Public Health Association of Australia and Australian Health Promotion Association submission on WA Methamphetamine Action Plan Taskforce community consultation

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

The Australian Health Promotion Association

The Australian Health Promotion Association Ltd (AHPA®) is the peak body for health promotion in Australia. It is the only dedicated professional association in Australia for people interested or involved in the practice, research and study of health promotion.

AHPA supports members and subscribers from government departments and agencies, universities, non-government organisations, community-based organisations and groups, private companies and industries. Membership of AHPA is diverse, and includes designated health promotion practitioners, researchers and students, as well as others involved in promoting physical, mental, social, cultural and environmental health, whose primary profession or area of study may be something different, but whose responsibilities include health promotion and promoting health more broadly. The Association is governed by a Board of Directors at a national level with operational branches in most states and territories across Australia.
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AHPA provides a forum for the exchange of ideas, knowledge, information and advocacy for population health and health promotion. One of AHPA’s main priorities is to contribute to discussion, debate and decision-making on health promotion policy, practice and research and advocate for evidence-informed approaches.

**Vision for the Australian Health Promotion Association (WA Branch)**

The vision of the AHPA (WA Branch) is to improve the health status of Western Australians by building the leadership capacity of our members and making health promotion a priority.

**Introduction**

PHAA and AHPA welcome the opportunity to provide input to the WA Methamphetamine Action Plan Taskforce community consultation. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on promoting a healthy ecosystem and reducing social and health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

**Supply, demand and harm reduction**

The Methamphetamine Action Plan (MAP) is focussed on the three pillars of harm minimisation to address methamphetamine use: supply, demand and harm reduction. PHAA and AHPA support this approach, which aligns with the Australian Government’s National Drug Strategy. However, the MAP should have a more balanced approach to the three pillars, with an increased focus on demand reduction, particularly in relation to preventing the uptake of methamphetamine use in the community. As the National Drug Strategy notes:

> “Prevention of uptake reduces personal, family and community harms, allows better use of health and law enforcement resources, generates substantial social and economic benefits and produces a healthier workforce. Demand reduction strategies that prevent drug use are more cost-effective than treating established drug-related problems.”

It is essential the MAP takes a coordinated, whole-of-government, State-wide approach to prevention, early intervention and treatment. Action should be adequately funded, evidence based, and should not normalise methamphetamine use or stigmatise those who do use. Strategies should be aimed at building resilience, maximising protective factors, minimising risk factors and providing support to individuals, families and communities affected, both directly and indirectly, by methamphetamine use.

PHAA and AHPA support the inclusion of drug education programs in schools in the MAP, but recommend that school drug education programs be mandatory, well-supported, evidence-based, take a health-promoting schools approach, and be available in all WA schools. Given declining rates of use among young people¹, demand reduction strategies should also be targeted at adult population groups. Further demand reduction priorities for the Taskforce should include:

- Continued investment in evidence-based public education campaigns through the Mental Health Commission. The current Drug Aware Methamphetamine Prevention Campaign phase, launched in December 2015, has achieved high performance in evaluation. There should also be adequate funding for specific campaigns targeting at-risk groups.
A continuum of care that acknowledges the importance of support and treatment services for individuals and their families who are affected by methamphetamine use. The MAP should maintain and enhance access to quality evidence-informed treatment through inpatient, outpatient, and community-based treatment services. A recent systematic review of the literature found that the most prevalent barriers to accessing methamphetamine treatment cited were embarrassment and stigma, not believing treatment was necessary, preferring to withdraw unassisted, and concerns about privacy. Many of these barriers can be addressed by improving education in the community about the effectiveness of available treatment options, and when an individual has a problem that may require treatment.

Methamphetamine use should be treated as a health issue rather than a criminal justice issue. This approach includes diverting users from the criminal justice system to treatment and support services.

Ensuring the continuation of adequately funded and sustained primary and secondary prevention strategies to prevent methamphetamine-related issues arising for individuals and communities will reduce the resultant health and social issues. This includes raising awareness of existing services, such as methamphetamine telephone support, that can provide confidential advice on available services and support. The WA Government should also continue to fund harm reduction services that provide peer support, health services and needle syringe programs.

