohol and Drug Support Service which provides telephone counselling support for those waiting to access treatment, and follow-up counselling support when treatment is finished;
- the Drug Aware website, funded by the Western Australian Government, which provides accurate, up-to-date information about amphetamines and their impact, as well as a live chat function with a qualified alcohol and other drug counsellor;
- the *Meth Can Take Control* community action tool kit, developed by the Western Australian Government-funded Drug Aware program, developed as a resource for communities which have identified methamphetamine as an issue for them;
- *The Green Book* and online app which provide a directory of alcohol and other drug service providers in Western Australia, (this resource is currently under review for improvement); and
- the Commonwealth Department of Health's *Cracks in the Ice* website and app provide information for individuals, families and communities about crystal methamphetamine, how people use it, its effects and where to go to get help and support. It also provides a number of interactive elements including a short survey that enables a person to get feedback on their use of ice and whether they should seek help for their use, as well as an online counselling resource for family and friends of individuals experiencing problems with methamphetamine and other drugs. *Cracks in the Ice* also provides comprehensive resources for teachers, parents and students as well as training, guidelines and other online resources for health professionals. The site has been developed with the involvement of the National Drug Research Institute, National Drug and Alcohol Research Centre and the National Health and Medical Research Council (NHMRC) Centre for Research Excellence in Mental Health and Substance Use.

The Mental Health Commission advises it is in the project initiation phase of an Online Services Directory, using the My Community Directory platform. The Mental



Health Commission and the WA Primary Health Alliance are platform partners of the My Community Directory. The Mental Health Commission advises the Online Services Directory will feature a unique shopfront design to enable ease of search capability for consumers, families and their carers across desktop computers, mobile phones and tablets. The Directory is expected to be available in late 2018 and the Mental Health Commission believes it will help address community need for a simple, easy to access resource to guide and assist users to connect with the right service.

### Taskforce conclusions and recommendations

The Taskforce notes the development by the Mental Health Commission of an online services directory and also notes there are a number of evidence-based sources of information aimed at individuals and families affected by methamphetamine use. However, the Taskforce has heard people do not appear to be sufficiently aware of these resources, indicating there is a disconnect between these services and their target audiences. The reasons for this have not been explored by the Taskforce in detail, but further examination is warranted to improve the accessibility of these services to meet the needs of consumers.

#### Recommendation 51:

The Mental Health Commission, in consultation with the Western Australian Network of Alcohol and other Drug Agencies, and target service consumers, evaluate the effectiveness of information services, including; awareness of services, reach of services, including to regional areas, suitability of current delivery modes, and optimal levels and mix of service provision, within 12 months.

#### 11.4.4 Looking to the future

The National Ice Taskforce found “existing data and research does not provide a sufficiently comprehensive evidence base to support optimal policy-making on ice and to measure the effectiveness of these responses.”<sup>554</sup> The Taskforce made several recommendations to fill the research and information gaps identified. In response, funding was allocated under the *National Ice Action Strategy* from July 2016, as follows:

- \$8.1 million to more broadly improve data sources on emerging trends in ice and other illicit drug use patterns, treatment options and early identification of newly emerging drug threats; and
- \$10.7 million to support clinical research into new treatment options, training, and evaluating the effectiveness of clinical care for those using methamphetamines, which includes establishing a Centre of Clinical Excellence for Emerging Drugs of Concern.<sup>555</sup>

The Centre of Clinical Excellence for Emerging Drugs of Concern commenced in March 2017. It has been established to support clinical research into new treatment options, training of health professionals and evaluating treatment effectiveness.

<sup>554</sup> Australian Government. Department of Prime Minister and Cabinet. Final Report of the National Ice Taskforce 2015. Canberra: The Department; 2015. p 150. [accessed 2018 Nov 7] Available from: [https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

<sup>555</sup> Senate Community Affairs Committee, Answers to estimates questions on notice, Health Portfolio, 1 March 2017, Ref No. SQ17-000346.

The National Drug and Alcohol Research Centre at the University of New South Wales leads a consortium including the National Drug Research Institute at Curtin University, the National Centre for Education and Training on Addiction at Flinders University and St Vincent's Health Australia. Given its very recent establishment, the Taskforce has not been able to determine what the key focus areas or activities of the Centre of Clinical Excellence for Emerging Drugs of Concern are likely to be.<sup>556</sup>

As part of the *National Ice Action Strategy* the Commonwealth Government also announced funding (although the Taskforce was unable to identify the amount) to expand the Victorian Ambulance Project to establish and maintain a National Surveillance System for Alcohol and other Drug Misuse and Overdose. The project aims to “provide detailed and timely data regarding alcohol and other drug acute harm and overdose, and address gaps in evidence needed to inform policy, intervention and evaluation activities at both a state and national level”.<sup>557</sup>

#### **11.4.4.1 Supporting alcohol and other drug research**

Research to improve care is core business for the health sector. Investing in research:

- provides positive health outcomes, driving down demand for and the cost of health care services, in addition to reducing the length of a patient's journey to good health;
- helps combat and reduce the human cost of chronic illness;
- attracts and retains distinguished clinicians and scientists;
- promotes innovation and economic diversity; and
- raises the international profile of Western Australia, with the potential for attracting wealth raising incumbents such as international students and commercial organisations in the fields of pharmaceuticals, biotechnology and medical devices.

Research provides the evidence foundation that guides clinical practice. There is an inherently incorrect belief that current clinical practice is best practice, and while this is not based on high-level evidence it is acknowledged changes in clinical practice should never occur within a vacuum of evidence. Clinical research, where patients are enrolled in studies including those which compare diagnostic and/or therapeutic strategies, is particularly important for guiding patient care.

The Taskforce has been told that alcohol and other drug research is not considered ‘sexy’ and that is why it isn’t a national research priority. It is still considered the ‘poor cousin’ compared to other high profile conditions, despite the fact that alcohol and other drug concerns are a major community issue that impacts multiple government agencies. For methamphetamine research, the use of pharmacotherapy where currently there are no options available, and rehabilitation approaches, are obvious areas of deficit.

A Taskforce examination of the 2017 round of National Health and Medical Research Council project grants reveals that overall, nationally there were 3,345 applications, with 550 funded resulting in a 16.4 per cent success rate. There were 239

---

<sup>556</sup> Australian Government. Department of Health. Information page: National Ice Action Strategy. 2018 March 14 [accessed 2018 Nov 7]. Available from:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/MC15-009596-national-ice-taskforce>

<sup>557</sup> Ibid.

applications from Western Australia with 33 funded, which is a success rate of 13.8 per cent.

A quick count of the 50 project grants funded in the public health category in that round indicated that eight were funded in the alcohol and other drug area, of which three were on illicit drugs. None of these projects funded were from Western Australia.

While this is not an exhaustive search through all 3,345 project grants, the Taskforce notes public health grants are likely to be indicative of other grant categories.

In July 2017, the Government committed to a \$1 billion Future Health and Innovation Research Fund in Western Australia to drive medical research and innovation. The fund will include a cancer research plan for the next decade, an innovation hub at Royal Perth Hospital, and incentives for corporate and philanthropic contributions for health and medical research.<sup>558</sup>

### **Taskforce conclusions and recommendations**

The Taskforce considers that Western Australian Government support for alcohol and other drug research should be a priority for improving clinical care. This should be viewed as an innovation and could be managed within existing Department of Health governance structures. This approach would also enhance Western Australia's prospects for achieving improved success for funding applications to the National Health and Medical Research Council, which are currently well below what we should be achieving per capita.

#### **Recommendation 52:**

The Department of Health works with key stakeholders to identify sources of support for specific alcohol and other drug research to make this a stated research priority.

#### **11.4.4.2 Addressing emerging drug use trends**

The Taskforce recognises that trends in drug use are constantly changing and has advised the Government's response should be adaptable to new and emerging drug trends. The Taskforce also recognises that intervention strategies and planning should occur prior to the emergence of escalations in drug use trends and associated problems, to avoid national epidemics such as that currently occurring in the U.S. concerning the re-emergence of opioid use, particularly pharmaceutical opioids such as OxyContin and synthetic opioids such as fentanyl (a high-strength prescription opioid).

