T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 13 November 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Mark Gepp
Ms Fiona Patten
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Witness

Ms Moira Hewitt, head, tobacco, alcohol and other drugs unit, Australian Institute of Health and Welfare.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I declare open this public hearing of the Parliament of Victoria's Law Reform, Road and Community Safety Committee, where we are holding the last of our public forums in regard to our inquiry into drug law reform. The first person we are hearing from today is Moira Hewitt, who is head of the tobacco, alcohol and other drugs unit within the Australian Institute of Health and Welfare. We thank you too for the submission that you have provided to us. You may have heard that we have had over 220 written submissions. We have been holding public inquiries for quite some time now to this stage, today, and we are certainly looking forward to the advice that you have got to offer from your area of expertise. You would be aware that we have got Hansard here recording what is being said, and in a couple of weeks a draft transcript of the discussion that we will have will come to you to correct or check for any errors. Other than that it will go on the public record as part of our hearings. So, welcome, I think that is all I need to provide by way of advice, but what we are looking for is for you to perhaps provide an overview of some of the key issues that you think are relevant to our committee, backing up the information you have already provided, and then we will enter into a discussion from there, so over to you.

Visual presentation.

Ms HEWITT — As noted, my name is Moira Hewitt. I am head of the tobacco, alcohol and other drugs unit at the Australian Institute of Health and Welfare. The AIHW was formed 30 years ago under the Australian Institute of Health Act 1987. It is an independent statutory authority of government, and the vision of the organisation is stronger evidence, better decisions, improved health and welfare, and our purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians. We manage a very large number of health and welfare datasets and a number of key surveys, including the National Drug Strategy Household Survey. We publish over 180 reports each year.

As an overview of the National Drug Strategy Household Survey, it has been conducted since 1985. The 2016 survey is the 12th in the series and the seventh one to be managed by the Australian Institute of Health and Welfare on behalf of the Department of Health. The fieldwork for the 2016 survey was conducted from June to November last year. It included people aged 12-plus, but the primary group was 14-plus in age — so a slightly shorter survey for the 12 and 13-year-olds — and it targets Australian households (one person per household selected). It is the most comprehensive and authoritative survey on drug use and prevalence, and it also captures information about people's perceptions and support for different policies in Australia. It uses a drop and collect method to collect the surveys. Roy Morgan is the fieldwork provider. They have staff that go out and drop off the survey and then go back and collect it, but there are multiple options for completion — paper, online or by telephone.

There are some limitations. It is a household survey, so it will exclude non-private dwellings, institutional settings such as drug and alcohol rehabilitation centres and prisons, homeless people, so some marginalised groups that have high illicit drug use might not be captured. However, biases in the survey are likely to be consistent over time, so it may not impact on prevalence, but, because it is reporting often illegal behaviour, it is likely to be underreported. As certain behaviours become less socially acceptable, underreporting may increase over time as well.

For a survey, lots of surveys are finding declining response rates, but to get a response rate of over 50 per cent in a sample survey, particularly when you are looking at the length of time this particular survey takes to complete, at 50 minutes, is really excellent and means that the data is very robust and reliable. So those were the total sample sizes (referring to slide 5 in presentation), highlighting that in 2016 we had over 23 000 and a response rate of 51.1 per cent, which is actually an improvement on both the 2013 and 2010 surveys. In Victoria the sample size was 5599, and that included a booster sample requested by Victoria of 500.

Ms PATTEN — What does that mean? So we just wanted more people? We wanted a bigger sample?

Ms HEWITT — Yes, you wanted more people. What it means is when you have got a low prevalence use of drugs it is very hard to break that down to lower levels and look at particular population groups. For example, if you have got a higher sample size, you are going to be able to get better disaggregation.

What I have got here (slide 8 in presentation) is just looking at some of the results comparing Victoria to Australia. Similar to the national trends, 15 per cent of Victorians aged 14 and over — most of the data refers to 14 and over as well, I will say that, rather than the 12-plus here — had used an illicit drug in the previous 12 months. Although this proportion did not significantly increase from 2013 to 2016, there has been a gradual

increase since 2007 from 12.8 to 15 per cent, and the number has increased from about 540 000 Victorians in 2007 to 750 000 Victorians in 2016.

