From the President's Office
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Professor Dan Howard SC
Commissioner
Special Commission of Inquiry into the Drug 'Ice'
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By email: inquiry@iceinquiry.nsw.gov.au

Re: Special Commission of Inquiry into the Drug 'Ice'

Thank you for the opportunity to make a submission to the Special Commission of Inquiry into the Drug 'Ice'. AMA (NSW) acknowledges the Terms of Reference, which require the Commission to inquire into and report to the Governor on:

- The nature, prevalence and impact of crystal methamphetamine ('ice') and other illicit amphetamine type stimulants ('ATS');
- the adequacy of existing measures to target ice and illicit ATS in NSW; and
- options to strengthen NSW's response to ice and illicit ATS, including law enforcement, education, treatment and rehabilitation responses.

It is worth briefly reiterating AMA (NSW)'s response to Special Commission of Inquiry into the Drug 'Ice' Preliminary Consultation, which reflects our organisation's view that addiction is primarily a health issue, requiring treatment and support.

Furthermore, AMA (NSW) supports a balanced approach to methamphetamine. As outlined in the AMA submission to Joint Parliamentary Committee on Law Enforcement Inquiry into Crystal Methamphetamine, law and order responses to the supply and demand of crystal methamphetamine must be offset by efforts to reduce demand for the drug, and for the provision of appropriate health care including referral to treatment and support for users.

Physical and health impact of crystal methamphetamine ('ice') and other illicit amphetamine type stimulants ('ATS')

ATS include amphetamine and methamphetamine and a range of other substances, such as methcathinone, fenetylline, ephedrine, pseudoephedrine, methylphenidate and MDMA, also known as ecstasy.[1] Crystal methamphetamine is a crystalline form of methamphetamine (known as 'ice') that is highly concentrated.

These stimulants increase levels of the monoamine neurotransmitters dopamine, serotonin (5-HT) and noradrenaline in the brain.[2] As previously indicated, ATS include both meth/amphetamine and MDMA, but the action of these stimulants is different. MDMA primarily inhibits serotonin reuptake and stimulates serotonin release, while methamphetamine has similar effects on dopamine.[3] As a result, the effects of the drug on the brain are unique. MDMA is associated with euphoria, mild hallucinations and feelings of emotional connection. Methamphetamine is more likely to produce alertness, sexual stimulation, energy, and enhanced confidence.[4]

There is no safe level of drug use and the use of any drug carries some risk. There are unique short-term and long-term adverse effects associated with meth/amphetamine, crystal methamphetamine, and MDMA. Short-term adverse effects of meth/amphetamine include confusion, agitation, restlessness, irritation, anxiety, tremor, teeth grinding, insomnia, increased heart rate and irregular heart beat, dilated pupils, abdominal pain, sweating, and parasitosis (picking and scratching skin).[5]

The short-term adverse effects of MDMA include panic attacks, tremor, muscle cramps, increased heart rate, dehydration, sensitivity to ambient temperature (resulting in hypo- or hyperthermia), insomnia, impairment of sexual functioning, racing thoughts, and depersonalisation.[6]

Crystal methamphetamine is concentrated and therefore stronger, more addictive and associated with more harmful effects than the powder form of methamphetamine. Ice is generally smoked, or injected, but can also be swallowed or snorted. If injected, there is increased risk of tetanus, infection and vein damage. If needles are shared, there is increased risk of hepatitis B, hepatitis C, HIV and AIDS. Snorting ice can damage the nasal passage and cause nose bleeds.

Long-term adverse effects are related to dose and frequency. ATS alters brain functions such as memory, regulation and executive function. Longer-term effects of MDMA needs further research. Some studies have linked use of MDMA with damage to serotonin levels in the brain, impairments to memory and attention and liver problems.[7] [8] [9]

With regular use, ATS may cause heart and kidney problems, depression, extreme weight loss due to reduced appetite, anxiety, paranoia, dependence, suppressed immune system, dry mouth and dental problems.

High doses of ice and frequent use may cause ‘ice psychosis’ which can cause paranoid delusions, hallucinations, and aggressive and violence behaviour.

Taken in large doses, ATS can cause overdose, stroke, heart attack or death.

Impact on emergency departments

A recent review into the safety of staff, patients and visitors in NSW public hospitals found doctors and nurses are reporting an increase in aggressive and violent behaviour. Part of the increase is attributed to alcohol and drug-affected patients, some of whom were experiencing an ice-induced psychosis.