<sup>558</sup> Government of Western Australia. Media statement: \$18 million boost for WA cancer research. 2017 July 3. Perth: WA Government. [accessed 2018 Nov 7] Available from <https://www.mediastatements.wa.gov.au/Pages/McGowan/2017/07/18-million-dollar-boost-for-WA-cancer-research.aspx>

Of increasing concern to the community are recent reports of new psychoactive substances (often purchased online) entering the illicit drug market with little known about their effects or toxicity.<sup>559 560 561 562</sup>

The Western Australian Illicit Substance Evaluation study at Royal Perth Hospital began in 2016. It is a two-year research initiative at the forefront of examining new and emerging drug use trends, addressing key research objectives identified by the National Ice Taskforce.

### **The Western Australian Illicit Substance Evaluation (WISE) Study**

In Western Australia, the Western Australian Illicit Substance Evaluation (WISE) study offers a promising means for discerning emerging drug trends in Western Australia. The Western Australian Illicit Substance Evaluation is a research collaboration between the Royal Perth Hospital Emergency Department, clinical toxicologists and the ChemCentre. Royal Perth Hospital's Emergency Department research infrastructure is supported through the Centre for Clinical Research in Emergency Medicine.<sup>563</sup>

The aims of the study are to:

- describe the pattern of emergency department presentations for patients intoxicated with methamphetamine;
- describe the role of methamphetamine in drug-induced psychosis;
- describe the injuries sustained by study patients while they are intoxicated;
- document injuries to staff from intoxicated patients;
- document the involvement of police and security officers to control these patients;
- identify other conventional and novel psychoactive drugs causing toxicity in patients presenting to the emergency department;
- relate the identified drugs, with their detected concentration in the blood, to their clinical effects on the patient;
- identify novel psychoactive substances and describe their clinical effects, many of which are currently unknown;
- relate the substance identified to what the patient thought they had taken;
- compare blood levels of the drugs to the clinical effects (not been done before);

<sup>559</sup> Adams A, Bannister S, Irizarry, L, Trecki, J Schwartz M, Gerona, R. "Zombie" Outbreak caused by the synthetic cannabinoid AMB-FUBINACA in New York., New Engl J Med. 2017: 376;235-242. DOI: 10.1056/NEJMoa1610300

<sup>560</sup> Australian Associated Press. Backpackers in Perth overdosed on travel sickness drug they thought was cocaine. The Guardian online; 2018 January 4. Available from:

<https://www.theguardian.com/australia-news/2018/jan/04/backpackers-in-perth-overdosed-on-travel-sickness-drug-they-thought-was-cocaine>

<sup>561</sup> Bonini T. Could fentanyl be Australia's next deadly drug epidemic? ABC News online; 2017 October 13. Available from: <http://www.abc.net.au/news/2017-10-13/could-fentanyl-be-australias-next-deadly-drug-epidemic/9048530>

<sup>562</sup> ABC staff reporters. Mass school overdose investigation focuses on banned Russian drug. ABC News online; 2018 February 22. Available from: <http://www.abc.net.au/news/2018-02-22/detectives-probe-if-drug-behind-school-overdose-bought-online/9471958>

<sup>563</sup> The Centre for Clinical Research in Emergency Medicine (CCREM) is a Centre within the Harry Perkins Institute of Medical Research, established in 2008 with start-up and ongoing funding from Royal Perth Hospital, the Royal Perth Hospital Medical Research Foundation and the University of Western Australia. Centre for Clinical Research in Emergency Medicine. Information page: About Us.2018. Available from: <https://www.perkins.org.au/ccrem/about/>

and

- act as an early warning system for drugs of concern.

De-identified blood samples are analysed from patients who are suspected by the treating doctor to be intoxicated with stimulant, hallucinogenic or cannabinoid drugs, and are already having blood tests as part of routine care. A sample of preliminary, unpublished results from this two-year study indicates:

- 160 of the first 237 patients included in the study had taken methamphetamine and/or amphetamine;
- 69 per cent were male;
- the mean age was 33; and
- 18.8 per cent had another illicit drug detected (of which 20 were novel psychoactive substances).

The WISE system may be instrumental in identifying new and emerging drug trends in Western Australia in the future, to assist with future strategies.

Early indications show the Western Australian Illicit Substance Evaluation Study has:

- demonstrated capability as an early warning system with a fast analysis response;
- unique methodology producing high quality data;
- provided information to users, clinicians, health services and government agencies;
- the world's largest emergency department case series of methamphetamine and drug-induced psychosis;
- and the world's largest case series of 25c-NBOMe.<sup>564</sup>

### Taskforce conclusions and recommendations

The Taskforce recognises that trends in drug use are constantly changing and has been mindful as it provides its advice to Government on its response to methamphetamine, that these should be adaptable to new and emerging drug trends.

The Taskforce is of the view that intervention strategies and planning should ideally occur prior to the emergence of or escalations in drug use trends and associated problems, to avoid national epidemics such as that currently occurring in the U.S. concerning the re-emergence of opioid use, particularly pharmaceutical opioids (e.g. OxyContin and more recently synthetic opioids such as fentanyl, a high-strength prescription opioid) as well as new little known substances entering the market.

#### Recommendation 53:

The Department of Health continues the Western Australian Illicit Substance Evaluation Study as an ongoing valuable early warning system for rapid identification and reporting of conventional and novel psychoactive drugs causing toxicity in patients.

<sup>564</sup> Information on WISE provided by Royal Perth Hospital 20 February 2018.

## 11.5 Opportunities for the business sector to contribute

Opportunities for the community to contribute to addressing the impacts of methamphetamine use, particularly in reducing demand have been considered in Chapter 4 which describes community-based initiatives supported by both the State, through the Mental Health Commission, and the Commonwealth through the *National Ice Action Strategy*.

Opportunities for the business sector to contribute as employers has been considered in Chapter 5.

This section looks at a relatively new model for the private sector to contribute to social services, Social Impact Bonds (SIBs), as a possible future opportunity for the business sector to contribute to addressing the impact of methamphetamine use in Western Australia.

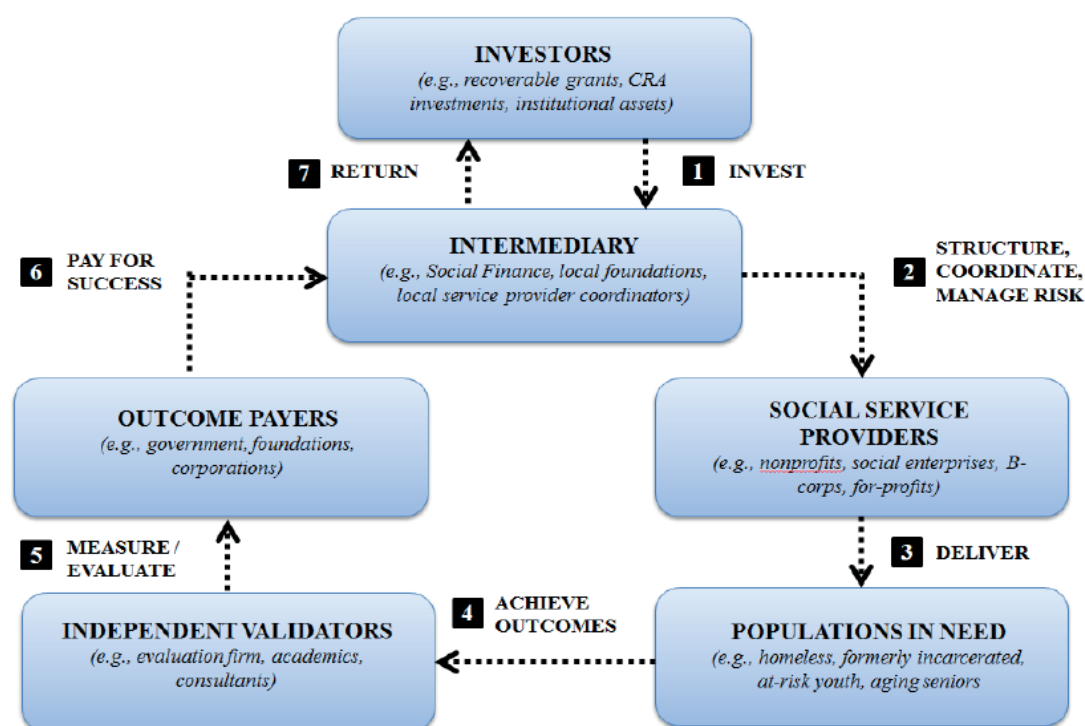
“A SIB is an innovative financing mechanism in which governments or commissioners enter into agreements with social service providers, such as social enterprises or non-profit organisations, and investors to pay for the delivery of pre-defined social outcomes (Social Finance, 2011: OECD, 2015). More precisely, a bond-issuing organisation raises funds from private-sector investors, charities or foundations. These funds are distributed to service providers to cover their operating costs. If the measurable outcomes agreed upfront are achieved, the government or the commissioner proceeds with payments to the bond-issuing organisation or the investors. In reality, the term “bond” is more of a misnomer. In financial terms, SIBs are not real bonds but rather future contracts on social outcomes. They are also known as Payment-for-Success bonds (USA) or Pay-for-Benefits (Australia) (OECD, 2015: Brookings, 2015).”<sup>565</sup>

