Submission No: 92
Supp to Sub:
AUTHORISED: KS
9/5/07

Dr A R MacQueen
MHS FRACGP FAChAM
Alcohol & drug problems
Mental health

19 February 2007

RE House Standing Committee on Family and Human Services:
Inquiry into the impact of illicit drug use on families.

"It is both wasteful and irresponsible to set [social] experiments in motion and to omit to record and analyse what happens. It makes no sense in term of administrative efficiency, and however little intended, indicates a careless attitude towards human welfare."

Seebohm Report, London HMSO, 1968.
Quoted in "Non random reflections on Health Service Research", 1997

Introduction

The use of illicit substances in our community causes many problems. My interest in drug and alcohol (D&A) problems began over 35 years ago as a medical student, and since then I have worked in this field as an RMO and rural GP, before becoming a full time Addiction Physician some years ago, and subsequently working in Qld, ACT and NSW. My perspective is one of evidence based health maintenance, promotion and improvement. Indeed, there is no justification for interfering in the use of illicit drugs unless it is from a health perspective. I believe there is little evidence suggesting our current approach has been very effective in promoting health, or that it represents good value for money. The time has come to ask whether a different approach may achieve both better value for money and better health outcomes for individuals, their families and our community. Responses to drug use at the legislative level are social experiments, and there is as much a duty of care to the subjects in these experiments, our citizens, as with any other experiment. Hence I welcome this inquiry.

Australia's current response to illicit drugs uses 97% of the budget on interdiction and legal approaches, generally based upon tradition and ideology, and 3% on harm minimisation and treatment, based upon evidence and clear goals. Prudent economic managers must examine the efficacy and value for money of prohibition as well as of harm minimisation. With the Chapter of Addiction Medicine now established within the RACP, evidence based approaches will increasingly guide interventions in this field, as they do the rest of medicine. It would be curious indeed for health professionals to increasingly base practice upon solid evidence supporting health promoting, harm minimising strategies, whilst some in positions of influence remained committed to the ideological positions of the past despite the evidence. Would we do the same with the management of cancer or heart disease? As Professor Webster noted some time ago, harm minimisation is just good medicine. I propose we all seek to facilitate good health via proven effective and cost effective approaches.

Summary of this submission

This submission will focus upon a few key points. These can be expanded upon with formal references either face to face, or by a second submission, should the committee wish. The points I wish to expand upon include:

1. why the terms of reference encompass illicit drugs only, rather than the impact of alcohol, tobacco, caffeine, prescription drugs and illicit agents, and what this narrow approach implies. In clinical practice, people tend to use many drugs, licit and illicit, and all such use can effect families;
2. the problems created when some harmful drugs are legal, whilst others perceived by many to be less harmful are declared illicit;
3. the two way impact of alcohol and drug use, young people causing problems for parents and grandparents, who in turn may have alcohol and drug issues of their own, and the determinants of poor outcome and help seeking, including poverty, homelessness, comorbid physical and mental health problems, racism, rurality and inequity;
4. so called drug related psychosis, an imprecise diagnosis and one used to underestimate and undertreat the complex problems with which people present;
5. the underestimation and undertreatment of more prevalent mental health (MH) problems, partly due to poor training, partly due to federal-state cost shifting issues, amongst those who present to both primary care and specialist (D&A or MH) services; and
6. the evidence supporting harm minimisation approaches, and some of Australia's successes, contrasting with enthusiasm for harm prevention or zero tolerance, terms which remain undefined and which have proven impossible to put into operation.

I will then conclude with some recommendations.

1. Why focus upon illicit drugs only?

Although over the years many bodies have focussed upon illicit drugs alone, the community is well aware that drug related harm comes about from a variety of legal and illicit agents. From a health perspective, including mental health and family and community wellbeing, there is much damage done by tobacco (financial hardship, premature illness and death, particularly amongst the poor, Aboriginal people and single parent families), alcohol use (a major contributor to poor health outcomes including accidents, illness, mental health problems and early death), prescription drug misuse (particularly benzodiazepines and opioids) and even caffeine (with an increasing number of heavily promoted "energy drinks" as well as older caffeinated drinks, coffee and chocolate available, effecting anxiety, sleep, appetite, obesity and financial wellbeing).