Patients with acute amphetamine intoxication are often agitated and aggressive and may require extensive resources, such as sedation.[10]

The NSW Health – Improvements to Security in Hospitals' review released an Interim Report with 48 recommendations, including changing the culture of under-reporting of security-type incidents.

NSW doctors report several barriers to reporting these incidents. Not only is it time consuming, but staff are reluctant to become involved in the criminal justice process as a witness, particularly when no actions are taken against offenders by the courts.

Addiction and treatment

Meth/amphetamines and crystal methamphetamine are addictive and require a tailored treatment response. Rehabilitation takes part in two stages. Recovering must first involve a physical detox, which takes almost twice as long as other drugs (10-14 days). Treatment after the detox may need to be continued for many months. Methamphetamine can cause long-term damage to the brain, which may require specialised treatment and continuous care over a sustained period of time. NSW needs to strategically plan for downstream effects of long-term usage, particularly those with high levels of cognitive dysfunction, who cannot live independently, and have difficulty finding placement in assisted-living facilities.

As noted in the AMA Position Statement "Methamphetamine – 2015" treatment for methamphetamine addiction is not very well suited to current treatment facilities available in emergency departments, general practices, or acute hospital admissions.

Traditional approaches include inpatient detox, drug substitution, and residential rehabilitation programs. Counselling, which may include cognitive behavioural approaches, are seen to be effective in helping people address problems associated with meth/amphetamine use.[11] Other counselling approaches include narrative therapy and solution-focused therapy. The ongoing cost of counselling can be prohibitive, as Medicare covers a limited number of sessions. Behavioural approaches can also be used in conjunction with CBT, which includes contingency management strategies. Other solutions include self help of mutual support groups, such as Crystal Meth Anonymous.

The demand for treatment often outstrips its availability. The lag time between problem use and treatment also presents difficulties. Users present to general practitioners and other clinicians typically quite late in the course of their illness, which increases complications and difficulties with follow up and adherence.

Treatment is often more effective when provided early. As acknowledged in the AMA submission to the Joint Parliamentary Committee on Law Enforcement Inquiry into Crystal Methamphetamine, the AMA was very supportive of the $13 million funding provided for the Addiction Medicine Medicare Benefits Schedule (MBS) items for addiction medicine. The item numbers have attracted new trainees to addiction medicine and will help build a specialist alcohol and other drug sector.

The funding of these dedicated MBS items, combined with efforts to develop and support the range of professionals who are deemed to be 'front line staff', including general practitioners, was an important measure. However, the AMA suggests greater support and resources need to be developed to reach 'occasional' users of ATS, or people who find they are increasingly using ATS. These patients may be more likely to present to general practitioners. As a result, general practitioners need access to clear referral pathways to drug-related services in their area.

More research is needed into methamphetamine pharmacotherapies. Studies show medication-assisted treatment of opioid-dependence is effective and safe. However, there has been little research into the efficacy of substitution therapies for methamphetamine. Examination into pharmacotherapies, such as lisdexamfetamine, dexamphetamine, modafinil, bupropion, oral naltrexone and N-acetylcysteine are needed.[12]

The AMA supports the introduction of innovative policy models and trials in a controlled manner, funded and evaluated appropriately that might reduce harms and improve outcomes for users and society at large.

Workforce shortages

Psychiatrists are one of a number of important healthcare professionals involved in management of addictions. Workforce projections indicate a future undersupply of 125 by 2030 for the psychiatry workforce. The modelling is based on an anticipated 2% increase per year (from 194 in 2015 to 234 by 2030) on the first year intake to the program. The projections also included the high reliance on overseas trained doctors (OTDs) continuing, with OTDs being projected at 55 new Fellows per year. To meet the expected undersupply projected by 2030, the new intake would need to increase from the projected 197 to 200 in 2016 up to 269 in 2025, which equates to an average annual increase of 3.3%. Local workforce and training needs must be taken into consideration for any strategy to be effective, which requires partnership between governments, employers, the college and trainees.[13]

Rural and remote

As identified by the NSW Ministry of Health in the December 2017 surveillance report "Methamphetamine Use and Related Harms in NSW," the use of methamphetamine appears to disproportionately affect some regional areas in NSW.