It is important the Taskforce recognises that social, economic, political and cultural factors shape risk behaviour and the health of people who use drugs, and there are groups that are more at-risk of drug-related harm, including Aboriginal and Torres Strait Islander people, people living with a mental illness, people in contact with the criminal justice system, and people identifying as LGBTI. The MAP should consider appropriate strategies that support these priority communities in addressing associated harm.

PHAA and AHPA recommend the Taskforce refer to the National Drug Strategy for guidance on evidence-based and practice-informed approaches to harm minimisation.

Response to the consultation questions

4. How do you think services to people and families affected by methamphetamines can be improved?

Any action taken to reduce harm from methamphetamine use and improve the quality of or access to treatment services in WA should be informed by the best available evidence as well as community consultation. Consultation with previous methamphetamine treatment service consumers, with support of the available literature, suggests a number of improvements can be made. They are as follows:

1. Provide GPs with more training and information about methamphetamine use. GPs can be the first point of contact for people seeking help and their families. With better knowledge of the problem, and the services available, GPs could more effectively support and refer clients.

2. Services in WA should be better equipped to treat clients presenting with co-occurring mental illness and drug use. Research has found a high prevalence of comorbid mental illnesses among individuals accessing substance use treatment in Australia. Drug treatment services should be more capable of addressing mental illnesses as well as drug use, mental health facilities need to be able to address drug use, and relationships between the two services should be enhanced and maintained. Too often people are turned away from services if they disclose co-morbid mental illness or drug use.
3. Reduce the waiting period for someone to enter a rehabilitation facility. Those seeking help have reported being told they have to detox and attend regular groups for a period of some weeks prior to being admitted, which can impact on whether the person seeking help returns. Consumers have reported that the Serenity Withdrawal Unit in Rockingham offering low medical detox and the Drug and Alcohol Withdrawal Network, a service for consumers wishing to reduce or cease their substance use in their home environment, go some way to address this issue. If evaluation shows they are effective models, these services could be expanded and replicated in other areas.

4. More detox services are needed to meet demand. Existing services such as Next Step do not have the required capacity currently.

5. Improved outpatient services, including post-residential support or transitional programs. Outpatient counselling has been effective in reducing methamphetamine use in the short term. Expanding outpatient counselling services as an option for commencing treatment when residential rehabilitation is unavailable may provide opportunities for quick engagement with people seeking help, as well as providing a cost-effective solution for treating more people. Outpatient services should also provide information on the variety of supports available such as SMART recovery, Narcotics Anonymous, and Grow groups.

Services must be culturally safe. For Aboriginal Western Australians, Aboriginal Community Controlled Health Organisations are best placed to provide holistic, culturally appropriate care.

5. What suggestions or new ideas do you have that could address methamphetamine abuse/harm in your local community?

Based on consumer consultation:

1. Public education campaigns that are evidence-based and well-researched in their design, like the current Drug Aware campaigns, that educate the community on the harms of methamphetamine use, including the economic and relationship harm that can be experienced, without stigmatising methamphetamine users.

2. Targeted support in local communities that experience the highest rates of methamphetamine use. This could include building the capacity of community services to refer users on to the appropriate treatment services and provide support to develop interagency networks for training and education of staff.

3. Prison services should be adapted to better address methamphetamine use. Prison contact is an opportunity to address methamphetamine use in the long term.

4. Peer-support models are effective in showing people who need help that it is possible to quit using methamphetamine and making meaningful changes to their life. These should be used more widely.

5. Partnerships between methamphetamine treatment and other services (e.g. food banks and welfare services) to engage with and provide information to those at risk in the community.
Conclusion

PHAA and AHPA supports the broad directions of the MAP Taskforce consultation. We are keen to ensure a focus on prevention in line with this submission. We are particularly keen that the following points are highlighted:

- a more balanced approach to the 3 pillars of harm minimisation requires an increased focus on prevention for demand reduction
- Strategies need to consider the social, economic, political and cultural determinants of health and health behaviours including illicit drug use
- Strategies need to be evidence based and support local communities

The PHAA and AHPA appreciates the opportunity to make this submission and the opportunity to contribute to the response in Western Australia to methamphetamine misuse.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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16 March 2018
References