The pattern of drug use seen in clinical settings is now rarely one of single drug use. Even older alcohol drinkers frequently use benzodiazepines (increasing the risk of intoxication, increasing friction within families) and maybe an antidepressant (with limited evidence of benefit in most cases, and the risk of death in overdose) as well as almost universally caffeine, tobacco and increasingly cannabis. From a legal viewpoint, only the cannabis would be relevant, but from the viewpoint of such a polydrug user's family, which one of these many drugs is *the* problem? Or is it the whole package? If this committee focuses exclusively upon legal matters, then only the cannabis use would matter, but if the desire is to understand and help troubled families, then it must examine all drug use, and the environment in which all such use occurs. A preoccupation with illicit drugs, as opposed to all drug use, reflects a naïve belief that illicit drugs do all, or even most of, the damage when that is demonstrably untrue. Most families know this.

2. Why are some drugs illicit and others not?

The usual answer is that illicit drugs are dangerous and the public must be protected. This in turn suggests that legal drugs are safe, which is nonsense, and further that making some drugs illicit reduces or prevents their use, which has yet to be proven. The then president Jimmy Carter noted that the penalty for using a substance must not do more damage than the law was supposed to prevent, and studies in Australia have shown that this is exactly what happens with respect to cannabis. Worldwide, studies have shown that prevailing legislation has little impact on cannabis use, but a substantial impact on how much the community pays for police, courts and prisons, let alone the less tangible effects of criminalisation and marginalisation. Police and judges are aware of this, hence the increase in cannabis cautioning systems, drug courts, diversion programs and so on. In California, the taxpayers voted to decriminalise cannabis use so their money could fund more universities instead of more jails. In most other jurisdictions, such insight has not effected legislative change, despite growing evidence that a punitive approach may be doing more damage, including to the taxpayers, than does the drug. This is not to say that cannabis is safe – even paracetamol is not safe and there have been calls to have it banned – but merely that our current response may spend a good deal of time and money doing more harm than good.

From a clinical viewpoint, we know that, for example, many opioid users have parents who are, or have been, heavy users of alcohol. We know that one route to alcohol problems is genetic variation in the capacity to regulate mood states and to feel happy, mediated by opioid receptors. There is thus a common neurological pathway to both alcohol and opioid problems (the brain being unaware which drug is legal and which illicit), and an increased risk of such problems in some families. Identification and treatment of high risk families and individuals and early users is both more effective and cheaper than current punitive strategies, and it would be unethical for health workers to treat one problem, the alcohol use, whilst leaving aside the issue of opioid use because it was illegal. In addition, many opioid users, perhaps tired of the troubled lifestyle but still carrying their neurological risk factors, cease opioid use in time and move into regular alcohol use (where the combination of hepatitis C and heavy alcohol use often leads to liver disease and premature death). It would be unethical and practically impossible for health workers to tease out that part of the problem related to illicit drugs (and use punitive strategies) and that related to licit drug use and treat that alone.

Other opioid users, perhaps those initially better off, remain in the legal supply system, obtain their opioids from their GP or specialist, but experience no less pharmacological difficulties (tolerance, dependence, intoxication, overdose, death), though less legal problems, than do their illicit drug using counterparts. Should we ignore such use because it is legal? And what of those street opioid users who shift to obtaining their drugs from a GP or specialist – many such people suffer illness, accidents and chronic pain and subsequently obtain legal opioids. Are their problems now over? Clearly, from a health promotion and treatment viewpoint, separation of drugs into illicit and licit is pointless.

3. The impact of drug use in families

My work takes me to Lithgow, Bourke, Walgett and Broken Hill, and recently to Balranald and Dareton, as well as regular clinical work in Orange. There is no doubt that the use of both illicit and licit substances has a substantial negative impact on many rural families. This ranges from financial hardship, emotional and mental health problems through to physical illness and premature death, often all in the same family. I have now seen children of parents I have treated previously, two generations with alcohol and drug problems, and clinical contact with extended families is also common. But there are limitations in focussing upon a clinical sample alone – we tend to believe these are the only drug users or are at least typical users. This is not so. Research from around the world suggests that poor people, those with less

support and resilience, those with comorbid mental and physical health problems, tend to suffer both more drug use, and more negative consequences from such use. Thus a clinical sample tends to be drawn from the most damaged, most unwell group, but tells us little about others who may use certain drugs. In Australia, the National Survey of Mental Health and Wellbeing noted a large burden of (MH and D&A) problems borne in silence, though the more problems experienced, the greater the likelihood of seeking help, as one would hope with a good health service. But it is estimated that each weekend in Australia, some 100,000 MDMA tablets are taken - most people only take note of such use if someone dies at a dance party. This focus solely upon serious but uncommon outcomes is not a reasonable way to gain insight into the consequences of using any drug.