SIBs can have different models and structures depending on the roles of the principal stakeholders involved, the way the deal is structured and the accountability for delivery of the outcomes. Figure 34 provides a guide to the SIB mechanism. An *investor* provides funding for the intervention. Sometimes an *intermediary* is involved to act as a ‘convener’ of all stakeholders to reach agreement on the transaction and it can also be responsible for raising the capital and ‘structuring the deal’. The *service provider* is responsible for the social service delivery and the attainment of agreed outcomes. The *populations in need* are the recipients of the intervention. Outcomes measurement is a crucial part of the SIB process, as this is the basis of payment to the investor including agreed interest, which is released by the *government* or the *commissioner*. An *evaluator* may in some cases be used to assess the agreed outcomes and their impact.<sup>566</sup>

<sup>565</sup> Galitopoulou S, Noya A. OECD. Understanding Social Impact Bonds. Paris: OECD; 2016. p.4. Available from: <http://www.oecd.org/cfe/leed/UnderstandingSIBsLux-WorkingPaper.pdf>

<sup>566</sup> Ibid.



**Figure 34: The Social Impact Bond Mechanism**

Source: Galitopoulou S, Noya A. OECD. Understanding Social Impact Bonds. Paris: OECD; 2016. p.4.

The benefits of Social Impact Bonds for the main stakeholders are reported as follows:

- for governments and public authorities – the focus on outcomes, along with cost-savings, accountability for taxpayer funds and value for money;
- for investors – the interest in corporate social responsibility has led investors to engage in SIBs, along with the value of the visibility associated with successful involvement in social service outcomes and the government's guarantee to pay them if the agreed outcomes are achieved;
- for social service providers the benefits extend to having access to (usually) long-term stable and predictable revenue without labour-intensive fundraising, enabling them to focus on the implementation of their program and develop a culture of monitoring and evaluation; and
- the motivation of intermediaries varies according to their role. Their interest is often similar to that of investors, being the opportunity to test new financial models to address social problems and achieve outcomes. Their involvement is sometimes finance through grants outside the SIB structure or can be linked to the SIB's performance.<sup>567</sup>

The Chamber of Commerce and Industry of Western Australia's (CCI's) 2018-19 pre-Budget submission identified social impact investment approaches as a way to help remediate or solve complex social challenges. It noted social impact bonds were mechanisms through which governments could undertake preventative measures where the risk of the programs was shared across multiple stakeholders, and that as

<sup>567</sup> Ibid. p. 9 and 10

the Western Australian Government was operating in an environment where it needed to identify novel ways to fund programs that resolved long-standing societal challenges, it should investigate how a social impact bond might be applied in Western Australia. The CCI recommended the Government set up a working committee with the Department of Treasury to define a strategy for adopting a social impact investment approach, including identifying potential areas in which a social impact bond could be created.

The 2017-18 Commonwealth Budget announced funding of \$30 million over 10 years and a planned approach to partner with states and territories to trial social impact investments.<sup>568</sup>

### **Taskforce conclusions and recommendations**

This report has previously noted, and the Taskforce recognises, there are not enough methamphetamine treatment places available and that demand is exceeding current resources. The Taskforce notes the \$30 million Commonwealth Government fund for social impact bonds, and its planned approach to partner with states and territories to trial social impact investments. The Taskforce recommends the Western Australian Government investigate options for applying a social impact bond in Western Australia, including through the Commonwealth Government's established \$30 million Social Impact Investment fund.

#### **Recommendation 54:**

The Department of Treasury and the Mental Health Commission establish a working group to define a strategy for the adoption of a social impact investment approach, including identifying potential areas in which a social impact bond could be created, for the Government's consideration.

---

<sup>568</sup> Social Impact Investing <http://treasury.gov.au/programs-initiatives-consumers-community/social-impact-investing/> [accessed 2018 Nov 7]

## PART 4 DEVELOPMENT OF PERFORMANCE INDICATORS AND TARGETS

### Chapter 12 Measuring performance

*Under its Terms of Reference, the Taskforce is required to advise the Government on the development of performance indicators and targets that can be used to measure the success of Methamphetamine Action Plan initiatives.*

*The Taskforce formed the view that its deliberations on measuring the success of the Methamphetamine Action Plan should also take into consideration performance measurement at other levels of the system that is involved in responding to methamphetamine use in the community.*

#### 12.1 Outcomes measurement

A range of people and groups with a stake in tackling the problems associated with methamphetamine have an interest in measuring the results or outcomes of the Government's efforts to reduce demand, harm and supply of methamphetamine. Furthermore, as the drug of most concern to the community, the community in general also has a primary interest in whether or not the efforts of governments and others are making a difference.

“Without effective outcomes measurement we are left in a state of uncertainty about whether our organisations and social programs are working effectively and if we are spending scarce resources in the best way possible to achieve the greatest social impact.”<sup>569</sup>

The University of Western Australia's Centre for Social Impact defines outcomes measurement as “the measurement of the difference that an initiative, program or organisation makes to the lives of people they engage with”.<sup>570</sup> The following four reasons are offered for measuring outcomes:

- “to provide evidence that a program is achieving its desired impact and organisations are making a difference to the lives of people they serve;
- to explicitly identify trade-offs when deciding which programs to fund;
- to provide the basis for learning within community organisations, and across the government and community sector; and
- to provide a framework for evaluation, strategic planning and good governance.”<sup>571</sup>