This is looking at illicit drug use by age group (slide 9 in presentation). Victorians in their 20s continue to be the most likely age group to use illicit drugs, with three in 10 doing so in 2016, and that is also consistent with what you would find in Australia — that is, the younger people are more likely to use illicit drugs. However, recent illicit drug use amongst Australians in their 40s has increased between 2013 and 2016 from 13.6 to 16.2 per cent, and there was a similar increase amongst Victorians in their 40s from 11.8 per cent to 15.1 per cent. However, that increase was not significant, again probably because of the low numbers and the reliability of the data. Using cannabis in the previous 12 months significantly increased among Victorians in their 40s from 7.2 per cent in 2013 to 10.3 per cent in 2016, and Victorians in their 20s were about two times as likely to use cannabis as people in their 40s — that is, 22 per cent compared to 10.3 per cent.

The most commonly used drugs in the previous 12 months amongst Victorians aged 14 and older were cannabis at 9.9 per cent; misuse of painkillers or opioids at 3.4 per cent; cocaine, 2.5 per cent; ecstasy, 2.4 per cent; tranquilizers and sleeping pills, 1.7 per cent; and methamphetamines, 1.5 per cent — that includes ice as well. Some drugs, however, were used more frequently than others. So, for example, very few cocaine or ecstasy users used the drug as often as weekly, but about 15 per cent of methamphetamine users would use it weekly or more often.

Ms PATTEN — Just to clarify, for example, with the cannabis, it is 29 per cent of that 9.9 per cent. Is that right?

Ms HEWITT — Yes, that is right.

Ms PATTEN — Then that is 1.8 per cent of that 2 per cent.

Ms HEWITT — Yes, that is right. So the 15 per cent of the methamphetamine users. Yes, so it is people who use and then that percentage. I think the key point, though, is with the ones that use it more frequently, like methamphetamine, it actually means it is used more commonly than, say, ecstasy and cocaine, even though overall —

Ms PATTEN — Yes.

Ms HEWITT — As I mentioned before, one of the key things we ask is about people's perceptions around drug use and their support for different policies. So we asked them how strongly they would support or be opposed to specific measures aimed at reducing problems associated with illicit drug use, using a 5-point Likert scale, and only those who said they supported or strongly supported the measure were taken as support for each policy. People who indicated that they did not know enough about the policy to give or withhold support were excluded from the analysis. Similar to national findings, the Victorian community showed an increased intolerance for cannabis use, with more Victorians supporting legislation and fewer supporting penalties for sale and supply. More people also supported cannabis being used in clinical trials to treat medical conditions. That was up to 87 per cent from 76 per cent. They also supported a change in legislation permitting the use of cannabis for medical purposes, up to 84 per cent from 69 per cent in 2013.

Participants in the survey were also asked how they would theoretically distribute a $100 budget to deal with illicit drug issues. The priorities of Victorians aligned conceptually with the three pillars of the national drug survey. We looked at how, say, a hypothetical $100 should be split between education, treatment or law enforcement to reduce illicit drug use. Overall, law enforcement received the greater proportion of the allotted $100. However, a lower proportion of funds was allocated to law enforcement in 2016 than 2013, and a greater proportion was allocated to treatment. The education budget stayed around the same.

They are the main points that I have captured in the presentation, and there is some specific data relating to Victoria in the tables in the attachment. We also have the detailed findings report, which has a state and territory chapter, and I think there is a summary sheet — a handout, like a flyer — with a fact sheet for each state separately that points out similar things to what we have highlighted in this attachment that we have given you.

The CHAIR — There is certainly a lot of useful feedback in that that we will find very interesting. I noticed also in the other notes that as well as the survey you have also been keeping statistics on a range of other areas

such as treatment, how treatment is being utilised and availability and so on. I was particularly interested in the issue of pharmacotherapy and methadone treatment facilities. Although you have not got this year's statistics, you did have last year's.