The determinants of drug use, and of problematic drug use, and of problems in families related to use, are complex. They range through genetic factors (mediating alcohol use, impulsivity, neuroticism) and intrauterine factors (maternal smoking and ADD, foetal alcohol spectrum), through early life experiences (neglect, abuse and affect regulation, sexual abuse and personality development) to social learning, peer modelling and early experimentation, thence through the interaction of all these factors to increase, or decrease, resilience and the likelihood of use, cessation, or problematic use. So called consequences of drug use may depend upon many factors other than drug use alone, and focussing solely upon an individual's use at one moment is simplistic. If we could eliminate one factor from this environment so as to improve health, the evidence suggests eliminating the abuse and neglect of children would have a far bigger impact than elimination of currently illicit drugs. Both goals are elusive, but the application of good science in a health promoting, harm minimising environment is the only logical way to proceed.

There are other costs related to drug use which have a less obvious but equally real impact upon families. These include the diversion of public money away from funding services like public school renovation and public health and housing, towards funding more police, court systems and new jails, as well as the costs to hospitals and health services treating drug related sequelae. Whilst some "drug related" costs stem directly from the use of a drug (in particular, tobacco and alcohol use), other costs (interdiction, police, jails) are a direct result of certain drug use patterns being criminalized. Many of these costs could be reduced and moneys transferred to community building projects if our governments implemented evidence based policy. The Dutch approach to cannabis sought to reduce the financial costs associated with policing and prosecuting personal use, and has been largely successful with few negative consequences except the outrage of those committed to prohibition above logic and fiscal responsibility. Cannabis cautioning schemes in Australia have also sought to reduce such costs, and have had similar results. We can do far more good with our money than we do at present.

For example, we could implement a well funded, universal, home visiting and support service for all pregnant women, continuing into the first two or three years of their child's life, with more or less intensive services provided according to the best available data. The evidence base supporting this is significant, and includes work done by many Australians. This single intervention has been shown to reduce a variety of health and social problems including crime and drug use, over the ensuing 10-15 years, and represents considerable value for money. It must be universal – it is not sufficient to target drug using families alone, or those with mental health problems, or whatever. It must not be stigmatising and in any case we cannot always accurately predict who will have problems – well off, well educated mothers get post natal depression, for example. Dismantling some of the more expensive, non productive aspects of our current approach would release significant funds. What is likely to be achieved by building new gaols to lock away, at $75 000 per year, an increasingly large group of citizens

who use drugs, when we know, in most cases, what could have been done to stop them getting to that point? This approach is neither rational nor humane, and penalises the taxpayer (who funds it to no personal gain), and the Aboriginal people, women, people with mental health problems and marginalised people who increasingly make up our prison population.

4) Drug related psychosis

I have worked in a psychiatric hospital for some years, and about 70% of my current patients have some degree of mental health problems. I keep up to date with the literature. The most recent literature from Australia suggests that "drug related psychosis" is a diagnosis most often made by politicians, less so by psychiatrists, and even less so by addiction physicians. We rarely see it in our Unit. Indeed, it was not so long ago that cannabis use was held to be the cause of most mental health problems including schizophrenia, and then along came ice, which has apparently taken over that role! As a clinician, it is difficult to escape the conclusion that governments are desperately keen to hold up illicit drug use as the cause of most mental health problems, to distract us from the ongoing, systematic under funding of mental health and D&A services.

There is no doubt that the use of psychostimulants, and occasionally other drugs, legal and illicit, is associated with psychosis. Some people are much more vulnerable to this problem, reflecting complex individual factors. But those whose symptoms persist after a week or so mostly have a far longer and more complex history of problems, usually preceding any drug use. These problems include impulsivity and ADD, conduct disorder, anxiety problems, sequelae from sexual and emotional abuse and difficulties with affect regulation and arousal, the aetiology of which has *nothing to do* with their drug use. These problems are, for complex reasons, more prevalent amongst drug using families and are associated, in turn, with increased drug use in the effected person, frequently to dampen anger or reduce arousal. But to confuse the effect with the cause will not advance matters much. Management requires a longer term approach than is common practice at the moment, including good engagement, a careful review and accurate diagnosis, and long term monitoring using the best evidence through clinicians skilled in working with both MH and D&A problems.