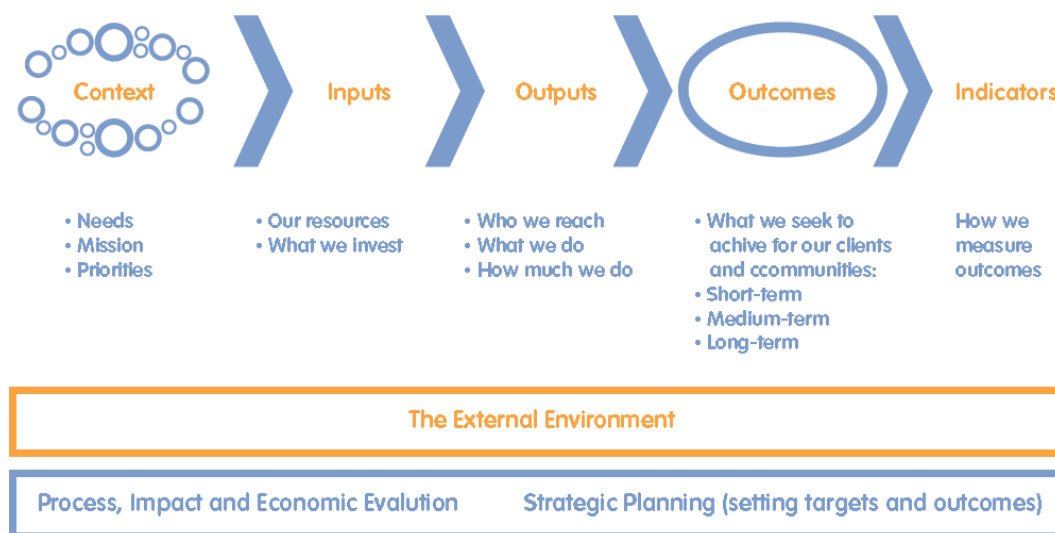
<sup>569</sup> Flatau P, Zaretsky K, Adams S, Horton A, Smith J. UWA Centre for Social Impact. Measuring Outcomes for Impact in the Community Sector in Western Australia. *Bankwest Foundation Social Impact Series* Issue No. 1. Perth: Bankwest Foundation; 2015. p. 4. [accessed 2018 Nov 7] Available from: <http://www.csi.edu.au/research/project/bankwest-foundation-social-impact-series-measuring-outcomes-impact-community-sector-western-australia/>

<sup>570</sup> Adams S, Flatau P, Zaretsky K, McWilliam D, Smith J. UWA Centre for Social Impact. Measuring the difference we make: The state-of-play of outcomes measurement in the community sector in Western Australia. *Bankwest Foundation Social Impact Series*, No. 3. Perth: Bankwest Foundation; 2015. p. 4. [accessed 2018 Nov 7] Available from: <http://www.csi.edu.au/research/project/bankwest-social-impact-series-3-measuring-difference-we-make/>

<sup>571</sup> Ibid.

Figure 35 illustrates how outcomes link to the overall design of services, the resources used to deliver services, the activities of service providers and the outcomes created by those services. The model illustrates how outcomes are created from the *context* in which an organisation operates, how resources or *inputs* invested into a program result in activities or *outputs* (the direct products or services of a program such as the number of people supported). *Outcomes* then, are the change as a result of these activities and can include changes in attitude, behaviour or conditions. These changes can be short, medium or long term. They can occur at an individual or a population level and are measured by *indicators*. Indicators are a numerical value to measure the rate or progress of change. Flatau et al. note the complexity and challenge of outcomes over inputs and outputs due to their “varying nature” and the fact they are “affected by external factors beyond the control of the program”.<sup>572</sup>

**Figure 35: Logic model illustrating the relationship between inputs, outputs and outcomes.**



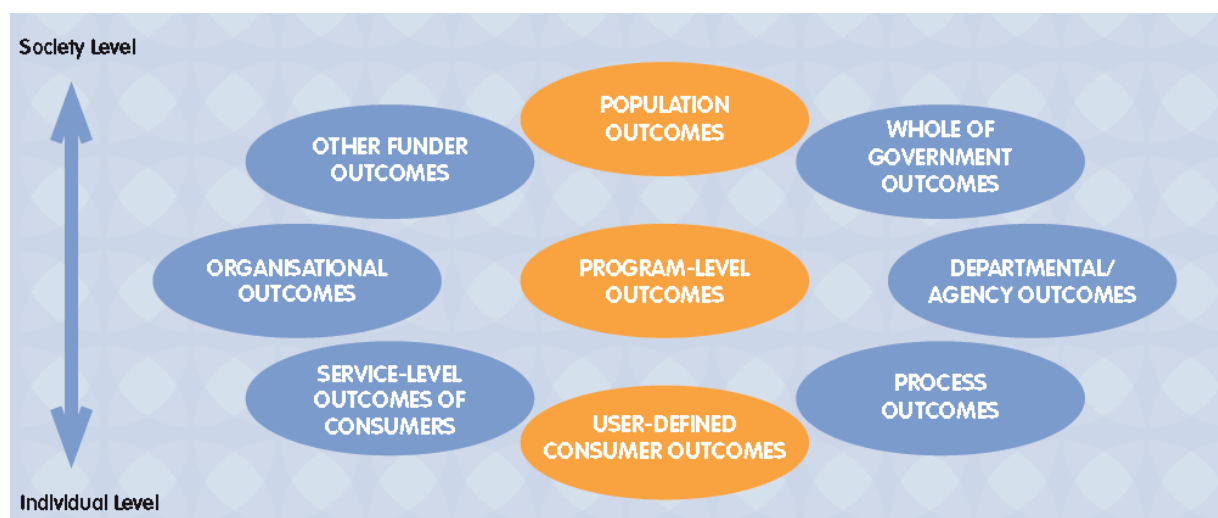
Source: Centre for Social Impact, Flatau, et al. 2015, p.5. Adapted from University of Wisconsin-Extension (2003).

Figure 36 suggests three levels at which outcomes could be measured:

- service level (measuring impact for individual consumers);
- program level (measuring impact at an organisational or agency level); and
- population level (measuring impact for the community beyond the target group/s of the service).<sup>573</sup>

<sup>572</sup> Flatau P, Zaretzky K, Adams S, Horton A, Smith J. UWA Centre for Social Impact. Measuring Outcomes for Impact in the Community Sector in Western Australia. *Bankwest Foundation Social Impact Series* Issue No. 1. Perth: Bankwest Foundation; 2015. p. 4. Available from: <http://www.csi.edu.au/research/project/bankwest-foundation-social-impact-series-measuring-outcomes-impact-community-sector-western-australia/>

<sup>573</sup> Ibid.

**Figure 36: Hierarchy of outcomes measurement**

Source: Centre for Social Impact, Adams et al, 2015, p.6.

## 12.2 Service (or consumer) level and program (or organisation) level results

Measurement of outcomes at a service and program level is becoming an increasing priority for governments, both in Australia<sup>574</sup> and internationally.<sup>575</sup> The Western Australian Government, through its *Supporting Communities* Policy and Forum is currently developing an Outcomes Measurement Framework for the community services sector and putting in place a range of measures to ensure that government agencies procure community services on the basis of outcomes, not outputs.<sup>576</sup> In addition, there are guides<sup>577</sup> and procurement training (through the Department of Finance) available to support service providers and funding agencies to implement outcomes measurement practice and systems in Western Australia.

The Taskforce has not undertaken an examination of the practice, prevalence and funding of outcomes measurement among alcohol and drug services at the service or program level. However, the Taskforce was advised by the Western Australian

<sup>574</sup> NSW Government. Department of Finance Services and Innovation. Human Services Outcomes Framework Guide. Sydney: The Department; 2017. [accessed 2018 Nov 7] Available from: <https://www.innovation.nsw.gov.au/sites/default/files/Human-Services-Outcomes-Framework-indicator-library-170616.pdf>

<sup>575</sup> Flatau P, Zaretsky K, Adams S, Horton A, Smith J. UWA Centre for Social Impact. Measuring Outcomes for Impact in the Community Sector in Western Australia. *Bankwest Foundation Social Impact Series* Issue No. 1. Perth: Bankwest Foundation; 2015. p. 4. [accessed 2018 Nov 7] Available from: <http://www.csi.edu.au/research/project/bankwest-foundation-social-impact-series-measuring-outcomes-impact-community-sector-western-australia/>

<sup>576</sup> Government of Western Australia. Supporting Communities Policy. Perth: WA Government; 2017. [accessed 2018 Nov 7] Available from: <https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/Supporting-Communities-Forum/Documents/Supporting%20Communities%20Policy.pdf>

<sup>577</sup> Muir K, Bennett S. The Compass: Your Guide to Social Impact Measurement. Sydney: The Centre for Social Impact; 2014. [accessed 2018 Nov 7] Available from: <http://www.csi.edu.au/research/project/compass-your-guide-social-impact-measurement/>

Network of Alcohol and other Drug Agencies in its submission to the Taskforce that in its view:

“The current data collection and analysis system, warehoused through the Service Information Management System by the Mental Health Commission, fails to support current government and service provider requirements for improved consumer and community outcomes.”<sup>578</sup>

The Western Australian Network of Alcohol and other Drug Agencies identified the “urgent” need to invest in alcohol and other drug service data and outcomes measurement, arguing “...data and outcomes measurement is of critical importance in the current service delivery, policy and reform environment. Data and outcomes is [sic] central to:

- maintaining community confidence in service provision and government initiatives;
- underpinning transparent procurement processes and decisions;
- demonstrating social return on investment;
- informing policy and planning, including collaboration priorities;
- measuring the outcomes of government initiatives;
- informing service organization continuous quality improvements;
- building on evidence based practice;
- informing targeted service design reflective of changing community needs; and
- giving consumers better information to make service choices.”<sup>579</sup>

The Western Australian Network of Alcohol and other Drug Agencies recommended to the Taskforce that “an improved data and outcomes system that enables the capture and demonstration of outcomes and supports improved quality of specialist alcohol and other drug services” is developed.