Ms HEWITT — We have got the 2016 out. The next one will be out probably April next year or March next year.

The CHAIR — Can I just check what the trend is showing on that particular area too, are you aware, in terms of availability of services and those seeking services? Did you have any feedback on that?

Ms HEWITT — For specific drugs or for methadone treatment?

The CHAIR — For methadone treatment.

Ms HEWITT — I would have to take that on notice and give you an answer to that.

The CHAIR — Thank you.

Mr THOMPSON — Thanks very much for an excellent presentation. I am just trying to interpret the data. In terms of increase, where has been the greatest increase over the last 12 months in use? Contrasting experimentation at one level used in the last 12 months, you might get one interpretation. Say in the case of cocaine, it is used weekly or more often but there is not a prevalent widespread use. Interpreting the data, where has been the chief increase in drug use over the last 12 months?

Ms HEWITT — I could not specifically say if it was an increase. I think the cannabis was the drug that had the increase. I would have to look at them closer together. But just comparing, say, the cocaine and the ecstasy with the methamphetamine directly, you are going to have more methamphetamine used over the last 12 months due to the frequency than you are with the cocaine and the ecstasy, but I have not got the figure exactly. It would probably be in one of the attached tables. I can take that on notice and get you some more detail if that is useful.

Mr THOMPSON — Thank you.

Ms PATTEN — Just generally speaking, we keep hearing, and certainly in the media, that we need more treatment beds. Is that confirmed by your surveys? Some people say we need more treatment beds; others would say actually we need more treatment at a lower threshold.

Ms HEWITT — The treatment data is not a survey; it is administrative data. None of that is included in here. We can get some treatment data for you. The number of treatment episodes has gone up over the years, certainly at the national level. We can also look at clients that are receiving treatment. We certainly know that alcohol is the main drug of concern for treatment. We know that pharmacological misuse is increasing as a treatment. I would say that the treatment echoes the patterns we find in the survey. So what is increasing in the survey is certainly increasing in what is coming through for treatment. But if you want more specific data, I would need to take that on notice.

Ms PATTEN — Yes. I am just wondering, when you do those surveys, does it actually highlight any gaps in the treatment?

Ms HEWITT — It does not.

Ms PATTEN — Yes, this does not, so it just really sort of gives you a snapshot of what is available.

Ms HEWITT — It is about prevalence, and it is about attitudes and perceptions.

Ms PATTEN — So it is not looking at waiting lists.

Ms HEWITT — No, it does not look at waiting lists. Even with the treatment services, I think some of the individual jurisdictions have ways of looking at waiting lists. We are doing some work at the moment where we are looking at developing data standards for waiting lists that we can apply nationally and also for outcomes of treatment that we can apply nationally, but it will probably be two years or so before we can start seeing data come through for anything like that.

The CHAIR — But your survey appeared to show that people's perceptions are favourable to increasing the amount of funding that goes to treatment as opposed to law and order.

Ms HEWITT — That is right, yes, and reducing harm. So the focus is similar to what the pillars are in the national drug strategy.

Mr DIXON — Do you ask a specific question about injecting rooms?

Ms HEWITT — No, not in this survey.

Ms PATTEN — Did you ask one years ago?

Ms HEWITT — There might have been. I have only been involved in this most recent survey, so I am not sure entirely. I can find that out for you, though.

The CHAIR — In drug use, can I just ask, I see in terms of the survey it appears to show that for the 14 to 19-year-olds the amount of drug use has dropped in the last three years or progressively over the last six years, whereas it has gone up for the 20 to 29-year-olds. Is there an explanation as to why that might appear to be the case?

Ms HEWITT — That seems to be a trend not just for illicit drug use but also for alcohol use and a whole range of different social issues as well.

The CHAIR — So we do not know whether it is as a result of better education or younger people's better sense of understanding of the dangers of some of these things.