The term "drug induced psychosis" is usually little more than a way of blaming people for their health problems. It is part of a punitive model and has nothing to do with good health care. When used by grandstanding politicians, shock jocks or (occasionally) by psychiatrists, the effect is to evade responsibility rather than to make an accurate diagnosis leading to effective treatment. This is not to say that families (and even drug users) do not also use the term. We regularly see families with a sick, occasionally quite psychotic, drug using loved one, seeking to understand how matters have come to be as they are. Humans try to make sense of the world, and use the words their community gives them, demon possession here, drug induced psychosis there. Without knowledge of neurophysiology and toxicology, under a barrage of shock horror media stories, they can perhaps do no better. Whether the term moves us to a better understanding and to better treatment and management of these complex problems is the crucial question. We do not base the rest of our health services upon such flimsy evidence, though.

5) Other more prevalent mental health problems

Although psychotic illnesses, particularly schizophrenia, rightly deserve our best clinical attention and care, so also do those other MH problems which effect 20 times more people. Some of these problems, such as uncomplicated depression or anxiety, can be dealt with by well trained primary care workers, but there remains a large group who suffer behavioural and MH problems that are difficult to define and who cycle in and out of social services, the court and prison system, and MH, D&A and hospital A&E services. These people often have

treatable MH problems, such as social anxiety and impulsivity, but when combined with rurality, poverty, D&A use, poor housing and social instability they more often fail to gain access to and remain engaged with health services, and are thus treated only at times of crisis. If this crisis involves them being charged with a criminal activity, such as being drunk and disorderly and resisting arrest (due perhaps to social anxiety, impulsivity and the more ready availability of alcohol than of good MH care), then their "treatment", at $75 000 pa, may be incarceration. This will worsen their prognosis, in the main.

About 70% of patients admitted to our Unit have clinical MH problems and many have had substantial (and expensive) interaction with many agencies. No doubt they often represent the hard end of complex, comorbid problems, but my observation is that despite having this time and effort expended, their level of function remains poor, and the likelihood of them stumbling from crisis to crisis remains. Part of the problem is that we are not sure if they are best managed as criminals, addicted people, mentally unwell people, or something else. So, often they get a bit here and a bit there, each services using a different model, and none monitoring outcomes or taking responsibility for what happens next. This is not fiscal responsibility, it is not good health care, and it is sloppy science, so why does it continue?

The Commonwealth is aware of these problems, and has run several workshops on comorbid MH and D&A problems seeking innovative strategies to engage with and treat such (usually young) people. Some of these involve setting up shop front services using multi skilled staff, to engage with troubled young people, who we know frequently receive poor service from existing providers. Some good work has been done in Victoria. This must continue, ideally as well monitored trials, and guide the setting up of new projects. My fear is that, again, they will fall foul to federal-state cost shifting. The future of such projects and trials would be more secure if both tiers of government agreed to shift money from interdiction and punitive strategies into treatment and evidence based preventive approaches, so that the ratio between interdiction and treatment/research is closer to 50:50 than the current 97:3 split, and any intervention was better informed by science and less by ideology. This would send powerful signals to the public, and to health workers, that this concern for youth, their families, and those with complex, comorbid and behavioural problems was not just a flash in the pan. Most families do not want more punishment, they want better treatment.

6) The impact of harm minimisation

I believe that this committee will receive considerable information on the beneficial impact of interventions based upon a harm minimisation (HM) approach. Consequently, I will confine this paragraph to the impact of HM in my clinical practice. Beginning in the early 80's, I worked with heroin users and noted a singular lack of success from then current strategies. Most people I saw had cycled in and out of jail, and had received some treatment, with little positive impact. After reading about methadone, and particularly how Dr Marie Nyswander, a psychiatrist who had worked with many heroin users, had been converted to this treatment, I started as a prescriber, and have now prescribed methadone to over a hundred patients for over 20 years. Based upon current data, this treatment has saved 5-7 lives per hundred users per year, or about 100-140 lives. It has attracted hundreds of unwell and unhappy people into treatment who would otherwise have avoided health services. It has attracted into treatment scores of marginalised poor pregnant women, and led to good antenatal care and healthy full term babies. I remain unhappy having patients dependant upon an opioid drug or upon my prescription, and when something better comes along, with a solid evidence base, I will change my treatment. But in the meantime, I practice harm minimisation because it is evidence based health maintenance and promotion.