### Taskforce conclusions and recommendations

The impetus for an increasing focus on outcomes measurement at a service level comes from both service providers and funders. Service providers are seeking to deliver the best service to their clients, as well as better understand and communicate their effectiveness more broadly, and funders of services (governments and philanthropists) are looking to measure the impact of their funding or investment.

The Taskforce recognises there are challenges in funding and implementing an outcomes measurement approach at a service level, however, it strongly supports service providers being accountable to consumers and funders for delivering results that make a difference in peoples’ lives. Just as funders, including government agencies, should be accountable to the community for resources spent which should be able to show positive change as a consequence of services being delivered. The Taskforce therefore notes, and is supportive of, the work underway in Western Australia to develop an outcomes measurement framework for community services, including alcohol and drug services.

---

<sup>578</sup> Western Australian Network of Alcohol and other Drug Agencies (WANADA), *WANADA Submission to the Methamphetamine Action Plan Taskforce Public Consultation*, 14 March 2018

<sup>579</sup> Ibid.



**Recommendation 55:**

The Mental Health Commission works with the Western Australian Network of Alcohol and other Drug Agencies to review the current data collection and analysis system, warehoused through the Service Information Management System, to identify and implement improvements that enable the capture and demonstration of outcomes and support improved quality of specialist alcohol and other drug services.

**12.2.1 Quality frameworks, standards and accreditation**

Quality frameworks, national standards and accreditation processes help provide consumers with assurances that the services they access will deliver the results they expect at a sector level.

There is a significant body of work being undertaken nationally and in Western Australia to ensure that the alcohol and other drug sector has appropriate quality frameworks, standards and accreditation processes in place.

Major national reviews of the sector have made recommendations to improve quality frameworks for treatment services. The *National Drug Strategy 2010-2015* identified this as one of four structural priorities.<sup>580</sup> In 2015, the National Ice Taskforce recommended:

“The Commonwealth, state and territory governments should work with the specialist treatment sector to design and implement a national quality framework that sets the standards for:

- the delivery of evidence-based services for the population, with clear expectations of the quality standard for each service type;
- workforce capabilities, which must be matched to the service-type and population need;
- cross agency partnerships and collaboration; and
- monitoring and evaluation of outcomes and effectiveness to inform continuous quality improvement.”<sup>581</sup>

This recommendation resulted in the *National Ice Action Strategy*, including an initiative to “implement a pilot quality framework to provide consistent and appropriate treatment in accordance with best practice”.<sup>582</sup>

The Parliamentary Joint Committee on Law Enforcement’s *Inquiry into Crystal Methamphetamine* also considered the issue of a national quality framework. The Parliamentary Joint Committee discussed this issue particularly in the context of unethical practices, as was highlighted in the Australian Broadcasting Corporation’s *Four Corners* report (12 September 2016) into the private rehabilitation sector. This

<sup>580</sup> Ritter A, Berends L, Chalmers J, Hull P, Lancaster K, Gomez M. Drug Policy Modelling Program, National Drug and Alcohol Research Centre, UNSW. *New Horizons: The review of alcohol and other drug treatment services in Australia*. Sydney: NDRAC; 2014, p. 268. [accessed 2018 Nov 7] Available from:

<https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/New%20Horizons%20Final%20Report%20July%202014.pdf>

<sup>581</sup> Australian Government. Department of Prime Minister and Cabinet. *Final Report of the National Ice Taskforce 2015*. Canberra: The Department; 2015. p x. [accessed 2018 Nov 7] Available from:

[https://www.pmc.gov.au/sites/default/files/publications/national\\_ice\\_taskforce\\_final\\_report.pdf](https://www.pmc.gov.au/sites/default/files/publications/national_ice_taskforce_final_report.pdf)

<sup>582</sup> Ibid. p.24.

report highlighted the cost of these services and the lack of regulation in the industry.<sup>583</sup>

Evidence was provided to the Parliamentary Joint Committee by the Commonwealth Department of Health that the regulation of these services is the remit of states and territories, making a national quality framework “[...] the important piece that holds this [the sector] together.”<sup>584</sup> The Department of Health (DoH) added that the national framework is being applied to the public sector, and would then be extended to the private sector.

“The committee reminded the DoH that the topic addressed in the *Four Corners* program was about private clinics and the damage that is being done by these unregulated service providers. In response, the DoH confirmed that this issue had been discussed by the National Drug Strategy Committee (NDSC) and the MDAF (Ministerial Drug and Alcohol Forum), largely ‘in the context of the quality framework and what we can do there and a conversation for individual jurisdictions to have about how they could regulate the private sector’.”<sup>585</sup>

Work on the national quality framework has progressed with the Ministerial Drug and Alcohol Forum stating in November 2017:

“Members approved in principle the National Quality Framework for Drug and Alcohol Treatment Services, whilst finalisation to be undertaken by a National Drug Strategy Committee Quality Working group. Members also agreed that consultation would occur with the Australian Commission on Safety and Quality in Health Care, and the state and territory peak bodies, to ensure alignment with current accreditation systems in place across jurisdictions and to minimise duplication. The Forum noted that this work will be finalised by the National Drug Strategy Committee by April 2018.”<sup>586</sup>

The Parliamentary Joint Committee report noted the position of the peak alcohol and other drug bodies on these matters. On 27 March 2017, the Australian Network of State and Territory Alcohol and Other Drug Peaks (Network of Peaks) released a press release on the national AOD quality framework. The Network of Peaks, drawing from previous attempts by governments to develop a national quality framework for the AOD sector, advocated for a quality framework that:

- is driven by the AOD sector and is a working collaboration with the health departments;
- involves leadership from the AOD peaks and national AOD research centres and is governed by a working group that reports to the NDSC (with co-chairing arrangements shared between a non-government

---

<sup>583</sup> Parliament of Australia. Commonwealth of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 34. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report)

<sup>584</sup> Ibid. p. 36.

<sup>585</sup> Ibid. p. 37.

<sup>586</sup> Australian Government. Department of Health. 27 November 2017- Ministerial Drug and Alcohol Forum Communique. Canberra: The Department; 2017. [accessed 2018 Nov 7] Available from: <http://www.health.gov.au/internet/main/publishing.nsf/Content/ministerial-drug-alcohol-forum>

- representative and a NDSC representative);
- is aligned with, and a component of, the National AOD Treatment Framework (that needs to be developed first); and
- has clear deliverables that includes start and end dates with adequate resources.