Ms HEWITT — No. I think it is something that needs further exploration. That said, though, different drugs are more prevalent in different age groups. Cannabis in the younger people is more prevalent, and methamphetamine tends to be more prevalent in the 20 to 30-year-old age group. Alcohol is more prevalent in your older age groups.

Mr GEPP — Moira, does your organisation have any conversations with other jurisdictions — police, for example — about comparing the results that you are seeing coming through your survey with their experiences on the ground or any published statistics that they might produce? It could be medical. It could be criminal justice.

Ms HEWITT — Not directly, but we are doing a piece of work where we are pulling a whole lot of other statistics together. The main focus is on health. This piece of work is funded by the Department of Health. We are going to be working with the ACIC and the AIC in relation to that piece of work and using illicit drug data and some of the arrests and seizures data to try and get a better picture overall at a national level of what is happening.

Mr GEPP — Just to confirm, I think it is already in the observations, or the statistical reporting in the observations, but what we have heard frequently throughout our inquiry is that there is certainly a bit of a theme about shifting away from the criminal justice system as the first port of call, which has I guess traditionally been the place where illicit drugs have been handled, to more education in harm minimisation through health strategies et cetera. Would you say that your statistics support that sort of approach?

Ms HEWITT — They support that approach but, as you will notice, support is still higher for law enforcement.

Mr GEPP — Yes, of course.

Ms HEWITT — And also it depends on the particular drug too. So I think there is, for example, more support for law enforcement issues around methamphetamine than there is, say, around cannabis, for example.

Ms PATTEN — Just following on from that question, looking at the policy survey particularly around cannabis, it seems that the legalisation of cannabis has gone from 25 to 34, so a 9 or 10 per cent jump, and actually it is the same with almost all of them. Is this an unusual change over a three-year period? It seems to me that it is quite a —

Ms HEWITT — No, I do not think it is necessarily. I think —

The CHAIR — The previous periods were —

Ms PATTEN — That is right, and then it looks like on this data there is quite a jump from 25 to 34.

Ms HEWITT — Well, interestingly, certainly at the national level, for most Australians — not Victoria but the national level — methamphetamine has become the drug of most concern, rather than alcohol. More people think it is an issue in terms of deaths than, say, tobacco, so perceptions are often driven more by what is in the media than by what is happening out there.

Ms PATTEN — That is right.

Ms HEWITT — I would suggest that the cannabis issue is driven by a lot of what has been happening around medical cannabis as well.

Ms PATTEN — Is this any different to the national —

Ms HEWITT — That is similar to the national level.

Ms PATTEN — So Victoria is not different in this.

Ms HEWITT — Yes. I think Victoria might have the highest use of cannabis, compared to some other jurisdictions. I think WA had a higher methamphetamine problem, so individual jurisdictions have different drugs that have peaked, but in terms of the national level, and if you are comparing to national, that was similar.

Mr GEPP — Just on that, on page 9 of your report about the cohort of 60-plus, I noticed that although it is still relatively small compared to the others, your statistics are suggesting a 75 per cent jump from 2010 to 2016 in the number of 60-plus-year-olds using illicit drugs.

Ms HEWITT — Yes. We think there is an ageing cohort of drug users, so we are trying to do some further analysis looking at people that were a certain age in 2001 and what has happened with their use. That is still a bit of a work in progress that we have got —

Mr GEPP — I would have assumed that if they had been moving through, we would have seen similar sorts of reductions et cetera in the 50 to 59 group, but the change has not been as volatile in terms of —

Ms HEWITT — No. We think it is a birth cohort effect, so we are looking at that in more detail.

The CHAIR — Can I ask, too, in terms of your funding, are you fully federally funded or do get funding to do your surveys and different work from different sources?

Ms HEWITT — We are fully federally funded for —

The CHAIR — And so you put forward proposals for further survey work to be approved and you would go through the system that way.

Ms HEWITT — Yes.

Mr THOMPSON — Just in terms of the survey work, your survey response of 50 per cent is a prodigious result. What is the background to that survey success?