Despite an increase in full-time equivalent registered medical practitioners in recent years, there remains significant healthcare workforce shortages in rural and remote NSW. Factors such as an ageing workforce, difficulties in attracting new graduates and recruitment and retention of mid-career professionals have contributed to the doctor-drought. The shortage of doctors in regional and rural areas forces patients to travel longer distances to access services, particularly specialist services.

Travelling long distances for treatment impacts on patients' time and also creates greater financial burden. As a result, regional and rural patients may delay in accessing drug treatment services, resulting in poorer success rates of treatment or relapse.

Response and treatment require approaches that take into consideration the unique aspects and challenges of delivering healthcare to residents in these areas. Solutions developed for metro areas of NSW may not be as effective in rural, regional and remote NSW areas, and therefore bespoke measures must be developed and adequately resourced.

Focus on Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander communities are vulnerable to the impacts of crystal methamphetamine. As outlined in the AMA's submission to the Joint Parliamentary Committee on Law Enforcement Inquiry into Crystal Methamphetamine, the AMA is supportive of commitments and funding that have been made to increase the Aboriginal and Torres Strait Islander drug and

alcohol workforce, as well as undertakings to work closely with Aboriginal Community Controlled Organisations to improve care for Aboriginal and Torres Strait Islander people.

Trial of pill testing

Debates around pill testing are informed by broader arguments about harm minimisation versus zero tolerance. Australia's approach to illicit drugs under the National Drug Strategy remains one of harm minimisation, and the country has in place a significant number of measures to reduce the harms caused by drugs. These include Sydney's Medically Supervised Injecting Centre, needle and syringe programs and opioid substitution treatment.

The National Ice Taskforce report emphasised drug treatment over law enforcement measures – a reflection of sentiments expressed by former Victorian Police Commissioner, Ken Lay, and many other law enforcement officers. They acknowledged Australia cannot win the war on drugs through law enforcement measures alone.

Despite this prevailing sentiment, the response from NSW Government to drug-related deaths at music festivals has been to increase police presence and medical personnel at music festivals, as well as a trial of Drug Criminal Infringement notices.

AMA (NSW) would like to reiterate its support for consideration of a pill testing trial as part of a wider harm minimisation strategy at festivals.

Pill testing is an opportunity to reduce harms associated with drug use through education and outreach. Pill-testing booths create an opportunity for providing support and information. International research suggests pill testing changes behaviour; negative results have deterred people from consuming drugs and warning their friends.[14] [15]

Pill testing enables the capture of long-term data about substances in the drug market and the potential for a warning system against new, unexpected, or very dangerous drugs and consumption trends.

With proper lab equipment, pill testing can determine potency – information which patrons can use to modify their consumption accordingly and reduce the risk of overdose.

Yours sincerely,

[1] https://www.who.int/substance_abuse/facts/ATS/en/
[2] (Rothman & Baumann, 2003).
[3] (Clemens et al., 2007; Dean 2004)
[4] Ibid.

[5] (ACON, 2006; Dean 2004)
[6] (Cohen 1998; Dean 2004; Peroutka et al., 1988)
[7] Green, A.R., Cross, A.J. and Goodwin, G.M., 1995. Review of the pharmacology and clinical pharmacology of 3,4-methylenedioxymethamphetamine (MDMA or "Ecstasy"). Psychopharmacology. 119: p. 247-260.
[8] Antolino-Lobo, I., Meulenbelt, J., van den Berg, M. and van Duursen, M.B., 2011. A mechanistic insight into 3,4-methylenedioxymethamphetamine ("ecstasy")-mediated hepatotoxicity. Veterinary Quarterly. 31(4): p. 193-205.
[9] Lieb, R., Schuetz, C., Pfister, H., von Sydow, K. and Wittchen, H., 2002. Mental disorders in ecstasy users: a prospective-longitudinal investigation. Drug and Alcohol Dependence, 68: p. 195-207
[10] https://www.mja.com.au/journal/2007/186/7/amphetamine-related-presentations-inner-city-tertiary-emergency-department
[11]http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/8D2E281FAC2346BBCA25764D007D2D3A/$File/tremeth.pdf
[12] Matthew Y Frei and Alex D Wodak Med J Aust 2017; 206 (4): 151-152. || doi: 10.5694/mja16.00108
[13] Department of Health Australia's Future Health Workforce – Psychiatry 2016
[14] https://onlinelibrary.wiley.com/doi/full/10.1111/dar.12576
[15] https://www.colleaga.org/sites/default/files/attachments/2015_ankors_smf_summary.pdf