The Network of Peaks highlighted the need for there to be a clear difference between a national AOD quality framework (focused on compliance and monitoring of evidence-informed practice) and accreditation (continuous quality improvement around systems management).<sup>587</sup>

The Parliamentary Joint Committee concluded that “these [treatment] services must be regulated to ensure best-practice treatment principles are applied in a cost-effective manner with the objective of achieving positive health outcomes for its residents” and “a national quality framework must be applicable to public, not-for-profit and for-profit residential rehabilitation service providers.”<sup>588</sup>

### 12.2.1.1 What’s happening in Western Australia

The position in Western Australia is such that Government-funded specialist alcohol and other drug services are required to be accredited or working towards accreditation against the *Standard on Culturally Secure Practice* or another appropriate accreditation approved by the funding body (Mental Health Commission) and to be compliant with relevant codes of conduct, maintain relevant staff clearances, implement evidence-based practices, and monitor and measure outcomes and key performance indicators.<sup>589</sup>

The *Standard on Culturally Secure Practice* (Alcohol and Other Drug Sector) was launched in 2012 and has been certified under the Joint Accreditation System of Australia and New Zealand (JAS-ANZ) to fall under ISO 9001 Human Services Standard as a recognised accreditation standard.<sup>590</sup>

In the context of this Standard, ‘culturally secure’ means “ensuring that the delivery of health services is such that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook. It applies to Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, or any specific population giving consideration to age, gender, disability or sexual orientation”.<sup>591</sup>

<sup>587</sup> Parliament of Australia. Parliamentary Joint Committee on Law Enforcement. Inquiry into crystal methamphetamine (ice) Final Report. Canberra: Parliament of Australia; 2018. p 37. [accessed 2018 Nov 7] Available from: [https://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Law\\_Enforcement/Crystalmethamphetamine45/Final\\_Report](https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Law_Enforcement/Crystalmethamphetamine45/Final_Report).

<sup>588</sup> Ibid. p.39.

<sup>589</sup> Western Australian Network of Alcohol and other Drug Agencies (WANADA), *WANADA Submission to the Methamphetamine Action Plan Taskforce Public Consultation*, 14 March 2018.

<sup>590</sup> WANADA email to MAP Taskforce, 1 May 2018.

<sup>591</sup> Western Australian Network of Alcohol and other Drug Agencies (WANADA). Interpretative Guide to the Standard on Culturally Secure Practice (Alcohol and other Drug Sector). 1<sup>st</sup> Edition August 2012. Perth: WANADA; 2012. p 4. [accessed 2018 Nov 7] Available from: [http://www.wanada.org.au/index.php?option=com\\_docman&view=download&alias=34-standard-on-culturally-secure-practice-alcohol-and-other-drug-sector-1st-edition-august-2012&category\\_slug=standard-on-culturally-secure-practice&Itemid=265](http://www.wanada.org.au/index.php?option=com_docman&view=download&alias=34-standard-on-culturally-secure-practice-alcohol-and-other-drug-sector-1st-edition-august-2012&category_slug=standard-on-culturally-secure-practice&Itemid=265)

To achieve certification against the Standard, agencies need to meet 80 per cent of criteria labelled as 'essential' under each of the following Performance Expectations:

1. Defining and understanding the target community;
2. Rights and responsibilities;
3. Consumer focused practice;
4. Evidence based practice;
5. Staffing, development and support;
6. Agency management; and
7. Organisational governance.<sup>592</sup>

With regard to private alcohol and other drug treatment services in Western Australia not in receipt of government funding, the Western Australian Network of Alcohol and other Drug Agencies submitted to the Taskforce that these be regulated by extending the powers of the Licensing and Accreditation Regulatory Unit of the Western Australian Department of Health. The Licensing and Accreditation Regulatory Unit is responsible for licensing and monitoring private hospitals in Western Australia, under the *Private Hospitals and Health Services Act 1927*, and the provisions of the *Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1967* and the *Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1996*.

#### **12.2.1.2 Mental Health, Alcohol and Other Drug Workforce Strategic Framework**

The Mental Health Commission is currently developing a State-wide *Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025* (Workforce Strategic Framework) as a guide for key agencies to support the growth and development of the mental health and alcohol and other drug workforce.<sup>593</sup>

The Mental Health Commission advises its aim is to “develop and commence implementation of a comprehensive mental health, alcohol and other drug workforce planning and development strategy that includes key priorities and strategies to build the right number and appropriately skilled mix of staff, and clarifies roles and responsibilities of commissioning agencies and service providers.”<sup>594</sup>

Information provided by the Mental Health Commission notes:

- an advisory group was convened to oversee the development of the Workforce Strategic Framework comprising senior representatives from government and non-government agencies, research academics and consumer, family and carer representatives; and
- the Western Australian Association for Mental Health and the Western Australian Network of Alcohol and other Drug Agencies were commissioned to undertake

---

<sup>592</sup> Western Australian Network of Alcohol and other Drug Agencies (WANADA). Interpretative Guide to the Standard on Culturally Secure Practice (Alcohol and other Drug Sector). 1<sup>st</sup> Edition August 2012. Perth: WANADA; 2012. p 4. [accessed 2018 Nov 7] Available from: [http://www.wanada.org.au/index.php?option=com\\_docman&view=download&alias=34-standard-on-culturally-secure-practice-alcohol-and-other-drug-sector-1st-edition-august-2012&category\\_slug=standard-on-culturally-secure-practice&Itemid=265](http://www.wanada.org.au/index.php?option=com_docman&view=download&alias=34-standard-on-culturally-secure-practice-alcohol-and-other-drug-sector-1st-edition-august-2012&category_slug=standard-on-culturally-secure-practice&Itemid=265)

<sup>593</sup> Mental Health Commission website:- Strategic Direction [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/about-us/strategic-direction/strategies-in-development/>

<sup>594</sup> Mental Health Commission website - Strategic Direction [accessed 2018 Nov 7] Available from: <https://www.mhc.wa.gov.au/about-us/strategic-direction/strategies-in-development/>

workforce mapping projects to inform the development of the Workforce Strategic Framework.

Community consultation on the Workforce Strategic Framework commenced in July 2018.

### Taskforce conclusions and recommendations

The Taskforce agrees it is essential that individuals seeking treatment for methamphetamine use and their families can be confident the services they access meet appropriate industry agreed and verified quality standards. Such standards are in place in Western Australia for government-funded services, however, are not applicable to those organisations which don't receive government funding.

While there is work being done at a national level to introduce a national quality framework for alcohol and other drug services, it is not intended that this be applied to the private sector in the first instance. Further, measures to regulate the national quality framework rest with the states and territories, not the Commonwealth.

With demand for methamphetamine treatment and support services currently exceeding the available supply, and noting the vulnerability of individuals and families seeking these services, it is the Taskforce's view that regulation of the non-government funded sector should be a matter of some priority for the Government and community.

#### Recommendation 56:

The Mental Health Commission and the Department of Health consult with relevant stakeholders to identify the appropriate mechanism for regulating alcohol and other drug specialist service providers, particularly those that are not government funded, to ensure that the community, vulnerable individuals, and potentially referring services can be confident in the quality of these services.

## 12.3 Whole-of-government impact and population level results

### 12.3.1 Whole-of-government impact

There is increasing recognition globally, including in Australia, that because complex social problems cross agency boundaries, there is a need to implement new ways of working across government in order to bring about meaningful long-term change. Reforms to the way in which governments tackle entrenched societal problems have focussed on 'joining up' the government's response through cross-agency strategies<sup>595</sup>, setting whole-of-government targets<sup>596</sup>, using linked data to inform

<sup>595</sup> Wilson S, Davison N, Clarke M, Casebourne J. Joining up public services around local, citizen needs: Perennial challenges and insights on how to tackle them. London: Institute for Government; 2015.

<sup>596</sup> Government of Western Australia. Department of Premier and Cabinet. Working Together. One public sector delivering for WA. Service Priority Review Final Report. Perth: The Department; 2017. p 27-32. [accessed 2018 Nov 7] Available from: [https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/ServicePriorityReview/Documents/SPR\\_Report\\_FINAL-5-Dec.pdf](https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/ServicePriorityReview/Documents/SPR_Report_FINAL-5-Dec.pdf)

policy development, as well as to assess change and results and focus on the delivery of outcomes, rather than outputs.<sup>597</sup>

The *Methamphetamine Action Plan* and the Community Safety and Family Support Cabinet Sub Committee, which oversees its implementation, are means by which a whole-of-government, collaborative approach is being taken in Western Australia to tackle methamphetamine use in the community.