Ms HEWITT — Very good people who understand survey methodology. I think we have got a very good fieldwork provider that understands how to do the sampling et cetera. I think it is a topic that the community are interested in too, so they seem to be willing to spend that time on doing it because there are no incentives given with it. We have looked at that to try and improve certain targeted response rates, but it is fraught with a lot of ethical issues. I think it is about approaching it via the right methodology, but it is also the follow-up that we do to get the response rates we have —

Mr THOMPSON — And is it done by direct access, say, through the Imperial Hotel or La Trobe University or North Richmond —

Ms HEWITT — No.

Mr THOMPSON — How do you —

Ms HEWITT — So the department fund us and we manage the surveys. We put out a tender for a fieldwork provider to go out and do the fieldwork. For the last seven or eight surveys it has been Roy Morgan Research that have done that fieldwork for us, but they work rigorously with us to do that sampling methodology and do that follow-up. They train people — their collectors. We have a technical advisory group that does the questions; they do not draft the questions for us. We —

Mr THOMPSON — Is that across Victoria or metropolitan Melbourne? It is a pub or club somewhere where you —

Ms HEWITT — No, it is households. They go to households and drop it off at households, and then they select the person in the household by the birth date. There is a rigorous selection procedure for how you select which person will do it so that it is all random sampling.

The CHAIR — To get a broad coverage across the state.

Ms HEWITT — That is right, yes.

Mr GEPP — So you do not target particular areas? You do not pick Mildura, for example, and say, 'We want a particular sample size from that community'?

Ms HEWITT — No, I think there is a minimum. I can get you some more detail on the exact sample procedure that we use, but we target statistical areas level 2 and SL1s across a certain geographical spread. I think if —

Mr GEPP — That was a bit related to my earlier question, because we hear it in the press and we hear it from different organisations that there might be a particular part of the state which may have a —

Ms HEWITT — Yes. It is done so that you get reliable data at the national and state levels. I do not know if they have in the past with the National Drug Strategy Household Survey, but theoretically — that is why some states boost their sample — to get a bigger sample so you can get a better disaggregation. There is no reason why you could not theoretically target it at certain areas, but it becomes more expensive. You are going to have to have a bigger sample and a larger pot of money to do it. And it is more a problem for your lower prevalence drugs than for the drugs that are used with fairly high prevalence. There is a detailed explanation of the methodology in the detailed report.

Mr GEPP — Oh, is there? Okay. I will have a look. Thank you.

Ms HEWITT — Yes, and we are happy to take any further questions on notice about that.

Ms PATTEN — Can I just go back to your treatment surveys? Do you actually identify how people come into the treatment, so whether they come in through the Drug Court or —

Ms HEWITT — First of all, it is an administrative dataset, not a survey. It is similar, I guess, to the hospital dataset, so it is an episode-of-care dataset. But, yes, we have information on referral — who the people are referred by where they were referred from.

Ms PATTEN — Do you happen to have that off the top of your head?

Ms HEWITT — No, I do not. If you have got internet access, I could go online and pull some of the data from last year down.

Ms PATTEN — Yes. It would be interesting to see how people are coming into the treatment programs.

Ms HEWITT — Yes.

The CHAIR — We could track that down.

Ms HEWITT — If that is of interest, we could certainly prepare some information along those lines.

Ms PATTEN — It would be of interest. and I guess if there have been any significant changes in those pathways to check that.

Ms HEWITT — In the referral pathway?

Ms PATTEN — Yes.

Ms HEWITT — Yes, it would be interesting.

Ms PATTEN — That would be great.

The CHAIR — Thank you very much. That is a very nicely presented and easy to absorb dataset that you have presented to us today, and obviously there is more that we might want to drill down on. As Fiona has indicated, that would be useful to help us get a picture in regard to the treatment area, which is clearly a significant part of our deliberations.

Ms HEWITT — Yes, certainly. Great.

Ms PATTEN — I just want to thank you.

Ms HEWITT — Thank you.

Witness withdrew.