For the same reason, I have supported half way houses for drinkers who are unable to reintegrate easily into their community, supported needle and syringe programs to reduce the spread of HIV and hepatitis, supported night shelters and booze busses so men who drink heavily do not crash their cars or go home to terrorise their families, and I talk to my patients and community honestly about these matters, avoiding at all costs the shock-horror approaches proven to be so counterproductive but much admired by quick fix adherents. Those who would condemn me, and my many medical, nursing and other colleagues, for doing these things must do better than offer glib catchphrases and empty rhetoric about "harm prevention" and zero tolerance, or blaming us for being a "treatment industry". This is serious medicine where people live and die, and we practice by the same standards as do our colleagues in other health fields. Our patients, their families, and the community will enjoy far better health and better value for their money when we as a community grasp the nettle and manage people with D&A problems in a health care rather than legislative environment.

Conclusion and recommendations

From the point of view of a rural clinician working in this field, I would like to make the following concluding remarks and recommendations:

- Our current approaches have not worked well, do not stem from good data or evidence, and represent a poor investment. Change is needed. Treatment of D&A use problems by the health care field shows good evidence of benefit in both harm reduction and health promotion, and represents a good investment. Whilst careful monitoring continues in a non-partisan environment, it is prudent to shift the funding balance in our response to illicit drugs away from the current mix (93% prohibition vs 3% treatment) towards a 50:50 mix initially, shifting money away from interdiction, police and prisons and into better evidence based prevention, early intervention and treatment services.
- At the same time, evidence based community building strategies need to be funded and run for at least a sufficient time to generate reliable data on benefit and, if found effective and efficient, they should receive recurrent budgetary commitment. Currently, universal early childhood intervention and home visiting have good evidence of benefit, including reduced crime, reduced drug use and higher employment in those receiving the intervention. Some results are measurable by age 3-5 years, so that even those committed to short funding time frames could see a change.
- Trials must continue seeking ways to attract into treatment those high risk people who do not benefit from existing health services. Targeting drug use alone, even in a health setting, is not appropriate. Many citizens who use drugs do not have problems, whilst many people who have problems do not use drugs. Many people suffer problems in many areas of their life, and they should not have to triage their own poorly defined, interconnected problems before they can access services. Offering attractive accessible services where people live and work is a prudent investment in health. This will involve reaching young people, homeless people, Indigenous people, rural people and others who currently often miss out on good health care, and will demand commitment, staff who are well trained and supported, a longer time frame than is often the case, and rigorous evaluation to guide future services. Rural areas in particular need a new funding model and a greater involvement of local health workers and communities, rather than city centred models focussed more upon control and damage containment than upon services.
- The physical and sexual abuse of children remains the cause of a substantial proportion of mental health and D&A problems. Current research shows us that feelings of deep anger and betrayal, difficulties with affect regulation and discomfort with intense feelings underlie many of these problems, perhaps 60-80% of D&A problems, for example. It would be foolish to think these issues can be addressed easily. But it would be a further betrayal of already hurt people to blame them for their problems and let this Standing Committee avoid the issue of abuse altogether. In clinical practice, D&A problems and

sexual abuse co occurring is the norm. We need an evidence based approach to tackling this problem as a matter of urgency.

- Most importantly, we need to decide whether Australian citizens who use drugs are first and foremost our citizens, at times in need of our understanding and help, or whether they are evil and in need of punishment. Interestingly, when ardent hard liners have a personal drug problem, or a loved one with a problem, they almost always choose a compassionate, understanding health care approach as opposed to a punitive one. It is more logical, honest, compassionate and health promoting to do likewise for all our citizens, and it represents far better value for money than our current rather confused approach.

I trust the members of the Standing Committee find this submission of some interest and value. I have been both privileged and challenged by gaining insight into the complex health problems of rural people over the last 30 years. It places upon me a burden to improve their lot to the best of my abilities, and this submission represents a small part of that process. I hope you will consider these issues honestly and carefully.

A R MacQueen

March 2007