The purpose of the Community Safety and Family Support Cabinet Sub Committee is to oversee integrated, across-government approaches to the development and implementation of social policies, including the *Methamphetamine Action Plan*, to improve the lives of members of the Western Australian community. It has the following members:

- Deputy Premier, Minister for Health, Mental Health (Chair);
- Minister for Education and Training;
- Minister for Corrective Services;
- Minister for Police;
- Attorney General; and
- Minister for Child Protection; Women's Interests; Prevention of Family and Domestic Violence; Community Services.

The Cabinet Sub Committee is supported by the Directors General Implementation Group, whose role is to receive direction and advise on the implementation of cross-government social policies. Membership is comprised of heads of the following agencies:

- Department of the Premier and Cabinet (Chair);
- Department of Communities;
- Department of Justice;
- Department of Education;
- Mental Health Commission;
- Western Australia Police Force; and
- Department of Health.

The *Methamphetamine Action Plan* consists of eleven initiatives to be implemented by these seven agencies. Individual agencies, partnering with other agencies, are assigned responsibility and accountability for the implementation and outcomes of their respective initiatives.

---

<sup>597</sup> Gold J. Tracking delivery Global trends and warning signs in delivery units. London: Institute for Government; 2017.



METHAMPHETAMINE ACTION PLAN			
Lead Minister – Minister for Health; Mental Health			
Policy Initiative #	Implementing Agency	Partner Agency	Initiative
MAP1	Mental Health Commission	Department of Treasury	Invest an additional \$2 million per annum into treatment facilities to respond to early intervention and severe methamphetamine dependence.
MAP2	Mental Health Commission	Department of Treasury	Expand specialist drug service into rural and regional areas of need and open specialised rehabilitation centres in the South West and Kimberley.
MAP3	Department of Health	Mental Health Commission	Introduce a Mental Health Observation area at Royal Perth Hospital Emergency Department for those that require assistance and close supervision for up to 72 hours.
MAP4	Mental Health Commission	Department of Education	Work with drug and alcohol education agencies to ensure Western Australia schools have the most up-to-date programs to better inform our young people
MAP5	Department of Justice	Mental Health Commission	Two dedicated drug and alcohol rehabilitation prisons from portioning existing facilities, with increased drug dog detection and urinalysis and greater post-release supervision.
MAP6	Department of Justice		Establish a Prisoner Triage Unit in courts staffed by 10 people to assess short-term non-violent prisoners for suitability to enter rehabilitation prisons.
MAP7	Department of Justice	Department of Health	Fast-track guardianship and administration applications for methamphetamine addicts who are not able to make their own decisions and need help managing their affairs and rehabilitation.
MAP8	Western Australia Police Force	Department of Immigration	Establish a Meth Border Force within Western Australia Police Force of 100 officers to stop methamphetamine coming

		and Border Protection	into Western Australia, with an additional 100 sworn officers.
MAP9	Western Australia Police Force	Department of Justice	Increase the maximum penalty for methamphetamine traffickers to life imprisonment.
MAP10	Western Australia Police Force		Ensure Western Australia Police Force has the resources to significantly increase the volume of roadside drug testing of Western Australia drivers.
MAP11	Department of the Premier and Cabinet	Mental Health Commission	Establish the Methamphetamine Action Plan Taskforce to provide advice to the Sub-Committee on the implementation of the Methamphetamine Action Plan.

### Taskforce conclusions and recommendations

The Taskforce has been asked to provide advice on the development of performance indicators and targets that can be used to measure the success of the *Methamphetamine Action Plan* initiatives for the Community Safety and Family Support Cabinet Sub Committee.

As with other matters considered by the Taskforce, it is important that the issue of outcomes measurement and performance is considered primarily from the perspective of those most affected by methamphetamine use – the Western Australian community. As methamphetamine is the drug of most concern currently to the community there would, and should, be an expectation from the community that the resources and effort invested by Government will lead to positive change or results, and that this is reported transparently.

The Taskforce has formed the view that further work is required to develop and finalise a framework with specific indicators and instruments to measure the performance of those initiatives that receive the bulk of Government funding under the *Methamphetamine Action Plan*. This needs to be developed in consultation directly with methamphetamine users, their families and the community – not just with service providers. The Taskforce believes any framework should be underpinned by a set of principles to ensure the delivery of quality assurances and services outcomes in the areas that matter most to the community, including, but not limited to:

- improved access to treatment;
- targeted prevention;
- the reduction of stigma;
- increased intervention;
- reducing health harms; and
- helping people to rebuild their lives.

This work should be undertaken by the agencies accountable for the major Government- funded initiatives including direct service provision. The work should also seek to assure both government and non-government funded agencies are

accountable for the delivery of services that are identified and agreed to in case management plans.

**Recommendation 57:**

The Community Safety and Family Support Cabinet Sub Committee establish a Methamphetamine Action Plan Senior Officer Working Group reporting to the Directors General Implementation Group. The purpose of which will include to:

- develop a plan to implement recommendations of this report supported by government;
- develop and finalise an accountability framework for measuring whole-of-government performance, including development of performance indicators (wherever possible drawing on existing preferably national data sets) and targets.



## Appendix A Methamphetamine Action Plan Taskforce Terms of Reference

### MEMBERSHIP

The Methamphetamine Action Plan Taskforce (the Taskforce) members and Chair will be endorsed by the Community Safety and Family Support Cabinet Sub Committee (the Sub Committee) and approved by Cabinet.

### FUNCTION

The Sub Committee will direct the Taskforce to provide advice and recommendations on specific issues relating to the implementation of the Methamphetamine Action Plan.

#### 1. Respond to Sub Committee requests for advice

- Provide advice and make recommendations in response to requests from the Sub Committee.
- Consider the needs of the Western Australian community generally, as well as the specific needs of vulnerable groups (as appropriate), when providing advice on methamphetamine matters.

#### 2. Identify opportunities for improvement

- Provide advice on how programs can be best delivered and targeted to areas of greatest need, including regional areas.
- Provide advice on how Government can best communicate with the community and vulnerable groups about methamphetamine.
- Provide insights into the lived experience of community members who have been directly affected by methamphetamine.
- Provide advice on how research can inform Government initiatives and programs aimed at reducing the harm, supply, and demand for methamphetamine.
- Review successful interventions from interstate and overseas with potential for adoption in Western Australia.

#### 3. Identify opportunities for cross-sector collaboration

- Identify opportunities for Government, community and/or business sector collaboration to reduce methamphetamine harm, supply and demand, and make recommendations for Sub Committee consideration.
- Identify opportunities for the community and business sectors to contribute to reducing methamphetamine harm, supply and demand.

#### 4. Advise the development of measurable performance indicators

- Advise the development of performance indicators and targets that can be used to measure the success of Methamphetamine Action Plan initiatives, for Sub Committee consideration.

## **ESTABLISHMENT OF ADVISORY GROUPS**

### **1. Obtaining advice on specific issues or populations**

- The Taskforce may establish time-limited advisory groups to make recommendations to the Taskforce on specific issues or priority population group and methamphetamine use.
- The Chair of any advisory group will be a member of the Taskforce.
- Minutes of meetings and a Chair update must be provided at Taskforce meetings as requested.

### **2. Consumer, Family and Carer Payments**

- Advisory group members who identify as consumers, family members and/or carers will be offered participation payments and reimbursement for out of pocket expenses.
- Participation and reimbursement will be in accordance with the Mental Health Commission's Consumer, Family, Carer and Community Paid Partnership Policy, which provides a framework for participation payments to be offered to consumers, families, carers, and community members.

## **OPERATION**

### **1. Confidentiality**

- Taskforce members may be exposed to information that relates to confidential Cabinet deliberations.
- Members must keep in confidence such material.

### **2. Duration**

- The Taskforce will operate for the life of the Sub Committee, unless directed by the Sub Committee to dissolve earlier.

### **3. Reporting**

- The Taskforce will receive direction from, and report to, the Sub Committee.
- The Chair of the Taskforce will attend Sub Committee meetings, as required and requested by the Sub Committee Chair.

### **4. Agenda Setting**

- The agenda will be set by the Taskforce Chair, and will be informed by direction provided by the Sub Committee.
- All submissions for Taskforce consideration should be addressed to the Chair.

### **5. Timing of Meetings**

- Quarterly.
- Additional meetings may be held on an 'as required' basis.

### **6. Attendance at Meetings**

- Taskforce members are invited as individuals, rather than as representatives of their organisation.
- Proxies cannot attend Taskforce meetings in place of official members.



## **7. Secretariat and Departmental Support**

- The Department of the Premier and Cabinet and the Mental Health Commission will coordinate secretariat support for the Taskforce.
- The role of the Secretariat is to provide administrative support to the Taskforce, and act as a conduit between the Sub Committee and the Taskforce.

## Appendix B Consultation List

### Workplace

Alcoa of Australia Limited  
Australian Manufacturing Workers' Union, WA Branch  
Australian Services Union, WA Branch  
Benestar Group (formerly Davidson Trahaire Corpsych)  
The Chamber of Minerals and Energy of WA Inc.  
Communicare Inc.  
Fortescue Metals Group Ltd  
Magenta – Sexworker Support Project for WA  
Master Builders Association of WA  
Max Solutions Employment  
Oars Across the Waters Pty Ltd  
Ochre Workforce Solutions  
PeopleSense Australia  
Regional Chambers of Commerce and Industry (WA) Inc.  
Small Business Development Corporation  
Stirling Business Association  
SMYL Community Services  
UnionsWA  
WorleyParsons Pty Ltd

### Service Providers

360 Health and Community  
Aboriginal Family Law Services  
Access Housing Australia Ltd  
AccordWest  
Alcohol and Drug Foundation  
Alcohol and Drug Support Service, Mental Health Commission  
Alcoholics Anonymous (Bunbury)  
Alive and Kicking Goals  
Anglicare WA  
Ashcliffe Pty Ltd (Matrix Model Psychology)  
Australian Red Cross  
Australian Sports Drug Education and Consultancy  
Bloodwood Tree Association Inc.  
Breakaway Aboriginal Corporation

Centrecare  
Cyrenian House (including the North Metro Community Alcohol and Drugs Service)  
Cyrenian House Milliya Rumurra Outreach Service  
Desert Blue Connect Inc.  
Doors Wide Open, Inc.  
Drug and Alcohol Withdrawal Network SJOG Subiaco Hospital  
Edmund Rice Centre Mirrabooka Inc.  
Far North Community Services  
Fresh Start Recovery Programme  
Goldfields Indigenous Housing Organisation  
Goldfields Rehabilitation Service Inc.  
Goldfields Women's Refuge  
Goomburrup Aboriginal Corporation  
Hearspace Pilbara and Mid-West  
HelpingMinds  
Heptatitis WA Inc.  
Holyoake (including the North East Metro and Wheatbelt Community Alcohol and Drugs Service)  
Hope Community Services (including the Goldfields Community Alcohol and Drug Service)  
Ice Breakers, Albany  
Kimberley Mental Health and Drug Service  
Kullari Regional Communities Inc.  
Life Without Barriers  
Local Drug Action Group Inc.  
Local Drug Action Group – Geraldton  
Local Drug Action Group – Bunbury  
MacKillop Family Services WA  
Mamabulanjin Aboriginal Corporation  
Mawarnkarra Health Service  
Midwest Employment and Economic Development Aboriginal Corporation Inc.  
Mercycare  
Milliya Rumurra Aboriginal Corporation  
Mirrabooka Methamphetamine Action Collective  
Mission Australia WA (including the Drug and Alcohol Youth Service and Pilbara Community Alcohol and Drugs Service)  
Narcotics Anonymous (Bunbury)  
Neami National  
Next Step Drug and Alcohol Services, Mental Health Commission

Nirrumbuk Aboriginal Corporation

Outcare Inc.

Palmerston Association Inc. (including the South Metro, South East Metro, Great Southern Community Alcohol and Drug Service)

Peer Based Harm Reduction WA (formerly WA Substance Users' Association Inc.)

Richmond Wellbeing

Rise Network

Royal Flying Doctor Service

Ruah Community Services

Rural Health West

School Drug Education and Road Aware

Shalom House

Sideeffect Australia

South West Aboriginal Medical Service

South West Refuge Inc.

St Bartholomew's House Inc.

St John Ambulance WA Ltd.

St John of God Hospital Bunbury (including the South West Community Alcohol and Drugs Service)

St Patrick's Community Support Centre

Swan City Youth Services

The Salvation Army Western Australia

Unitingcare West

WA AIDS Council and the M Clinic

Wirraka Maya Health Service Aboriginal Corporation

Women's Health and Family Services

Wonnarua Nation Aboriginal Corporation

Wungening Aboriginal Corporation (formerly Aboriginal Alcohol and Drug Service Inc.)

Yaandina Community Service - Turner River Rehabilitation Centre

Youth Focus Inc.

Youth Futures WA

Youth Involvement Council Inc.

## **Consumers and Families**

Aboriginal Consumers and Family Members Forum (Wungening Aboriginal Corporation)

Broome Aboriginal Consumers and Family Members Forum

Bunbury Consumers and Family Members Forum

Geraldton Consumers and Family Members Forum

Kalgoorlie Consumers and Family Members Forum

Karratha Consumers and Family Members Forum

North Metropolitan Consumers and Family Members Forum - Mirrabooka

South Hedland Consumers and Family Members Forum

South Metropolitan Consumers and Family Members Forum - Armadale

## **Government agencies/funding bodies/representatives**

Anne Aly MP - Parliamentary Joint Committee on Law Enforcement - Inquiry into crystal methamphetamine (Ice)

Australian Federal Police - Exmouth

City of Armadale

City of Belmont

City of Kalgoorlie-Boulder

Commissioner for Children and Young People WA

Crimestoppers

Department of Communities (including Housing, Child Protection and Family Support, Youth, and regional offices in Kalgoorlie, South Hedland and Karratha)

Department of Education (including regions office in South Hedland)

Department of Human Services, Broome Office

Department of Justice (including regional offices in Broome, Karratha, and Roebourne)

Department of Local Government, Sport and Cultural Industries (including Office of Multicultural Interests)

Department of Mines, Industry Regulation and Safety

Department of Premier and Cabinet, Victoria

Department of the Prime Minister and Cabinet – Karratha, Geraldton and Kalgoorlie

Department of Social Services – Kalgoorlie

Department of Training and Workforce Development

Edith Cowan University – General Counselling Support Services

Exmouth District High School, Year 9 and 10 students

Healthway

Mental Health Commission

The Office of the Member for the Mining and Pastoral Region

School Curriculum and Standards Authority

Shire of Exmouth

The University of Western Australia

WA Aboriginal Advisory Council

WA Health (including WA Country Health Service)

Western Australia Police Force (including Goldfields-Esperance District Office, Mid-West-Gascoyne District Office, Kimberley District Office, and Pilbara District Office)

WA Primary Health Alliance

## Advocacy and Peak Bodies

Association of Independent Schools Western Australia

Aboriginal Health Council of WA

Australian Health Promotion Association, WA Branch

Australian Medical Association WA & the Royal Australian College of General Practitioners

Catholic Education Western Australia

Chief Psychiatrist of Western Australia

Council for the National Interest – WA

Goldfields Land and Sea Council

Legal Aid Western Australia

Public Health Association of Australia Inc. WA Branch

WA Association for Mental Health

WA Local Government Association

WA Network of Alcohol and other Drug Agencies

Youth Advisory Council WA